THE STEPHEN GROUP

LB 1173 WORK GROUP

Strategies and Recommendations Supporting the Practice and Finance Models

Legislative Work Group Report

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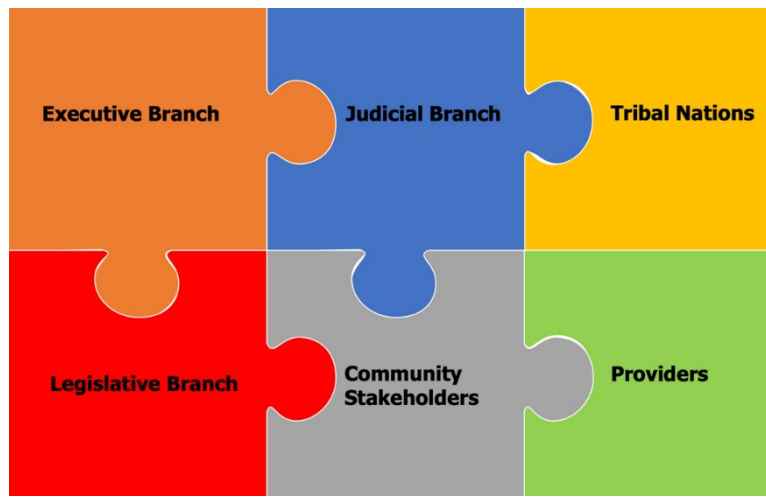


Intersectoral Engagement

Table of Contents

Executive Summary 1

Purpose and Scope 1

Building On Prior Effort and Success 3

Methodology 3

Overview 3

Research and Evaluation 4

Project Kickoff 4

Engagement 5

Collaborative Framework Development 7

Finance Sub-Work Group 8

Work Group Meetings & Presentations 9

Key Highlights &Themes 11

Recommendations and Strategies for Future Transformation 17

I. Enhance primary prevention strategies by creating a Community Response Pathway 18

A. Develop and Support an Effective Community Pathway for At Risk Children and Families 20

B. Establish a Warm Handoff to the Community Response Pathway for Screened Out Calls 23

C. Establish a Family Support Warm Line 25

D. Use the Community Response Pathway as Referral Source for Certain Families Seeking Economic Assistance at DHHS 25

E. Involve Community Response Pathway in Coordination with the Medical Provider Community as a Pathway for Parents with Pre-natal Risk or Children 0 to 5 Years of Age 26

F. Leverage Existing Community Collaborative Structure as the Community Response Pathway Hub 28

G. Shift Child Abuse Hotline Practice to Connect Reporters with Supportive Family Resources through the Community Response Pathway 32

H. Develop a System to Measure the Quality of Service and Work of the Community Response Pathway 32

I. Consider Expanding Primary Prevention Approach to Schools and Ensure Connection to Community Response Pathway 34

J. Expand the Reach of Evidence Based Home Visiting Programs Aligned with Community Response Pathway 36

K. Focus on Adding Home Visiting and Parenting Classes for those Families with Children After Kindergarten 38

L. Expand Efforts to Educate Families about Critical Prevention Focus Statewide 38

M. Consider Utilizing Community Pathway as a Standalone Evidence Based Intervention Meeting Title IV-E Federal Clearinghouse Standards in Future 39

N. Continue Focusing on Reducing Disparities, Including Offering Services Through the Community Response Pathway That Are Tailored to Meeting Families Cultural/Linguistic Needs 40

II. Continue Efforts with Alternative Response, and In-home Evidence-Based Interventions 41

Alternative Response 42

In-Home Services 43

This Focused Effort Has Resulted in Reductions in Foster Care Entries 44

A. DHHS Continue to Provide Alternative Response 47

B. More Focused and Coordinated Effort Is Needed on Enhancing Timely Exits from Foster Care, Including Sustained Engagement of Intersectoral Partners 48

III. Develop Skilled and Responsive Workforce 53

Workforce Training 54

Nebraska Children and Family Services Child Protection & Safety New Worker Training Overview 55

Nebraska New Worker Training Survey 57

Trends in Child Welfare New Worker Training 60

A. Work Group Recommended Strategies for CFS New Worker Training 64

CFS Workforce/Caseload Review 65

B. Work Group Recommendation for CFS Caseload 72

C Work Group Recommendation for CFS Salary 76

D. Workgroup Recommendations for More Effective Recruitment, Selection, and Retention 81

1.Recruitment 81

2. Selection 82

3. Retention 82

IV. Maximize the Value of Existing Medicaid and Create Additional Opportunities and Innovation to Meet Gaps in Service 83

Managed Care Organizations as Valuable Intersectoral Partners 83

A. MCOs Need to Be Held Accountable in the New Child Welfare System 84

B. Preventative Care Collaboration: MCOs Should Collaborate with Pediatricians 89

C. Expand Efforts to Educate Communities About MCO Services to Children and Families Statewide 90

D. Medicaid State Plan Amendments Should Be Considered to Reduce Barriers and/or Cover Additional Services as Part of a New Child Welfare System 92

E. Consider Medicaid Provisions Where Evidence Can Be Demonstrated on Financial Budget Neutrality 95

F. Consideration Should be Given for a Future Specialized Foster Care MCO Program as Part of Child Welfare Practice Transformation 97

G. Create Solutions Where Intersectoral Partners Can Share Critical Member Data 99

H. Areas of Opportunity 100

V. Enhance the Accessibility of Behavioral Health Services for Children, Youth, and Families Engaged with the Child Welfare System 103

Community Feedback: Behavioral Health Services for Children, Youth, and Families Engaged with Nebraska CFS 104

A. Consider Existing and Effective State Models for CMS Behavioral Health/Substance Use Disorder/Serious Emotional Disturbance Waivers in Future Child Welfare Transformation 108

B. Recommendations for Future Child Welfare Transformation 116

1. Consider Aligning Behavioral Health (Mental Health and Substance Use Disorder) Services Definitions Across All Departments 116

2. Consider Assessing all Existing Spa and Waiver Services Definitions and Credentialing Requirements 116

3. Consider Developing and Implementing a Comprehensive Behavioral Health, IMD Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver 116

4. Consider a Waiver Administrative Platform of an Administrative Services Organization 117

5. Expand Opportunities for the Regional Behavioral Health Authority System to be a vital partner of the future child welfare transformation 118

6 Consider the Professional Partnerships program as the Statewide HUB 119

7. Consider Developing a Method that Balances Currently Appropriated RBHA Funding with New and Revised Financial Income Guidelines that are More Flexible..... 119

VI. Additional Child Welfare Practice Recommendations 120

A. Increase Efforts to Address Disproportionality 120

B. Continue to Expand Authentic Engagement of Those with Lived Experience..... 123

C. Continue to Engage Tribal Nations During LB 1173 Transformation..... 124

D. The Crossover Youth Practice Model is Effective and Aligned with the LB 1173 Child Welfare Practice Model and Should Continue To Be Implemented in every Region Statewide. 127

E. Consider Implementing Douglas County Youth Impact! Initiative Statewide for Cross Over Youth 129

F. All child welfare system stakeholders should continue to collaborate and work on LB 42 to redefine the definition of Neglect. 131

G. Enhance Collaboration, Communication and Partnership with County Attorneys..... 134

H. Concrete and Economic Supports As Part of New LB 1173 Child Welfare Transformation 136

I. Enhance Family Peer Support 137

J. Consider Expansion of Lancaster Family Treatment Drug Court Model 140

K. Consider Improvements to the N-Focus system Functionality to Guide Future Case Worker Decision and Support..... 142

L. Consider Changes to Drug Testing Policy that Promotes Safety and Accountability.... 144

M. Future Performance Measures to Consider In Evaluating Success of LB 1173 Child Welfare Practice and Finance Model..... 146

Appendix A - List of Community Sessions and Surveys..... 147

Appendix B – Full-Service Community Schools 2021 – 2022 Evaluation Report..... 148

Appendix C – Matrix of Neglect Definitions 172

Appendix D County Attorney Survey Results..... 188

Appendix E - Comparison Matrix of the Nebraska DCFS 2017, 2018 and 2022 Proposed Policy Regarding Drug Testing 199

Executive Summary

(To be drafted upon approval of final draft of LB 1173 Practice Model and Finance Model).

Purpose and Scope

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

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

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

1. The DHHS Director of the Division of Behavioral Health or the director's designee
2. The DHHS Director of the Division of Children and Family Services or the director's designee
3. The DHHS Director of the Division of Developmental Disabilities or the director's designee

4. The DHHS Director of the Division of Medicaid and Long-Term Care or the director's designee
5. The DHHS Director of the Division of Public Health or the director's designee
6. The Commissioner of the Nebraska Department of Education (NDE) or the commissioner's designee
7. The State Court Administrator
8. A representative of the state Judicial Branch to be appointed by the Chief Justice; and
9. Representatives from each federally recognized Indian tribe within the State of Nebraska, appointed by each tribe's Tribal Council or Executive Committee

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

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

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

Building On Prior Effort and Success

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

Methodology

Overview

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

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

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

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

Research and Evaluation

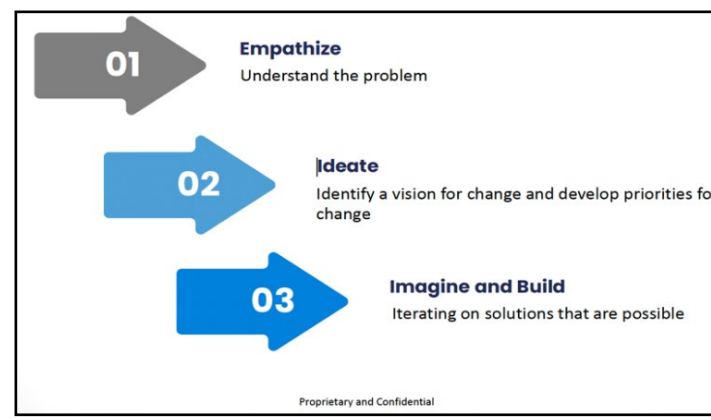
In order to lay a foundation of understanding the current state of child welfare in Nebraska as well as previous work done, information requests were sent to DHHS to gather data, reports, state funding information, and other resources. Work was also done to assemble other necessary background information. This process included the review of numerous reports, statutes, best practice briefs, as well as other materials, along with a detailed assessment of current child welfare practices, functions, conditions, and partners.

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

Project Kickoff

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

Design Thinking Model



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

Engagement

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

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

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

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

May 31 Kearney Community Forum

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

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

Collaborative Framework Development

As these engagement sessions and individual meetings occurred throughout the state, the Work Group held monthly meetings to discuss the project, learning and insights from stakeholder engagement, and to hear from experts on topics such as prevention work in communities, disproportionality in the Nebraska child welfare system, juvenile probation in Nebraska, Medicaid and behavioral health services, and education efforts in Nebraska. The full Work Group meeting schedule, with agendas, presentation and materials, can be found on the Reimagine Well-being Work Group website[1]. Work Group meetings and their related materials were subject to the Open Meetings Act and comported with these requirements, including required notice and the opportunity for public comment. These meetings drew the attendance of not only voting members of the Work Group, but also ex-officio non-voting members, DHHS staff, and members of the public, with the option of attending and participating virtually.

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

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

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

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

June 1st Work Group Meeting

Finance Sub-Work Group

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

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

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

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

Regular progress updates were provided to the Work Group members and stakeholders attending the Work Group Meetings. During these meetings, they were

offered the opportunity to ask questions, provide comments, and have discussions pertaining to key findings and each recommendation being presented. Updates on this work, including progress reports, next steps, and upcoming meeting dates were also included in monthly status reports.

Work Group Meetings & Presentations

Monthly LB 1173 Work Group meetings were an opportunity for the Work Group and stakeholders to hear from subject matter experts, ask questions, provide input, move deliverables forward, discuss critical concepts for developing the Practice and Finance Models under LB 1173. Below is a schedule of Work Group meetings beginning in February along with agenda items and presentation titles. Full presentations from each Work Group meeting can be found on the Reimagine Well-being Work Group website.[3]

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

Agenda Topics & Presentations	• **Practice Strategy Presentations**
	  ○ Collective Engagement: "*Collective Engagement*" presentation, CEO Smith, DHHS; "Prevention"
	  ○ Prevention: "*Community Well Being Collaboratives*" presentation, Jennifer Skala, Executive Vice President Nebraska Children and Families Foundation
	  ○ Family First Prevention Services Act: "*FFPSA Implementation in Nebraska*" presentation, Jamie Kramer, DHHS Children and Family Services Administrator
	  ○ Public Health: Presentation by Charity Menefee, DHHS Director of Public Health
	  ○ Best Practices: "*Community Pathways and Innovations*" presentation, The Stephen Group
	• **Work Group Discussion of Practice Strategies**
	• **Finance Update**, David DeStefano, The Stephen Group

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

	• **Mission, Vision, Values, Priorities:** draft based on stakeholder meetings, findings from previous and ongoing work on the child welfare system in Nebraska, The Stephen Group
May	

Agenda Topics & Presentations	• **Practice Strategy Presentations**
	  ○ "Children and Family Services: Case Management Work Flow" presentation, Suzanna Borowski, Protection & Safety Administrator, Children and Family Services, DHHS
	  ○ "Nebraska Juvenile Justice System Map" presentation by Kari Rumbaugh, Assistant Deputy Administrator for Juvenile Services, Administrative Office of the Courts & Probation
	• **Disproportionality**
	  ○ "Safe, Strong, Supportive: A journey through Nebraska child protection system" presentation, Steve Ellis, Data Advocacy Analyst, Casey Family Programs
	  ○ "Disproportionality in Nebraska Child Welfare: The Community Speaks" presentation, Sharon R. Williams, The Stephen Group
	• **Finance Work Group Updates**, David DeStefano, The Stephen Group

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

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

August	
Agenda Topics & Presentations	• **Emerging Themes**, John Stephen, The Stephen Group • **Training Recommendations**, John Cooper, The Stephen Group • **Finance Update** • **Regional Behavioral Health System Overview**, Tony Green, Director of Behavioral Health, DHHS

	• **Professional Partners Program**, Patti Jurjevich, Regional Administrator, Region 6 Behavioral Healthcare • **Future State Front End Prevention**: "Community Pathways Prevention: Future State Prevention Model" presentation by John Stephen and David DeStefano, The Stephen Group
September	
Agenda Topics & Presentations	• **Themes from Lincoln Community Forum** • **Education as Primary Prevention**, Dr. Zainab Rida and Lane Carr, Department of Education • **LB 1173 Final Report Framework**, John Stephen, The Stephen Group
October	
Agenda Topics & Presentations	▪ **Draft Child Welfare Practice Model, Finance Model and Supporting Report**
November	
Agenda Topics & Presentations	▪ **Finalize Child Welfare Practice Model, Finance Model and Supporting Report**

Key Highlights &Themes

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

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

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

Workforce	
+ CFS staff turnover is a challenge in many areas of Nebraska, causing	+ CFS and JPO case workers would benefit from knowing

Workforce	
case delays, gaps in knowledge about cases as it is handed from worker to worker, and creating frustration for families, both birth and foster/adoptive. + Staff shortages making it a challenge to keep up with parental inquiries about children's status after placement + Communication issues with CFS case workers in the Omaha region in returning calls to families and updating on case plan + State child welfare staff should respect and understand culture and traditional values. + CFS case workers are not given enough on the job training and case worker burnout/trauma are also issues; need support from supervisors, lack of diversity is an issue. + Trainings/provision of tools for case workers to connect families to resources would be helpful; need for more in-service training on Economic Assistance or Social Supports and on what MCOs can do/assist with. Closed loop referral resources connecting case workers to social services in the community would be a valuable resource tool. + CFS training not adequately preparing case workers to be in the field; low training relevance and application to the job. + Training on the effects of poverty across systems would be beneficial.	expectations/culture of the courts they are working in; would benefit from their supervisors (with knowledge of the court) attending with them for mentoring and guidance as needed. + More focus needs to be paid to case worker safety in the field: cultural issue that everyone thinks CFS can solve all problems. + Offering employment incentives could help recruit/retain younger skilled professional workers. + Adapt training requirements for people with requisite experience. + Workforce/turnover - Increase longevity, stability, decrease turnover, increase diversity of staff/better recruitment, support, professional development, training + Review current CFS training model to ensure workers are receiving quality learning + Comprehensive review of current CFS training recommended. Suggest developing caseworker Toolbox ex. Crossover Policy, "Medicaid 101/How MCOs work," "Economic Assistance 101," accessing Social Determinants of Health (SDOH), Intellectual and Developmental Disabilities and Autism fundamentals + CFS documentation requirements are labor and time-intensive, current technology worsens this issue. N-Focus often requires duplicative information and a time consuming manual process

Prevention	
+ Need for a robust community-based prevention system + Need for a prevention pathway, including a warm line, resources to refer to in the community, without threat of retaliation for parents; this will require more resources and training at local level, including proper screening and assessment tools. Hub prevention resource concept for parents but also MCOs, schools, even DCF hotline + Local prevention pathways to divert hotline calls are critical strategy, but there will need to be the development of a referral structure, additional resources, need for creativity/flexibility on funding of these services and building the infrastructure to implement them.	+ Substance Abuse, Mental Health, and Child Welfare; filing a petition should not be used as the only way to get needed services + Local prevention pathways to divert hotline calls are a critical strategy, but there will need to be the development of a referral structure, ”warm line,” additional resources, need for creativity/flexibility on funding of these services and building the infrastructure to implement them + Funding prevention services is a potential barrier: to fund prevention services, need to identify entities that can get private funding/foundation funding and use for federal match for FFPSA and other federal funds. + Community Collaboratives have built a foundation for a future enhanced prevention model.
Cultural Competency	
+ Invest in culturally appropriate/regionally equitable systems and services/need for more bilingual services, especially in rural areas of state + For representatives of Winnebago, Santee, and/or Omaha tribes, common views of “community well-being” includes more community events (tournaments, dances, “carnivals”), cultural-based events and programs, and culture-centered activities, education, programs, families, and communities.	+ Families with limited English proficiency may not be receiving adequate services/supports. For example, courts have limitations on interpreter services, telehealth services are not available for families/youth with English as a second language. + Outreach to Tribal Nations needs to be better coordinated/strategic; outreach to Tribal Nations needs to be individual to the tribe, not treated like approaching other types of communities—they are sovereign nations. Each Tribal Nation needs

Cultural Competency	
+ "Come to the Tribes" when developing the trust needed; respect the strength of the Tribal Nations; need to build services "inside the Tribal culture" + Culture is a protective factor, but with multi-generational child welfare involvement, trauma-informed approach and more intensive case management may be needed	liaison or point person but need to make sure this is coordinated throughout efforts; more attention has been paid to Tribal involvement by state agencies + Gap in standardized training on cultural competency. + Cultural/language gaps adversely impact family supports
Family Engagement	
+ Broader community support, resources, and involvement for high-risk and special ed children and biological/foster families + Peer support for families is a valuable option for families in Nebraska, but there is often a delay in having peers put in place + Parents sometimes do not know about family peer support, nor do they fully appreciate this service, until months after their child has been removed + Trauma sensitivity in all services and supports to children and families	+ Family Engagement is critical in building protective factors and in reducing the risk of removal + Parents also need to be held accountable: for truancy, child support, meeting case plan elements. + Families should be viewed as the solution + Supports should be designed and delivered with the family early to build on family strength. + Families should be kept together whenever safe to do so
Well-Being	
+ Lack of mental health and substance abuse services (especially in rural areas of Nebraska) + Enhance support for social determinants of health (housing, transportation, food…) + Poverty and lack of resources should not be grounds for removal	+ Medicaid coverage and benefits are unknown, knowledge of resources across systems and within communities are often unknown as well, including how to access services + Medicaid Managed Care Organization care coordination benefit is often underutilized or unknown

Well-Being	
+ Address significant service/support resource access issues in rural counties + There is a need for a statewide community resource page: statewide with county and community data that is streamlined, accessible with cultural translations on food banks, housing help, transportation, etc. + Lack of resources in rural Nebraska. "There is little in our community to tell parents where to go"	+ Economic Assistance (EA) eligibility staff are important assets at the front end to help families in need but not easily accessible to CFS staff early on in the process + Need for more mobile crisis response services, especially in rural communities + Substance Use Disorder (SUD) treatment initiation needs to be expedited/aligned with removal/reunification court orders + Need for greater access to SUD treatment services

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

Authentic Collaboration with Community and Stakeholders	
+ Need to build trust/communication and collaboration with all stakeholders and partners in the community + Involve schools in system re-design + Uniform concern on DHHS enacting policies that impact entire child welfare process without real	+ Building trust with families is a theme throughout the state. + Families are blamed if they can't engage in required services because of a lack of providers so they end up back in front of the Court. + The need for authentic engagement and ethical partnership with youth

Authentic Collaboration with Community and Stakeholders	
"meaningful" engagement and collaboration with courts," This theme was also heard from law enforcement and county attorneys	+ Value lived experience + Value peer support services + Listen to families - co-creation of plans of care
Intersectoral/Stakeholder Relations	
+ Inter and Intra-agency communication and coordination is needed to best serve families and keep a clear line of sight on cases and how to assist and collaborate. + Institution of statewide training/collaboration between CFS and school districts is strongly encouraged + Define key data and performance metrics in collaboration with system partners and use them to drive innovation and change across all systems + Improve relationship with providers, including fair and reasonable rate/performance-based system + Shared accountability across systems + Technology enhancements needed to support caseworkers/interagency partners/providers + Structured and routine training for school system administrators/educators and mandatory reporters on alternatives to mandatory reporting/referral options + Alignment of agency resources (e.g., Medicaid, CFS, Education, Housing, Behavior Health, Developmental Disabilities, etc.) + Improved coordination between Tribal Child and Family agencies and	+ More collaboration is needed between the agencies who are involved in the child welfare system. This includes legal parties, law enforcement, community stakeholders, probation, and education. More collaboration with all of Nebraska state services. Teamwork across the board; should be about the child and all involved. + Providers would like to have access to on-going system of record that can be shared across systems with proper consent + Tribes want more recognition that they are not just communities, but sovereign nations and have their own "agencies" under the law, so any intersectoral focus on LB 1173 should include the Tribal Nations as an "Agency" partner + There is a need for clear lines of responsibility between Juvenile Probation and CFS + Stronger communication and collaboration with the Early Care and Education system - Need to better promote Early Care and Early Education programs for children, including: Six Pence, Head Start, Early Head Start, Migrant Education, Healthy Family America, MIECHV programs.

Intersectoral/Stakeholder Relations	
the institutional system to foster better coordination of Tribal children between the two systems + Enhance current training to include initiatives such as cross-over youth policy, and training on culture and expectation of the Courts, County Attorneys before starting Hearings + Where crossover youth are concerned, there is an effective crossover youth practice model in place. Need for this practice model to be followed more regularly, especially in reviewing cases involving institutional care and lengths of stay to assure least restrictive placements. Need uniformity of training and combining resources needed between juvenile probation and CFS	+ Some providers agree they are paid without having to show meeting measurable performance outcomes but want to be sure that data is transparent and accurate in future if CFS develops a more performance-based system of contracting. Need to restore trust + Judges and County Attorneys open to learning more about FFPSA/Community Collaboratives/prevention work so as to become comfortable with the focus on front end diversion + High level of hotline referrals from school districts may be rooted in risk of legal reprisals for failure to report suspected abuse/neglect. Education will be needed for effective alternative response where safety is not an issue

Recommendations and Strategies for Future Transformation

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

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

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

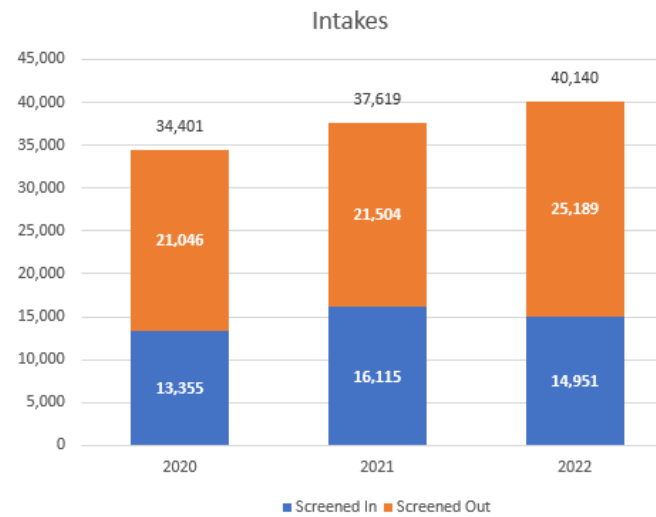
1. Enhance primary prevention strategies by creating a Community Response Pathway so that more and more children at risk of entry or re-entry into the system and their families are provided services that meet their needs in the community
2. Continue efforts with alternative response, and in-home evidence-based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

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

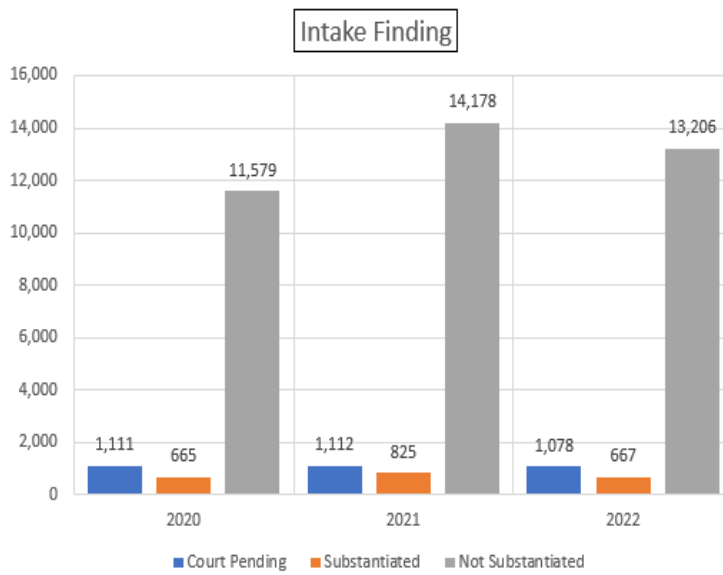
I. Enhance primary prevention strategies by creating a Community Response Pathway

Enhance primary prevention strategies by creating a Community Response Pathway so that more and more children at risk of entry or re-entry into the system and their families are provided services that meet their needs in the community. In the last three years, Nebraska has averaged over 37,000 reports to the child abuse and neglect hotline. As can be seen by the data received by DHHS, approximately 60% of

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



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



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

This pattern has been consistent for years in Nebraska and has not changed. Thus, most of these reported cases that are screened out are for children and families that could benefit by support in the community in which they live. With such support,

reports of abuse and neglect may also reduce where mandatory reporters recognize an effective community response to poverty, mental illness or financial stress.

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

LB 1173 Prevention Vision: Enhance Protective Factors

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

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

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

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

In the current child welfare approach, the majority of services are provided after abuse and neglect is reported. In substantiated cases, most resources are directed toward out-of-home care, reunification, adoption, or another permanency option, rather than on "front-end" primary prevention prior to public child welfare

intervention. Child welfare agencies are challenged to respond effectively to complex needs of children and families for a variety of reasons, and there is often a lack of collaboration among intersectoral partners in the primary prevention area further limiting family awareness and access to local services and resources.

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

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

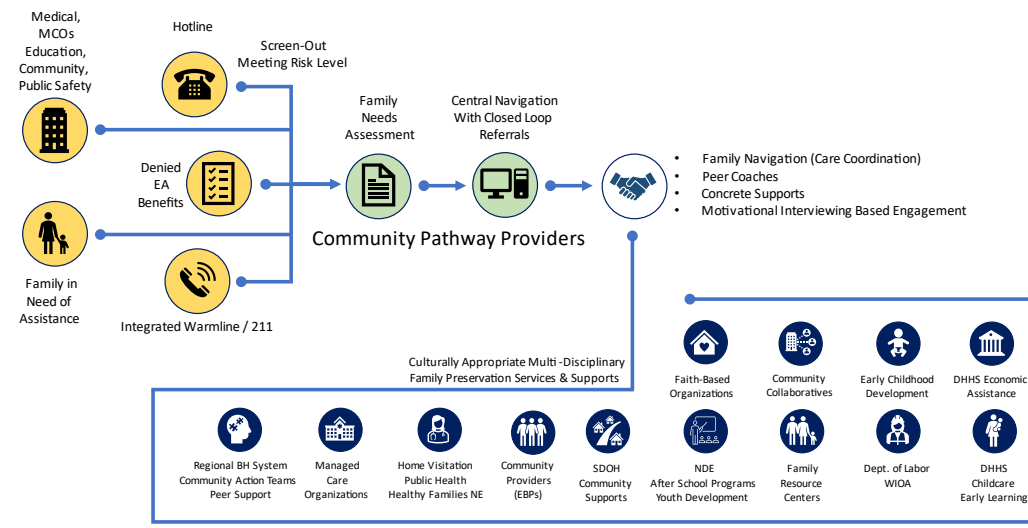
These referrals can be parents with no or poor compliance with pre-natal care, a single parent, primary caregiver under 21 years of age, or a caregiver with inadequate income meeting the HFNY eligibility criteria. The Community Pathways can also offer coaching and referral paths to many services for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

As part of the LB 1173 Practice Model's focus on enhancing primary prevention services, and the goal of reducing unnecessary system involvement or removals to

foster care, the Work Group recommends a Community Response Pathway that would include a coordinated and *integrated* service model for "at risk" children, youth, and families in a community. In recommending this pathway, the Work Group remains mindful that child safety must be the paramount priority.

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

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



How a Community Response Pathway Would Work

After referral, the pathway would conduct a family needs assessment and provide central navigation, through a closed loop referral connection, for a family, child or youth to access services. Specifically, the pathway would offer navigation through a care coordination lens with peer coaching and could make referrals to a vast number of partner agencies or organizations in the community to help this family through a particular crisis. The Work Group envisions these organizations all coming from multi-service sectors that are offering both publicly and privately funded resources that are available in the community to the family, such as the Regional

Behavioral Health System, Medicaid Managed Care Organizations, home visiting providers, evidence based program providers, social service nonprofits, faith based organizations, family resource centers, workforce programs funded by the Department of Labor, Child Care, early learning and development and screening, educational assistance and afterschool programs offered by the NDE, and/or DHHS, DHHS economic assistance programs. An example of this vision is a referral by the navigator to the child's Medicaid Managed Care Organization to provide important medical and behavioral health care coordination, and to an Early Development Network (EDN) service coordinator to provide early childhood development resources and case management. The referral could also include a transportation service to meet emergent needs, home repairs from a local church whose parishioners have volunteered to offer these needed services, as well as connection to the Department of Labor's Workforce Investment Opportunity Act vendors to provide job skill development, training and apprenticeship opportunities for a parent struggling to pay living expenses for a family and needing a good job.

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

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

In the Work Group's proposed community response pathway model, the community pathway will work with the CFS hotline and offer a path to services for families in need of services through a new and structured process developed at the hotline. Today, CFS does not have a uniform process for reviewing calls that are screened out by the hotline intake worker or to determine which screened out reports are appropriate to be sent to the community response pathway vendor for outreach to the family or outreach to the reporter, with appropriate confidentiality protections and in an effort to voluntarily assist the family.

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

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

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

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

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

C. Establish a Family Support Warm Line

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

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

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

There are a number of families in Nebraska each year that apply for Economic Assistance (TANF, SNAP, Child Care) and are either denied, pending an application review, or provided some assistance but have additional barriers that could destabilize their families, impact the lives of their children, and lead to future entry into the child welfare system. The Work Group believes that a number of these families could benefit from this approach where there is a voluntary referral from the DHHS economic assistance to the community response pathway for navigation and peer coaching to help the family through a particular crisis with an approach that centers on the whole family. If an assessment determines additional risk factors, a referral to the community pathway may lead to mitigating these risks for the family and their children.

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

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

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

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

In 2022 in Nebraska there were 181 reports of abuse and neglect made to the hotline related to substance exposed infants and over 86% of the calls were screened in for investigation. In 2021 there were 242 such cases and in 2020 279. In a number of these cases infants were removed to foster care after a safety and risk assessment. The state, however, led by DHHS, is currently focusing its efforts around a more robust community response to these cases, as well as cases where medical and other providers have become aware of substance abuse issues that warrant prevention and intervention before an infant or child is removed to foster care. Currently, CFS is working in two regions of the state in offering innovative

navigation and connection to substance abuse services and programs for caregivers and families where there is evidence of substance abuse exposure either prenatally or after a POSC has been developed. In Hastings and North Platte, CFS is working with a number of entities in the community where pre-natal binders outlining care are put together for expectant mothers and Nebraska Community Collaboratives are providing navigation, coaching and connection to substance abuse treatment services.

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

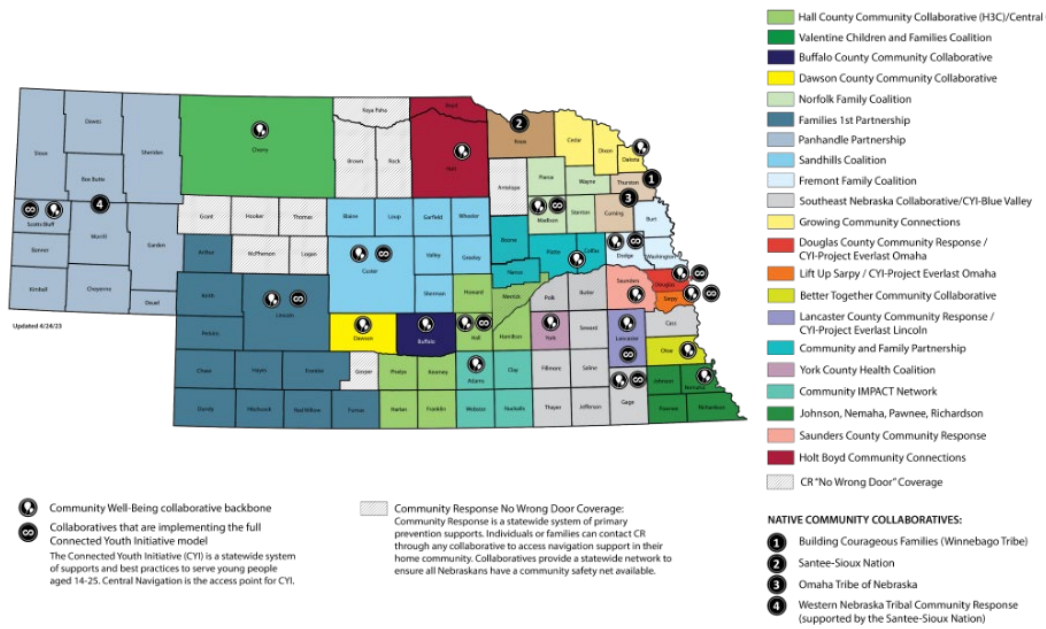
In Douglas County, CFS is working within its own division as well as with 211 United Way, The Bridge (Family Resource Center), Project Everlast, local hospitals, home visitation providers, Nebraska Early Childhood Initiative, Sixpence, Children's Hospital, Douglas County Public Health, Monroe Meyers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

The Work Group envisions, as part of the future LB 1173 practice transformation, that the community response pathway would include this level of coordination and support for moms with prenatal risk factors and parents with children aged 0 to 5 in every region of Nebraska, where there are signs of substance abuse exposure or substance abuse issues needing attention during the pre-birth and early years of a child's development. The Work Group also believes that where there has been a

removal of an infant to foster care, the courts, county attorneys, and GALs involved could also find benefit in the community pathway provider being part of the multi-disciplinary team working together to reunify the infant with his or her mother or caregiver, so as to reduce the length of stay during these important early years.

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

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



These community collaboratives have implemented partnerships focused on prevention strategies unlike other single entities in Nebraska and have a common vision and mission to really help serve these families in crisis in their own communities and keep them out of system involvement through their collaborative

model. NCFF has been an instrumental partner in this initiative, along with other foundations, businesses, community leaders and community-based organizations.

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

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

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

In this newly re-imagined community pathway structure, the community response pathway builds a continuum of community-based supports and resources that strengthen families and prevent child maltreatment. Reform efforts would place the

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

highest priority on starting early and linking families to local support and resources in a more intentional and effective manner to support families throughout a child's lifespan. The prevention practice principles that would support improved outcomes for children and families would include:

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

Prevention Practice Principles
Accountability
Accountability is shared, to the community and to each other, including families

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

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

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

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

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

Developing more accountabilities across the system, as well as system for effective data and outcome monitoring were not only key themes the Work Group heard during the community forums but were key components of what the Legislature wanted contained within the LB 1173 practice and finance models. Thus, assuming the Child Welfare Transformation Work Group focus more effort and funding at the front end by providing more resources to the Nebraska Community Collaboratives to meet the priorities and goals of the new practice model, the Work Group recommend that there also be a system in place that measures the quality of service and the outcomes in providing support to at risk families in the community through the community pathway vendor. Assuming the pathway is the Nebraska Community Collaboratives, DHHS should work with NCFF and other funders, such as counties and municipalities, as well as other intersectoral partners to design and develop a

quality measurement system that engenders confidence in families, funders and staff of these programs and raises the level of professionalism expected of the different community Pathways across the regions. This expectation will define and promote quality practice.

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

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

- The Collaborative demonstrates fiscal responsibility in the use of concrete support services by maximizing the use of all available resources before such funding is utilized

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

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

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

Since 1991, the state of Kentucky has utilized a model called Family Resource Youth Service Center Kentucky (FRYSCKy) where community based non-profit family

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

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

The most critical component of a successful FSCS site is the site coordinator who can provide central navigation, readily identify the changing needs of students and rally community resources to address those needs. FSCS are particularly effective in providing tailored wraparound services to schools with higher concentrations of poverty. If Nebraska were to leverage this strategy in schools with higher than 60% of students identified for free or reduced-price lunch, the total number of schools would be approximately 123 schools, according to NDE. Of note, this model does not have to result in the hiring of new site coordinators in all of these schools. Rather, it can be done on a regional basis and can also be maximized by leveraging the resources of the 23 Nebraska Community Collaboratives, that are already well connected with the school districts in every one of the regions. A continuation of

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

collaboration here, with a FSCS enhancement will bring to the schools the intersectoral connection and approach envisioned in LB 1173.

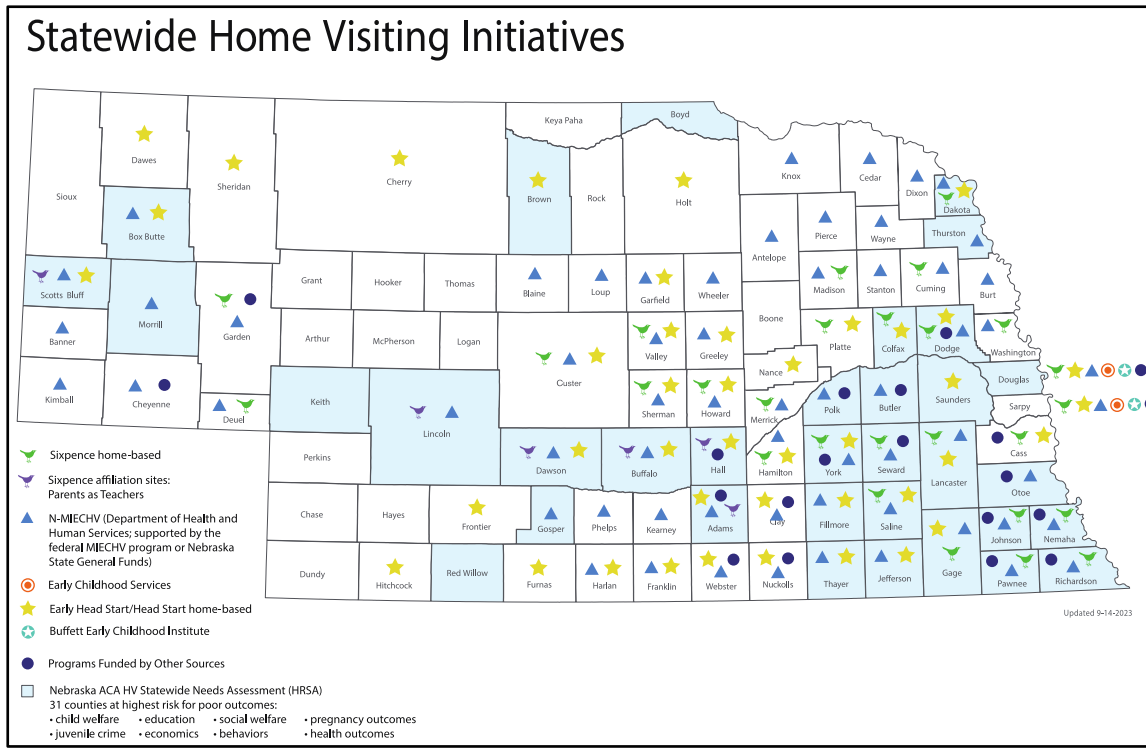
J. Expand the Reach of Evidence Based Home Visiting Programs Aligned with Community Response Pathway

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

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

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

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



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

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

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

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

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

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

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

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

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

Moreover, in relation to the Tribal Nation understanding, involvement and participation, Tribes must be made aware of those building strategic plans in the

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

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

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

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

As mentioned earlier in this section, a few states have received approval to implement a Community Pathway to identify and serve families with risk factors that could lead to entry into the child welfare system. These risk factors are identified in the states Title IV-E Prevention Plan, and they are the initial qualifying criteria for FFPSA eligible service delivery. Through this community pathway, families with children having these risk factors are referred by the child welfare agency or come into contact directly with the Community Pathway through community-based

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

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

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

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

A December 2019 American Bar Association (ABA) Report: Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners, identified that nationally, African American, Native American and children from families with English as a Such disproportionality exists in Nebraska's child welfare system and is discussed in more detail later on in the Additional Child Welfare Practice Strategies section of this report. However, as the state focuses on co creation of a more

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

prevention oriented and family/child/community supportive child welfare infrastructure, the ABA report offers several solid recommendations. Exercising cultural empathy contributes to better awareness' varying backgrounds/cultures and ESL. Exposure to individuals from other cultures can mitigate biases, reduce stereotyping and enhance consideration of provision of wholistic services tailored to families' cultural/linguistic needs.

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

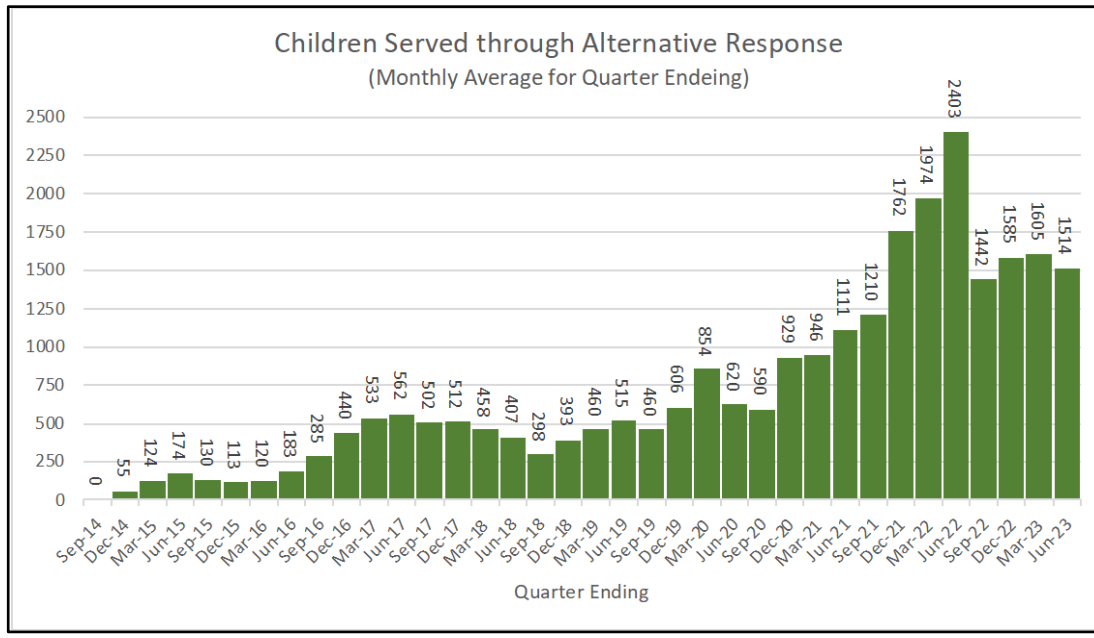
By meeting the need for language assistance, you are raising the bar in treating English language learners/limited English proficient community members with grace, respect, and dignity for the diversity of humanity we serve. - -Oregon Department of Health and Human Services, Office of immigration and Refugee Advancement

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

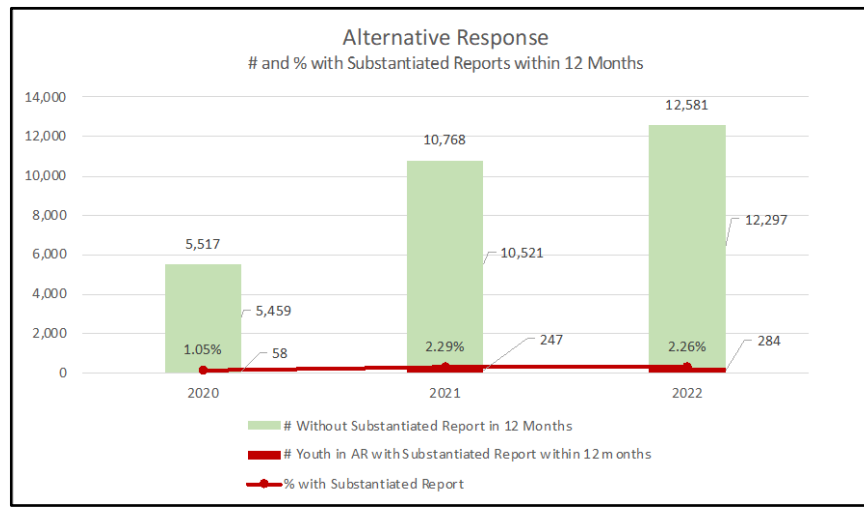
Continue efforts with alternative response, and in-home evidence-based interventions, including developing enhanced capacity for implementation of Families First Prevention Services Act, while Focusing on Increasing Exits to Permanency. Many of the prior reforms in Nebraska have sought to strengthen in-home supports when children are assessed to be safe in their own homes and where alternatives to removing a child can exist safely. In such cases, these in-home services serve to build parental capacity without disrupting family routines and relationships.

Alternative Response

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



As can be seen by the above chart, Alternative Response has increased substantially since 2014 in Nebraska. Additionally, once families are put into the Alternative Response track in Nebraska, the data shows that there is a very low % of reports of continued abuse and neglect to the CFS hotline within 12 months after entry into Alternative



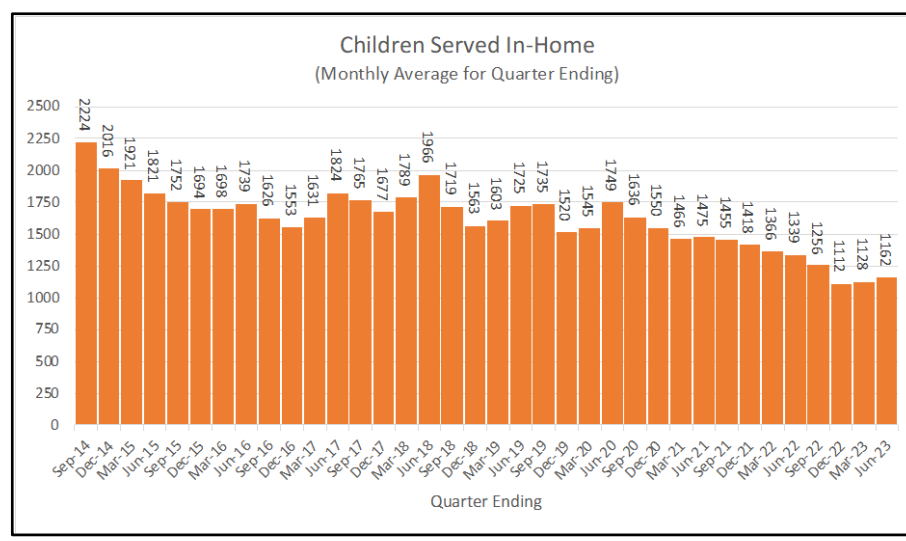
Response. In 2020, for example, there were over 5,517 youth that were in Alternative Response in Nebraska. Out of those youth, only fifty-eight had a substantiated report of abuse within the 12 months following the Alternative Response track. In 2021, there were over 10,768 youth in AR and 247, or 2.29% had substantiated reports of abuse in neglect within 12 months of the AR track. In 2022, there were 12,581 youth in AR and only 284, or 2.26% had substantiated reports of abuse and neglect within 12 months following the Alternative Response track.

In-Home Services

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

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

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



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

Additionally, DHHS presented its updated Title IV-E FFPSA plan to the Work Group and indicated that it planned to roll out, as part of its FFPSA program, the following evidence-based programs, which are already in place in Nebraska, by May of 2023: Healthy Families America (HFA), Parents as Teachers (PAT), and Family Centered Treatment (FCT).

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

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

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

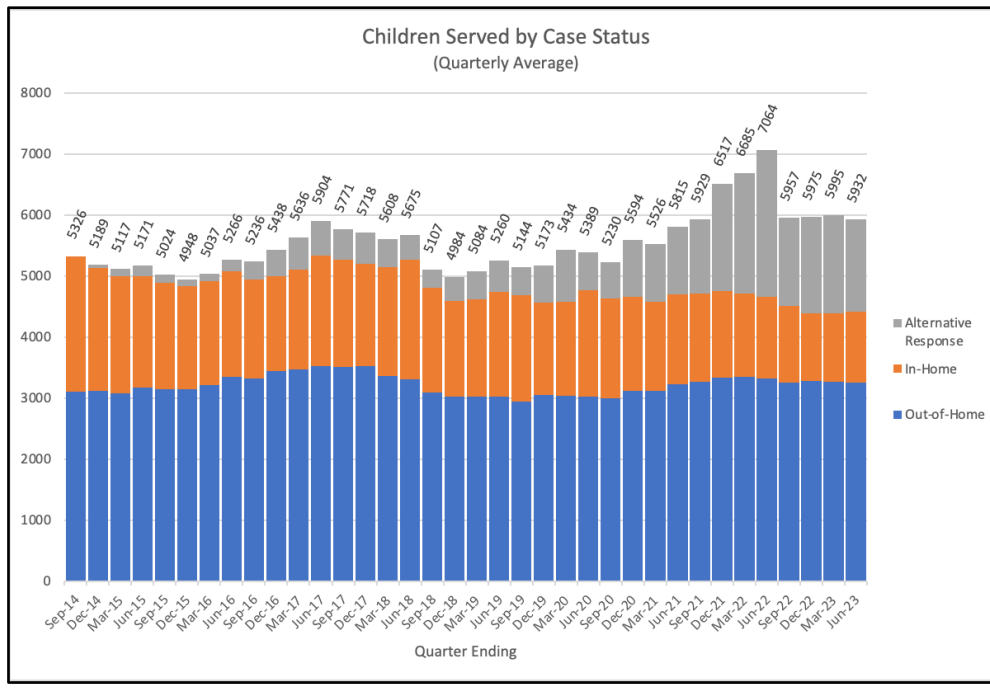
Clinical Evidence-based Programs that Address Gaps/Needs

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

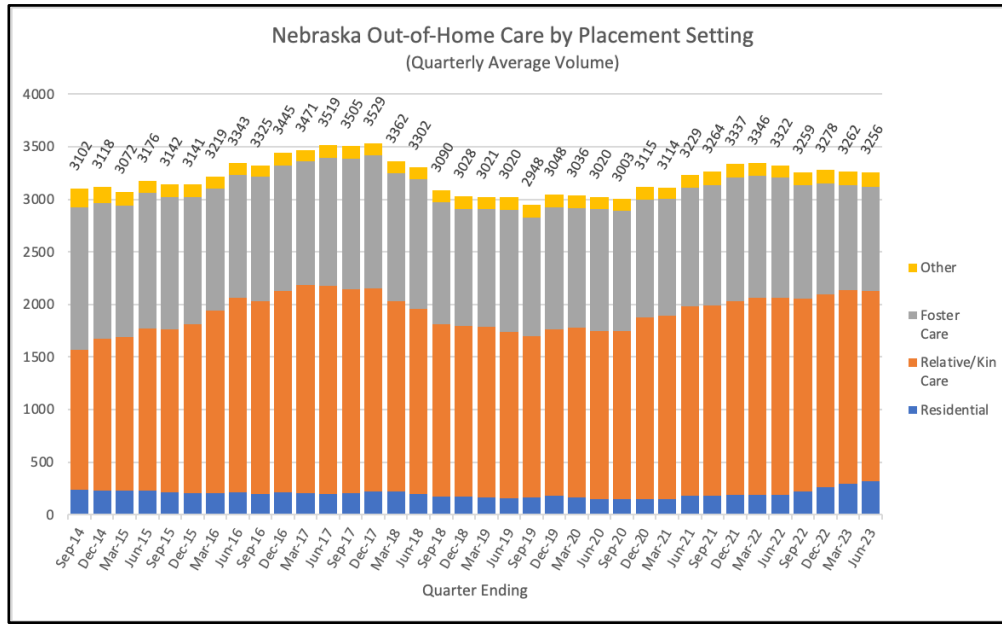
This Focused Effort Has Resulted in Reductions in Foster Care Entries

Despite the delay in FFPSA roll out in Nebraska (see Financial Framework section on claiming practices) a review of overall Nebraska child welfare system entry data clearly demonstrates that the focused approaches of in-home services and Alternative Response have proven to be effective in reducing entries to foster care. Specifically, our review of the data shows that the number of children served per year has increased by approximately 1,000 per month since the quarter ending

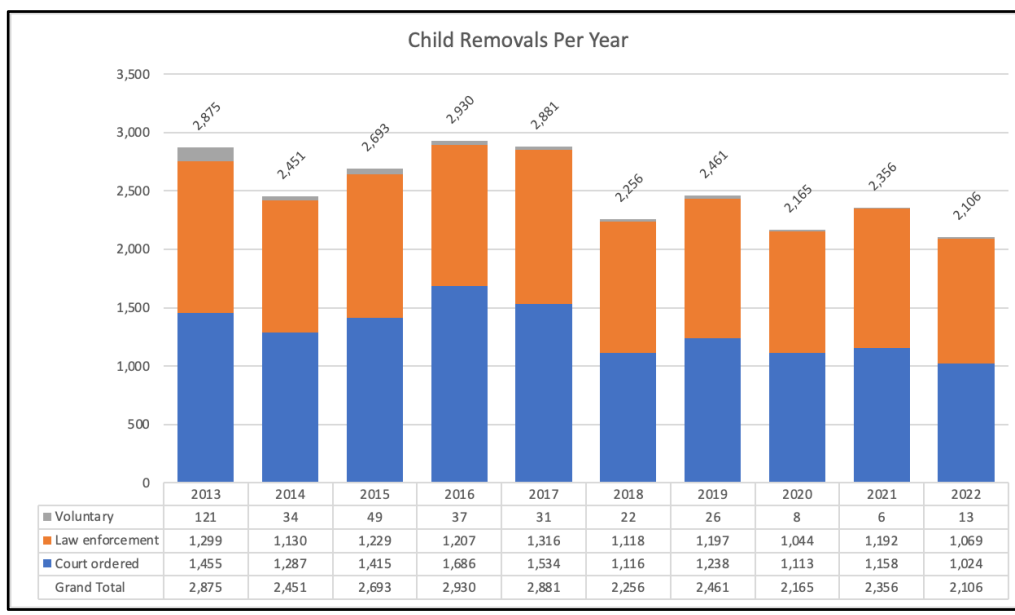
December 2015. The majority of these additional children are being served through Alternative Response, since the number of children in out-of-home care hasn't changed substantially, and the number of children being served with in-home services has been reduced.



Overall, the number of children in out-of-home care has increased slightly since the quarter ending September 2014. During this period, the number of children in out-of-home care placed with relatives has increased by 36% while the number of children served in foster care has decreased by 27%. The number of children served in residential out-of-home care has increased by 31%. However, this equates to only seventy-five children in this relatively small placement cohort.



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



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

From our review of prior reports and discussions with front line CFS staff engaged in both Alternative Response and in-home services in Nebraska, including implementation of FFPSA, a substantial amount of careful planning, training, and

development has occurred to ensure that these approaches are executed with fidelity and without compromise to child safety. Legislation has also specifically exempted cases with specific criteria related to a report that make many cases ineligible for Alternative Response, such as cases involving domestic violence, sexual assault, and other cases where there is a safety risk. Legislation in 2020 (LB 1061) has also created an Alternative Response Advisory Committee under the umbrella of Nebraska Children's Commission to examine the DHHS efforts at Alternative Response and to make recommendations to the legislature and the DHHS.

A. DHHS Continue to Provide Alternative Response

It is the Work Group's recommendation that, in the future, as DHHS continue to develop a focused strategy on providing comprehensive prevention services as outlined in this report, DHHS continue providing its Alternative Response efforts and non-court and court ordered in-home service programs, while at the same time ensure that key LB 1173 key Intersectoral partners, including families, those with lived experience and Tribes, county attorneys, be included in future program policy-related decisions with authenticity and transparency. Adherence to a new LB 1173 child welfare practice model throughout continued implementation will serve to enhance collaboration and engagement and Nebraska will be able to build on its prior success. In particular:

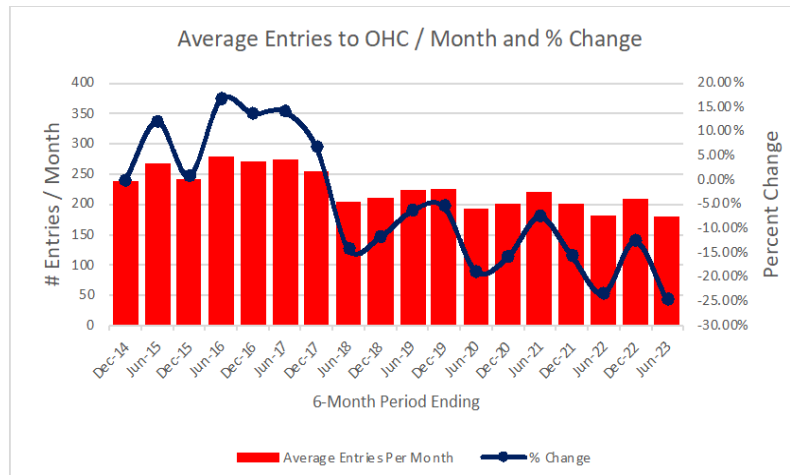
- DHHS should work closely with the Nebraska Children's Commission, Alternative Response Advisory Committee in considering all of its recommendations, including continuing to meet with the Advisory Committee to discuss the best and most feasible ways to measure outcomes related to Alternative Response and the development of much more robust and transparent data system around implementation of Alternative Response.
- DHHS should also make specific data on Alternative Response metrics and outcomes regularly available to the legislature, courts, county attorneys, GALs, and other Intersectoral partners; Specifically, DHHS should track data on how many families decline Alternative Response services and make improvements to N-Focus to capture this data more easily than having to do manual reviews. This data could also allow for continued review, discussions, and collaboration with stakeholders around the best and most effective engagement strategies in the future, including possibly adding a family peer support component to outreach.
- DHHS should ensure more effective collaboration and communication with county attorneys when opening and closing Alternative Response and non-

court voluntary in-home cases and provide information on Alternative Response and voluntary in-home cases at 1184 meetings.

- DHHS should also work closely with the county attorneys to ensure that either the county attorneys or child advocacy centers are notified when a family refuses to engage in Alternative Response or voluntary non-court case, after a substantiated report of abuse and neglect, and the CFS case worker plans to close out the case. These stakeholders should be given an opportunity to review and consult with the CFS case worker about any other action that could potentially enhance future child safety and/or mitigate any potential risk, including the county attorney calling a staffing. Here is one comment from our county attorney survey that is apposite: "We have workers that are not familiar with these families or the services in the area, yet they are making decisions on these families with no input from anyone in the community. If I did not constantly monitor intakes and follow up with DHHS, numerous children and families who need assistance would fall through the cracks."
- In rolling out future changes to its FFPSA plan, including adding to the proposed service array, meeting additional gaps in service, and before submitting any amendments to the current FFPSA Plan, including changes to the definition of "candidacy," DHHS should engage and include key Intersectoral partners, in-home service providers, families and individuals with lived experience and Tribes in decision making.

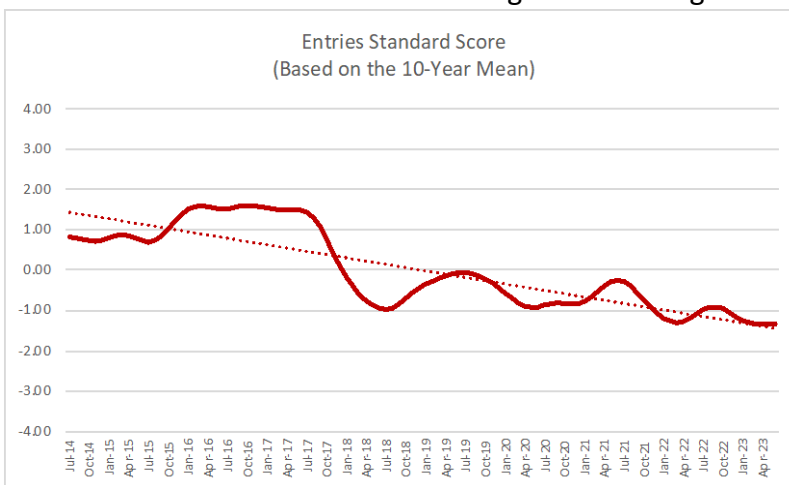
B. More Focused and Coordinated Effort Is Needed on Enhancing Timely Exits from Foster Care, Including Sustained Engagement of Intersectoral Partners

Out-of-home care was reviewed by the Work Group to assess whether and how alternative response efforts and prevention efforts have impacted the child welfare system as a whole. Between July 2014 and June 2023, the number of entries to out-of- home care reduced from an average of 239 to 180 children per month (25%). This reduction in entries largely correlates with the implementation of

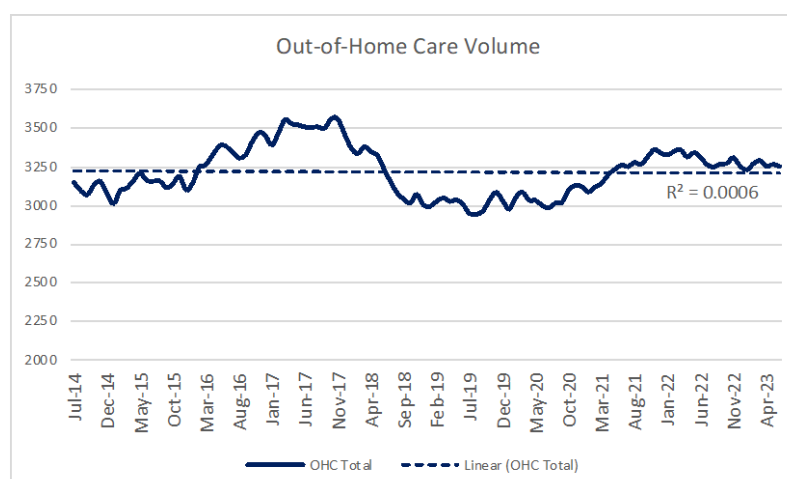


Alternative Response programming and its subsequent expansion in mid-2017. It is important to note, in 2017 CFS also modified drug testing policies, which relaxed testing standards and may have also contributed to a reduction in entries to out-of-home care.

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



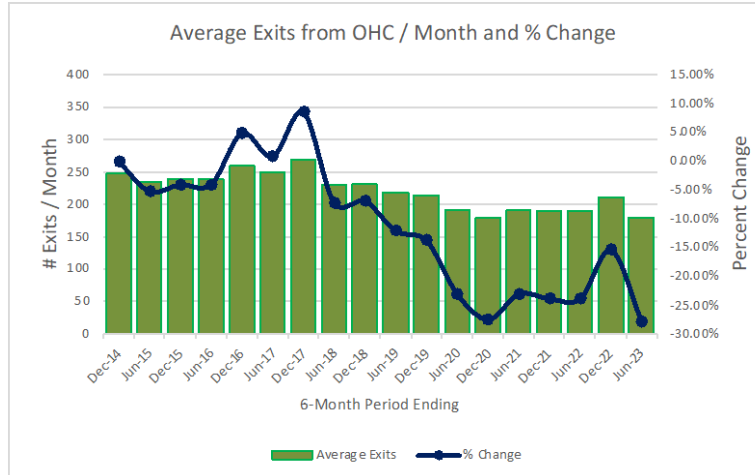
However, during this period, while the number of children entering care per month has been significantly reduced, the number of children remaining in foster care has not fallen proportionately. As a result, the Work Group continued their efforts by reviewing statewide permanency (exits from out-of-home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



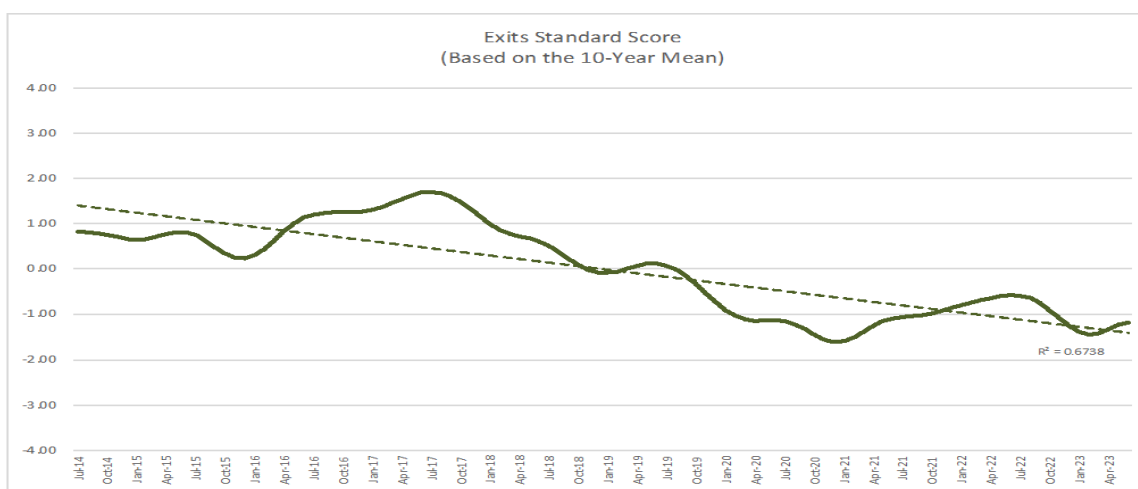
steady, from 2,277 in 2020, to 2,224 in 2023 (6-month data, extrapolated to a full calendar year).

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

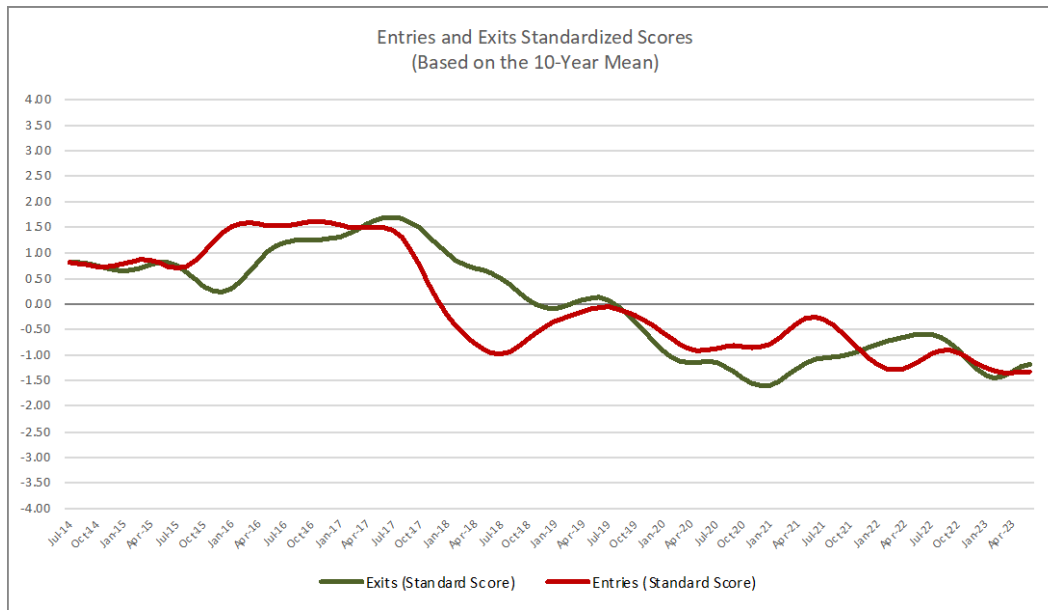
Data for the past ten (10) years shows the overall number of exits from out-of-home care has fallen from an average of 248 children per month during the ten-year period covering July 2014 through June 2023. This equates to a 28% reduction in exits per month.



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

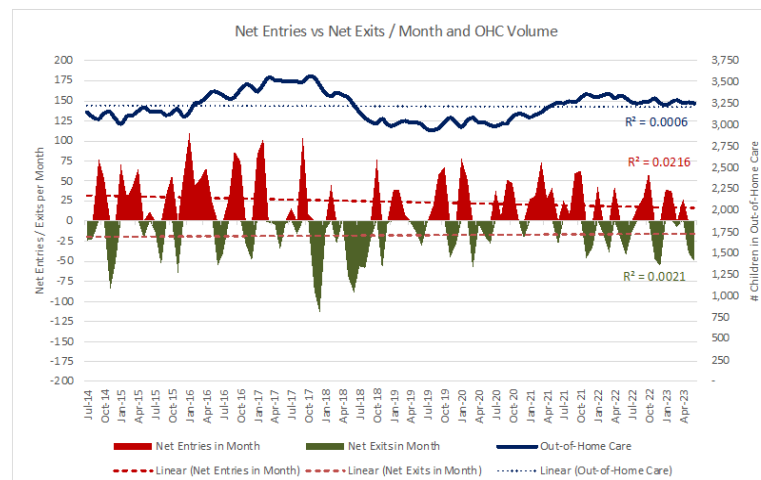


Overlaying the statistical entry and exit charts, provides a visual comparison of the similar reduction to both entries and exits from out-of-home care over the time period is clearly shown.



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

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



We heard that many of these cases where permanency goals are not being met involve higher needs children that require more intensive support. The future Treatment Foster Care model and roll out should help address some of these cases in a timelier way. We

also heard other factors such as continued parental substance abuse issues, including lack of access to effective treatment; Multiple case managers assigned to a case, due to high turnover; Parents not able to access timely behavioral health services, or parent education services; and, in a number of cases parents not engaged in case planning and, thus, a case plan not filed timely enough. In addition, unstable housing, lack of employment and issues of economic distress result in further delays in permanency.

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

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

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

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

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

programs that will enhance the state's ability to reunify a child and youth with plans in place and access to necessary services and supports.

- LB 1173 implementation should include a comprehensive plan to include additional Intersectoral partner agencies and stakeholders in providing support to the CFS case workers including help with facilitating access to any service that the family many need to sustain permanency. This could include assistance with housing, childcare, workforce, parent education, public benefits, and other supportive services. This could also include assistance with grandparents/relatives and caregivers that may need kinship support in the community with resources, such as respite, transportation, accessing medical services through the Medicaid managed care organization, school services through the local school district, etc.
- Support from the community where the child and family live, whether it involves navigation, coaching, or help with active parenting. The community can help the case worker in helping a family build the foundations needed to ensure children and families are safe and are thriving.
- Review and consider strategies that have been adopted by states, including the work of Casey Family Programs, and best practice strategies brought by Annie E. Casey Foundation to states that center around permanency planning tools and resources that help case workers and supervisors understand factors that are barriers to permanency and help address through teaming, facilitation, practice, and planning.
- Replicate court multidisciplinary team models that focus on early intervention and timely treatment and services, like the Lancaster Family Drug Treatment Court that has developed some outstanding outcomes to reducing the time to permanency for many cases since 2014.

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

III. Develop Skilled and Responsive Workforce

Nebraska needs to continue to cultivate a skilled and responsive workforce made up of professionals to deliver a family-centered model of practice that emphasizes child safety, well-being, and accountability. Training is critical to the development of a skilled child welfare workforce and to achieving the outcomes of safety, permanency, and well-being for children and their families. Child welfare case managers provide a unique and essential service to support children and families.

The job of a child welfare case manager is part of a complex and challenging field that exacts significant mental and emotional demands (Kothari et al., 2021; Annie E. Casey Foundation, 2003). As a result, the field has seen significant levels of turnover for more than three decades (Lipien et al., 2020). A solid base of new worker training is pivotal to child welfare worker retention.

Workforce Training

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

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

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

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

Given the demands of working with families in child protection, transferring knowledge gained in training into practice to bolster a worker's skills and confidence

is essential (Liu & Smith, 2011). New worker training sets the stage and foundation but is only the beginning of new knowledge and skill development. Agencies need to acknowledge and prepare new workers that pre-service training is just the beginning and learning is an ongoing journey.

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

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

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

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

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

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

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

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

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

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

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

- To promote the transfer of learning from the classroom to the field, trainees complete field tasks and structured field observations by the FTSs
- A final demonstration and assessment of skills

Nebraska New Worker Training Survey

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

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

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

Survey Results

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

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

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

- Twenty-four (24) percent completed training in 2023
- Forty-one (41) percent completed training during calendar years 2021 – 2022

- Eleven (11) percent completed training during calendar years 2019 – 2020
- Eight (8) percent completed training during calendar years 2015 – 2018
- Fifteen (15) percent completed training prior to 2015

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

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

The analysis of the New Worker Training survey responses identified several strong emerging themes. The responses identify a significant disconnect between the training content and real-time job applicability to expectations. It's not surprising and should be expected, child welfare pre-service training throws a lot at new workers, and it's not uncommon for new workers to feel overwhelmed as they begin

their new career journey. Although the respondents were clear with some very high percentages, the training was not always throwing the right things at the new workers.

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

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

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

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

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

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

Focus Group Summary

TSG met with a focus group of tenured supervisors from different parts of the state to discuss CFS new worker training. When asked what was working, all of the supervisors agreed the base training of child and family assessment, Structured Decision-Making, policies, and regulations was on point, but there was acknowledgement it was a tremendous amount of information for new workers to absorb. Following up on what was working, the supervisors were quick to highlight the role and experience of the Field Training Specialist. The supervisors also agreed the experience and knowledge of the CCFL trainers was excellent. The supervisors also mentioned the online training as positive and shadowing in "real" cases as excellent modalities in the new worker training.

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

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

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

Trends in Child Welfare New Worker Training

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

Research indicates that as little as 10 to15% of training content is actually transferred to practice in the workplace (Kontoghiorghes, 2004). Collins, Amodeo, and Clay (2007) evaluated numerous federally funded training projects to determine if training had the necessary impact on new workers. These authors recognized that classroom instruction models can be effective for transfer of certain learning tasks but stated "they may be highly limited when applied to the complex nature of intervening with families with great challenges."

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

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

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

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

During the last several years, many child welfare agencies have adopted simulation training to strengthen worker confidence, build capacity, reinforce learning, and expand child welfare skill sets. The training simulates real-life situations and conditions to provide the most comprehensive experience for child welfare trainees.

Simulation and role play training are considered types of experiential learning but have distinct differences. Role play scenarios are done in the classroom without specific rehearsal, staging, and props. Simulation training strives to create real-world situations, conditions, and scenarios to reflect an environment a worker may actually experience.

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

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

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

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

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

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

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States are also exploring the implementation of professional certification programs for their child welfare workforce. Certification would provide evidence that Nebraska's child welfare professionals have demonstrated competency in their field by successfully passing a rigorous evaluation. Certification demonstrates the workforce has the knowledge and skills to perform and practice high quality child welfare services.

Professional credentialing also strengthens the public's confidence in the skills and integrity of the certified professional. Research shows that certification programs benefit the public, the employer, and the certified employee. Additionally, the Child Welfare League of America published a study suggesting credentialing child welfare workers can promote competent care.

According to the National Certification Board for Child Welfare Professionals, the employer benefits include:

- Demonstrates agency commitment to superior service by qualified individuals
- Reduces turnover as certified professionals report greater job satisfaction
- Encourages on-going professional development

- Allows real-time verification of potential employee's qualifications and disciplinary history

The certified individual benefits include:

- Enhances confidence in ability to recognize and respond to risk indicators and use appropriate decision-making skills
- Provides portability – the credential belongs to the individual
- Increases sense of professional accomplishment and credibility
- Supports continued professional development through annual educational requirements
- Demonstrates commitment to ethical and professional conduct

Nebraska New Worker Training Strengths

- The long-term relationship with University of Nebraska adds significant credibility to the new worker training and adds consistency to the training model
- Center on Children, Families, and the Law (CCFL) has a combined 700+ years of child welfare experience; to include a training manager, curriculum designer, industrial psychologist, attorney, trainers, and field trainers
- National child welfare publications have recognized Nebraska for their training approach using a blended-learning model
- The use of a Field Training Specialist to introduce and reinforce practice techniques and approaches real-time in the field during the shadowing experiences
- The Service Area Learning Teams provide an additional layer of support and the monitoring progress for new trainees

A. Work Group Recommended Strategies for CFS New Worker Training

The following strategies should be considered by DHHS in adopting new worker training for CFS staff:

- The curricula should be redesigned using the newly created and adopted Nebraska child welfare practice to shape and inform the construction of the new worker training
- Rebrand the training model to include worker wellness throughout the training to prepare the workforce for the demands of the profession and increase retention rates

- Re-imagine and develop a new "Core" training module that focuses on the foundational elements and knowledge all new workers should understand – the "Why" and "What" of the Nebraska child welfare system
- Re-imagine and develop specialty tracks (Intake, Initial Assessment, On-going, Adoption) to streamline and reduce the amount of time trainees spend in training and allow workers to focus on their selected stage of service
- Include testing and require a passing score after the "Core" and "Specialty" training blocks to measure knowledge acquisition, training effectiveness, and worker preparedness
- Re-examine the existing blend of experiential and simulation training to include more "Real" field practice aligned with the most prevalent skills and practices required to prepare a new worker
- Continue to build on the experiential platform by modernizing the simulation training and incorporate virtual reality to augment real-life scenarios a worker may experience
- Consider partnerships with local Community Colleges in the West and Northwestern parts of the state or find creative ways to deliver training in the remote parts of the state
- Create dedicated mentors to assign to all new workers for a period of at least six months
- Adopt an initial and ongoing professional certification process for the child welfare workforce
- Adhere to a manageable glidepath for the assignment of child welfare cases (families) to new workers

CFS Workforce/Caseload Review

Child welfare leaders have long recognized the value of organizational stability to achieve desired outcomes. The impact of instability and an inexperienced workforce has severe consequences in many fields, but exponentially more in child welfare. The need for well trained, experienced, and those committed to the mission of child protection are critical to achieving the best outcomes for the children and families served.

The workgroup sought to explore actionable factors most relevant to improving recruitment and retention of Nebraska's child welfare workforce. The body of work to address the acute and systematic problems of Nebraska's CFS workforce challenges used an analytical approach to identifying a set of actions that held a reasonable probability of improving outcomes with recruitment and retention. We used data collected during a series of community forums and focus groups

conducted around the state during the Summer of 2023, national research and data, and incumbent surveys to isolate key factors and related recommendations.

Improving quality outcomes for children and families is directly aligned with an agency's ability to build a high-quality, professional, and stable workforce with manageable caseloads. Child protective services (CPS) workers help children and families in complex environments that demand a skilled and professional workforce. The work requires a specialized set of intellectual and behavioral skills with appropriate and effective training.

Child protective services workers provide a unique and essential service to support the children and families served by Nebraska's Children and Family Services Division (CFS). The role is a complex and challenging job that requires significant mental and emotional demands (Kothari et al., 2021; Annie E. Casey Foundation, 2003). As a result, the field has seen significant levels of turnover for more than three decades (Lipien et al., 2020).

High CFS turnover disrupts continuity and stability of service for the families they serve, but also creates instability in the workplace through increased workload and the depletion of skilled workers. Child welfare leaders know high attrition amongst the CPS workforce has a direct effect on the quality of services and a negative impact on service outcomes. Improving the recruitment and retention of skilled workers is of critical importance to ensure the continuity of quality services and maintaining reasonable stability in the workforce and workload.

Even after the Covid-19 Pandemic, the current labor market continues to present challenges to both private and public sector employers at all levels. The combination of the pandemic, changing perceptions of the workplace to include remote work options, shifting employer needs, and life priorities all perpetuate skill shortages in key categories and industries.

A plethora of research indicates that unmanageable workloads are a key contributing factor in child welfare turnover. High caseloads drive both high turnover and poor outcomes for children. This produces a Freudian effect leading to higher levels of turnover, lower job satisfaction, increased workloads, and poor quality of service delivery (Clark et al., 2011). In a 2008 report, the Child Welfare League of America suggested that,

> "*No issue has a greater effect on the child welfare system's capacity to serve at-risk and vulnerable children and families than a shortage of competent and stable workforce."*

The workgroup identified numerous comments and observations, most, if not all provide confirmation of issues and concerns previously identified in other national child welfare workforce research. The themes were repeated often in the community forum meetings and routinely identified as a key challenge across the entire state. The findings offered insight into the overlapping and complex root cause factors that create issues with recruitment and retention. The most often repeated themes related to workforce challenges, included:

- High caseloads / workload
- Low compensation
- Lack of resources
- Work-life balance
- Multiple job demands

Caseload / Workload

Workload was highlighted in the community forums, focus groups, and surveys as a primary reason CFS staff leave. The findings are consistent with national studies suggesting one of the most prevalent reasons workers leave child welfare is workload.

Nebraska law 68-1207 requires the Department of Health and Human Services to maintain caseloads to carry out child welfare services which provide adequate, timely, and in-depth investigations and services to children and families. The law requires caseloads to range between twelve and seventeen cases based on the following criteria:

1) If children are placed in the home, the family shall count as one case regardless of how many children are placed in the home
2) If a child is placed out of the home, the child shall count as one case
3) If, within one family, one or more children are placed in the home and one or more children are placed out of the home, the children placed in the home shall count as one case and each child placed out of the home shall count as one case
4) A child is considered to be placed in the home if the child is placed with his or her biological or adoptive parent or a legal guardian and a child is considered to be placed out of the home if the child is placed in a foster family home, a residential child-caring agency, or any other setting which is not the child's planned permanent home.

Additionally, 68-1207 requires the department to include the workload factors that may differ due to geographic responsibilities, office location, and the travel required to provide a timely response in the investigation of abuse and neglect, the protection of children, and the provision of services to children and families in a uniform and consistent statewide manner.

Nebraska 68-1207 also requires the department to utilize the workload criteria established as of January 1, 2012, by the Child Welfare League of America (CWLA). 68-1207.1 requires the department to annually provide a report to the Legislature and Governor outlining the caseloads of child protective services, the factors considered in their establishment, and the fiscal resources necessary for their maintenance. The department's annual report shall also include changes in the standards of the CWLA or its successor. Several years ago, the CWLA discontinued publishing their caseload standards and began shifting their efforts to focus on the related workload.

The annual report to the Legislature and Governor outlining the caseloads of child protective services must include the following:

1) A comparison of caseloads established by the department with the workload standards recommended by national child welfare organizations along with the amount of fiscal resources necessary to maintain such caseloads in Nebraska
2) The number of child welfare case managers employed by the State of Nebraska and child welfare services workers, providing services directly to children and families,
3) Statistics on the average length of employment in such positions, statewide and by service area
4) The average caseload of child welfare case managers employed by the State of Nebraska
5) The outcomes of such cases, including the number of children reunited with their families, children adopted, children in guardianships, placement of children with relatives, and other permanent resolutions established, statewide and by service area
6) The average cost of training child welfare case managers employed by the State of Nebraska statewide and by service area

The Child Welfare League of America (CWLA) has long been the premier resource at setting caseload and workload standards since the 1980s. For decades, the benchmark caseload standards for child protective investigations (Nebraska refers to these as Initial Assessment (IA) workers) was no more than 12 active cases and

12-15 children for foster care workers (Nebraska refers to this workforce as Ongoing). Additional benchmarks for child welfare workers working with child welfare involved families varies by the number of families and the corresponding level of risk. See below CWLA previous caseload standards.

Previous CWLA Caseload Standards	
Worker Type	**Caseload Standard**
Workers making initial CPS assessments	No more than 12 active reports per month
Workers providing ongoing CPS support	No more than 17 active families, assuming the rate of new families assigned is no more than one for every six open families
Working both making initial CPS assessments and providing ongoing CPS support	No more than 10 active ongoing families and no more than 4 active initial assessment
Worker providing Intensive Family-Centered Services	2-6 families
Worker providing Family-Centered Casework	No more than 12 families
Worker counseling with birth families, preparing and assessing adoptive applicants for infant placements and supporting these families following placement	20-25 families
Worker preparing children for adoption who are older or who have special needs	10-12 children
Worker assessing and preparing adoptive applicants for the placement of children whoare older or have special needs and providing support to these families following placement	12-15 families
Worker assessing and preparing adoptive applicants for inter-county adoption	30-35 families
Family foster care social worker	12-15 children, depending on the level of services required to meet the assessed needs of each child

The Nebraska Legislature requires the department to utilize the workload criteria of these standards established as of January 1, 2012, by the Child Welfare League of America. The law is ambiguous because it also describes caseloads of 12 – 17 children per worker based on defined case types that are not aligned with the criteria established by the CWLA.

Although the CWLA had previously recommended no more than 12 – 15 children per worker for foster care workers and a certain number of families served by a worker, depending on case type, Nebraska blends their workforce with Ongoing workers that serve foster care and children served in the home. The children and caseload data provided and maintained by CFS makes it challenging to calculate using the required Nebraska 68-1207 or the CWLA standards.

For example, after reviewing the most recent July 2023 CFS Caseload Status Report, that tracks monthly caseloads of CFS Specialists and CFS case manager positions, we

were unable to determine how the above CWLA standards were applied. The report blends several of the CWLA caseload standards for children served in the home and out of the home and uses percentages of staff in compliance with the standards rather than actual caseload ratios. The report indicates that statewide IA workers are 96.6 % in compliance with the CWLA standards and Ongoing workers are only 61.9% in compliance with the CWLA standards. Additionally, when both types of workers are combined, CFS reports they are 70% in compliance with the CWLA standards.

Additionally, the calculations are limited to staff with one or more assigned CFS cases. The report has 381 workers with one or more assigned cases. At the time the report was filed, there were 549 filled positions (625 CFS positions authorized including Hotline and Adult Protective Services). 525 of the CFS positions are assigned as CFS Specialists and lead workers (IA & On-going), although CFS does not assign a dedicated number of positions to the Initial Assessment and On-going job type. Additionally, a percentage of the CFS workforce do both IA and On-going job functions. This further complicates the task of calculating and projecting caseloads. The difference in filled positions and workers assigned cases is caused by the number of workers in training and a small percentage not assigned cases for other reasons, e.g., FMLA.

As comparison, TSG reviewed a larger sample of CFS data related to both IA and Ongoing workers using the number of intakes and children served over the last three years to show a caseload ratio. This method does not consider if there is more than one child in the home, therefore, the calculated and projected caseloads in the below chart could be slightly lower. We were able to identify an average of 14,814 cases that were accepted for investigation during this time period – see below.

Intakes						
				Accepted	Not Accepted	Total
Year	Substantiated/Court Pending	Alternative Response	Not Substantiated			
2020	1,776	1,528	10,051	13,355	21,046	34,401
2021	1,937	3,358	10,820	16,115	21,504	37,619
2022	1,749	4,338	8,885	14,972	25,542	40,514
			Avg	14,814		

Using this calculation, based on the number of filled IA positions as of July 2023, CFS would appear to meet the CWLA standard of 12 active cases per month for IA workers. However, please note that assigned cases are not the same as active. CFS

is actually in a position to reallocate some of its IA workforce to On-going to balance the workload – see below chart.

	Initial Assessment Workers	2020 – 2022 Avg Monthly Intakes	Caseload
Filled Positions	141	1,234	8.75
Authorized Positions	120	1,234	10.28

For Ongoing workers, the average number of children served monthly from July 1, 2022, through June 1, 2023, was used to calculate the average number of children assigned to a CFS Ongoing worker per month – see below.

Monthly Children Served

Date	Residential	Kinship	Foster Care	Other	Total Out of Home	In Home	Alternative Response	Total Children Served
6/1/2023	315	1801	985	150	3251	1173	1485	5909
5/1/2023	318	1812	996	139	3265	1161	1543	5969
4/1/2023	313	1819	996	124	3252	1152	1515	5919
3/1/2023	303	1829	1030	128	3290	1078	1774	6142
2/1/2023	288	1857	985	137	3267	1128	1580	5975
1/1/2023	294	1828	985	122	3229	1178	1460	5867
12/1/2022	280	1805	1047	122	3254	1105	1527	5886
11/1/2022	256	1858	1068	128	3310	1105	1682	6097
10/1/2022	241	1842	1052	135	3270	1126	1546	5942
9/1/2022	233	1850	1051	132	3266	1213	1288	5767
8/1/2022	217	1840	1069	122	3248	1299	1446	5993
7/1/2022	206	1832	1099	126	3263	1256	1591	6110
							Avg	**5,964**

The number of filled and authorized Ongoing workers was used to calculate the average number of children assigned per month per worker. Using the modified CWLA standard, it appears that CFS does not meet the target with filled positions. It should be noted that the caseloads are exponentially higher for much of the workforce because a portion of the workforce is new with protected caseloads. However, as can be seen below, if CFS was able to fill more of their authorized positions, they could meet the caseload standards of 12 to 17.

	Ongoing Workers	2022 – 2023 Avg Monthly Children Served	Caseload
Filled Positions	273	5,964	21.8
Authorized Positions	405	5,964	14.73

The caseload standards reflect the maximum number of children or cases for which a worker should be responsible. Recently, the CWLA recognized that the number of children or families was not sufficient, and that the actual workload associated with each child or family should also be considered.

The CWLA reported that most agencies tend to focus only on the caseload size standards, and not on the actual work required for each child or family. Therefore, the CWLA Program Specific Standards of Excellence recommends that a workload study be conducted to reflect a better benchmarking of what an actual caseload should be in relation to work being done, including the consideration of local context. A 2018 CWLA report did not offer a definitive solution to the challenges of measuring and interpreting child welfare caseload and workload, it actually reported the field is not there yet (2018 Collins-Camargo et al.,)

CWLA is currently updating its Program Specific Caseload/Workload Standards and moving away from the traditional focus on caseload standards by creating outcome-based workload standards. The CWLA is also developing a methodology for managing the new standards. The Nebraska Legislature's foresight many years ago to include workload factors such as geographic responsibilities, office location, and staff travel is aligned with the direction the CWLA wants to take child welfare workload standards. A complete workload analysis would also include, but not be limited to, case acuity, identifying all activities and tasks for each stage of service, court time, activity time studies, data entry, etc.

As noted earlier in the workgroup report, the CWLA reports that unmanageable caseloads/workloads impact a worker's ability to achieve results for the children and families they are assigned, but it is also a catalyst in worker turnover.

Therefore, child welfare agencies should strive to ensure that their staff has manageable workloads (not caseloads) to achieve positive outcomes for the children and families they serve. The recent CWLA National Blueprint for Excellence in Child Welfare recommends that child welfare agencies develop a system appropriate to its size and function for evaluating the effectiveness of its workforce and the efficacy of each person's workload.

B. Work Group Recommendation for CFS Caseload

The workgroup recommends Nebraska adopt the CWLA approach and conduct a caseload / workload analysis to set new standards of monitoring and evaluating their child welfare workload.

Nebraska CFS Best of the Best Survey Results

TSG conducted a survey of tenured (three or more years of experience) Nebraska child welfare professionals. Forty-one staff with 3 or more years of experience responded to the survey. Half of the responses were received from the Eastern and Southeastern service areas, and the remaining responses from the Central, Western, and Northern service areas.

Eighty percent of respondents indicated that child welfare became their career goal after college or after their first job and a related question revealed that child welfare was not their ultimate career choice before or during college for seventy-five percent of the respondents.

Ninety percent of the best of the best had prior job experience and almost seventy percent had job experience in a related human services field.

Survey results also reinforced similar themes highlighted during the community forums around the state. When the best of the best survey participants were asked why their co-workers leave child welfare, the top three answers were: emotional exhaustion, high caseloads, and low compensation. The participants were asked to identify what they like least about the job and the top answers included high caseloads, stressful nature of the job, amount of paperwork, compensation, and lack of salary progression.

When asked if their co-workers were actively searching for a new job in the last 6 – 12 months, seventy percent responded yes. When the best of the best were asked if they were actively searching for a job, fifty-one percent responded yes.

When the best of the best were asked what they liked most about their job, the number one response with a ninety-one percent response, helping children and families. The best of the best were asked to identify their top retention strategies and the top two answers were manageable caseloads and improved compensation.

Similar surveys were conducted in Florida and Texas (2014 – 2021) and child welfare workers reported that workload, low compensation, and the lack of career progression were significant contributing factors to turnover (FCC 2021; Texas 2015, FCC, 2014). All three studies found more than 80% of respondents felt workload and compensation were key factors that led to turnover. Moreover, in 2021, when asked what they liked least about their job, case managers reported that compensation (54.13%) and lack of salary progression (67.7%) were the two top reasons for dissatisfaction. Similarly, when asked why their coworkers left their

position, the stressful nature of the work, work/life balance, and compensation were the top three reasons suggested for turnover.

CFS Leader Survey Results

Fifteen CFS leaders and supervisors were asked a series of questions to compare and validate the survey results of their staff across the state. Like their staff, seventy-four percent of CFS leaders did not consider child welfare as a career goal until after college or their first professional job. When asked if turnover and high caseloads were a problem, one hundred percent answered yes to both questions. When CFS leaders were asked what their staff like least about their job, the top answers were:

1) High caseloads
2) Stressful nature of the job
3) Compensation
4) Lack of salary progression

When asked why their staff leave child welfare, the top answers were:

1) Emotional exhaustion
2) High caseloads
3) Work/life balance
4) Compensation

As expected, the results of why staff leave child welfare align closely with what staff like least about their job. CFS leaders were asked to identify the top traits for an ideal child welfare worker, the top answers were:

1) Passion for helping children and families
2) Ability to handle stress
3) Personal resilience

CFS leaders were asked to identify strategies to retain high quality child welfare workers and reduce turnover, overwhelmingly, the top answers were:

1) Manageable caseloads
2) Improved compensation

One of the leaders' responses was a good summary of the results, "More child welfare workers - the amount of work expected is very high and we are constantly adding more to their plate. To do good work staff should be kept at the designated

case cap and really give them time to do good work - that only comes from lowered caseloads".

CFS Salary

The Nebraska child welfare worker salary reported by CFS reflects a worker that has completed new worker training, OJT, and promoted to the full CFS Specialist position is $51,064. Nebraska's starting CFS worker (trainee) salary is $43,546. The current average salary for a CFS Specialist is $54,458. Both the trainee and CFS Specialist received a ten percent increase during the summer of 2023. The recent increase makes Nebraska more competitive with other nearby states and only 6.46% behind the average salary of $57,978 of the following eight states we compared.

State	Education Requirements	Salary	Career Path / Title
Illinois	Bachelor's in social work or related human services field	$51,270 - $70,715	8 steps
Texas	Bachelor's – preference given to human services & social work	$45,800 - $58,500	Level I – Level V
Kansas	4-year degree in Social Work, Psychology, Sociology, Criminal Justice or related field	$49,000 - $51,000	Child Protection Specialist
Missouri	B.A. or B.S. Social Work, Psychology, Counseling and 1 year of related experience	$57,000 - $59,000	Foster Care Case Manager
Ohio (Toledo)	Bachelor's in human services related studies	$47,297 - $61,085	Child Welfare Worker I - III
Nevada	Bachelor's degree, Social Work required for Level III	$53,966 - $67,693	Social Worker I - III
Colorado	Bachelor's degree	$64,053	Child Welfare Case Worker
Iowa	Bachelor's in social services or related field	$50,731 - $76,502	Social Worker 3
	Avg Salary	**$57,978**	

When comparing the average salaries of Nebraska jobs with similar experience and education requirements, such as police officer, teacher, social worker, nurse, and probation officer; child welfare workers are paid slightly less than some of the related careers and aligned closely with some of the similar careers in the state. Without the recent increase, there would have been a noticeable salary gap between the jobs.

*Actual salary

According to Zippia.com (the Career Expert) website, Nebraska ranks as the 33rd best state for child welfare workers.

C Work Group Recommendation for CFS Salary

Going forward, the Workgroup recommends there be continued effort to ensure Nebraska's CFS case worker salaries continue to be competitive to similar positions in the state. Although Nebraska offers pay bands in their employee classifications, it is recommended this classification include delineated tiered salary progression opportunities for tenure and performance to retain child welfare staff.

Moreover, the same can be said for Juvenile Probation Officers who provide critical case management for youth in the state, including some that are also in foster care, and both of these front-line staff positions are a key ingredient to meeting the overall objectives of an integrated, transformed, and effective future child welfare model of practice.

Recruitment

Considering the important role of the CPS worker in the child welfare system, a successfully executed recruiting and selection strategy is paramount to serving Nebraska's families. While there are many organizational and personal variables that lead to a highly motivated and successful workforce (e.g., training, workload, compensation, supervision, etc.), a key foundation to further develop the Nebraska CFS workforce begins with selecting the right individual.

To complicate the recruiting conundrum, the amount of negative local and national media attention makes it difficult to attract qualified candidates to public child welfare. Nebraska CFS must improve the image of their workforce by increasing awareness of the profession by highlighting the excellent and sometimes lifesaving work done every day.

All levels of staff in child welfare acknowledge that CFS workers perform complex, challenging, and worthwhile work. However, community forum feedback and national research pointed to the following recruitment challenges:

- Awareness and understanding of job – most potential candidates lack awareness of the opportunities available in child welfare as well as possess a lack of comprehensive knowledge of the day-to-day demands of the job
- Continuous need – high levels of turnover require near continuous hiring of new case managers, thus reducing confidence and morale of current staff
- Weak branding – lack of a strong marketplace image for child welfare-related work. Employment branding focused on traditional sources of applicants and does not leverage social media and other non-traditional recruitment sources
- Strong labor market competition – changes in the level of competition in the labor market and opportunities for entry-level white-collar workers limit the ability of agencies to compete for child welfare workers
- Lack of candidate skills – the multitude of required skills necessitate careful evaluation of candidate's capabilities and a commitment to skill development

Selection

A TSG survey of tenured Nebraska child welfare workers revealed additional insight on pre-hire job experience and educational training. Specifically, the survey showed that 90% of child welfare workers with three or more years of experience had previous professional work experience, in many instances in areas other than child welfare. Additionally, the survey captured education background. The top college majors of child welfare workers were social work (22%), criminal justice (17%), psychology (15%), education (12%) and other (29%).

In the past, some states, including Florida and New Mexico, have advocated for specific degree requirements for child welfare professionals. However, numerous studies from both the child welfare and business management literature suggest that specific educational and work experience are weak predictors of turnover in most organizational contexts (Van Iddekinge et al., 2019; Perry, 2006; Nissly et al.,

2005; Rosenthal et al., 1998). New Mexico abandoned the Social Work degree requirement and Florida has recently allowed related experience to substitute for post-secondary education.

The Nebraska CFS selection process was not studied, but it is not uncommon to find varying practices for screening candidates across different geographical regions of a state agency. The on-going need to fill positions to alleviate higher caseloads results in agencies hiring quickly to prevent additional turnover. While agencies experience similar recruitment challenges, the combination of a lack of standardized and effective selection practices as well as the volume of turnover generates both a recruitment/selection and operational dilemma. Typically, child welfare agencies struggle with:

- The lack of consistent criteria and practices for selection
- The absence of a success profile (key traits and characteristics) for child welfare workers

The best of the best survey participants were asked to identify the top traits and characteristics that would make an ideal child welfare candidate and the top responses include:

- Ability to handle stress
- Passion for helping children and families
- Personal strength and resilience
- Good organizational skills
- Strong work ethic
- Previous work experience

The qualifications for Nebraska CFS Specialist require a bachelor's degree in social work, psychology, sociology, counseling, human development, mental health care, education, criminal justice, or other closely related degrees. The department prefers experience in child welfare, juvenile justice, case management experience, and/or internships with human services/child welfare agencies.

Recently, to assist in attracting candidates from a very tight labor market, one state in particular, Florida, expanded its candidate profile for individuals performing child welfare services to include related work experience to substitute for post-secondary education. Individuals with an associate degree from an accredited college or 60+ college credits from an accredited college or university and one of the following:

- Two years of professional work experience or,

- Two years of full-time social work or human services experience

Examples of professional work experience could be, although not limited to: Guardian Ad Litem or similar child advocate role, family support worker, teacher's assistant/aide, childcare provider/worker, therapeutic assistant, behavior health technician, home health aide, nurse (LPN or RN), Emergency Medical Services (EMS), or other professional jobs that require an assessment of factors that can contribute to trauma or protective capacities with children and families. Additionally, a high school diploma or GED equivalent and four + years of full-time social work or human services experience.

During each of our community forums, recruiting a more diverse and professional workforce capable of handling the future challenges of child welfare case management, especially in addressing many of the behavioral health, substance abuse and increased social care needs of families and children coming into the system, was a priority item continuously raised.

The Work Group believes that opening up this type of broader pathway for individuals dedicated to helping others could meet the Practice Model goal of increasing representation in a professional workforce and staffing. This could also include veterans, former law enforcement, and other professionals that have direct or related experience.

Retention

Retention is the outcome of multiple actions taken by an organization. Job requirements and environmental factors impact an organization's success with employee retention. The most common challenges for retention fall into three categories: type and level (degree of difficulty) of work, rewards (salary and benefits), and culture. Feedback and survey data collected points to a significant gap in employee expectations and the actual reality related to the type and level of work and inadequacy of rewards. The major retention challenges associated with the child welfare work performed include the following:

- Type of work – child welfare workers work includes several stressors, including conflictual interactions with multiple parties, thus necessitating a broad set of critical competencies.
- Level of work – current workloads, lack of automated tools, and the multi-faceted nature of the work creates a work environment that leads to higher turnover; and

- Value proposition – when considering continued employment, employees desire predictable as well as escalating rewards and opportunities for advancement.

As mentioned earlier, high CFS turnover disrupts continuity and stability of service for the families they serve, but it also creates instability in the workplace through increased workload and the depletion of skilled workers.

High employee turnover rates are prevalent in modern workplaces, creating challenges for leaders and human resource professionals. The national turnover situation only escalated following the COVID-19 pandemic. During the 2021" Great Resignation" the number of quits hit a historic high of 4.5 million people by November.

Nebraska CFS had an annual worker turnover rate of 42.8 for calendar year 2022, with the additional challenge of not being able to fill their allocated Specialist positions. The annual turnover rate was calculated by dividing the number of employees who left during 2022 by the average number of employees and multiplying that number by 100. For calendar year 2022 there were 214 CFS case manager separations and the average number of case managers was 500 (214/500*100 = 42.8%). Generally, annual employee turnover in the United States averages 18% (Lumina 2023).

The department is trending in a good direction for calendar year 2023. Using separations for the first six months of the year and projecting a total number of separations signals turnover is on the decline. TSG is projecting 164 separations and the average number of staff at 520 for the year, for an annual turnover rate of 31.5% (164/520*100 = 31.5%). The turnover rate could continue to trend in the right direction as the department continues to hire vacant positions.

In January 2022, CFS received a 33% increase in the number of CFS Specialists (150) to reduce caseloads and workload. During the first quarter of 2022, CFS did an exceptional job of filling positions and reducing the vacancy rate from 30% to 13%. CFS has made recent progress for July and August of 2023 and reduced the vacancy rate to 9%, but for the last 18 months, vacancies have remained at approximately 14% or 80 unfilled positions each month. (See chart below)

CFS Trainees & Specialists					
Month	Year	Filled Positions	Vacant Positions	Total Authorized Positions	% Vacant
DEC	2021	400	53	453	12%
JAN	2022	405	183	588	31%
FEB	2022	444	147	591	25%
MAR	2022	489	102	591	17%
APR	2022	517	74	591	13%
MAY	2022	496	93	589	16%
JUN	2022	495	96	591	16%
JUL	2022	503	89	592	15%
AUG	2022	512	79	591	13%
SEP	2022	517	74	591	13%
OCT	2022	513	78	591	13%
NOV	2022	507	83	590	14%
DEC	2022	500	90	590	15%
JAN	2023	509	81	590	14%
FEB	2023	510	80	590	14%
MAR	2023	510	80	590	14%
APR	2023	515	74	589	13%
MAY	2023	513	76	589	13%
JUN	2023	522	78	600	13%
JUL	2023	549	52	601	9%
AUG	2023	546	56	602	9%
SEP	2023	537	63	600	11%

Lower turnover rates are meaningless if a significant number of positions remain unfilled. A 30% turnover rate would be more manageable with the additional 80 positions filled, vs. a 20% turnover rate and the 80 positions unfilled. The unfilled vacancies exasperate the caseload/workload issue identified by CFS staff and leaders as a challenge to employee retention.

D. Workgroup Recommendations for More Effective Recruitment, Selection, and Retention

1.Recruitment

- Develop a strategic marketing and recruitment plan that contains a complete profile of the ideal candidate, a more creative and targeted analysis of the

best places to source for talent (considering the majority of tenured workers has other professional jobs before child welfare), and positive branding and messaging to promote positive occupational awareness about the position
- A mandatory and rigorous, realistic job preview process that is moved forward in the hiring process and completed before an application is submitted that will improve the understanding of the role, increase the quality of the applicant pool and create incoming job expectations
- Continue to monitor compensation so as to align with similar careers and job demands in Nebraska
- Focus on early career education of child welfare opportunities with high school and college students
- Develop and deploy a community awareness campaign to increase understanding and desirability of child welfare as a career
- Develop a digital-based employment branding plan to increase the size and quality of candidate pools
- Create recruitment partnerships with educational organizations to offer job shadowing and internship opportunities

2. Selection

- Strengthen and standardize the hiring process to improve applicant quality and timeliness of hire
- Implement screening procedures based on relevant occupational factors and competencies
- Expand candidate profiles for individuals performing child welfare work to allow non-degreed individuals with specified backgrounds and experience

3. Retention

- Job Design - Create paraprofessional support positions below the case manager to improve efficiency and effectiveness
- Promotional Track - Align compensation with career demands and offer opportunities for salary progression
- Workload - Implement a scalable staffing model (anticipating and planning for turnover) to improve workload management and conduct a workload analysis as described earlier in the report
- Improve Workplace Culture - It has a direct effect on people factors such as employee engagement and motivation, productivity, quality, and retention

Key Takeaways

- Historical data and current trends predict child welfare will continue to have higher than average attrition rates and implementing a scalable staffing model to improve workload management is paramount. The emphasis should be on anticipating turnover and keeping positions filled. Nebraska CFS needs to emphasize filling the vacant positions to reduce caseload and workload
- Compensation is a critical element for recruiting and retention success in more challenging careers and positions. The lack of a strong compensation strategy and salary progression signals to potential applicants limited opportunities and the unpredictability of rewards
- Develop and deploy a community awareness campaign to increase understanding and desirability of a Nebraska CFS career to include digital-based marketing
- The job design should include dedicated paraprofessional support positions below the case manager to improve efficiencies and effectiveness
- The Work Group is not recommending any new staff positions as part of the LB 1173 Child Welfare Transformation. We believe that CFS needs to prioritize filling existing vacant positions and conduct a workload analysis to modernize a set of standards for monitoring and evaluating their child welfare workload

IV. Maximize the Value of Existing Medicaid and Create Additional Opportunities and Innovation to Meet Gaps in Service

Managed Care Organizations as Valuable Intersectoral Partners

There is an untapped resource when states overlook opportunities to engage Medicaid Managed Care Organizations (MCOs) as valuable intersectoral partners for child welfare systems and community collaborative strategies. The engagement of an MCO can and should go beyond the payor source because MCOs have healthcare insight on their members that can further maximize the benefit and value of state and federal engagement strategies, such as LB 1173 and the Family First Preservation Services Act (FFPSA). Medicaid is an integral piece of the community pathways network because many families that come through the child welfare system are Medicaid beneficiaries, and states can leverage MCOs to identify at-risk families and support preservation. For example, The MCO must conduct outreach to all Medicaid members upon enrollment into their health plan to identify the Member's immediate healthcare needs. MCOs will help schedule and coordinate healthcare appointments, help members better understand their health conditions,

and serve as healthcare experts when navigating the Medicaid system. The MCOs will offer comprehensive case management services and treatment plan support by licensed and clinical professionals to Members with high-acuity healthcare needs. MCOs will also initiate referrals to community organizations to help members with social determinants of health.

MCOs know what Medicaid services their Members access through claims submissions, as Medicaid providers must submit a claim to receive payment for services rendered. MCOs can track claims data to identify members who are high utilizers of Medicaid services, those with high acuity medical conditions and behavioral health diagnoses, and those identified as high cost because of treatment expenses incurred to support the Member. Particularly, claims insight for pharmacy utilization, psychiatric facility visits, inpatient admissions and readmissions, emergency medical department visits, intensive in-home services, and mobile crisis responses can be helpful in identifying at-risk families. MCO data insights can also lead state discussions and influence decisions for FFPSA evidence-based program (EBP) planning since many of the FFPSA EBPs are Medicaid allowable and Medicaid is under federal law the payer of first resort. Medicaid data can also support the development of blended and braided funding strategies for FFPSA which we outline further in our Finance Model, and assist the state with capacity building by utilizing its provider network and relaxing provider requirements to expand access to services.

A. MCOs Need to Be Held Accountable in the New Child Welfare System

MCOs are critical players in state Medicaid programs because they help improve individuals' access and quality of care, increase budget predictability, and constrain Medicaid spending by receiving a set capitation payment per member per month for comprehensive acute care and sometimes long-term services and support. Capitation models allow health plans to receive fixed payments upfront for the anticipated utilization of covered services by members to cover the administrative costs and allow for profit. States will utilize varying systems within their contracts with MCOs to modify risk, incentivize performance, and ensure payments are not too low or too high. However, MCOs can gain higher enrollment of members and increase monthly capitation payments made to their health plan by exerting flexibility in provider payment rates and offering value-added services (additional benefits) beyond the state requirement.

As states pay and hold MCOs accountable for improving the access and quality of care to Medicaid beneficiaries, DHHS should consistently require MCOs to become active participants to assist CFS staff, Juvenile Probation, courts, community

collaboratives and stakeholders in helping the child welfare community with navigating healthcare issues and resolving barriers within Medicaid. It is common practice for child welfare professionals and community-based organizations to absorb the responsibility to lead and drive healthcare efforts despite the state already having a paid healthcare contractor and expert available within Medicaid. It can be overwhelming and confusing for CFS case workers and caregivers to navigate through a Medicaid health plan, or three, such as in Nebraska, beyond keeping children safe, protected, and thriving in foster care.

It was evident through feedback at the community forums that the community is unaware of the Medicaid benefits and resources available to children at risk of foster care entry or in foster care. While the Work Group did not perform a detailed analysis to uncover and identify the barriers or lack of healthcare accountability, participants consistently conveyed an apparent disconnect between CFS, the child welfare community and the three Medicaid health plans. Stakeholders and Tribal communities do not hear from MCOs. They do not know who their MCO case manager is. They do not know if their child has enrolled in case management. There is no consistent engagement between the MCO plan representatives and the child welfare community to validate multidisciplinary support or communication for a child's healthcare.

Creating a multidisciplinary approach to support children at risk of entry into foster care or in foster care and those who care for them provides immediate opportunity and benefit. Recognizing the MCOs as the health plan experts and requiring them to share their data and expertise with CFS caseworkers, family providers, including Child Welfare placement providers will result in big wins to enhance care coordination and access to services, improve health care outcomes, and create a path for developing electronic medical records. As a start, requiring MCOs to designate staff or dedicated liaisons to support CFS children will instantaneously:

- **Increase the transparency of the child's medical and behavioral needs**
  - At the time of removal, families undergoing an investigation for child abuse and neglect are not always forthcoming with healthcare information for their children. When removed from their care, parents do not always provide CFS caseworkers with their child's medications or durable medical equipment (DME). Even though most children who enter foster care have Medicaid coverage, CFS does not have an established rapport with the MCOs to have support of caseworkers as CFS brings children into the state foster care system. This systemic gap often leads CFS case workers to investigate and troubleshoot to identify what

medications the child was on to avoid an abrupt disruption to medication regimens. We have heard from CFS staff how caseworkers will call in favors to secure medical equipment on an emergency basis to secure placement and often do not have the extra bandwidth to seek information about which medical professionals the child would see to support continuity of care.

These realities can be overwhelming and go beyond the expertise of a CFS caseworker and Tribal CFS Departments. If CFS could begin capturing what Medicaid MCO the family has at the time of an investigation, the investigator could then coordinate with the MCO liaison to gather intel on the child/ren medications, DME, health care diagnosis, and provider network established. This process could begin the child's medical record and become a standard investigation practice to ensure CFS understands the child's immediate health care needs to support continuity of care as the child enters foster care. Should the child not enter foster care, this information would still be valuable to CFS for future abuse/neglect concerns reported. The information would be a great resource to review and compare the child's condition between investigations. Implementing this best practice would provide an immediate health care expert to CFS and Tribal CFS Departments in navigating health care barriers upon removal and further promote transparency into the true nature of the child's health care condition when making placement decisions, conducting permanency planning, and informing the Court of the child's medical and behavioral health progress.

- **Promote consistent information distribution amongst authorized consenters.**
  - All children placed in foster care are high priority and high profile. The family underwent a process where CFS determined the child/ren were victims of abuse or neglect or were at further risk of harm where they could not remain with their caregivers. As a ward of the state, a child placed in foster care has many professionals advocating for them and being accountable for their well-being. This practice requires documentation to validate the efforts and actions taken on each party's behalf, often including treatment planning. Plans of care, service plans, and treatment plans are often created for the same child by various professionals such as CFS caseworkers, Tribal community agencies, placement providers, the Medicaid health plan, Medicaid providers like primary care physicians/therapists/home visiting providers, community-

based organizations, their educational provider, the orders of the Court, etc. If no multidisciplinary approach exists or there is no intentional effort to align practices, these various care plans can be duplicative, siloed, conflicting, and confusing. Utilizing the MCO to become the expert go-to source and lead of all healthcare-related information for the treatment planning process promotes consistent data for the child to work towards their treatment goals. It also helps define roles of accountability and minimizes the administrative burden to authorized consenters who must research what medications the child is on, what healthcare professionals they see, what Medicaid services they accessed or have not begun, and concerns remain unaddressed.

- **Cultivate opportunities for health plans to offer technological solutions that are child welfare friendly.**
  - Child welfare professionals must investigate health care information for the children they serve and are accountable to ensure children are getting the care needed in a timely manner. CFS must incorporate a child's health care information into court reports, treatment plans, placement decisions, and case audits. CFS caseworkers need validation that the child is consistently getting the required treatment. CFS also want to know that the child is getting better while under CFS care. As child welfare professionals are not well versed in claims and healthcare protocols, what resources do contract MCOs have to offer insight into a member's well-being? Can MCOs share medical information with the child welfare communities so the data can provide initiative-taking measures to stabilize placements rather than keep this insight as an internal resource? How can MCOs support CFS caseworkers, Tribal CFS, and placement providers with multiple children under their care as the healthcare expert?
  - As noted, Medicaid MCOs receive a monthly capitation rate upfront for their members' anticipated utilization of covered services regardless of the reality of services accessed. MCOs must be engaged, utilized, and accountable for participating actively with CFS and stakeholders supporting children and families, including those in Tribal communities. As the healthcare expert, if engaged with notification, MCOs can report healthcare data of their members placed in foster care, members identified as needing support through community collaboratives, and even families who may become at-risk. Through claims data, MCOs can create dashboards identifying EPSDT exams completed, psychotropic medication utilization, inpatient admissions to medical and psychiatric facilities, length of stay for inpatient admissions, the number of days

children stay in the hospital beyond medical necessity, data insights for maternal health members, mobile crisis responses initiated, etc. These data outcomes can identify the referral source and the household setting of the Member to differentiate if the child/family is involved with the CPS system, if the member is from a Tribal community, if the referral escalated through a community collaborative or the abuse/neglect hotline. The process to begin this type of reporting may be manual at the onset of this practice. Still, it will take consistent conversations, open communication, willingness to collaborate, and a path for accountability to determine the best approach for future automation.

- **Competitive advantage for increased enrollment with an MCO.**
  - Deploying a multidisciplinary approach allows for contract accountability to MCOs. It will require them to actively lead and report on their care coordination/management efforts, resulting in healthy competition amongst the three MCOs. By openly publishing population outcomes, the community can get insight as to which MCO is the leading health plan to improve the well-being of its members. As Medicaid beneficiaries can choose which health plan they enroll in, the designated authorized party can determine which health plan best suits their health care needs, increasing the MCO's volume of capitation payments. It will be imperative for Medicaid to have a defined path to hold these MCO contractors accountable for their members' care coordination, management, and healthcare outcomes.

Children who enter the state foster care system should have the same, if not better, access to Medicaid services and health plan support because now the state is their legal conservator. Luckily, Nebraska ranked in the Top 10 in a state-to-state comparison of overall child well-being within the Annie E. Case Foundation (AECF) Kids Count Data Book for 2023[8].

AECF is a national foundation recognized for its commitment to enhancing the lives of children and youth. AECF strengthens families, builds stronger communities, and ensures access to opportunities by advancing research, offering tangible solutions for improvement, and sharing outcomes for investing strategies based on reliable evidence. AECF assesses state trends in child well-being each year and publishes the Kids Count Data Book report. The Data Book tracks how children are progressing in every state and nationally through sixteen key indicators of child well-being across four domains: (1) Economic Well-Being, (2) Education, (3) Health, and (4) Family and

[8] aecf-2023kidscountdatabook-2023.pdf

Community. Composite scores get combined and converted into state rankings to identify overall child well-being nationwide.

In the AECF Kids Count Data Book for 2023, a state-to-state comparison of overall child well-being identified Nebraska as eighth in the nation. Nebraska ranked the best number 1 in the country within Economic Well-Being. For the three other domains, Nebraska ranked as follows:

AECF Domain	2023 National Ranking	2022 National Ranking
Overall Well-Being	8th	8th
Economic Well-Being	1st	1st
Education	12th	14th
Health	15th	16th
Family and Community	20th	20th

As CFS becomes the "parent" of a child who enters foster care, and there are a few thousand children under CFS care, CFS as the parent has an invested interest in ensuring any contractor receiving funds to manage the large volume of their children's health care needs remains actively engaged to support as needed. Enhancing communication engagement and establishing a multidisciplinary approach with all three MCOs will further increase Nebraska's rankings to strengthen families and build stronger communities.

B. Preventative Care Collaboration: MCOs Should Collaborate with Pediatricians

Preventative and routine care are essential practices within the healthcare industry. These practices can reduce the risk of disease, disability, and even death. These also help minimize health care costs through the prevention of health problems from occurring and can find and treat concerns before becoming serious. Children need regular well-child and dental visits to monitor development and identify health problems early for the onset of treatment. Timely Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) exams are vitally important for children entering the foster care system because the exams validate and document the child's health condition and need for treatment by a medical professional after entering the care of CFS. This insight must be included in the child's medical record to drive treatment planning and access to specialty services while under the supervision of CFS.

MCOs must have network adequacy that meets the needs of their membership population, which includes an adequate network of pediatricians. As a contracted provider with an MCO, Pediatricians must undergo training by the health plan to

understand contract requirements in serving their members. Requirements can include the notification of early onset health care conditions, reporting concerns about social determinants of health, and offering clinical expertise for treatment planning of members enrolled in case management programs. With a multidisciplinary approach focus, MCOs can utilize and potentially incentivize their pediatric network to provide MCO notification when prevention issues arise for immediate intervention. For example, suppose a pediatrician identifies early childhood development concerns during an office visit. In that case, the pediatrician could escalate their concern to the MCO through a secure email, designated health plan representative, or fax capability to ensure the MCO coordinates with the Office of Early Childhood, Nebraska's Early Development Network (EDN), and Community Collaboratives as appropriate. As the first five years of a child's life are the most critical for development, impacting their health, well-being, and the overall trajectory of their lives, interagency collaboration must exist and have an established protocol for expedited coordination of care concerns, which the MCO can lead. Deploying this type of accountability and partnership can also decrease calls to the abuse/neglect hotline. Pediatricians will have a path to engage the MCOs on the early onset of concerns. As the MCOs engage the appropriate parties, the designated case managers of those agencies can meet with the family to offer community-based services voluntarily to address the immediate concerns and preserve the family unit.

C. Expand Efforts to Educate Communities About MCO Services to Children and Families Statewide

To effectively deploy a statewide intersectoral collaboration, it will take an intentional effort for communities to understand the available benefits and resources. There must be a recognized value of a health plan partnership to support CFS caseworkers, foster parents, kinship families, placement providers, community collaboratives, and community-based organizations. The MCOs should be more assertive in marketing strategies to educate the community on the types of support the health plan can deliver, respectfully operating within the marketing guidelines of Medicaid. As a start, MCOs can create or modify new provider and member orientations that explain the Medicaid benefits and enhanced services they offer to Medicaid members. Specifically, these orientations should identify the designated staff or health plan liaisons and the established protocol for connecting with them so that CFS caseworkers, community collaborative staff, and community-based organizations that support at-risk families can utilize them. In outlining our future Prevention vision with a community pathway, we identified the MCOs as key partners for pathway navigation. This will mean they will need more than indirect

connection to the pathway vendor in order to be available to and effectively assist families.

In the future, DHHS should require each MCO to create a training calendar that identifies how their education and awareness strategies will be delivered throughout the state, including Tribal communities. It should include the approval of presentation material, the dates training will occur, the targeted audience invited, the method by which invitations to attend the training will occur, geographic locations covered, and the presentation delivery technique. In addition to a general orientation on the explanation of Medicaid benefits, MCOs should offer healthcare training to support their membership and improve their healthcare outcomes, such as: What types of telephonic outreach does the MCO complete for their members? What kind of care coordination does the health plan do, and what does the Member benefit from enrolling for case management services? What kind of support can the health plan offer caregivers and case workers needing to admit a child into a psychiatric hospital? What training or support can the health plan offer when children are discharged from a hospital? What type of support can the health plan provide for children who enter foster care without their medications or if the child changed placements and the medicines do not come with them to their subsequent placement? What should occur when there is a concern about the medication a child is taking? What happens if there is a medical or behavioral health emergency after hours? Is there a nurse or clinician available?

Equally, children in foster care with diabetes or seizures cannot find placement easily because caregivers may get intimidated to care for these types of health conditions without specialized training. Children with these diagnoses may stay in medical hospitals beyond medical necessity or in-state caseworkers' care in state offices or hotels until placement is secured. When this occurs, it jeopardizes the child's health if no trained individual is available to care for them with these conditions. Licensed caregivers with this type of medical experience capable of caring for these children often remain at total capacity, providing placement for more medically complex children. There is also a demonstrated need for health plans to support better medically complex children discharged from hospitals and transitioned to caregivers who may not be as experienced in caring for these issues. While the state may have a family willing to care for a child and eager to learn how to support these healthcare needs, onsite training at the medical facility may be required before a discharge can occur. When training cannot be scheduled timely, placements get delayed for the child, and many staff hours are exhausted at CFS and with caregivers to coordinate this type of care, resulting in administrative redundancy, duplication of efforts, and placement delays.

MCOs know health care. MCO staff understand their health plan's network landscape. They are the experts in their industry to provide equitable healthcare access to all members despite their culture, Tribal association, linguistic, and healthcare needs. The MCOs have clinical and non-clinical staff, a 24-hour nurse advice line, and a 24/7 mental health and substance use crisis line to support their members throughout their Medicaid coverage. MCOs receive payment to manage their members' care and improve outcomes. DHHS must align these MCO contract requirements with the efforts of CFS staff to keep children safe and help them thrive while these children are under CFS conservatorship. Defining interagency roles and expertise accountability allows the state to maximize the use of its staff resources for a more significant impact.

D. Medicaid State Plan Amendments Should Be Considered to Reduce Barriers and/or Cover Additional Services as Part of a New Child Welfare System

Medicaid state plans vary in the types of populations they serve, the provider network they allow, and the benefits they offer because states have the authority to determine what to include in their managed care solution as long as it meets federal rule requirements. MCOs also have the flexibility to decide certain aspects of their operations, such as provider payment rates and what additional benefits to offer their members beyond those required by the state for increased enrollment.

There has always been a shortage of mental health providers within behavioral health, especially in pediatrics. While the need to expand provider access is nationwide, it is particularly evident in Tribal communities and rural areas.[9] The shortage of providers includes child therapists, social workers, psychologists, and licensed professional counselors. By 2030, the demand for behavioral health workers will increase by 13% for mental health counselors, 15% for addiction counselors, 9% for marriage & family therapists, 12% for social workers, and 5% for psychologists.[10]

The shortage of mental health professionals and the increase in the need for mental health support have prompted states to partner with public health, developmental disabilities and behavioral health entities, and other licensing agencies to identify areas of opportunity where standards can be relaxed to maximize workforce capacity. Many states are incorporating trainee programs to expand their non-licensed staff capacity. For example, North Carolina is offering Family Center Treatment (FCT) as an alternative or "in lieu of" service with staffing requirements

[9] The Youth Mental Health Crisis Worsens amid a Shortage of Professional Help Providers - Scientific American

[10] Behavioral Health Workforce Projections | Bureau of Health Workforce (hrsa.gov)

modified, allowing non-licensed staff to be credentialed as qualified professionals if they are fully certified in FCT within 12 months and can show competence in the required components of certification. Supervision is still required by FCT Supervisors who are associates or fully licensed behavioral clinicians practicing within the scope of their license. FCT is one of the initial FFPSA Evidence-Based Programs that DHHS rolled out to the communities, and we heard how effective the service is in Nebraska, especially in the Western part of the state. However, we also heard that the licensing standards have made it difficult to continue this intervention program in Western Nebraska.

Legislators can play an essential role in supporting the state's health workforce policies to meet the behavioral health needs of the state in addition to rural and underserved communities. For example, Oregon, through House Bill 4071 and House Bill 2949, increased the recruitment and retention of behavioral health providers who are people of color, Tribal members, or residents of rural areas of Oregon that can provide culturally responsive care for diverse communities by directing the Oregon Health Authority to create a Behavioral Health Workforce Initiative. The initiative was intended to develop a diverse behavioral workforce in licensed and non-licensed occupations through scholarships, loan repayment, retention, and peer workforce development. It also allocated funding for grants to license behavioral health providers to provide supervised clinical expertise to associates or other individuals so they may obtain a license to practice. [11]

It is also becoming more common for state Medicaid agencies to utilize non-licensed workers such as counselors, peers, and other qualified staff to accommodate the increasing need for SUD treatment and recovery services for Medicaid beneficiaries. For example:

- Louisiana allows counselors in training to provide screening, evaluation, assessment services, counseling, and crisis intervention services under the supervision of a licensed mental provider to be reimbursed.
- Washington State allows chemical dependency professional trainees to be reimbursed if they can provide screening, evaluation, assessment services, counseling, case management, and care coordination under the supervision of a certified individual who has completed some college. [12]

[11] Oregon Health Authority: The Behavioral Health Workforce Initiative : Behavioral Health Services : State of Oregon

[12] 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce - NASHP

- Maryland allows alcohol and drug trainees to practice clinical drug and alcohol counseling without a license or certificate through telehealth while under supervision and meeting specific experiential or course study requirements.[13]
- Minnesota expanded the mental health practitioner requirement by including individuals completing a practicum or internship as part of their undergraduate or graduate-level social work, psychology, or counseling programs. This change allows a mental health agency to bill for the work provided by people doing a practicum or internship, with the intern being paid for their work.[14]

As MCOs must demonstrate network capacity, they should utilize their best practices from other state contracts to offer workforce shortage solutions that have demonstrated outcomes. Strategies for consideration include telehealth options or mobile clinics to provide comprehensive care and promote patients to access treatment with selected high-performing, high-quality, trauma-informed providers who serve as the preferred hub for services. As Nebraska evaluates how it can leverage opportunities to support workforce shortages, it should consider the National Academy for State Health Policy state strategies[15] of:

- Prioritize behavioral health recruitment and retention of the healthcare workforce. Utilize Medicaid data to identify workforce gaps and opportunities for development by capturing provider licensure and certification information to understand behavioral health workforce needs better.
- Apply the state Workforce Innovation Opportunity Act[16] plan, which allows policymakers to incorporate interagency diversity initiatives and programs promoting workforce development.
- Create a more culturally inclusive workplace. Recognize and respond to the lived experiences of Black and Indigenous People of Color (BIPOC) communities through meaningful engagement, outreach, and planning to consider building diversity and equity initiatives.
- Engage and align all pertinent agencies under centralized state leadership to connect and maximize resources and minimize duplication in support of diversity and equity initiatives.

[13] Legislation - HB1287 (maryland.gov)
[14] HoW66_PFjk6vuGtwo9aNug.pdf (mn.gov)
[15] State Strategies to Increase Diversity in the Behavioral Health Workforce - NASHP
[16] Workforce Innovation & Opportunity Act (WIOA) - Texas Workforce Commission

- Explore and leverage all funding opportunities available to invest and maximize a diverse workforce with recent federal initiatives and potential legal settlements in using non-workforce specific dollars to address behavioral health workforce needs.
- Leverage new and emerging funding opportunities to invest in a diverse workforce. Recent funding options through federal initiatives and potential legal settlements offer states a unique opportunity to consider using non-workforce-specific dollars to address behavioral health workforce needs.

In addition, specific attention in Nebraska, should be given to the following ideas gathered through the LB1173 community forums:

- Review and adjust the MCO menu of covered mental health services for children and youth, including the Community Treatment Aide Definition recommended by the Nebraska Commission and Justice Committee for Nebraska Commission.
- Expand the Medicaid definition for Multisystemic Therapy (MST) to include a bachelor's level practitioner, supported by national MST EBP requirements.
- Align the Medicaid rate for Functional Family Therapy (FFT) with the current MST rate to support providers launching services in Nebraska. In addition, consider the bachelor's level inclusion for FFT to expand resources.
- Include all eligible Medicaid Probation Youth or Legislative language that requires Medicaid to include all Medicaid-eligible youth (including probation) in the plan and waiver for the new service Therapeutic Family Care system of care rollout.

E. Consider Medicaid Provisions Where Evidence Can Be Demonstrated on Financial Budget Neutrality

States have various opportunities to pursue Medicaid provisions that will enhance access to behavioral health services for vulnerable populations like children placed in foster care. With an intersectoral approach, interagency leaders must ensure that implementing a new program design will meet Medicaid requirements and the needs of the populations being served. State strategies to consider include:[17]

- **Massachusetts**: Deployed a Medicaid State Plan Amendment that allows targeted case management (TCM) for Wraparound Intensive Care Coordination to assist children with behavioral health needs, including intensive in-home services, family support, and therapeutic mentoring. The

[17] Medicaid Waiver Authorities – Casey Family Programs

Medicaid Rehabilitation Services Option is also utilized to help children and youth with disabilities, including those with serious behavioral health needs, to live in community-based settings.

- **Michigan**: Utilized a Home and Community-Based Waiver to support youth with severe emotional disturbances who meet the criteria for risk for psychiatric hospitalization without intensive community-based services in child protection. Services are delivered within a system of care framework, and child protection funds are transferred to the behavioral health authority to maximize the Medicaid match. This strategy allows increased dollars for more intensive home- and community-based services for those with "substantial impairment" on the Child and Adolescent Functional Assessment Scale.
- **New York**: Combined several waivers into one to address services for children with serious emotional disturbance, developmental disability, or who are medically fragile, and provide for services, such as accessibility modifications, crisis response, care coordination, and respite, among others.
- **Arizona**: Through an 1115 Research and Demonstration Project Waiver, Arizona uses a single Medicaid physical and dental health plan for foster care. Behavioral health services are provided through a managed care system overseen by the Arizona Department of Health Services and Division of Behavioral Health Services featuring:

    - Risk-adjusted rates;
    - Using child welfare funds to draw down additional Medicaid match;
    - Specific child welfare-focused Medicaid practice guidelines and protocols;
    - Co-location of behavioral health and child welfare staff;
    - Respite and family peer support;
    - 72-hour behavioral health screens following a child's entry into care;
    - Focus on appropriate psychotropic medication use;
    - Specialty providers, and
    - Utilization tracking for child welfare involved children and youth.
- **Massachusetts**: Provides a capitated managed care system with an 1115 waiver that is described as a physical health and behavioral health integrated care system for minors, including those in child protection:

    - Mandatory behavioral health screening (part of EPSDT);
    - A continuum of HCBS services;
    - Peer support; and
    - Mobile crisis with longer-term crisis team involvement.

- **North Carolina:** Offers approved Behavioral Health "In Lieu Of Services" through a specialized Foster Care Plan such as:
    - Behavioral Health Urgent Care
    - Institution for Mental Disease (IMD) for acute psychiatric care
    - Behavioral Health Crisis Risk Assessment and Intervention (BH-CAI)
    - Rapid Care Services
    - Family Family-centered treatment[18] is an alternative model to Intensive In-Home Services and Residential Treatment Levels II and III. Established with comprehensive, evidence-based treatment components, the FCT program addresses the causes of family system breakdowns and promotes positive changes to sustain family functioning improvements after treatment completion. FCT therapists are available 24/7.[19]

In Lieu of Services may also be explored to provide housing support for Nebraskans. Our research revealed that states require MCOs to support housing initiatives to improve their members' health through Medicaid contract requirements.[20]

F. Consideration Should be Given for a Future Specialized Foster Care MCO Program as Part of Child Welfare Practice Transformation

A number of states have developed focused Medicaid MCO specialty foster care plans for foster children and youth that have promising results in enhancing care coordination for this vulnerable population. Some of the programs we highlight as follows:

- **The OhioRISE (Resilience through Integrated Systems and Excellence) Program** aims to shift the Ohio care system and keep families together by creating new access to in-home and community-based services for children with the most complex behavioral health challenges.
    - Through a 1915(c) Medicaid Waiver, Ohio works to improve cross-system outcomes for its enrollees with intensive care coordination and new and enhanced behavioral health services. It addresses gaps in the health care system by developing a network of care management entities (CME) and working with Ohio's behavioral health providers to offer new, intensive, coordinated services for children and families statewide.
    - The Ohio Department of Medicaid oversees and coordinates quality Monitoring and accountability. They also manage Aetna Better Health,

[18] PowerPoint Presentation (ncdhhs.gov)
[19] SUPPLEMENTAL SERVICE DESCRIPTION (vayahealth.com)
[20] Addressing Housing Insecurity via Medicaid Managed Care - Manatt, Phelps & Phillips, LLP

the single statewide specialized care plan, using a shared governance structure with other Ohio Departments and agencies.
    - Aetna contracts with the Care Management Entities (CMEs) and service providers to offer a full continuum of care. They perform utilization of management operations, quality improvement, network development, and provider reimbursement.
    - The Care Management Entities (CMEs) serve as the locus of accountability for members with complex challenges and offer two tiers of care management: intensive and moderate.
    - The Managed Care Organizations are responsible for assuring access to the Child and Adolescent Needs and Strengths (CANS) assessment to determine when a child needs the enhanced services of the OhioRISE plan. Until then, MCOs will cover existing Medicaid behavioral health services, Mobile Response and Stabilization Services, administrative care coordination, utilization management, and quality improvement efforts. If a member enrolls in OhioRISE, the MCO will provide all non-behavioral health care to youth, including physical health, dental, etc. Assist with referrals, transitions of care, and basic care coordination. The providers provide behavioral health services, intensive in-home treatment, inpatient, mobile response, and stabilization services.
- **Washington State Wraparound with Intensive Services (WISe)** provides comprehensive behavioral health services and support to Medicaid-eligible individuals up to 21 years of age with complex behavioral health needs and their families. Core elements include Engagement, Assessing, and Teaming, Service planning and implementation, Monitoring and adapting, and the Implementation of WISe based on interagency coordination with measured outcomes to reduce the impact of mental health symptoms on youth and families, increase resilience, and promote recovery; Keep the child safe, at home, and making progress in school; Help youth to avoid delinquency; and Promote youth development, and maximize their potential to grow into healthy and independent adults. The funding is 100% Medicaid and delivered through a statewide managed care model. There is improvement in keeping families together as Crisis intervention, and crisis prevention services are available to Medicaid-eligible DCYF-engaged families before a child is removed from the home. However, the child would need to be enrolled in CHIP, the family already enrolled in traditional or expansion Medicaid, and Assessment standards and medical necessity criteria must also be met.
- **Virginia and Georgia**: Taking note from these two states, it is becoming the new innovative practice for state Medicaid programs to issue procurements

to establish a contract with a certain number of qualified Medicaid MCOs that will provide Medicaid managed care services to the state Medicaid population and the state will plan to contract with one (1) of the selected MCOs for the provision of Benefits and Services for the state's Medicaid children, youth, and young adults in Foster Care, Adoption Assistance and select youth involved with the Department of Juvenile Justice. Both Virginia and Georgia recently released RFPs with such a focused system, and a review of the RFP shows a much more required intensive MCO provider, network, and care coordination effort on children and youth removed to foster care.

As part of the future Child Welfare Transformation, Nebraska should look to these state models in developing a more specialized and accountable focus of its Medicaid MCO program for children in foster care, the Juvenile Justice system, and children who have been adopted out of the child welfare system.

G. Create Solutions Where Intersectoral Partners Can Share Critical Member Data

There remains an opportunity within DHHS to create a future system or practice where the Division of Medicaid and Long-Term Care, working with MCOs, could share critical Medicaid member data with CFS. We were provided with examples where Medicaid data provided to a CFS worker could have been effective in helping reduce crisis or assist the CFS case worker. For example, we heard about a number of adoption disruptions that have occurred where it may have been prevented if CFS was made aware of a number of repeated medical or behavioral health episodes and was able to intervene with some additional intervention. We were told by CFS staff that they are never notified of any medical or behavioral health episodes, including hospitalization even though the DHHS Medicaid claim system and MCOs have data on claims that were paid for the child or youth that was adopted, since many continue to stay on Medicaid during the adoption. Sharing of data early on could be used in a proactive way to help this family and child. There are many other examples we heard from CFS field staff where a case manager would clearly benefit by being alerted to or knowing in more real time any medical or behavioral health episode where a claim was paid to a provider or hospital. Again, all of this data is available and should be shared with the CFS case workers in the field. Additionally, such data would be valuable to staff trying to expedite permanency planning so a child or youth can be reunified. Since both divisions are part of DHHS, we do think that identifying solutions of interoperability and sharing of data should be a top priority.

Moreover, as efforts of sharing critical child member data become intentional, Nebraska should review the efforts of the Children's Partnership, which launched a 5-year pilot initiative to promote electronic care coordination for children in foster care. The pilot's goals were to support the exchange of critical care-related information amongst multidisciplinary teams and to provide youth with the resources to empower self-management of their medical records and health. In 2016, a lesson-learned publication shared guidance for future efforts to promote the importance of critical health information being shared within an electronic record initiative[21]: Through their review, they identified five lessons for success:

- Build upon robust and committed leadership.
- Know your target audiences and involve them in the design, implementation, and improvement process.
- Cultivate trust in the tool and the process.
- Design to demonstrate value.
- Understand the evolving landscape.

They recommend six critical elements to ensure foster care electronic record initiatives achieve their fullest potential:

1. Gain further insight into how best to engage consumers through electronic records.
2. Initiatives should increase and improve communication across the care team.
3. User-centered design and testing must be more rigorous.
4. Evaluation and ongoing, iterative improvement should be strengthened.
5. Privacy challenges are real but not insurmountable.
6. Federal and state support is needed.

This effort could be expanded to Nebraska's current 1184 multi-disciplinary team process where multiple teams, including investigative, treatment, and specialized service providers, are brought together through facilitation to improve the handling of child abuse and neglect cases.

H. Areas of Opportunity

The foster care landscape has become more complex. Nationwide, children entering the system with higher acuity health care needs and state departments must align to address placement capacity issues together. Children requiring more intensive services require caregivers and placement providers to become better equipped to meet these challenges or children having more placement disruptions. It also

[21] Foster-Youth-and-Parents-E-Records-Lessons-Learned_2016.pdf (childrenspartnership.org)

increases psychiatric inpatient stays, reoccurring admissions, the potential of children remaining in hospitals past medical necessity, and the possibility of hospitals not getting paid for those extended days. The outcome of this pattern is not positive. For the child, prolonged hospitalizations cause them to deteriorate emotionally and behaviorally. They miss critical developmental milestones and fall drastically behind in school on top of all the other layers of trauma. For the state, healthcare costs increase, and it poses a risk to CFS to now house children at child protective offices, hotels, and other unlicensed settings.

State child welfare systems struggle to access and coordinate health care for the children they serve. They benefit from a health plan partnership to take on accountability to ensure health care services are readily accessible and to confirm that services delivered are quality regardless of their living setting. Nebraska must examine what type of managed care solution and partnership most benefits their child welfare system, community collaboratives, and Family First Preservation approach. Nebraska has an opportunity to enhance current MCOs' roles and heighten their accountability to engage and support CFS throughout all stages of services. It is incredibly critical for interagency partners supporting family preservation and child welfare issues to band together to improve healthcare equity throughout the child welfare continuum. Efforts should begin with preventing abuse and neglect to preserve families through the experience of a call made to the abuse/neglect hotline. There is an opportunity to escalate cases closed at intake by implementing a community pathway model. For those that move through investigation and enter foster care, an MCO should be accountable for leading all health care navigation through permanency of family reunification, adoption, and transition out of care.

MCOs can also unify with community stakeholders to impact change through innovative pilot programs that lead to policy changes, such as supporting long-term permanency efforts with biological families, adoptive parents, and youth transitioning out of care. They can help families access and monitor healthcare services beyond permanency to ensure long-term success once child welfare cases close, but families remain covered by Medicaid. There is also an opportunity for MCOs to support child welfare systems in their state's family preservation efforts under the implementation of FFPSA. Focusing on the family should be a state priority when serving the child. Helping biological families access treatment, connecting them with community resources, and overcoming healthcare barriers will help expedite family permanency for children.

To immediately deploy a statewide intersectoral collaboration, Nebraska should require and hold MCOs accountable to lead all healthcare coordination for CFS and community collaborative cases. It is critical to identify and engage MCOs as key intersectoral partners to explore solutions for systemic gaps beyond requirements in their healthcare contracts to provide equitable and holistic care to all Medicaid families, especially children in foster care because they are wards of the state. Intersectoral healthcare outcomes should also align with the goals of the physical and behavioral health system[22] and include specific insights into child welfare, Tribal communities, and community collaboration. Monitoring outcomes should be consistent and shared publicly to demonstrate state oversight of the MCO and MCO accountability.

To begin, MCOs can ensure healthcare services are accessible and consistently utilized and remove existing barriers to promote family preservation. For example:

1. DHHS can establish the MCO as a key intersectoral partner with healthcare accountability supporting CFS leadership, community collaboratives, and community-based care organizations serving at-risk communities by:
    a. Providing crisis support to county child welfare investigators for pre/post removal support of community and health care resources.
    b. Taking the lead in coordinating immediate health care needs for CFS caseworkers, Community Collaborative Meetings, and cases where calls to the abuse/neglect hotline were closed and not assigned for investigation. Nebraska can take note of the state of Connecticut, which contracts with an outside Care Management Entity to work with families and local providers in providing services to families referred by the state through the abuse/neglect hotline but do not present immediate safety concerns.
2. Offering MCO designated staff/liaisons to serve as the Medicaid expert and resource to:
    a. Resolve healthcare barriers.
    b. Improve access to health care services.
    c. Case manage children in foster care.
    d. Initiate referrals to community-based resources
    e. Monitor utilization of ongoing services for short-term and long-term success, focusing on family preservation.
    f. Share data on the member's well-being.

[22] Contract Year 2022–2023 External Quality Review Technical Report for Heritage Health Program (ne.gov)

Nebraska can take note of the practices of Washington, DC, which supports families with substantiated abuse and neglect reports but currently have low or moderate risk and those families with high levels of risk. Still, there is no substantiated finding with case management models using motivational intervention to connect families with specific services based on their needs.

V. Enhance the Accessibility of Behavioral Health Services for Children, Youth, and Families Engaged with the Child Welfare System

The Annie E. Casey Foundation defines core elements of a state's Child Welfare Practice model to include "evidence-based case management, targeted services to address risk and protective factors and evidence-based treatment models." [23] The 2022 edition of the AECF's "Kids Count Data Book"[24] finds that:

The accessibility of evidence based Mental Health and Substance Use Disorder services for the children/youth and families engaged with state child welfare agencies is critical for enhancing child/family wellbeing and their importance cannot be overestimated. Recent data highlighted by the Children's Bureau of the Administration of Children, Youth and Families (ACYF)[25] points out that:

- Mental and behavioral health is the largest unmet health need for these children and teens.
- Up to 80 percent of children in foster care have significant mental health issues, compared with approximately 18 to 22 percent of the general population.
- Native American/Alaskan Native people report experiencing serious psychological distress 2.5 times more often than the general population over a month's time. (Native and Indigenous Communities and Mental Health)
- Only one-in-three African Americans who need mental health care receives it. (Mental Health Disparities: African Americans)

[23] https://www.aecf.org/resources/putting-family-first#findings-and-stats

[24] https://assets.aecf.org/m/resourcedoc/aecf-2022kidscountdatabook-2022.pdf

[25] https://www.childwelfare.gov/fostercaremonth/awareness/facts/#:~:text=Mental%20and%20behavioral%20health%20is,percent%20of%20the%20general%20population.

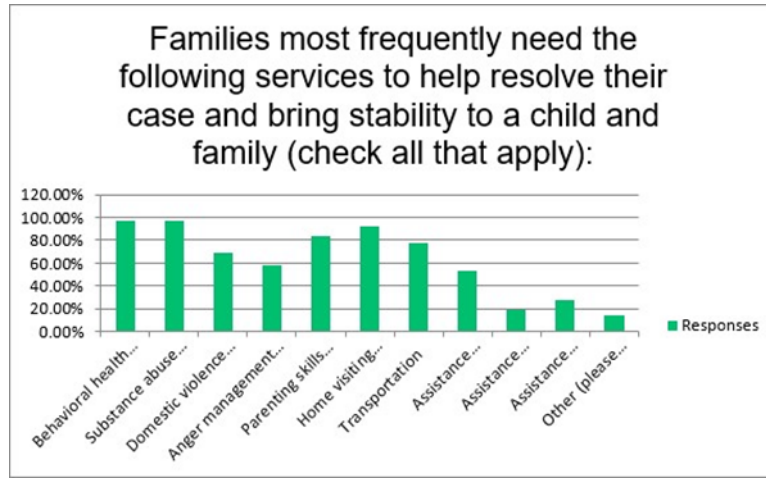
- Nearly 90 percent of Latinx/Hispanic people over the age of 12 with a substance use disorder did not receive treatment. (Latinx/Hispanic Communities and Mental Health)
- Language barriers contribute to the difficulty in finding health care and other services. Overall, 32.6 percent of Asian Americans do not speak English fluently. (Asian American / Pacific Islander Communities and Mental Health)
- Because of the complex traumas faced by children and youth in foster care, foster care alumni experienced posttraumatic stress disorder at a rate nearly five times higher than the general adult population.
- Youth in foster care are prescribed psychotropic medications at a much higher rate (ranging from 13 to 52 percent) than youth in the general population (4 percent).

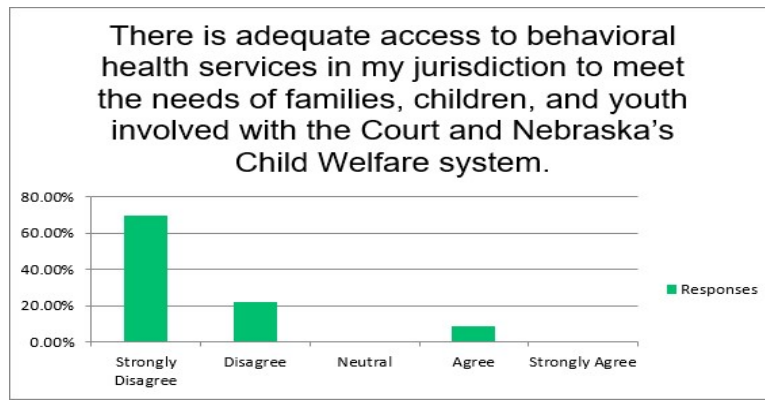
"Mental health is just as important as physical health. And as with other components of child well-being and success, the foundation for good mental health is laid during early childhood. Cognitive abilities, language proficiency and social skills develop alongside mental health."

Community Feedback: Behavioral Health Services for Children, Youth, and Families Engaged with Nebraska CFS

The Work Group approved project plan included meetings with the Tribal Nations, community members, judges, county attorneys, law enforcement, CFS case workers and supervisors, foster parents, youth with lived experience, parents currently engaged with CFS, advocacy organizations, prevention mission driven organizations, and the academic community. During the project multiple public meetings were conducted in Omaha, Lincoln, Columbus, Kearney, North Platte, and Scottsbluff. Well over 600 Nebraskans dedicated to and concerned about the state's Child Welfare system and related services participated.

One of the most prevalent concerns across the state we heard from the community was the lack of timely, accessible, and trauma informed. behavioral health services (mental health and substance use disorder) for children, youth, and parents/caregivers engaged with the CFS system. As an example, a survey of 36 of the state's county attorneys indicated that behavioral health services is the "most frequently" needed service to assist families and stabilize children/youth and that access to the current system was "inadequate" in meeting these needs within their jurisdictions.





Additionally, in a meeting we held with county sheriffs in the state, we heard that law enforcement is "seeing more and more Mental Health issues than we ever have in children of young ages." Moreover, "sheriffs are struggling to find behavioral health resources and where to send these youth."

The following "Voice of the Community" statements from across the state provides a representative sample of the concerns of Nebraskans regarding Behavioral Health Services and the Child Welfare system we heard across the state.

- "Placement challenges for children and youth with high trauma, behavioral health needs, aggressive, assaultive, and sexualized; Providers are unwilling to take these kids even where homes are available." (3/23)
- " Mental health resources and funding for them are significant areas of need – "We are seeing more and more Mental Health

issues than we ever have in children of young ages; "Sheriffs struggling to find behavioral health resources/where to send these youth." (3/23)

- "Behavioral health providers won't take Medicaid because rates are too low." (3/23)
- "Crisis management and services is not just a challenge on the Reservation but across the state." (3/23)
- "Need for mobile crisis services; need for Multi-Disciplinary Teams at the beginning of the process of engaging families." (4/23)
- "Substance Use Disorder (SUD) treatment initiation needs to be expedited/aligned with removal/reunification court orders." (4/23)
- "Families need crisis navigation assistance in their language to access Regional Behavioral health services." (4/23)
- "Cycle of behavioral health crises in youth: children need behavioral health services–no access-problem behaviors-crisis-child ends up in residential placement." (6/23)
- "Behavioral health wait lists for services are very long, up to six months, leaving parents and foster parents feeling very alone; Sometimes it takes multiple calls for Managed Care Organizations to find providers that will accept patients and even more difficult for certain conditions. This shortage of care makes it difficult to be proactive. The farther away from Lincoln and Omaha you get, the farther you get from help." (6/23)
- "Lack of mental health and substance abuse services (especially in rural areas)." (6/23)
- "The regional behavioral health system is an integral partner of CFS, and they need to be included in any future participation with a Community Pathway." (6/23)
- **"**When a youth needs residential treatment services MCOs won't move the residential services paperwork or provide transportation in the rural areas. They say they pay for treatment, but other payers have to pay other non-RX costs and there are no other payers." (7/23)
- " Need for more Mental Health services." (7/23)
- "Professional Partner program cannot serve CFS kids because it was deemed that this service was duplication of CFS case manager work. The Regional Behavioral Health Authorities could provide Professional Partnership (Fidelity Wrap Around) services for these kids with braided funding. " (8/23)
- "Regional Behavioral Health Authority services would be more available for low income families if the department's

financial guidelines were reviewed and increased to current economic conditions so that more people could be served, and the Cliff Effect would not hinder individuals and families seeking needed mental health services. The Eligibility worksheet should be revised. The number of families who are ineligible for the Professional Partner Program continues to increase every year. Also, the max cap for expenses do not reflect the current markets or inflation." (8/23)

- "Paperwork required of parents/guardians is not completed for many children and youth that need mental health treatment. Student Counseling referrals in 90% of referrals made to one of the two Region 3 behavioral health services contract providers in Buffalo County is often not completed, thus, many youths are not being connected to behavioral health services and are on waiting lists." (8/23)
- "Continue to find that, by and large, CFS workers are not communicating with Medicaid to ensure that there is the type of care coordination that should exist for children with really high needs, who are on Medicaid and the MCO is being paid on a monthly basis to offer care coordination. This lack of effective engagement, especially as it relates to care coordination for children with high needs, is a continuation of the need for better coordination within DHHS/Medicaid/CFS and the MCOs." (8/23)
- "Opportunity for increased coordination and communication between MCOs and CFS case workers based on MCO requirements to identify CFS-eligible children/youth as a High Risk Population with an assigned MCO case manager." (8/23)
- "There is a need to find safe places and services for crisis stabilization for children and youth who do not meet inpatient criteria but cannot go home for short periods of time." (8/23)
- "During the privatization era across the state there were units for wraparound but once this stopped in most of the state this was lost along with residential capacity." (9/23)
- "Medicaid has never ("refused") supported High Fidelity Wrap Around as a service." (9/23)
- "Cycle of behavioral health crises in youth: children need specialized behavioral health services–access is an issue-crisis occurs and a child ends up in residential placement. Law enforcement with behavioral health provider model works well to break that cycle; mobile response is a great idea, but

needs to be responsive, especially in rural areas." (9/23)
- "Many developmentally disabled children are only in the CFS system to access services – there is a gap between the ages on 19 – 21 when they become waiver eligible." (9/23)
- "Medicaid uses ASAM clinical criteria in managed care but not in a comprehensive manner matching service needs to benefit." (9/23)
- "Substance abuse services for youth are limited – no residential services other than PRTFs." (9/23)
- "The MCOs are limited based on provider capacity and availability after hours even if the plan is meeting 'network adequacy'". (9/23)
- "There is a need for a wide campaign for provider capacity expansion across the state connected with the University of Nebraska's Workforce Development Project – which has helped to increase the behavioral health work force in Nebraska, but many of these providers are not signing up as Medicaid providers." (9/23)
- "DHHS needs to look at licensing authority for behavioral health assessment and service qualifications to expand capacity to get adults, children and youth more timely service than the current state of the system." (9/23)

A. Consider Existing and Effective State Models for CMS Behavioral Health/Substance Use Disorder/Serious Emotional Disturbance Waivers in Future Child Welfare Transformation

Background

All states are challenged on the best methods to deliver Behavioral Health (Mental Health/Substance Use Disorder (SUD)) services to their high risk/high need adult and infant, child, youth Medicaid eligible populations and their families. States have responded to this challenge with a variety of Medicaid waiver authority models that reflect the uniqueness of their state's health care system and economics as well as the political will to innovate, plan, implement, and accept accountability. Over time the Centers for Medicare & Medicaid Services (CMS) has developed new policy supporting innovations at the state level including managed care models, fee for service models, and derivative models of covered populations, benefits design, and payment methods.

In November 2018, CMS issued a "State Medicaid Directors" letter[26] that outlines "existing and new opportunities for states to design innovative service delivery systems for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The letter includes a new opportunity for states to receive authority to pay for short-term residential treatment services in an institution for mental disease (IMD) for these patients" thereby integrating IMD exclusions with community-based delivery systems – a critical advance for state flexibility at that time. In order for states to receive greater flexibility in the design of their SMI/SED/SUD strategies and benefits they must agree "good quality of care in IMDs, improve connections to community-based care following stays in acute care settings, ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries with SMI or SED, provide a full array of crisis stabilization services, and engage beneficiaries with SMI or SED in treatment as soon as possible." State 1115 waiver designs must address: 1) earlier identification and engagement in treatment (including improved data-sharing between schools, hospitals, primary care, criminal justice, and specialized mental health providers to improve communications); 2) integration of mental health care and primary care that can help ensure that individuals with SMI or SED are identified earlier and connected with the appropriate treatment sooner; 3) improved access to services for patients across the continuum of care including crisis stabilization services and support to help transition from acute care back into their communities; 4) better care coordination and transitions to community-based care; and, 5) increased access to evidence-based services that address social risk factors including services designed to help individuals with SMI or SED maintain a job or stay in school[27]. Waivers approved under the expanded spending authorities must be budget neutral.

New Hampshire Fidelity Early Childhood Wraparound Program (works in coordination with the NH SUD/SMI/SED waiver through a Systems of Care Model)

- **NH Wraparound Model:**
  - The FAST Forward Early Childhood Wraparound program serves the mental and behavioral health needs of at-risk young children (ages 0-5) and their caregivers by providing enhanced care coordination through the state's two contracted Care Management Entities (CME) chosen through a RFP process. The CMEs provide a modified version of the evidence-based practice of NH Wraparound, which provides support to families in figuring out what their strengths and needs are and

[26] https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf
[27] Ibid

connecting the family with appropriate supports in their communities. Established by state statute.[28]

- **Payment Model:** State General and Department of Education funds/Contract Billing
- **Eligible Population:**
  - Children aged 0-5, includes children in Foster Care and their families
  - Dual Eligibility Criteria: 1) Children who may already have a mental health diagnosis or who have a mental health or behavioral concern; 2) Caregivers who are dealing with their own mental health needs, have current/past substance use, are in recovery, have had a history of their own adverse experiences in childhood, have other systems involved with the family such as the state child welfare agency, and/or there are concerns for abuse/neglect; all of which are impacting their child's needs.

- **Early Childhood Wraparound and related FAST Forward services:** All services are based on child/caregiver needs. Along with care coordination there may be referrals such as:
  - Child-Parent Psychotherapy, an evidence based practice, or other mental health services.
  - Home visiting programs, parent education programs
  - Family Centered Early Supports and Services
  - Other services as needed.
  - Case coordination with managed care

- **New Hampshire Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver[29]**

  - **Purpose:** 1. Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI/SED while awaiting mental health treatment in specialized settings; 2. Reduce preventable readmissions to acute care hospitals and residential settings; 3. Improve availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and

[28] Bill Text: NH SB14 | 2019 | Regular Session | Amended | LegiScan

[29] https://www.medicaid.gov/sites/default/files/2023-04/nh-sud-treatment-recovery-demnstrtin-aprvl-ca2-04142023.pdf

residential treatment settings throughout the state; 4. Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI/SED, including through increased integration of primary and behavioral health care; and 5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities. Includes Corrections related reentry services.

- **Eligible Populations: Enrolled** Adults: 21-64 (capitation payment); Youth under 21 (Fee FS payment authority)
- **Model of Waiver Administration:** Administered through two state Care Management Entities outside of state Medicaid managed Care Organizations
- **Payment Model**: Capitation/Fee For Services/state and Medicaid federal share
- **Clinical Assessment Method for Services Eligibility:**
  - State child welfare agency nurse assessments: under 21/Child Welfare engaged
  - CANS/CAT Assessment
  - ASAM Levels of Care Assessment Model: American Society of Addiction Medicine

- **New Hampshire SUD/SMI/SED 1115 Waiver Eligible Populations and Continuum of Services**

Benefit	Population	Medicaid Authority	Expenditure Authority
Outpatient Services	SMI/SED and/or SUD	State Plan	N/A
Intensive Outpatient Services	SMI/SED and/or SUD	State Plan	N/A
Inpatient Services	SMI/SED and/or SUD	State Plan (Individual covered services)	Services provided to individuals residing in IMDs
Residential Treatment Services	SMI/SED and/or SUD	State Plan (Individual covered services)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	SUD	State Plan	Services provided to individuals in IMDs
Medication Assisted Treatment – MAT	SUD	State Plan (Individual covered services)	Services provided to individuals in IMDs
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SUD	State Plan	N/A

Benefit	Population	Medicaid Authority	Expenditure Authority
Partial Hospitalization	SUD/SMI and/or SUD	State Plan	N/A
Recovery Support Services	SUD	State Plan	Services provided to individuals in IMDs

Kansas Serious Emotional Disturbance Waiver (SED): 1915 (C)/1115[30]

- **Purpose:** The Serious Emotional Disturbance (SED) waiver provides children with some mental health conditions, special intensive support to help them remain in their homes and communities. The term "serious emotional disturbance" refers to a diagnosed mental health condition that substantially disrupts a child's ability to function socially, academically, and/or emotionally. Parents and children are actively involved in planning for all services. Enrollment is through KS Community Mental Health Centers. This waiver operates within an 1115 waiver for managed care.
- **Payment Model**: Capitation and FFS
- **Eligible Population:** Individuals with serious emotional disturbance ages 4-18 years who meet a hospital level of care and financially eligible for Medicaid.
- **Assessment Method for Services Eligibility:**
  - Be age 4-18 years old
  - Have a diagnosed mental health condition which substantially disrupts the ability to function socially, academically, and/or emotionally
  - Be at risk of inpatient psychiatric treatment
  - Meet CAFAS assessment and CBCL threshold for eligibility
- **Waiver Services:**
  - Attendant care
  - Independent living/skills building
  - Short-term respite care
  - Parent support and training
  - Professional resource family care
  - Wraparound facilitation services individuals with serious emotional disturbance ages 4-18 years who meet a hospital level of care
- **Organization of the Models Functions[31]:** entity either supervises the function or establishes or approves the delegated function:

[30] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/KS0320.zip
[31] Ibid, p. 20

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	✓	✓	✓	✓
Waiver enrollment managed against approved limits	✓	✓		
Waiver expenditures managed against approved levels	✓	✓		
Level of care evaluation	✓	✓	✓	✓
Review of Participant service plans	✓	✓	✓	
Prior authorization of waiver services			✓	
Utilization management	✓	✓	✓	
Qualified provider enrollment	✓		✓	
Execution of Medicaid provider agreements	✓	✓	✓	
Establishment of a statewide rate methodology	✓	✓	✓	
Rules, policies, procedures, and information governing the waiver program	✓	✓	✓	✓
Quality assurance and quality improvement activities	✓	✓	✓	✓

Alaska Substance Abuse Disorder Treatment and Behavioral Health Program 1115 Waiver Model[32]

- **Model of Waiver Administration: ASO model designed to:**
  - Increase regional access to appropriate BH services
  - Standardized assessment and treatment planning for all eligible populations
  - Improve health outcomes for all publicly funded beneficiaries of BH services (i.e., Medicaid and non-Medicaid State and federal grant funded BH programs); and
  - More efficiently and effectively manage the cost of BH service delivery in Alaska.
- **Payment Model**: capitated payments to ASO; FFS to providers
- **Eligible Populations:**
  - Group 1: Children, adolescents, and their parents or caretakers with or at risk of mental health disorders and SUDs

[32] https://health.alaska.gov/dbh/Documents/1115/1115_Waiver_RenewalApplication.pdf

  - Group 2: Transitional age youth and adults with acute mental health needs
  - Group 3: Adults, adolescents, and children with SUDs
- **ASO Clinical Assessment Method for Services Eligibility:**
  - LOCUS: Versions 20: American Association of Community Psychiatrists
  - ASAM Levels of Care Assessment Model: American Society of Addiction Medicine
  - ABA Clinical Criteria assessment

Alaska SUD/BH 1115 Waiver Continuum of Services

- **Covered SUD Program Services:** Early Intervention- Services*; Outpatient Services*; Medication-Assisted Treatment (MAT)*; Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD); Intensive Outpatient Services; Ambulatory Withdrawal Management; Partial Hospitalization Program (PHP); Residential Treatment; Clinically Managed Residential Withdrawal Management; Medically Monitored Intensive Inpatient Services; Medically Monitored Inpatient Withdrawal Management; Medically Managed Intensive Inpatient Withdrawal Management. (*Services authorized under the State Plan).
- **Covered Behavioral Health Services:** Community Recovery Support Services (CRSS); Home-based Family Treatment; Intensive Case Management Services (ICM); Partial Hospitalization Program Services (PHP); Intensive Outpatient Services (IOP); Children's Residential Treatment (CRT); Therapeutic Treatment Homes; Assertive Community Treatment Services (ACT); Adult Mental Health Residential Services (AMHR); Peer-based Crisis Services; Mobile Outreach & Crisis Response Services (MOCR); 23-Hour Crisis Observation & Stabilization Services (COS); Crisis Residential/Stabilization Services.

Florida Department of Children and Families Mobile Response Teams and Community Action Teams[33]

- Mobile Response Teams (MRT) provide 24/7 emergency behavioral health care to anyone having a severe emotional or behavioral health crisis in their home, school, or wherever they are. MRT services are available statewide, managed through the state's seven Regional Behavioral Health Managing Entities at 50 sites covering the state.
- Designed to reduce trauma, prevent unnecessary psychiatric hospitalizations and criminal justice involvement through de-escalation, appropriate crisis intervention, and connecting people to resources in their communities

[33] www.myflfamilies.com/

- Program Eligibility: have an emotional disturbance; or are experiencing a mental health or emotional crisis; or experiencing escalating emotional or behavioral health reactions and symptoms that impact their ability to function typically within their family, living situation, or community environment; or are served by the child welfare system and are at high risk of placement instability.
- MRT teams include: a Licensed Mental Health Professional; Certified Peer Recovery Specialist; access to an On-Call Psychiatrist or Psychiatric Nurse Practitioner; and Support Staff.
- MRTs provide in-person and telehealth services that provide on-demand crisis interventions in any setting in which a behavioral health crisis occurs. Services offered include Screenings and Assessments; Crisis De-escalation and Stabilization Services;
- Crisis Counseling: Development of Safety or Crisis Plans; Psychoeducation; and Care Coordination (connects systems including behavioral health, primary care/Medicaid, peer and natural supports, housing, education, vocation, and the justice systems.
- **Community Action Teams (CAT)** help children and young adults with behavioral health concerns to recover at home safely. These teams also assist families in building and maintaining a support system within their community. CAT is a safe and effective alternative to out-of-home treatment or residential care for children with serious behavioral health conditions. Sixty teams across the state provide CAT services.
    - Eligibility: Children and young adults with serious behavioral health conditions.
    - Youth with complex needs that contribute to family disruption or increase the risk of family separation such as: Multiple behavioral health hospitalizations; Involvement with the Department of Juvenile Justice or law enforcement; School challenges like poor academic performance or suspensions; and Repeated failures at lower levels of care.
    - Youth younger than 11 years old may be able to receive services if they have more than one of the needs described above.
    - Treatment models: **Traditional CAT Teams** serve children and young adults with a behavioral health condition and at risk of out of home placement. **Family First Prevention Services Act (FFPSA) Teams** serve families where the child(ren), parent(s), or caregiver(s) have a behavioral health condition that contributes to risk of family separation or child out-of-placement. **Family Support Teams (FST)** serve families where frequent use of emergency psychiatric services contributes to family separation or child out-of-home placement.

- Services: Care Coordination; Case Management; Crisis Intervention; Therapy; Mental Health and Substance Use Treatment; Psychoeducation; Respite Care; and Transportation Assistance.

B. Recommendations for Future Child Welfare Transformation

The following recommendations for future child welfare transformation aligned with LB 1173 practice model to enhance Nebraska's children's mental health and substance use disorder system of care

1. Consider Aligning Behavioral Health (Mental Health and Substance Use Disorder) Services Definitions Across All Departments

DHHS should consider aligning Behavioral Health (Mental Health and Substance Use Disorder) services definitions across all Departments providing these services with Medicaid definitions as the foundation across DHHS.

- Clarify the "care coordination" definition across all DHHS divisions and programs touching CFS children in care and at risk and reach a decision on specific purpose of the service, operational responsibilities to provide care coordination for transitions and provider search, programmatic/clinical use, commonalities, variances, eligible populations, and funding source.
- Clarify the "case management" definition across all DHHS divisions and programs touching CFS children in care and at risk: see below under RBHAs.

2. Consider Assessing all Existing Spa and Waiver Services Definitions and Credentialing Requirements

Nebraska Medicaid should consider assessing all of its existing SPA and Waiver services definitions and credentialing requirements and comparing them to Evidence Based Practices reviewed and listed by sanctioning entities such as SAMHSA, California Evidence-Based Clearinghouse for Child Welfare, Oregon Health Authority approved practices, Tribal Programs, and SBIRT tools, or the Pacific Northwest Evidence-Based Practice Center (Oregon Health & Science University funded by AHRQ) and update accordingly. In addition, current credentialing requirements should be compared to states that have recently adjusted key BH provider requirements to expand workforce capacity in a safe manner.

3. Consider Developing and Implementing a Comprehensive Behavioral Health, IMD Exclusion, Substance Use Disorder, and Serious Emotional Disturbance 1115 Waiver

DHHS/Medicaid should consider developing and implementing a comprehensive Behavioral Health, IMD Exclusion, Substance Use Disorder, and Serious Emotional

Disturbance 1115 Waiver based on a standardized assessment of acuity levels and carved out from the existing managed care program.

- The covered population would be all eligible infants, children, youth, and adults who upon standardized assessment are determined to have a high level of acuity/severity/persistence. Services definitions should be evidence based to the maximum extent possible and include mobile crisis services, inpatient, residential, day programs, outpatient, fidelity Wrap Around services, evidence-based Prevention services, and SDOH/In Lieu of Services.

- The delivery system for this waiver could be anchored in the strengths of Nebraska's Certified Community Behavioral Health Clinics/CCBHCs, Federally Qualified Health Centers/FQHCs, and the Regional Behavioral Health Authorities. The operational model would include a standardized scope of work, Evidence Based Practices, an agreed upon standardized assessment instrument that determines acuity levels and service needs, a standardized treatment planning method, and a direct relationship with or provider of fidelity Wrap Around services. Bi-directional care coordination between these entities and the Managed Care Organizations would be embedded in a Memorandum of Agreement.

4. Consider a Waiver Administrative Platform of an Administrative Services Organization

Nebraska Medicaid could consider a waiver administrative platform of an Administrative Services Organization (similar to Alaska). The ASO model could provide the state with more direct oversight of and accountability for the behavioral health delivery system for high acuity/high cost infants, children, youth, and adults.

- An augmented Fee For Service rate for specified services coupled with a single provider revenue cycle (compared to multiple MCOs) could provide an incentive for more credentialed private sector providers[34] to become Medicaid providers.

- Nebraska Medicaid could also consider embedding this waiver within the existing managed care contract model (similar to KS) thereby inheriting the existing strengths and challenges of that system. This approach would also be expedient and rely on the existing MCO capacities for care coordination of

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

high acuity/high costs individuals which, based on community comments across the state, would have to substantially improve.

5. Expand Opportunities for the Regional Behavioral Health Authority System to be a vital partner of the future child welfare transformation

Expand Opportunities for the Regional Behavioral Health Authority System to be a vital partner of the future child welfare transformation through the new system of care for children and families struggling with Behavioral Health and Substance Abuse Disorder and Serious Emotional Disturbance issues.

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

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

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

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

6 Consider the Professional Partnerships program as the Statewide HUB

Consider the Professional Partnerships program as the statewide HUB (or a participant HUB with the CCBHCs and FQHCs based on regional variations) for fidelity Wrap Around within the recommendation for a Medicaid BH/IMD/SUD/SED 1115 waiver. Note that currently the RBHA Professional Partnership Program serves approximately 1,000 children on an annual basis at a cost of approximately $6 million of non-Medicaid funds (SAMHSA, state funds) across the state.[35] Further note that the need for a DHHS wide definition of BH/SUD/SED case management services mentioned previously is supported by the current understanding that children and youth in Foster Care, who could benefit from Professional Partnership services, are not eligible because CFS case workers are assumed to provide Fidelity Wrap Around services as part of their case management duties, however, while Juvenile Justice Cross Over youth, we are told, are eligible and receiving these services.[36]

RBHAs are well positioned in their communities/region to provide or partner with Mobile Crisis teams based on Paramedic/EMT participation such as the models we learned about in the Kearney and Omaha regions sponsored by Lutheran Family Services.

7. Consider Developing a Method that Balances Currently Appropriated RBHA Funding with New and Revised Financial Income Guidelines that are More Flexible

Between FY 2019 and FY 2023 DBH provided a total of $435,435 million in SAMHSA Block Grant and state general fund dollars for RBHA services with a total of $351,591 million expended during this time period. Several RBHA directors we spoke with indicated the current state Financial Income Guidelines for RBHA services eligibility was often too high for struggling families whose income was just above current guidelines, falling within the "Cliff Effect."[37] We recommend that DHHS/DBH consider developing a method that balances currently appropriated RBHA funding with new and revised Financial Income Guidelines that are more flexible in managing over or under budget expenditures throughout the Fiscal Year. These

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

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

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

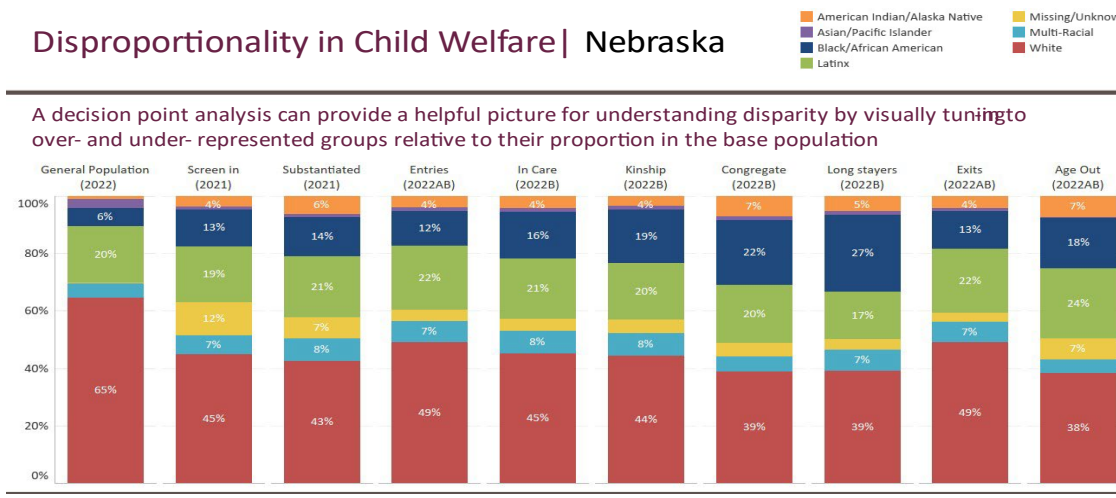
additional dollars represent funding that currently exists in the system that can be used by leveraging existing dollars.

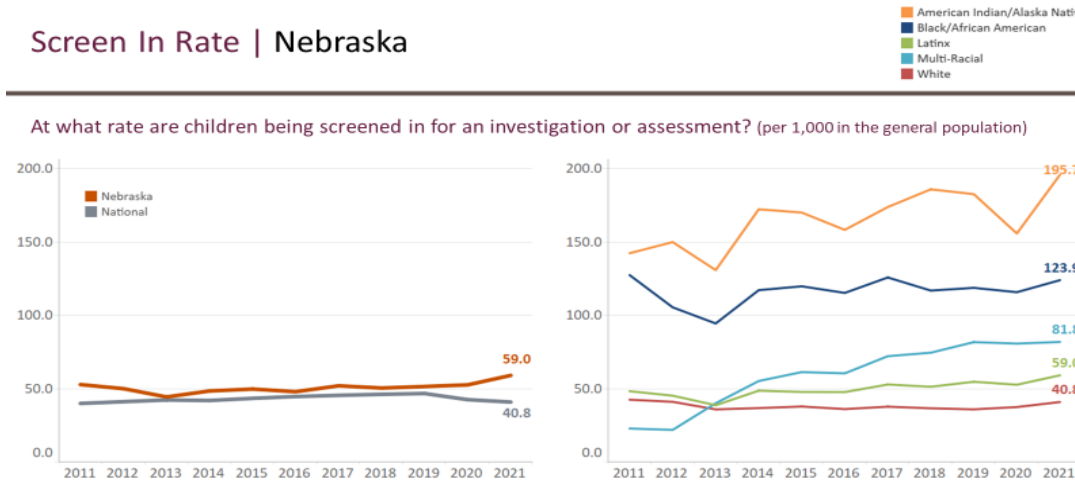
VI. Additional Child Welfare Practice Recommendations

The following recommendations are aligned with the LB 1173 Child Welfare Practice Model.

A. Increase Efforts to Address Disproportionality

The disproportionate representation of African Americans and Native Americans in Nebraska's child welfare system was documented in a May 1173 Work Group session during a presentation from Casey Family Services. (based in part on data from Nebraska's AFCAR). This presentation identified that as overall percentages of the population, there is a significantly higher per capita representation of these families in the child welfare system which is represented below.





Many of these families also experience higher levels of poverty, lower education achievement, higher unemployment rates and higher rates of incarceration.

Concerns about these kinds of statistics were also expressed consistently at the community forums and in individual meetings. Issues were also raised about the system's inability to provide culturally appropriate preventive and post-engagement services to families of color and how that may impact their disproportionate representation in the child welfare system. It was reported that among Latino populations, not only is there a dearth of culturally appropriate supports and services-there were also large gaps in service regarding translation/interpretation services. We also heard about the need to address the dialectic variations of Spanish that are spoken among Nebraska's diverse Latino population. The absence of appropriate interpretation/translation services, especially at legal hearings, may increase the risk of more punitive child welfare actions as families struggle to understand the complexities of the court system without interpretation/translation support.

We also learned that while the availability of translation/interpretation support is a challenge statewide, it is more acute in rural areas. Moreover, state supported translation/interpretation assistance for other English as a Second Language (ESL) populations is severely limited. According to Acutrans, the top foreign languages spoken in Nebraska, include Chinese, Vietnamese, Arabic, Amharic, Tagalog, in addition to many Tribal tongues.

Compounding the ESL issues were reports from stakeholders that the deployment of culturally competent services/support throughout the child welfare system is

inconsistent. The National Center for Cultural Competence at Georgetown University, defines cultural competence best practices for organizations as follows:

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities they serve.
- Incorporate the above in all aspects of policymaking, administration, practice and service delivery, systematically involve consumers, families and communities.
- Recognize that cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum.

The feedback received from stakeholders and sovereign nations across the state suggests that there needs to be an enhanced focus going forward in transformation on recognizing the unique cultural needs for disproportionately represented Nebraskans throughout the child welfare system. Many believe that further development of more culturally sensitive prevention and community development support can strengthen families'/communities' capacity to nurture children safely and successfully at home.

Adoption of statewide culturally competent services in child welfare can entail a number of practices including increasing the utilization of organically grown community organizations as valued community partners. This can lend more credibility to initiatives to enhance cultural competence in the child welfare system. Working with trusted grassroots organizations such as Midland's Latino Community Development can also bolster trust and support at risk communities. These organizations can provide locally developed solutions to locally defined issues.

Disproportionate rates for children of color in out-of-home care remains a critical issue to be examined and addressed, regardless of which agency or agencies are involved.

B. Continue to Expand Authentic Engagement of Those with Lived Experience

The increased deployment of LivedEx as peer support can bolster state led child welfare initiatives. LivedEx peers can also provide support for families struggling to navigate the complexities of the child welfare system and provide guidance on referrals for local community services and neighborhood resources.

The value of the collective voices of those with LivedEx has been profound as we have collected empirical data across Nebraska. These very unique experiences speak to both the challenges *and* the hope for the child welfare system. Many urged the transition of the child welfare system as a punitive engagement to a family support mindset. They repeatedly called for the system transformation to adopt a less punitive approach to supporting families in need.

Moreover, the inclusion of these LivedEx *experts* and families at the state's system/administrative levels to inform policies and practices will also support better experiences and outcomes for families and communities. Their input should be reflected in all critical aspects of the transformed system. This bold step will require meaningful sharing of *power* between state/agency level professionals and family/community stakeholders. Simply put-to improve child and family experiences and create a more efficient and effective system, their direct input must be considered highly valued and integral to transformation. As we heard from several stakeholders-they want the recognition that this initiative reflects the statement, 'nothing about us, without us!'

The community collaboratives framework, via NCFF, has provided solid support to myriad community based organizations-contributing to an integrated infrastructure that emphasizes alignment of multiple resources to strengthen families. We observed considerable cross-functional engagement amongst the local community collaboratives-which foster a 'no wrong door' approach to providing preventive services to minimize child welfare reporting and subsequent actions. To maximize the impact of this approach, a full family risk assessment can be completed no matter which organization was initially sought out by the family/community referral source. These full risk assessments can expedite the delivery of critical services/supports and mitigate potential child welfare system reporting. NCFF also exemplifies the practices of LivedEx inclusion in this work, as their workforce includes a significant number of these valuable community representatives.

Practices for youth aging out of foster care is another significant opportunity for LivedEx input to improve outcomes. According to feedback from stakeholders within the child welfare system and from those providing wrap around services, Nebraska's

strategies for supporting youth aging out of foster care would benefit from a more intersectoral focus. Many LivedEx participants reported having experienced inconsistent support to prepare them for transitioning out of foster care. Some reported it as akin to poor hospital discharge planning-there was little support for sustainability in the community post discharge. As a result, many Nebraska young adults fall prey to the circumstances listed above-dropouts, homelessness, incarceration, etc. Building a more robust aging out model may also reduce generational child welfare participation, a concern raised by many stakeholders.

The socioeconomic impact on families and communities can be significant when aging out youth are not primed to be contributors in the community. As noted in the Annie E. Casey report, Future Savings The Economic Potential of Successful Transitions From Foster Care to Adulthood[38] with the right resources applied to foster care youth transitions:

- Education: 5,290 more young people would graduate from high school each year, leading to $2.17 billion in economic gains through increased lifetime income.
- Early Parenting: 2,866 fewer young women would experience early parenthood by the age of 19, resulting in avoided societal and taxpayer costs of $295 million for the first 15 years of the child's life.
- Homelessness: 4,370 fewer young people would experience homelessness, which would save $9.6 million in spending on beds, per night across homeless episodes, needed to provide temporary shelter.
- Incarceration: 4,870 fewer young people would experience the juvenile justice system, resulting in $1.6 billion less spent on the cost of per-day detention, cost of crime to society and victim and recidivism rate.

Engaging those with LivedEx to support the redesign of success-oriented transition programming could significantly improve outcomes for the affected youth. Leveraging community-based organizations and school based support systems authentically working with such youth strengthens their long term viability as community contributors.

C. Continue to Engage Tribal Nations During LB 1173 Transformation

The Casey Family Programs presentation during the May 2023 Work Group meeting provided detailed data about Nebraska's higher rates of disporportionality in child welfare-especially for Tribal families. Tribal families experience higher screen-in rates

[38] https://assets.aecf.org/m/resourcedoc/aecf-futuresavings-2019.pdf

for investigations and enter care more frequently than other non-Tribal famialies. In addition to disproportionate representation in the child welfare system, Tribal families continue to grapple with historical and intergenerational trauma, disconnection from culture and loss of cultural identity, poverty, high unemployment and, a lack of access to adequate resources.

According to the 2021 Kids Count in Nebraska Report by Voices for Children, Native American children continued to comprise only one percent of Nebraska's population but represented nearly four percent of children in the state's child welfare system.[39] Data published by the National Indian Child Welfare Association in 2021 ranks Nebraska as the fifth highest child welfare disproportionality rate out of the top 15 states in the Nation.[40]

Addressing Tribal communities in child welfare entails consideration of factors that are unique to these communities. First among them is Tribal sovereignty, protected and guaranteed by myriad federal/state legislation including but not limited to:

- Indian Reorganization Act, 1934
- Indian Civil Rights Act, 1978
- Indian Child Welfare Act, 1973
- Indian Tribal Justice Act, 1993
- Nebraska Indian Child Welfare Act, rev. 2015

Tribal nations are authorized to engage in self-government which includes oversight of child/family welfare infrastructures. State child welfare systems must accede to these federal laws in the systemic design and administration of child and family welfare programming. Ideally, state child welfare systems are aligned with Tribal systems for improved child/family safety, coordination of additional support/services and reduction in adverse outcomes. A primary premise of the Indian Child Welfare Act (ICWA) calls for prioritization of culturally appropriate placements for Tribal children who are removed from their homes. However, according to NICWA, currently there are no licensed foster homes classified as Tribal foster homes in Nebraska.

During the course of the LB 1173 system evaluations, we convened a number of key meetings with Tribal stakeholders, including a Winnebago reservation-based session, to gain better insight into sovereign nation child welfare administration and

[39] https://kidscountnebraska.com/child-welfare-2022/

[40] https://www.nicwa.org/wp-content/uploads/2021/12/NICWA_11_2021-Disproportionality-Fact-Sheet.pdf

to represent the Work Group's desire to support a more intersectional approach to addressing Tribal disproportionality. We have gathered sage and practical insight from meetings with organizations like, The Nebraska Indian Child Welfare Coalition, the Nebraska Urban Indian Health Coalition (NEIHC), and from several one-to-one interviews.

One issue that was repeatedly echoed throughout these meetings was the need to recognize that Tribal nations' cultures are not homogenous. Each has a distinct history/culture-akin to the differences between Japanese, Portuguese and German cultures. These nuances color Tribal governmental infrastructure design and their approaches to child welfare. The state child welfare system transformation must factor in these unique considerations in planning for broader Tribal understanding, support and engagement.

Distrust of the state system among Tribal Nations is another significant factor-as is the case for many of the disproportionately represented populations. This distrust may be primary borne out of the perception that the state system has limited recognition and responsiveness to the Tribal culture and rights. Several of the goals of the NICWC include, '…reconnect Native children with their families, communities, cultures and heritage; promote education about Native American cultures…advocate for the ICWA to be respected.' This group has worked successfully with coalition partners across the state to achieve these objectives and reported an improvement in state/Tribal connectivity. They strongly recommend imbedding culturally sensitive training across CFS, courts, healthcare, etc.

We also learned that routine communication between state government entities and Tribal governments is lacking. This impacts the efficacy of Tribal agencies' service to their communities. For example, termination of Medicaid coverage occurs with very little communication with Tribal agencies that may have been able to provide intervention to mitigate loss of coverage. Tribal representatives also reported concerns with the onerous nature of the Medicaid eligibility process for Tribal families. In some cases, Tribal agency staff are not well versed in the complexities of the Medicaid program impacting their capacity to support families. There's an opportunity for cross training between Tribal/state agencies to improve access to Medicaid services, including utilization of Medicaid covered preventive services that enhance family stability. Additionally, better coordination and standardized application of Medicaid services between Indian Health Centers (IHC) and other clinical entities providing Medicaid covered services can reduce barriers to access to care. Training and technical assistance for state and Tribal agencies regarding unique Medicaid program coverages/exclusions for Native Americans-

including their participation in Medicaid MCOs would augment navigation support provided to families. In many instances, limited Tribal funds-designated for other purposes- can be diverted to cover family services that are eligible for Medicaid reimbursement.

Stakeholders also reported that all Tribal child welfare systems are not created equally. While some function very efficiently, others struggle to keep up with growing demands and delivery of high-quality services. These disparities can lead to longer wait times for assistance, increasing the risk for child welfare intervention. For many Tribal communities there is a single Tribal Court Judge or Prosecutor, which means dockets are backed up. Concerns were raised about some Tribal courts' availability of funding for public defenders to represent families/children. The Nebraska child welfare transformation should address development of more intersectional engagement between state and Tribal child welfare agencies- including leveraging funding to create equity among Tribal child welfare systems.

Feedback from Tribal related conversations also indicated that there is often a lack of synthesis between Tribal and state child welfare statutes, regulations, and policies. Without considering the impact on Tribal communities, development of some state policies/practices have negatively impacted Tribal children/families. Organizations like NICWC are committed to constant policy monitoring to advocate for reforms that are reflective of implications for Tribal nations. Tribal stakeholder representation in any transformation efforts going forward will be critical to ensuring the transformation process reflects the best interests of all clients- particularly Tribal nations.

Within this report, enhancing community pathways as a coordinated option to avoid child welfare engagement is shared as a recommended strategy. We acknowledge that today, Tribal Nations are part of the Bring Up Nebraska Community Collaborative system. These community pathways can be beneficial to Tribal families/children if they are designed to reflect the diverse culture/needs of Tribal communities. The design of community pathways programming that is culturally appropriate for high-risk communities is essential to successful support for all child welfare clients.

D. The Crossover Youth Practice Model is Effective and Aligned with the LB 1173 Child Welfare Practice Model and Should Continue To Be Implemented in every Region Statewide.

Over the last year, we have had the occasion to meet with many front line CFS and Juvenile Probation Officers at their Regional Offices as well as leadership from both

agencies. Based on all of our discussions, it is clear that both agencies have so much to offer cross over children and youth and embody a clear and unified vision to enhance the well-being of every youth in care. There will be a need to continue this spirit of collaboration with an enhanced focus on adherence to the Crossover Youth Practice Model (CYPM), in alignment with the transformative LB 1173 Child Welfare Practice Model. The CYPM has been in existence in Nebraska for a few years not and we have found that this model, when practiced with fidelity, is a best practice collaboration between the Administrative Office of the Courts and Probation (AOCP) and Department of Health and Human Services – Division of Children and Family Services (DCFS) and will lead to more effective outcomes for these Crossover youth. The CYPM is created as a guide for agreed on expectations and daily work procedures to improve outcomes for these dual system involved youth. It also can be a vehicle to provide clarity on the different roles and responsibilities between a juvenile probation officer in Nebraska and a CFS case manager, which was a theme we heard in our meetings that, at times, is needing clarification for not just for both agency staff, but for courts and other stakeholders.

The CYPM enables effective early identification of a dual system youth, contact and effective and continuous communication between staff of each agency, supported by established, consistent supervisory staff collaboration. Pursuant to the CYPM, every regional/local CFS and AOCP Probation District creates a "Local Process" document to note how the following key process steps will be accomplished in their area:

- Supervisory Collaborative Support: Regular staffing of emergency and temporary placements, such as detention, crisis intervention, respite and shelter. Monthly supervisory meetings to review operations, connect any needed staffing, discuss services and approvals of recommendations for case disposition.
- Identification of Youth: Every youth entering system checked to identify if they are a dual-system youth. This would include both emergency and non-emergency situations.
- Aligned Assessment and Planning: Once a youth is identified, immediate contact between Probation Officer and CFS case worker to prepare for detention/removal and court hearings in emergency situations. In Non-emergency situations contact between two agency workers made timely, usually within 5 business days and a plan for formal exchange of case information in a timely manner after notification. Schedule assessments and interviews and continue to coordinate on the schedule and work.

- Coordinated Case Management: Timely ongoing communication between both agencies, ongoing team meetings, consistent documentation, attending all court hearings and use of a Crossover Collaboration Report to represent collaboration to the court.

We believe that this is an effective model and that it should continue as it is already aligned with some of the key LB 1173 themes, as well as the recommended Practice Model. In the future, we would strongly recommend that the Judicial Branch and DHHS consider including Alternative Response cases in the dually involved definition, and also ensure that there is proper training for new hires about the Model and its importance.

E. Consider Implementing Douglas County Youth Impact! Initiative Statewide for Cross Over Youth

In 2007 Casey Family Programs and the Center for Juvenile Justice Reform at the Georgetown University Public Policy Institute (CJJR) began partnering to develop the Crossover Youth Practice Model (CYPM) that describes the specific practices that need to be in place within a jurisdiction in order to reduce the number of youths who crossover between the child welfare and juvenile justice systems. In February 2012, Douglas County, Nebraska agreed to become a CYPM site and on November 1, 2012, the CYPM was officially implemented in Douglas County. In 2014 this initiative was re-branded Youth Impact! to reflect the intentional youth focus of the initiative.

The Douglas County Youth Impact! Initiative is a voluntary coordinated effort of public and private agencies that have come together to address the unique issues presented by children and youth who are known to both the child welfare and juvenile justice systems. In this best practice model, Douglas County, through leadership of Judge Chad Brown, is utilizing the 1184 Crossover Team created by statute to bring members together for coordinated case planning.

The 1992 Nebraska Legislature created the teams in LB 1184, and it is from the bill number that they received their popular name. Every county in Nebraska is required to create and maintain 1184 Teams in order to monitor and coordinate investigations when abuse or neglect has been reported. The teams also coordinate and monitor treatment for families where child abuse or neglect has been found. The teams operate pursuant to protocols that provide for coordinated joint law enforcement and Health and Human Services investigation of cases; ensure law enforcement participation; reduce the risk of harm to child abuse and neglect

victims; ensure that children are in safe surroundings; share information among professionals; and manage the team's activities.[41]

The Douglas County Youth Impact! Initiative is using the 1184 process, formalized by a Memoranda of Understanding (MOU), coordinated through the Child Advocacy Center, that binds the partners together, including parent and youth. Following are the outcomes and goals included in the MOU.

Outcomes:

- Reduce recidivism.
- Reduce youth from crossing over.
- Reduce the number of youth in out of home placements.
- Reduce use of detention.
- Reduce disproportionate minority contact.

Goals:

- Promote increased cooperation, coordination, and integration at the administrative and service delivery levels for the benefit of children and families.
- Achieve and institutionalize greater multi-system coordination and integration to achieve the intended outcomes (stated above) set out for the Youth Impact! for Douglas County children, youth and families.
- Strengthen the family voice and choice by engaging parents and youth throughout the Youth Impact! process.
- Maintain the interests of community safety while recognizing the need to support the safety, permanency, and well-being of children and youth.

These outcomes and goals, along with leveraging the existing 1184 Team consisting of intersectoral partners, is directly synergistic to the efforts of LB1173. We recommend considering implementing the Douglas County Youth Impact! Initiative statewide through leveraging the intersectoral partnerships of the existing statewide 1184 Teams and the Nebraska Community Collaboratives to provide crossover youths with much needed support and successful outcomes.

[41] https://ccfl.unl.edu/our-work/projects/resource-center-child-abuse-and-neglect-teams-rccant

F. All child welfare system stakeholders should continue to collaborate and work on LB 42 to redefine the definition of Neglect.

One of the most common themes we heard during the community forums and in many of our stakeholder meetings was that poverty does not equate to neglect and should not be the reason for removing a child from his or her parents. Families should be supported where children are safe, rather than reported when there is no risk to safety but a need for services and support for families in their communities. Our LB 1173 Child Welfare Practice Model embraces the practice of helping these struggling families as its first priority:

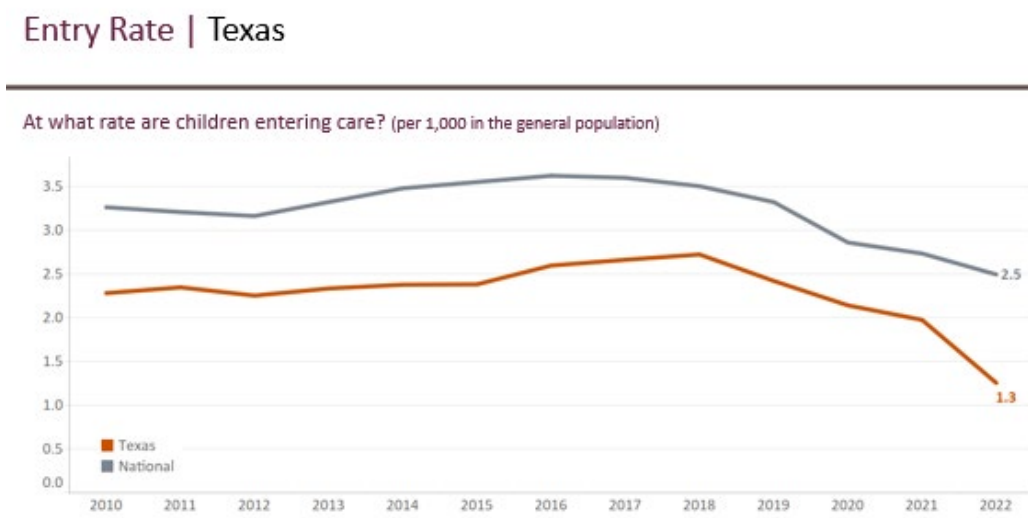
- When safely possible, children should be raised in their family - families should be viewed as the solution and not the problem.
- We will design and deliver supports early to build on family strengths.
- We will prioritize supporting the family unit by identifying the most prevalent issues with matching intensity and focused solutions.

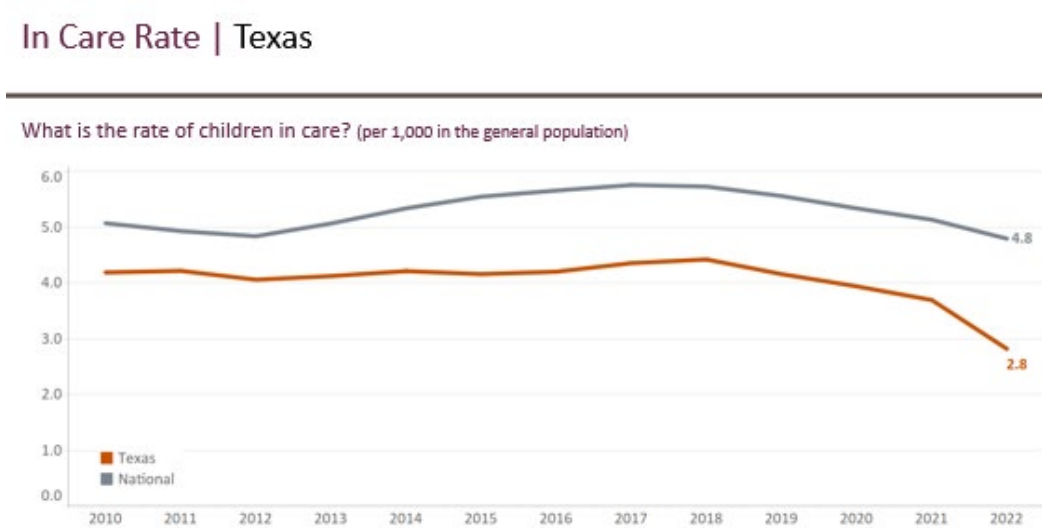
Nebraska LB42 seeks to redefine Neglect and provides definition for independent activities. It has broad support from a variety of diverse stakeholders to include Nebraska Children and Families Foundation, Nebraska Appleseed, Let Grow, and Home School Legal Defense Association, Voices for Children in Nebraska, Americans for Prosperity, Nebraska Christian Home Educators Association, and the ACLU. As of this writing, LB42 was referred to the Judiciary Committee where it still sits after a hearing in February[42].

While LB42 is silent on the topic of poverty and economic disadvantage ***Senator Hansen stated in his testimony to the Judiciary Committee that "Oftentimes, what should be identified as poverty is often labeled as child neglect by those on the outside looking in, hardship does not equal harm."***[43]. Neglect has an overly broad definition that leaves room for families struggling to meet their basic needs to be unnecessarily involved in the child welfare system due to economic circumstances which could be ameliorated by connecting the family to services. We recommend including language as Texas did recently regarding the fact that economic disadvantage does not constitute clear and convincing evidence sufficient for a court to remove a child[44].

[42] https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=49881
[43] Page 2 https://www.nebraskalegislature.gov/FloorDocs/108/PDF/Transcripts/Judiciary/2023-02-22.pdf
[44] https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB00567F.pdf#navpanes=0

In HB567, the State of Texas redefined Neglect and eliminated non-emergency removals which went into effect in September of 2021 and has led to positive changes in reducing removals. The following graphs provided by Casey Family Services show the longitudinal decline in Texas foster care entries and children in care. Comparing 2018 to 2022, removals dropped by 53%.

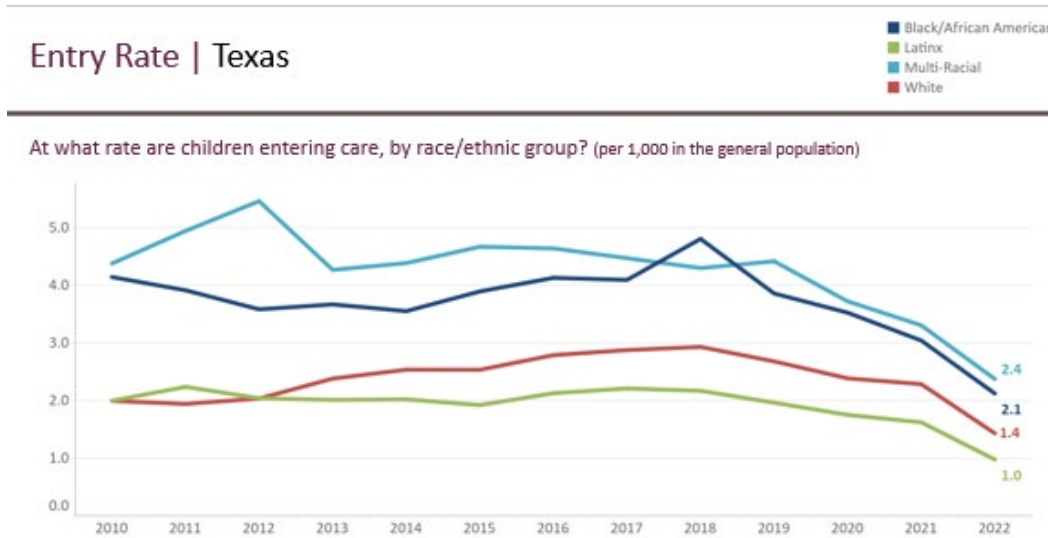




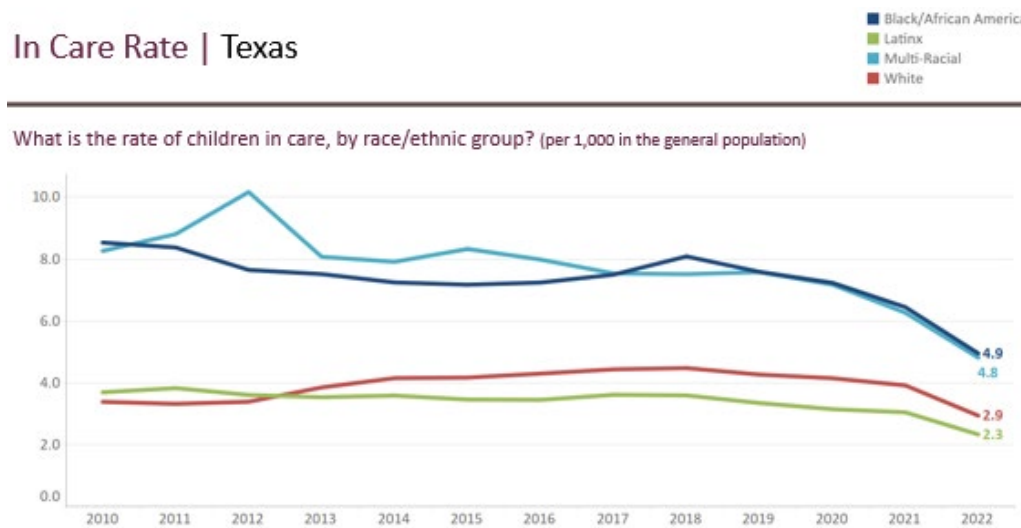
[45]

[45] Lower rate is considered better. Point in Time 09/30/2022

The data also indicates all population cohorts benefited from the reduction in removals. No cohort was left behind and the rate of decline is fairly consistent across population cohorts. The following graphs provided by Casey Family Services illustrate the removals by race/ethnicity.



[46]



We recommend all stakeholders, and intersectoral partners continue to work on the LB42 legislation and try to achieve common ground on redefining Neglect or work together to achieve the goal of reducing unnecessary system involvement where

[46] Asian/Pacific Islander and American Indian/Alaska Native not displayed due to < 100 children of those races in care.

family supports would be an appropriate intervention. Furthermore, as stated above, we recommend amending the language of LB42 to include that economic disadvantage does not constitute clear and convincing evidence sufficient for a court to remove a child from its family. Additionally, we believe that defining independent activities, as LB42 currently does, should expect to support a decline in unnecessary removals as well as serve to preserve and strengthen families. See Appendix C for comparison of both bills.

G. Enhance Collaboration, Communication and Partnership with County Attorneys

County Attorneys in Nebraska are key intersectoral child welfare partners and their input on system improvements is invaluable. Their main focus is to ensure the safety and protection of any child or youth that has been abused and neglected under state law. They are also key in moving a case through the process in a timely manner, which is so critical in reducing trauma from placements and involvement with the foster care system.

We were encouraged during our meetings and discussions with several county attorneys across the state with their willingness to provide input on the LB 1173 process and future child welfare Transformation. County Attorneys we met see their role as a partner in the child welfare system and appreciate that lens as opposed to being viewed as an advisor when collaborating on cases.

We also appreciate their openness to embrace, as part of the new practice model, the focus on front end prevention without system involvement. In our discussions they recognize the validity of the prevention focused community pathway to strengthen families by meeting them where they are in their communities with appropriate interventions. However, they want to be assured that safety is the first priority, and the resources are provided on the front end to assist these families, which would include greater access to mental health and substance abuse services.

In all of our discussions, it was clear that where there are true and authentic partnerships, with great collaboration early on in any case, between a county attorney a CFS case worker, and/or a juvenile probation officer, the process worked in a much more effective manner. Where there was not good collaboration between the county attorney and the case workers, usually the result was not as positive. Thus, consistent with the Practice Model, we recommend that case workers involved in the Child Welfare system in Nebraska enhance collaboration, communication and authentic engagement with county attorneys by way of real and meaningful partnerships.

Our emphasis here is not only based on our interviews, but on the results of a survey we conducted where 36 County Attorneys around the state participated and answered twenty-one questions and also provided detailed comments on system improvements. – See results of survey at Appendix D. These county attorneys offered great insight into a number of areas that should warrant attention during Transformation and are also addressed in the LB 1173 Practice Model and in a number of our engagement strategies and recommendations. The results of the survey can be summarized as follows:

CFS case worker Court Preparation

The results show majority of county attorneys believe that CFS caseworkers are able to meet their requests for information in preparing petitions for removal, but there is strong disagreement that CFS caseworkers are prepared for court and, even with proper training most did not agree that they are well suited to make final decisions on whether a child can safely be left in a home with a safety plan in place.

CASA and GAL Participation

County attorneys strongly value the input, involvement and recommendations of GALs and CASA and believe overwhelmingly that they both serve to facilitate or expedite permanency efforts in a case.

Petition for Removal

Largely county attorneys feel that petitions for removal contain sufficient information regarding reasonable efforts and exigent circumstances.

Birth and Family involvement

County attorneys believe that families are involved in decision making and court hearings. Conversely, they feel foster parents are not.

Service Access and Coordination

County attorneys overwhelmingly believe there is inadequate access to mental health and substance abuse services to meet the needs of families, children and youth. They have also identified behavioral health services, substance abuse services, parenting sill development, home visiting services, and transportation as significant areas of need to bring stability to a child and family. Additionally, the majority of county attorneys do not believe that DHHS does an excellent job in linking and coordinating all departments and services needed for families.

The vast majority of County Attorneys also do not believe that CFS caseworkers should be given more discretion over the decision to remove children or in making decisions for the family.

Training and Understanding

County Attorneys believe they have had sufficient training to understand childhood trauma and in understanding their role in helping a child reach permanency, but the majority do agree that they need more training related to understanding the child welfare system and its decision tools. Collaboration and Permanency County Attorneys overwhelmingly believe there is not enough collaboration with DHHS attorneys, and that cases do not reach permanency in a timely manner.

Enhancing collaboration, communication, and partnership with the County Attorneys is an area ripe with opportunity under our recommendations and the implementation of the Practice Model. Going forward, we would recommend that DHHS meet regularly with County Attorneys to provide regular reports regarding the status of cases in their jurisdictions, including those that are non-court or Alternative Response. These reports should include at minimum the number as well as the status of engagement with families under these categories. The data can be used to collaborate and engage with the County Attorneys to help the families before becoming court involved. Additionally, another way of showing collaboration is where DHHS provides updates on these types of cases at the 1184 team meetings where transparency with intersectoral partners serves to strengthen those relationships and improve outcomes for families.

H. Concrete and Economic Supports As Part of New LB 1173 Child Welfare Transformation

We have heard during many of our community forums and discussions with stakeholders, including CFS staff in the field, about the need for essential concrete and economic supports for families that are struggling in order to bring stability to the family unit. This could be funds to pay for short term housing or rental assistance, or for essential child care so a parent can work, or transportation to and from a job site, especially in rural areas of the state, including Western Nebraska. We have also heard stories about case workers not being able to access some basic concrete support for a parent that could allow for a child to return home. In addition, we heard from a number of stakeholders that in foster care cases permanency planning is sometimes delayed because a parent does not have stable housing or access to quality child care. (As referenced by Foster Care Review Office in its June 2023 Quarterly Report: “eviction and other forms of housing instability

have been tied to increased risk for child welfare involvement, out-of-home placement, and longer lengths of time in care (Bai et al., 2022; Bassuk et al., 1997; Berg & Brannstrom, 2018; Marcal et al., 2022; Tang et al., 2022)).

We were also encouraged to hear how some of the Community Collaboratives have raised funding from the community to provide flex funding for up to $500 dollars per family to allow for payments for emergency rental assistance or needed child care, and the Collaboratives also have been laser focused on the issue of access to quality child care in their communities for quite some time.

In the child welfare system, short term concrete and economic supports can make the difference between being reported to the abuse and neglect hotline or staying out of the system all together. They can also be the difference in having your child return home after a removal to foster care, as we heard a number of times from CFS staff. However, in the new child welfare transformation, such supports need to be made available to the case workers and to the community to provide assistance, with flexibility and accountability. This will lead to more positive outcomes, especially in the permanency planning and reunification area to also reduce the length of stay in foster care, which is an area that this Work Group feels needs priority attention System Transformation going forward.

Several recent studies have demonstrated the effectiveness of concrete and economic supports in reducing overall child welfare expenditures significantly. (more detail about these studies is provided in the Finance Framework attached to this Report). Additionally, both childhood exposure to housing instability and involvement in child welfare is associated with short- and long-term detrimental outcomes for children such as increased risk for juvenile justice system involvement (Almquist & Walker, 2022), mental and physical health concerns (Bomsta & Sullivan, 2018; Marcal et al., 2022), and housing and socio-economic struggles in adulthood (Bassuk et al., 1997; Jasinski et al., 2005). In its June 2023 Quarterly Report, the Nebraska Foster Care Review Office identified that it was working in collaboration with the University of Nebraska at Omaha/Creighton, as the University is conducting a study to explore the connections between eviction and out-of-home foster care in Nebraska. It will be important for the Legislature to review the findings of this evaluation when making its policy decisions related to LB 1173 Child Welfare Transformation.

I. Enhance Family Peer Support

Another key theme we heard at all our community forums is how valuable and effective family peer support engagements can be for families involved in the

Nebraska child welfare system. Many do not know what their rights are, the certain aspects of an investigation and the court process if there is a petition for removal filed. We have heard from key Intersectoral partners, including judges, that if families are provided with peer support early on in the process it has resulted in much better outcomes for all parties involved.

Additionally, the utilization of Family/Peer Support Programs is highly touted as an effective tool to empower families engaged in the child welfare systems. These programs have been proven to enhance the experiences of and outcomes for families engaged in child welfare system-especially those who have experienced child removal. The value of families working with people with LivedEx to provide trusted, nonjudgmental, personalized support, counsel and navigation assistance for the complexities of the child welfare system cannot be understated. LivedEx peers' personalized experiences aid families in reunification efforts, referrals/resource utilization, diminishing trauma, etc. Peer support mentors are also invaluable in mitigating many of the disparities driven challenges for families.

Ideally, these mentors are trained representatives from families' communities-with common cultural/linguistic and child welfare LivedEx. Community based peer mentors are more accessible, trusted, and empathetic. Peer mentors can also be valuable allies for CFS staff through their personal connections to families.

A study of the Iowa Parent Partner Program found that involvement with the program reduced re-entry rates within 12 months by more than 40% and significantly increased the likelihood of reunification. Additionally, an evaluation of Kentucky's Sobriety Treatment and Recovery Teams (KY START), a program that pairs child protective services workers trained in family engagement with family peer support mentors (employees in long-term recovery) using a system-of-care and team decision-making approach with families, treatment providers and the courts, found that:

- Children in START are 50 percent less likely to enter out-of-home placements than children from a matched comparison group.
- At case closure, more than 75 percent of children served by START remained with or were reunified with their parent(s).

Additionally, from an economic perspective, investments in peer support interventions make fiscal sense. The same KY START evaluation, for example, found that for every $1 spent on START, $2.22 is saved on out-of-home placement costs. Thus, this evaluation clearly aligns with the common theme throughout this report

which is the significant value of preventive services and early interventions from the family/child, community and taxpayer perspectives.

We further learned more details about the Nebraska Family Peer Support Programming in a unique forum that featured dialogue with individuals from three of Nebraska's Family Peer Support organizations. They reported very positive results with the families with whom they've been engaged. They also raised concerns about how systemic/financial challenges impede broader efforts to successfully support families/children. Some comment concerns noted include:

- There is inconsistent utilization of family peer programming across the CFS system. Some offices welcome the support and provide opportunities for early engagement to maximize outcomes. Others rarely make referrals or do not provide timely referrals/communication-leaving families at risk. Early intervention is the foundation of family peer support efficacy and a strong deterrent to child removal.
- More training on the value of family peer support programming could increase CFS referrals. Additionally, standardizing successful practices from engaged CFS offices could contribute to more engagement efficacy.
- More concentrated efforts to connect English as a Second Language (ESL) and other immigrant communities with family peer supports can help reduce the cultural and linguistic barriers they face. The state should invest in recruiting peer mentor trainees from these communities.
- Many participants reported concerns about the billing/payment process. Errant paperwork, delays in finalizing contracts, etc., have resulted in ineligible billing/rejected payments. More training and standardized practices would help minimize these errors.
- Several stakeholders commented that there is often an adversarial reaction from some CFS offices as they work to advocate for family rights in the system. Family/Peer mentors can provide useful support to both CFS workers and families.
- There is a scarcity of state certified family/peer support organizations in Nebraska. Several participants suggested that addressing the cost and cumbersome work involved in the certification process might encourage broader organizational participation.
- Nebraska workforce challenges-create capacity challenges for established and emerging organizations. They recommended state sponsored recruitment and training programming. Emphasis on recruitment /training of LivedEx.

As part of the future LB 1173 child welfare Transformation, the Work Group believes that enhancing Nebraska's family peer support services and capacity can improve state performance outcomes, strengthening family/children stability and provide much needed 'extenders' to be part of a multi-disciplinary team needed to provide additional support to the CFS workers. Per studies quoted here and around the nation, family peer support services support families/children by offering relevant LivedEx experiences that can help reduce shame and isolation and assist with navigation through myriad state systems.

One additional area that was raised in the community forums that we believe should be part of the consideration of providing enhanced family peer support in the future is around the area of engaged families with special needs children and early identification, assessment and supports. Some of these families involved in the child welfare system may be reluctant to engage in any further 'state' intervention-creating further risk. This is an area where specially trained/experienced peers can provide focused guidance and advocacy to ensure that these children receive Early Development Network services/supports.

J. Consider Expansion of Lancaster Family Treatment Drug Court Model

"Family treatment Courts (FTCs) have proven to support positive outcomes for families affected by parental substance use disorder, including improved recovery for adults, safety for children, and timely permanency for families."[47] In these special courts, judges, attorneys, child protection service workers, and treatment personnel unite with the goal of providing safe, nurturing, and permanent homes for children, while simultaneously providing parents with the necessary support and services to encourage abstinence from drugs and alcohol. These multidisciplinary teams allow collaborative, evidence-based efforts to be delivered efficiently to shorten the time a family spends in the court system. These Family Treatment Courts aim to combine court procedures, substance use treatment, employment, transportation, safe and affordable housing, and mental health treatment with the help of their network of agencies and partners.

In Nebraska, the Family Treatment Court model is being deployed in Lancaster County as the Family Treatment Drug Court FTDC. This model has been in existence since 2014 with cases assigned to the docket of Lancaster Judge Roger Heideman. The main components of this court are identification and selection of families; monthly team meetings; emergency team meetings; 90-day review hearings; specialized, trauma-informed substance use treatment and parenting services; and

[47] https://www.casey.org/ftc-brief-two/

timely implementation of intervention measures. In the FTDC, court orders often include chemical testing, behavioral health treatment, and participation in monthly Family Team Meetings with case managers, attorneys, service providers, support persons, and Judge Heideman. A similar model is also being used by Judge Elise White on parental domestic violence cases involving the child welfare agency.

Both of these courts are a partnership with CFS as they are focused on abuse/neglect cases. There is also a current MOU that includes the Administrative Office of the Courts, Juvenile Probation which allows for data sharing, plus there is a hired Coordinator that reports to both courts. See feature article Family Treatment Courts in Nebraska by Adam Jorgensen Adam Jorgensen, the State Problem-Solving Court Director of the Programs & Field Services Division in the Nebraska Administrative Office of the Courts and Probation. The Nebraska Lawyer 28 July/August 2020.

For these models to work, Judicial leadership is critical to the effective planning and operation where the judge works collectively with several stakeholders and agencies to establish clear roles and shared mission and vision. As part of the development of our LB 1173 Child Welfare Practice Model, The Work Group met with both Judge Heideman and Judge White for the purposes of exploring this and other models further with the judges and we are extremely grateful for their time and also for their valuable efforts in developing such best practice models in Nebraska.

In fact, there have been measured outcomes from Judge Heideman's court including enhancing timely permanency. In fact, a 2020 evaluation by the University of Nebraska-Lincoln, Center on Children, Families, and the Law (CCFL) supported a number of positive outcomes that show how such a focused, collaborative team based, early intervention strategy could bring to any court in Nebraska, as well as reunifying children with families in a safe and stable environment. (2016 to 2020 evaluation by the Nebraska Resource Project for Vulnerable Young Children, University of Nebraska – Lincoln, Center on Children, Families, & the Law showed, in comparison to a controlled group that did not participate in the Family Treatment Drug Court, higher rates of parent participation, cases reaching important milestones faster, more cases closing through reunification, more families completing substance abuse treatment and cases reaching permanency faster[48].

We have also reviewed outcomes of a the FTDCs models nationally and we are of the opinion that such a multidisciplinary process with positive outcomes should not

[48] https://nebraskababies.com/sites/default/files/2022-09/nrpvyc-lancaster-ftdc-findings.pdf

only be exclusive to Family Treatment Courts or other specialty courts, but, in fact, similar MDT strategies should be implemented in any child and family well-being system and in any family court in Nebraska. This type of Intersectoral system collaboration between the courts, county attorneys, CFS and numerous other stakeholders, including treatment and service providers, can lead to positive results for families in any area of the state. Thus, as part of LB 1173 Implementation, the three branches should consider making these strategies consistent statewide for other complex child welfare cases where permanency and timely and safe exits from foster care are the goal.

K. Consider Improvements to the N-Focus system Functionality to Guide Future Case Worker Decision and Support

We have heard from DHHS leadership and from CFS workers in the field throughout the LB 1173 process about the lack of accurate and real time reporting that comes from the N-Focus system. In the child welfare transformation, there will need to be decisions made about how the state will improve data system functionality to facilitate accurate and real-time reporting of key performance indicators and support data driven decision making for case workers based on the facts contained within data. The Work Group believes it is important to have a more intricate knowledge of the N-Focus data model and system workflows in order to assess future system upgrades and integrations. It will be important here to explore all options related to leveraging existing N-Focus functionality and inventory usable artifacts in order to drive a fiscally responsible future upgrade solution to improve upon transactional integrity.

In moving forward, key decisions will need to be made on improvements to the entire N-Focus data management system, including its usability and functionality for case workers that achieve the following goals:

Decision Supports

A system that analyzes large amounts of client data in real-time and proactively pushes *critical* information to workers that includes worst case scenarios and best possible options.

Interoperability with other programs

A system that interoperates with other human service programs areas including health, education, courts, Medicaid, and ancillary systems used by staff.

Data Exchanges

A system that allows sending and receiving of batch or transactional data backed by quality and interface standards.

Single source of truth

A system that aggregates data from across the agency as well as other human service programs and that no reporting requirements rely on siloed data. This centralized client perspective will also assure a master client index, linking client information between other source records.

Zero duplicate data management

No data management concludes with source data that resides outside the single source of truth; that information contained in the single source of truth does not have to be re-entered in any other system module; that all reports required by the agency represent the same data outputs and that there are no discrepancies across reports.

Front-line tools including mobility

A system where front-line staff benefit from real-time interactions, bi-directional informational flows, about their case load (including but not limited to risk indicators, action items, late action items, court information, education information, foster parent information, etc.). The system must provide the ability to submit information directly to the single source of truth from the field and not require intermediate steps for the information to reach its final destination.

Operationalized data for daily use

Unlike reporting that will support scorecards and performance outcomes, the point here is that data will be readied and used daily to drive conversation, used for decision making, provides real-time interactions, and that the purpose of the data is always well-known.

Other considerations:

- Business processes and alignment w/ technology and associated automation
- Eliminate all use of paper and spreadsheets to track business level data
- Eliminator or integrate ancillary systems (outside of SACWIS/CCWIS)
- Programming interfaces and data sharing between partners and contributing agencies

- Electronic signatures
- Mobile apps
- Mobility integration with backend systems (SACWIS/CCWIS) and interfaces to support them
- Complete Master data management strategy and operational compliance
- Support for web services, API's
- bi-directional data sharing
- Single audit pane and 360-degree views
- Data quality improvements aligned with a data quality plan
- Data sharing agreements for external partners and covered entities
- Productivity tools for front line (not just mobile, but front-line use activity lists, caseload-based dashboards, etc.)
- Foster parent participation using technology
- Comprehensive Electronic Document libraries
- Master document index
- Master client index
- GIS services
- Alerting, notification (automation, what, who, when)
- System performance, bottlenecks, why, when
- IT continuity and communications plan
- System capacity

L. Consider Changes to Drug Testing Policy that Promotes Safety and Accountability

In 2017 Nebraska DCFS drug testing policy allowed CFS workers to conduct drug testing as one tool to determine if a parent is using substances and to facilitate decision making with families affected by substance use disorders to ensure the safety of children in the home. Under this policy DCFS was required to pay for the testing. In 2018 this policy was changed and the CFS workers no longer had drug testing as a tool. Instead, the CFS worker must make a referral to a provider for the assessment. Under the current (2018) policy the provider must arrange payment with the parent vis-à-vis insurance or some other arrangement. We learned that neither county attorneys nor courts were included in any meaningful collaboration when this policy was changed.

As a result of the policy change, the assessment of parent(s) or caregiver(s) for a substance use disorder must wait for an evaluation to be scheduled or for a CFS worker to request a court order. This leads to delays and burdens an already overburdened system along with negative outcomes for families and children.

In 2022, DCFS worked on a proposed change in the policy which would give the drug testing tool back the CFS worker. It is important to note that in the proposed Standard Operating Procedure the following was noted in bold:

"**A drug test alone, whether positive or negative and whether a drug test has been taken or not, will not be used alone to determine the safety of children**."[49]

This process for this proposed policy change did allow some consultation with the courts in its development. It would allow for the CFS worker to use a substance use screening tool identified as the Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool as part of the safety assessment.

The Nebraska Family Treatment Drug Court (FTDC) in Lancaster County uses a standardized drug testing protocol to monitor participants' use of illicit and licit substances throughout their FTDC participation. The FTDC ensures that participants are tested randomly a minimum of two times per week (whether by the FTDC or its partners), which is usually frequent enough to detect any substance use quickly and reliably. The FTDC's drug testing protocol specifies the frequency, scheduling, randomization procedures, observation, duration, and breadth of testing. The protocol also outlines processes for confirmation, notification, and dissemination of test results. One evaluation of an FTDC reported a 50% decrease in positive tests when the program increased its random, observed testing to twice weekly

Having a drug testing tool is recognized as a best practice nationally. According to the National Center on Substance Abuse and Child Welfare:

"The most effective way to identify a substance use disorder or determine if a child is at risk for maltreatment or neglect is to use a combination of screening and assessment tools, including safety and risk assessments: clinical instruments, random drug testing, self-reports, and observations of behavioral indicators. Assuming there are no other safety concerns, a positive drug test or a series of positive drug tests should not be used as the sole factor in the removal of a child from the home or to determine parental visitation."[50]

We recommend DCFS implement the proposed policy change contemplated in 2022 and provide CFS workers with the tools necessary to make an assessment of a parent

[49] DHHS T-102.SOP Template, V. 1.0

[50] https://ncsacw.acf.hhs.gov/topics/drug-testing/

or caregiver where there is a reported substance use allegation to ensure the safety of children in the home.

It should be noted that the LB 1173 Practice Model provides for the authentic engagement of County Attorneys, Courts, and other partners such as GAL, families with lived experience to engage and collaborate in future policy changes which will strengthen the system and keep children safe in their homes. See Appendix E for a comparison matrix of the Nebraska DCFS 2017, 2018 and 2022 proposed policy regarding drug testing.

M. Future Performance Measures to Consider In Evaluating Success of LB 1173 Child Welfare Practice and Finance Model

Collecting and analyzing data to evaluate child welfare programs and services facilitates the ability of leaders to make informed policy and practice decisions. In turn, these decisions lead to improved outcomes for children and families.

Thus, as mentioned, the Three Branches should continue to meet regularly and assess outcomes of the new LB 1173 Practice and Finance Models. In doing so, it will be critical to identify and focus on specific system-wide measures that can be tracked and directly relate to program objectives, goals, and service efficacy. As part of transformation, the legislature should identify key system-wide performance measures that all intersectoral partners, including the Three Branch leadership, can consider for ongoing monitoring of the impact of future child welfare system transformation and the achievement of positive outcomes of safety, permanency, and child well-being. Some, but not all, of the key measures directly connected to the success of the LB 1173 Practice and Finance Model recommended strategies to consider could include:

- Rate of Children Entering Foster Care
- Length of Stay of Children Exiting Foster Care
- Percentage of Children and Youth in Care Greater than 24 months
- Percentage of Children Adopted after Termination of Parental Rights
- Number of children served by Community Response Pathway
- Percentage of Expenditures tied to Source of Funds (Fed, State, Foundation, Private)
- Access to and Utilization of Behavioral Health and Substance Abuse Services
- Racial Equity Service Indicators

Appendix A - List of Community Sessions and Surveys

Community Sessions:

- Project Kickoff/Workgroup Stakeholder Engagement – Omaha
- LB 1173 Reimagine Well-Being Listening Session – Lincoln
- LB 1173 Community Forum – Columbus
- LB 1173 Community Forum –Kearney
- LB 1173 Community Forum –Omaha (2)
- LB 1173 Community Forum –Scottsbluff
- LB 1173 Community Forum –North Platte
- LB 1173 Community Forum –Lincoln

Surveys

- CFS New Worker Training Survey
- CFS Best of the Best Survey
- CFS Leader Survey
- Nebraska County Attorney Survey

Appendix B – Full-Service Community Schools 2021 – 2022 Evaluation Report

Full-Service Community Schools

2021 - 2022 Evaluation Report | August 2022

Together, Better Initiative

A partnership of **Nebraska Department of Education** and the **Nebraska Children and Families Foundation**

Full-Service Community Schools

2021 - 2022 Evaluation Report

The Full-Service Community Schools pilot was launched in fall 2021 in four Nebraska communities: Fremont, Grand Island, Schuyler, and South Sioux City. All four Full-Service Community School sites began the implementation in September 2021. NDE and NCFF provided strategic support to build a learning cohort across the four locations, define a shared understanding of Community Schools, identify the measurable results they'll be working toward, understand the current conditions for each of the sites/communities, and develop key strategies to accelerate the work. Each of the four sites has created plans and started the implementation of strategies that will accelerate

- Student Learning and Development;
- Family and Community Engagement, and;
- Partnership Development.

This evaluation report aggregates data collected at all four pilot sites and serves as a starting point for further development of a comprehensive evaluation plan that can inform these communities and stakeholders across the state about the impacts of the Full-Service Community Schools initiative.

Report prepared by Teresa Wanser-Ernst, Ph.D., Cultural Competence Center LLC.
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Table of Contents

Executive Summary 3

The Full-Service Community School Approach 4

Nebraska Community Schools 6

Better, Together Initiative: A Full-Service Community Schools Pilot 6

Nebraska's FSCS Communities 7

- Fremont, Fremont Middle School 8
- Grand Island, Early Childhood Education at O'Connor Learning Center ... 9
- Schuyler, Schuyler Elementary School 11
- South Sioux City, Dakota City Elementary School 12
- Aggregated FSCS Outcomes from Year 1 14
- Strengths 15
- Recommendations for Next Steps 16

Appendixes

- A - Better, Together Initiative 18
- B - Fremont Impact Report 19
- C - Grand Island Impact Report 21
- D - Schuyler Impact Report 22
- E - South Sioux City Impact Report 23
- F - 2021-2022 FSCS Site Visits Aggregated Feedback 24

Executive Summary

The Full-Service Community Schools (FSCS) strategy supports the planning, implementation, and operation of services to provide comprehensive academic, social, and health services for students, students' families, and community members. The goal is to improve educational outcomes for students.

The Nebraska Department of Education (NDE) and the Nebraska Children and Families Foundation (NCFF) developed the *Better, Together Initiative* to pilot the Full-Service Community School strategy in Nebraska. Four communities were identified to participate in the pilot. The communities began the implementation of the Full-Service Community School strategy in the fall of 2021. The public schools in the communities of Fremont, Grand Island, Schuyler, and South Sioux City agreed to partner in this pilot project.

The following were accomplished during the 2021-2022 school year:

- School leaders and staff were trained on the FSCS model
- School Community Coordinators (SCCs) were hired at each FSCS
- NDE and NCFF built relationships with staff at the four FSCSs
- SCCs began identifying student and family needs
- SCCs connected with community partners to plan and implement services to meet the identified needs
- Parents and the communities developed an emerging awareness of the FSCS strategy potential

The next steps for further implementation of the FSCS strategy include:

- Developing an FSCS evaluation plan that includes stakeholder involvement. The evaluation plan should provide the necessary data collection and data management tools to ease that burden on FSCS staff.
- Facilitating the intentional communication to parents/caregivers who are unaware or reluctant participants of these services
- Developing School and Community Advisory Committees who are tasked with developing and implementing plans to address the community's needs
- Expanding the network, reach, and impact of the FSCS strategy

The Full-Service Community School Approach

According to the Department of Education, Office of Elementary & Secondary Education[1], Full-Service Community Schools are defined as a strategy that

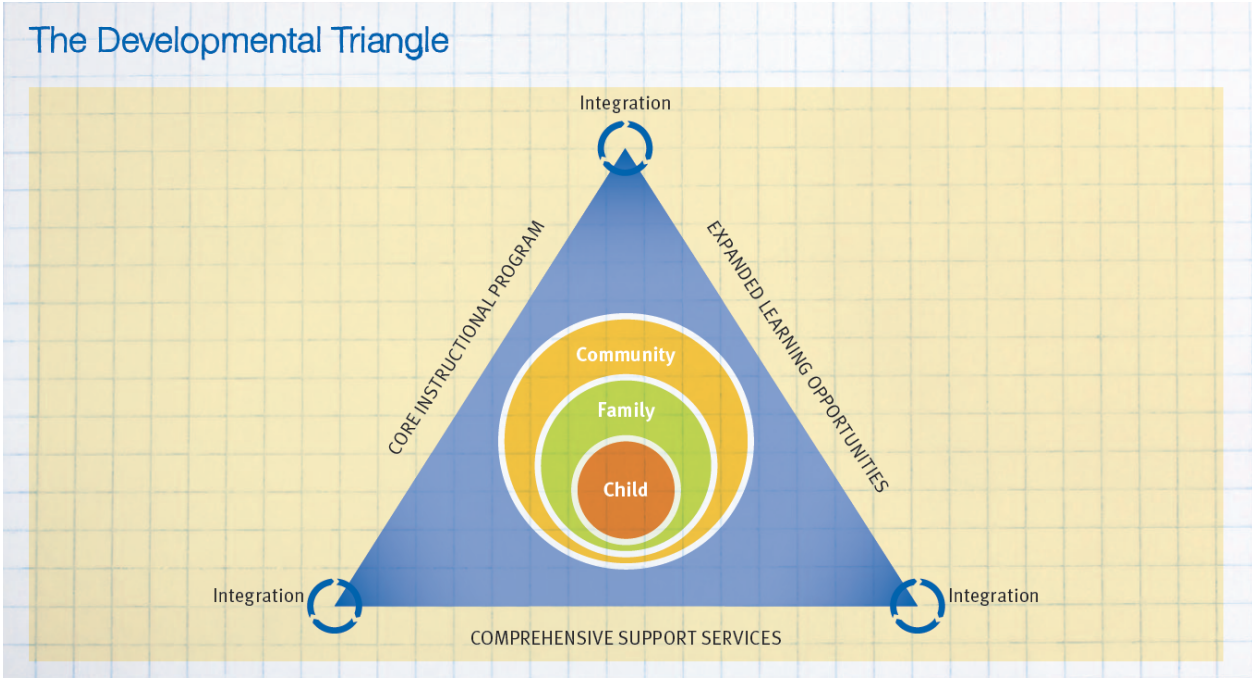
> "... provides support for the planning, implementation, and operation of full-service community schools that improve the coordination, integration, accessibility, and effectiveness of services for children and families, particularly for children attending high-poverty schools, including high-poverty rural schools. FSCSs provide comprehensive academic, social, and health services for students, students' family members, and community members that will result in improved educational outcomes for children.
>
> These services may include:
>
> - high-quality early learning programs and services;
> - accelerated learning aligned with academic supports and other enrichment activities, providing students with a comprehensive academic program;
> - family engagement, including parental involvement, parent leadership, family literacy, and parent education programs;
> - mentoring and other youth development programs;
> - community service and service learning opportunities;
> - programs that provide assistance to students who have been chronically absent, truant, suspended, or expelled;
> - job training and career counseling services;
> - nutrition services and physical activities;
> - primary health and dental care;
> - activities that improve access to and use of social service programs and programs that promote family financial stability; mental health services; and
> - adult education, including instruction of adults in English as a second language."

The National Center for Community Schools (NCCS) was established by Children's Aid in 1994 to answer the nationwide call to build schools that surround students with support.[2] In the nearly 30 years since NCCS has been developing and studying the impacts of community schools, they have developed a firm theoretical grounding of the community schools strategy. This strategy, coupled with strong empirical evidence,

[1] Retrieved from https://oese.ed.gov/offices/office-of-discretionary-grants-support-services/school-choice-improvement-programs/full-service-community-schools-program-fscs/
[2] See https://www.nccs.org/

indicates that in the presence of a “whole child” approach to education, all children can succeed and thrive.[3]

NCCS has created several resources to guide new communities in the development of highly effective full-service community schools. *Building Community Schools: A Guide for Action* describes and outlines the stages and capacities for effective community school development. The Developmental Triangle modeled below, places children at the center, surrounded by families and communities. Fundamentally, students’ academic success, health, and well-being are the focus of every full-service community school. In this model, the legs of the triangle represent the interconnected support systems.



The *Core Instructional Program* is designed to help all students meet high academic standards. *Expanded Learning Opportunities* enrich the learning environment for students and their families. A *comprehensive range of physical and mental health support services* promote students’ well-being and remove barriers to learning. The corners of the triangle represent the critical integration of services where community schools ensure coherence in service integration. No entity acting alone can improve educational outcomes for all students. Partners in the full-service community school (FSCS) strategy must develop a set of shared goals and a system to accomplish those goals. They also share leadership and accountability for results.

[3] The Children’s Aid Society & National Center for Community Schools. (2011). *Building Community Schools: A guide for action.*

Partnerships in the areas of health, social services, academics for children and adults, sports, recreation, and culture transform schools into vital hubs, benefiting students, their families, and the surrounding community. Key components of the FSCS approach include

- a focus on school, family, and community engagement;
- expanded learning opportunities for children and adults;
- comprehensive partnerships;
- site coordination;
- wellness, and;
- sustainability.

Compared to traditional schools, community schools offer a wide range of programs for students, families, and the community.

Nebraska Community Schools

Many Nebraska communities already have key components of a Full-Service Community School (FSCS) in place. The 21st Century Community Learning Center Program is one such example, providing core support for the coordination of school-based services, out-of-school learning, and family engagement activities. Additionally, several localities throughout the state have established Community Well-Being (CWB) Collaboratives with the assistance of the Nebraska Children and Families Foundation. The CWB Collaboratives provide a proven structure for leveraging and aligning a variety of resources from diverse partners, with intentional inclusion of student and family voices as well as shared leadership between the collaborative and the school. By building on those examples and existing partnerships, the FSCS approach creates a great opportunity for a coordinated, collaborative community platform through which the needs of all children and families are more effectively and efficiently met.[4]

Better, Together Initiative: A Full-Service Community Schools Pilot

To assist schools, children, and families in Nebraska, the Nebraska Department of Education (NDE), in partnership with Nebraska Children and Families Foundation

[4] Nebraska Department of Education & Nebraska Children and Families Foundation. *The Full-Service Community School (FSCS) Approach.*

(NCFF), leveraged the influx of pandemic related funding to form the *Together, Better Initiative*, which is a series of strategic investments in authentic, evidence-based, and reimagined learning supports and family and community engagement. NDE and NCFF are collaborating to address these critical needs for students, families, and communities with five strategies. One of the strategies included creating the Full-Service Community Schools (FSCS) Pilot Project. This effort was launched in fall 2021 in four communities: Fremont, Grand Island, Schuyler, and South Sioux City. All four Full-Service Community School sites began the implementation in September 2021. NDE and NCFF provided strategic support to build a learning cohort across the four locations, define a shared understanding of Community Schools, identify the measurable results they'll be working toward, understand the current conditions for each of the sites/communities, and develop key strategies to accelerate the work. Each of the four sites has created plans and started the implementation of strategies that will accelerate

- Student Learning and Development;
- Family and Community Engagement, and;
- Partnership Development.

The initial success parameters for each of the sites are being reinforced through the *Together, Better Initiative* partnership between NDE and NCFF. The collective team members meet regularly for planning and update sessions and meet with each of the sites to provide implementation support. This team will continue to work with the sites to design and implement the formal evaluation, and to help sites quickly adapt to emerging needs in their communities as the pandemic persists.[5]

Nebraska's FSCS Communities

The four pilot programs include Fremont Middle School in Fremont, Early Childhood Education at O'Connor Learning Center in Grand Island, Schuyler Elementary School in Schuyler, and Dakota City Elementary School in South Sioux City. Each program hired a full-time school-based School Community Coordinator (SCC). The person in this position is charged with building partnerships with students, families, and the community and works under the vision and direction of the community collaborative leadership, school principal, and site-based FSCS team. Site-based FSCS teams are composed of the SCC, school principal, representatives from partnering agencies, and may also include a parent or other stakeholders. Partnerships will apply the core components of a community school and other relevant frameworks, identify the needs present in the school by addressing academic, social-emotional, health, basic needs, and other key priority areas. All of this is coordinated within the context of community and school partnerships that support the whole child and their family.

[5] See NDE/NCFF FSCS one-sheeter_Feb2022

The program information presented on the following pages were collected from site visits, focus groups, the NDE Education Profiles,[6] and local data. School Community Coordinators provided the data that were collected at the site (e.g., surveys and needs assessments).

Fremont, Fremont Middle School

Data from the NDE Education Profile

Paraphrased school description

Fremont Middle School serves approximately 600 7th and 8th graders each school year. Each student and staff member are provided a Chromebook that supports cross-curricular academics. Students are taught in approximately six teams, averaging 100 students per team and three teams per grade level. Two-thirds of a student's day is spent in math, science, social studies, and English. Students also have opportunities to engage in physical education, computer coding, business/computer apps, family and consumer science, art, industrial technology, and fine arts. Fremont Middle School implements a Multi-Tiered System of Support (MTSS) to help students achieve social, emotional, and academic success.

2020-2021 Data for Fremont Middle School

- 43 Teachers
- 661 students, grades 7-8
- 8% English Language Learners
- 61% Participating in the Free or Reduced-Price Lunch Program, 15% higher than the state average
- 16% Gifted

Program Goal

One of the key issues recognized by this site team is related to the barrier of reliable transportation so families can be connected to the school. This site will be working to address transportation issues for family and community engagement events to ensure all families can attend.

FSCS Outcomes from Year 1

Staff from the Fremont Family Coalition reported the following achievements from the past school year and goals for the coming school year.

[6] See https://nep.education.ne.gov/ for each Nebraska public school's profile.

Achievements include

- A School Community Coordinator was hired
- Experiential field trips for middle school students throughout the summer
- Vision Mobile from Children's Hospital in Omaha provided vision screenings for 12 students with four of those students receiving eyeglasses
- Engaging the middle school principal in FSCS goal setting and program planning
- Connecting resources for families and teachers with students who are struggling with behavior issues in school
- Applying a community-based database system
- Building relationships across systems with 10 active partnerships currently in place
- Developing a resource room within the middle school that has basic-needs items for students and parents/caregivers to access
- Using language interpretation devices that an interpreter can speak into and parents/caregivers can hear the interpretation of a speaker's message through earphone device. Parents were very appreciative of this.

Plans for the coming year include

- Connecting school social workers to the community-based database to ensure referrals to services are consistent and tracked appropriately
- Developing and holding parent/family engagement events, such as basic literacy, inclusive communities, life skills, and parent/child interactive experiences
- Further development of the partnership with the school principal, staff, and faculty, including professional development and relationship building opportunities
- Identifying resources for sustainability

Grand Island, Early Childhood Education at O'Connor Learning Center

Data from the NDE Education Profile

Paraphrased school description

The Early Learning Center (ELC) serves children ages three to four in an inclusive, half-day preschool setting. Preschool students and families are served by 10 certified teachers, 20 paraeducators, and a support team. Educators strive for every child to have access to meaningful experiences in a play-based, language-rich environment to empower the whole child through family and

community relationships. Educators are empowered to be instructional leaders, personalize learning pathways for each student, design decisions using data, and partner with the community. Students are prepared to make positive contributions to society and thrive in an ever-changing world.

2020-2021 Data for O'Connor Learning Center, Grand Island Public Schools

- 13 Teachers
- 263 students, preschool students ages 3-4
- 95% Participating in the Free or Reduced Lunch Program, 49% higher than the state average

Program Goal

A key goal for this site was to address the need for childcare for early learning students when they were not in the program. As a result, this site established a partnership with local YWCA to provide on-site childcare for out-of-school time. Additionally, this collaboration team is exploring the idea of "success planning" for each early learner to ensure each student has a successful transition to elementary school.

FSCS Outcomes from Year 1

Staff from the Grand Island CommUNITY Schools reported the following achievements from the past school year and goals for the coming school year.

Achievements include

- A Family and Community Engagement Coordinator was hired
- Identified goals for parent engagement
- Developed a parent/guardian volunteer program
- Held the first Community Café in January of 2022 with the goal to share collective knowledge and wisdom for a better future together
- Held Parent Advisory meetings to collect ideas for the CommUNITY school, plan family nights, develop a newsletter, create goals for the school, and discuss questions and concerns
- Developed 24 community partnerships
- Developed a food pantry

Plans for the coming year include

- Further develop Parent Engagement through shared responsibility and power, creating a welcoming environment in the school, facilitation of respectful interactions, practicing two-way communication
- Further develop the parent/guardian volunteer program
- Identifying resources for sustainability

Schuyler, Schuyler Elementary School

Data from the NDE Education Profile

Paraphrased school description

Schuyler Elementary School serves approximately 800 students in grades Kindergarten through 5th grade and is composed of an ethnically diverse student body. Most students (~80%) are Latino/a, from countries in Central and South America. Special emphasis placed on English Language Learners, Title I students, and students receiving Special Education services. The school improvement goal focuses on interventions to improve reading skills for all students. Schuyler Public Schools opened this building for the first time in the 2009-2010 school year as a Kindergarten through 3rd grade school. Recent construction has expanded to house students in grades Kindergarten through 5th grade. Schuyler Elementary School is a Title 1 School-wide school.

2020-2021 Data for Schuyler

- 54 Teachers
- 669 students, grades 7-8
- 61% English Language Learners
- 66% Participating in the Free or Reduced Lunch Program, 20% higher than the state average
- 4% Gifted

Program Goal

This site has been engaged in the ongoing development of cross-sector site team to address the needs that were identified by families. One of those needs is related to adult and family literacy, and as such, the Site Coordinator is developing a partnership with the Family Literacy Program to provide programming for adults of children attending the Schuyler Elementary School.

FSCS Outcomes from Year 1

Staff from Schuyler Elementary School reported the following achievements from the past school year and goals for the coming school year.

Achievements include

- Family Literacy program to support parents' understanding of their child's academic experiences to help them feel more confident in supporting their child's learning at home
- Partnering with local mental health providers to inform them about the impacts of the COVID-19 pandemic effects on children and their parents/caregivers

- Provided free vision screenings to 33 1st and 2nd grade students
- Securing funding for the TeamMates mentoring program to purchase academic activities and t-shirts for participants
- Development and scaling of a mobile food pantry that distributed 225 sets of food
- Began discussions on how to best support students struggling with behavior challenges in school
- Development of a Community Site Team, composed of members from across the community

Plans for the coming year include

- Supports to address chronic absenteeism
- Access to criminal justice concerns
- Before school learning programming
- Weekend learning programming
- Computer skills
- Mental health services
- Summer learning programming
- Access to the arts
- Early childhood education programs
- Family and student resource center
- Family education & support networks
- Community partners & non-profit organization and businesses

South Sioux City, Dakota City Elementary School

Data from the NDE Education Profile

Paraphrased school description

Dakota City Elementary is dedicated to maintaining a safe, productive, and positive learning environment encouraging all students to be lifelong learners while promoting a partnership with families, staff, and the community. Dakota City Elementary houses students in grades Kindergarten through 5th with a population of about 225 students who engage in rigorous academic experiences aligned to the Nebraska State Standards. School staff collaborates weekly to focus on student learning, student growth, and planning supports for all students to be successful. Educator teams intervene using the MTSS model and work collaboratively to ensure all students are getting what they need. In addition to school day offerings, Dakota City also has a Beyond School Bells program for afterschool services throughout the school year. The PTA meets regularly to plan a variety of activities for students, staff, and families.

2020-2021 school year data

- 19 Teachers
- 202 students, grades 7-8
- 33% English Language Learners
- 72% Participating in the Free or Reduced Lunch Program, 26% higher than the state average
- 2% Gifted

Program Goal

This site has continued development of a cross-sector site team to address the needs that were identified by families. Similar to the needs identified at the site in Schuyler, one need shared by families related to family literacy supports. The Site Coordinator is also cultivating a partnership with the Family Literacy Program to provide programming for families with children enrolled in elementary school.

FSCS Outcomes from Year 1

Staff from Dakota City Elementary School reported the following achievements from the past school year and goals for the coming school year.

Achievements include

- Development of 7 partnerships
- Held a 6-week class on mental health
- Held a 6-week class on technology
- Held a Love & Logic class
- Provided free summer meals
- Held School & Home Partnership adult meet-up to openly discuss community, education, parenting, and home life
- Monthly meetings were held with Heartland Counseling

Plans for the coming year include

- Development of afterschool academic supports
- Implementation of social-emotional wellbeing curriculum
- Field trips to build world knowledge
- Develop clarification of role for school community coordinator
- Build relationships with school and district administrators
- Develop college and career opportunities for students
- Discussion for supporting families with health and preventive care needs

Aggregated FSCS Outcomes from Year 1

Each Full-Service Community School focuses the development of their work around four main goal areas. These include

- integrated student and family supports;
- expanded and enriched learning time and opportunities;
- active family and community engagement, and;
- collaborative leadership practices.

Site-based teams develop project plans each year that identify the program goals and the services that will be put into place to meet those goals. The annual plans are shared with their communities, NDE, and NCFF. The annual plans help guide how resources are most effectively coordinated and which services will best serve the needs of students, families, and the community. The goals and services identified in the annual plan can be used by the site-based teams to identify the benchmarks for evaluating the impact of services provided.

Site visits and focus groups were held in each community during the spring of 2022. To facilitate this data collection, a framework was created by the Better, Together leadership team and key stakeholders from each FSCS community (see Appendix F). Indicators were selected from the Community School Standards developed by the Coalition for Community Schools and the Institute for Educational Leadership.[7] Selected indicators were identified specifically for these newly developed FSCS programs. Upon the request of evaluators from NCFF, site-based teams identified school leadership, parents, and students who were willing to participate in focus groups. The hour-long focus groups were segregated by key stakeholder group (school leadership, parents, students). There were at least two participants in each group. Focus groups were held for all key stakeholder groups except in one community where no parents arrived for the focus group.

An aggregated summary of the focus group findings and site observations can be found in Appendix F. Highlights of the strengths and recommendations for next steps from the aggregated report will be listed below.

[7] Retrieved from https://www.communityschools.org/resource/community-schools-standards/

Strengths

Family Engagement

1. Family Literacy programs have occurred in at least two of the sites. This has been a success for the participants who feel well-informed about their children's education and educational needs.
2. Sites are meeting the needs of the parents/caregivers and community they serve through food pantries, medical services (vision, dental, mental health), etc.
3. The locations (schools) of these sites have quickly become the "hub" for full-service community school services. This is an asset of the FSCS model and is already realized in these communities.
4. The sites have some form of parent/caregiver group that engages with some decision-making.
5. Parents/caregivers are becoming more engaged in the schools their children attend.

Partnership Health and Development

1. Each FSCS has hired a full-time School Community Coordinator (SCC). This person's primary role is to facilitate partnerships between the school, families, and community. The SCC identifies the needs of families and the community and develops plans and resources to meet those needs. This added resource for the FSCSs has had a tremendously positive impact on these school communities. Each site has shared the various benefits from this person's role in meeting the needs of the community, which are reflected throughout the strengths identified in this report.
2. Discussions to sustain the SCC position have already started within each of the FSCSs, including discussions about local, state, and national funding streams.
3. Many families are involved and feel more connected with FSCS supports in place.
4. Conversations on how to build community awareness of FSCSs is already occurring.

Student Learning and Development

1. Sites began identifying community needs and those results were reviewed and used as the starting point for providing services.

2. School Improvement Teams are beginning to involve the SCC in developing School Improvement Plans (SIPs). The integration of FSCS practices is beginning to be evident in SIPs.
3. Schools are well-adept at developing IEPs for qualifying students as well as implementing the MTSS process to support students as needed.
4. Educators and school staff have received professional development on supporting families with trauma, human trafficking, mental health needs, and social-emotional learning.
5. Schools are aware of community resources and the SCC works with the school counselor(s) and social worker(s) to access those resources to meet the needs of students and their families.

Recommendations for Next Steps

Family Engagement

1. All parents/caregivers need to be made aware of services and opportunities offered. Communication between school and home can be a challenge. Multiple methods of communicating information need to be used.
2. Verbal translation services need to be available for parents/guardians at Full-Service Community Schools as well as translated written materials for all newsletters, notes, and other information going home from school. The student should not be primary translator between school and parent/caregiver.
3. All parents/caregivers need to have the opportunity, and be encouraged, to complete annual surveys, needs assessments, etc. This ensures that all voices are contributing to the improvement and identification of services for the FSCS. Multiple methods (e.g., phone calls, paper-pencil, electronic/e-mail) and opportunities for providing feedback need to be offered to parents/caregivers.
4. More opportunities to develop skills to support student learning need to be offered to all parents/caregivers, which may require targeted outreach to families that live a distance from the school or who are reluctant participators in at-school functions.
5. Teachers may need professional development on how to engage and empower families, especially those whose cultures may differ from their own.

Partnership Health and Development

1. An adequate needs assessment needs to be developed. The needs assessment should identify who is and is not receiving services and what needs are present

for all stakeholders in the community. A strong model should be developed by NDE and NCFF leaders that can be tailored to each community's needs.
2. MOUs need to reflect responsibilities of each entity, provide clearly defined roles for each partner, and be signed annually.
3. Site-based School and Community Advisory Committees should be established with actionable goals that will address the community's needs.
4. Community Cafés should be held regularly (e.g., every quarter or semester), with outreach to community organizations invited to participate with the purpose of identifying needs and connecting resources.
5. Community directories of resources should be developed and widely disseminated using a variety of methods to increase awareness and access.

Student Learning and Development

1. FSCSs may need guidance from NDE and NCFF for the development of surveys that can inform and improve services and resources provided at each site.
2. Training on the use of data for identifying student needs and providing appropriate supports would be beneficial for key staff and groups (e.g., School and Community Advisory Committee).
3. Involve the SCC in MTSS meetings and IEP meetings as non-academic supports are considered for students.
4. Professional development should be provided for school staff, SCC, and community partners to participate together to establish common language/frameworks and build relationships.
5. School staff, SCC, and community partners would benefit from professional development on culturally affirming practices, building awareness of community resources that would meet families' needs, responding to evidence of child abuse, neglect, or domestic violence, and social-emotional learning.

Appendix A - Better, Together Initiative

Shared Priorities, Goals, and Guiding Principles:

- Nebraska Will Have the Most Robust Community Well-Being Model in the US
- Connected Systems of Supports for Children and Families
- Children and Families Can Thrive with Support
- Intentional Family Engagement Promotes Sustainability
- Robust Community Well Being Will Impact Economic Growth
- Partnership Will Yield Greater Impact and Extend the Reach of Services
- Success and Well-Being for Children, Families, and Community

In order to...

- Address learning and opportunity disparities
- Deepen investments in primary prevention
- Enhance efficiency for basic needs supports
- Ensure all can live "The Good Life"
- Rebuild connectedness and trust in institutions
- Reduce impact of poverty on life outcomes for youth
- Support pandemic recovery

Key Strategies:

- Afterschool and Summer School
- Community Schools
- Early Learning
- Family Engagement
- Provide High-Quality Learning
- Rural Community Focus
- Whole Child Approach

Existing WorkStreams to Leverage and Expand:

- Beyond School Bells
- 21st Century Learning Centers
- Communities 4 Kids
- Community Response
- Connected Youth Initiative
- Rooted in Relationships
- Postsecondary Readiness
- Sixpence
- Statewide Family Engagement Center

Desired Results:

For Our Youth

- Academic Growth and Learning
- Connected to Advocates & Navigators
- Developed 21st Century Skills
- Enhanced Equitable Access to Needed Services
- Expanded Opportunities and Experiences
- Post-secondary Readiness
- Successful School Transitions

For Our State

- Inspire Future Partnerships with State Agencies
- Integrated Resources to Further Reach
- Maximized Services Without Duplication
- Productive School - Community Partnerships
- Robust Learning and Continuous Improvement
- Rural Vitality and Sustainability
- Supported Schools
- Thriving Families and Communities

Appendix B - Fremont Impact Report

AUGUST 2022

FULL SERVICE COMMUNITY SCHOOLS

FREMONT IMPACT REPORT

COMMUNITY PARTNERS:

- Aspire
- Children's Hospital Vision Mobile
- Salvation Army/ Summer Lunch Program
- Nebraska Extension
- FPS Migrant Education Program
- Capstone Behavioral Health
- Life house/ entity that manages McKinney Vento grant
- FPS social workers
- YMCA
- Inclusive Communities

ACHIEVEMENTS:

This summer we achieved much in terms of youth and community engagement:

- Work with Aspire and providing students with experiences and field trips throughout the summer
- We scheduled a visit from the Vision Mobile (from Children's Hospital, Omaha) and had 12 students' vision checked. 4 received eyeglasses.
- This summer we have been very intentional in building our relationships with the school system. We have parent/family engagement activity ideas we are exploring.
- Having new administration at the middle school has been super exciting, the principal has been very engaged and includes FSSC and ED in decision making regarding plans for this school year.
- Examples of plans for this school year include sponsoring and assisting with back-to-school bash, FSSC was added to the tier teams and received training this summer to connect resources for families that have students struggling with behavior in school, supplying resources to encourage and motivate staff and students. FSSC will introduce herself at the back-to-school event to the parents and students. Andrea along with the school social workers will utilize Clarity our community-based database to ensure that information and referrals are consistent and tracked appropriately. Along with this we have a standing meeting with school social workers this school year to review cases that school and community partners share through CR.
- Last school year was spent mostly building relationships. Since I came into my position at the end of last year, it took me a few months to understand what this role could look like that best fits the needs of our community. Andrea felt that she had little guidance from prior director. I am so excited for this year! We are going to knock it out of the park.

COMMUNITY-SCHOOL FUNDS HAVE BEEN USED FOR:

- Back-to-school efforts
- Training for faculty
- Parent engagement activities, such as basic literacy, inclusive communities, life skills and parent/child interactive
- Teacher and student incentive items
- Huge success! Interpretation devices, one device is for an interpreter to simultaneously interpret for the speaker and the Spanish speaking persons have an earphone device that allows them to hear presentation in their language. Parents were so appreciative!

STUDENT INFORMATION:

7th Grade: 394 students

Free/reduced lunch: 253
Special Education: 92
English Language Learners: 61

8th Grade: 380 students

Free/reduced lunch: 207
Special Education: 72
English Language Learners: 46

ONGOING ACTIVITIES:

- Vision Mobile @ summer school programming – 12 families participated and 4 received glasses
- Summer Lunch/school programming
- Urban Tiger - resource room within the middle school that has basic need items for students and parents to access
- Parent engagement planning - We have 4 engagement activities planned at this time but working on a basic literacy program for parents that would be a series of classes.
- MEP family engagement activity - 12 families participated and 4 received glasses
- The attendance numbers from the summer programming were consistently around 240. Previous summers programming for kids over 5th grade was nonexistent.
- Andrea - through her outreach - had a consistent group of 12 students that attended. The youth that were targeted were unconnected youth.
- There are 64 MEP families and 13 were in attendance. The focus was to connect families to the school and FSS.

CHALLENGES:

- We knew from the start that our public school system would be a challenge. Unlike other schools in our state, they have a long history of keeping others out. Their first contract for having others do work within the school was this one. It has been a major shift of mindset for the Administrators. We as the entity coming into the school system must carefully balance how we approach our working relationship. In other words, they need to see the value of FSS concept. We have invited administrators and social worker to attend FSS conference coming later this year. The vice principal and social worker have agreed to attend with Andrea. We are very excited about this! I do believe that in our school system it would be valuable to have a longer grant period. We are just getting started and grant will be over this year. The first year for new programming is usually relationship building and the implementation process. None the less we will do our very best to take full advantage of this opportunity for this year. Through our work my hope is for our school and community want to have funding conversations because they see the value.
- Scheduling
- Transportation for parents

nebraskachildren AND FAMILIES FOUNDATION

NEBRASKA DEPARTMENT OF EDUCATION

Appendix C - Grand Island, O'Connor Learning Center CommUNITY School

Nebraska Department of Education

Full Service Community Schools: Grand Island

Individual Impact

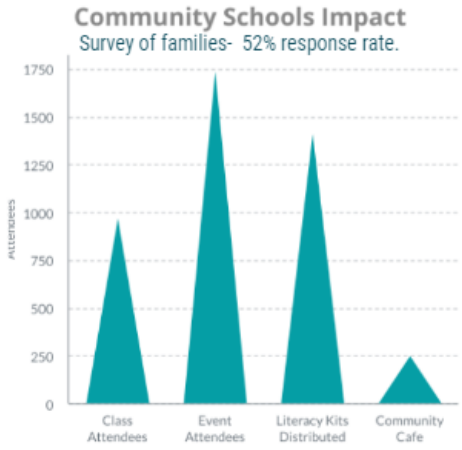
" You guys have so many great resources, made our children feel loved and cared for and made it a great experience for our family."

$10,000
Community Cafe Grant

$2,000
GIPS Foundation: Food and Hygiene Party

$1,000
Last Day of Schoo Celebration and Fa Family Night at the Pumpkin Patch)

Impact



"One of our primary goals during our first year of Community Schools work was to help our families feel welcomed and engaged."

99% of respondents felt satisfied or very satisfied with the programs and services offered at school.

74% of respondents reported that they attended at least one opportunity at school (class, event, etc.).

99% of respondents felt comfortable or very comfortable in the school.

24 Community Partners

- Central Community College
- Early Development Network
- Clearwater Counseling
- Multicultural Coalition
- Grand Island Public Library
- Legal Aid

25 Activities completed

- Food Pantry
- Healthy Lifestyles Series
- Math In Real Life/Family Bowling Night
- Stress Less Strategies
- UNL Extension Nutrition Class
- YWCA Employment & Training Program
- Zumba Class
- Parent Orientation Community Fair
- Health Fair
- COVID vaccinations

Appendix D - Schuyler Elementary School

Nebraska Department of Education

Full Service Community Schools: Schuyler

Activities

- Ongoing comprehensive vision exams
- Extending vision exams to older students and families
- Off comprehensive vision exams annually

Impact

Vision Clinic

- **5** students referred for additional eye care
- **10** volunteers from the community
- **33** 1st & 2nd grader students received eye vision exams
- **4** vision techs
- **33** students served, they all needed glasses

Community Partners

Nebraska Foundation for Children's Vision

Steps to Program Success

- Gaining trust from parents in receiving vision services
- Educating parents on the importance of vision care
- Educating parents on the importance of follow up visions after initial vision exam

Appendix E - South Sioux City, Dakota City Elementary School

Nebraska Department of Education

Full Service Community Schools: Dakota City

About Dakota City

Dakota City Elementary is a two section K-5 elementary school. The student population is approximately 100. About 51% of the students at Dakota City are minority students

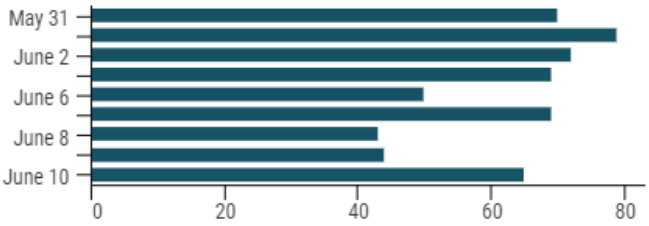
First year summer meals were offered at Dakota City Elementary

Monthly meetings with Heartland Counseling

Monthly classes with NE Extension

Impact

Number of free lunches served



Monthly family classes to expand learning with Ne Extension- Sewing, photography, cooking, etc.

10% of families attended empowered parents meetings

21 adults participated in adult education

Summer meals served for the first time in Dakota City

Family outings to "new places"

Development of a Family Resource Center at School

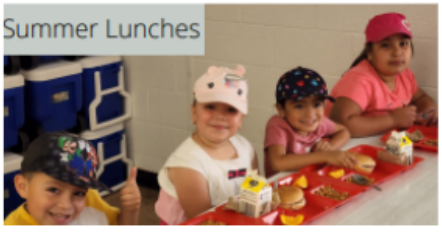
Increased PTA involvement

First time families volunteering in their community

Community Partners

- Dakota City Public Library
- NE Extension in Dakota County
- Heartland Counseling
- Northeast Community College
- LaunchPad Children's Museum
- Sioux City Art Center
- Norm Waitt Sr. YMCA

Events



- Mental Health Workshop - 6 week class
- Technology Classes - 6 week class
- Love & Logic class
- Free Summer Meals
- School & Home Partnership adult meet-up to openly discuss community, education, parenting, home life

Appendix C – Matrix of Neglect Definitions

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
Source: https://nebraskalegislature.gov/bills/view_bill.php?DocumentID=49881 Introduced 1/5/2023 Referred to Judiciary Committee 1/9/23 Judiciary Hearing 2/22/23 – last action on bill	https://capitol.texas.gov/tlodocs/87R/billtext/pdf/HB00567F.pdf#navpanes=0 – Enrolled Version https://capitol.texas.gov/BillLookup/History.aspx?LegSess=87R&Bill=HB567 – Full History Filed w/out Governor's signature 5/15/2021 – Effective 9/1/21
A BILL FOR AN ACT relating to children and families; to amend sections 43-247 and 43-292, Reissue Revised Statutes of Nebraska, and sections 28-101, 28-707, 28-710, and 43-2,129, Revised Statutes Cumulative Supplement, 2022; to define and redefine terms; to change provisions relating to what constitutes child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code; to change grounds for juvenile court jurisdiction and termination of parental rights; to harmonize provisions; and to repeal the original sections.	AN ACT relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
28-707 (1) Subject to section 4 of this act, a ~~A~~ person commits child abuse if he or she knowingly, intentionally, or negligently causes or permits a minor child to be: (a) Placed in a situation that endangers the minor child's ~~his or her~~ life or physical or mental health under circumstances such that the danger is sufficiently obvious that no reasonable person would cause or permit the minor child to be placed in such situation; 28-710 (2) (b) Child abuse or neglect means, subject to section 4 of this act, knowingly, intentionally, or negligently causing or permitting a minor child to be: (i) Placed in a situation that endangers the minor child's ~~his or her~~ life or physical or mental health under circumstances such that the danger is sufficiently obvious that no reasonable person would cause or permit the minor child to be placed in such situation;… (b) (iv) Left unattended in a motor vehicle if such minor child is six years of age or younger in conditions likely to cause serious harm that have not been mitigated by reasonable precautionary measures; Sec. 4 (1) Permitting a minor child, who is of sufficient maturity, physical condition, and mental abilities to	SECTION 3. Section 161.001(c), Family Code, is amended to read as follows: (c) Evidence of one or more of the following does not constitute clear and convincing evidence sufficient for a court to ~~[A court may not]~~ make a finding under Subsection (b) and order termination of the parent-child relationship [~~based on evidence that the parent~~]: (1) the parent homeschooled the child; (2) the parent is economically disadvantaged; (3) the parent has been charged with a nonviolent misdemeanor offense other than: (A) an offense under Title 5, Penal Code; (B) an offense under Title 6, Penal Code; or (C) an offense that involves family violence, as defined by Section 71.004 of this code; (4) the parent provided or administered low-THC cannabis to a child for whom the low-THC cannabis was prescribed under Chapter 169, Occupations Code; [or] (5) the parent declined immunization for the child for reasons of conscience, including a religious belief; or (6) the parent allowed the child to engage in independent activities that are appropriate and typical for the child 's level of maturity, physical condition, developmental abilities, or culture.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
avoid a substantial risk of physical harm, to engage in independent activities, either alone or with other children, shall not be considered child abuse under section 28-707 or child abuse or neglect under section 28-710. (2) For purposes of this section, independent activities include, but are not limited to: (a) Traveling, including, but not limited to, by walking, running, or bicycling, to and from school or nearby commercial or recreational facilities; (b) Playing outdoors; (c) Remaining unattended in a motor vehicle, unless it is in conditions likely to cause serious harm that have not been mitigated by reasonable precautionary measures; or (d) Remaining at home unattended for a reasonable amount of time, provided the person has made provisions for any reasonably foreseeable emergencies that may arise. 43-247 (3) (a) Subject to section 6 of this act: (i) Who ~~who~~ is homeless or destitute, or without proper support 3 through no fault of his or her parent, guardian, or custodian; (ii) Who ~~who~~ is abandoned by his or her parent, guardian, or custodian;	SECTION 4. Section 161.101, Family Code, is amended to read as follows: (b) petition or motion filed by the Department of Family and Protective Services in a suit for termination of the parent-child relationship is subject to Chapter 10, Civil Practice and Remedies Code, and Rule 13, Texas Rules of Civil Procedure. SECTION 5. Section 261.001(4), Family Code, is amended to read as follows: (4)"Neglect" means an act or failure to act by a person responsible for a child 's care, custody, or welfare evidencing the person 's blatant disregard for the consequences of the act or failure to act that results in harm to the child or that creates an immediate danger to the child 's physical health or safety and: (A) includes: (i) the leaving of a child in a situation where the child would be exposed to an immediate danger [~~a substantial risk~~] of physical or mental harm, without arranging for necessary care for the child, and the demonstration of an intent not to return by a parent, guardian, or managing or possessory conservator of the child; (ii) the following acts or omissions by a person: (a) placing a child in or failing to remove a child from a situation that a reasonable person would realize requires judgment or actions beyond the child 's level of maturity, physical condition, or mental abilities and that results in

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
~~who lacks proper parental care by reason of the fault or habits of his or her parent, guardian, or custodian;~~ (iii) Whose ~~whose~~ parent, guardian, or custodian, through willful, reckless, or grossly negligent conduct, neglects or refuses to provide the minimum ~~proper or~~ necessary subsistence, education, or other care necessary for the health, safety ~~morals~~, or well-being of such juvenile; (iv) Whose ~~whose~~ parent, guardian, or custodian is unable to provide or neglects or refuses to provide special care made necessary by the mental condition of the juvenile; (v) Who ~~who~~ is in a situation, including labor trafficking of a minor or sex trafficking of a minor, as defined in section 28-830, which is ~~or engages in an occupation, including prostitution~~, dangerous to ~~life or limb or injurious to~~ the health, safety, or well-being ~~or morals~~ of such juvenile; or (vi) Who ~~who~~, beginning July 1, 2017, has committed an act or engaged in behavior described in subdivision (1), (2), (3)(b), or (4) of	bodily injury or an immediate danger [~~a substantial risk~~] of [immediate] harm to the child; (b) failing to seek, obtain, or follow through with medical care for a child, with the failure resulting in or presenting an immediate danger [~~a substantial risk~~] of death, disfigurement, or bodily injury or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child; (d) placing a child in or failing to remove the child from a situation in which the child would be exposed to an immediate danger [~~a substantial risk~~] of sexual conduct harmful to the child; … (e)…(b) does not include: … (ii) allowing the child to engage in independent activities that are appropriate and typical for the child 's level of maturity, physical condition, developmental abilities, or culture [~~Subparagraph (ii)~~]. SECTION 6. Section 262.116(a), Family Code, is amended to read as follows: … (6) allowed the child to engage in independent activities that are appropriate and typical for the child 's level of maturity, physical condition, developmental abilities, or culture; or (7) tested positive for marihuana, unless the department has evidence that the parent 's use of marihuana has caused

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
this section and who was under eleven years of age at the time of such act or behavior; (b)(i) Who ~~who~~, until July 1, 2017, by reason of being wayward or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously the morals or health of himself, herself, or others; or who is habitually truant from home or school; or (ii) Who ~~who~~, beginning July 1, 2017, is eleven years of age or older and, by reason of being wayward or habitually disobedient, is uncontrolled by his or her parent, guardian, or custodian; who deports himself or herself so as to injure or endanger seriously ~~the morals~~ or health, safety, or well-being of himself, herself, or others; or who is habitually truant from home or school; or (c) Who ~~who~~ is mentally ill and dangerous as defined in section 71-908; Sec. 6. (1) The fact that a person permits a juvenile, who is of sufficient maturity, physical condition, and mental	significant impairment to the child 's physical or mental health or emotional development SECTION 7. Section 262.201, Family Code, is amended by amending Subsections (e), (g), (h), and (n) and adding Subsections (g-1) and (q) to read as follows: … (g) In a suit filed under Section 262.101 or 262.105, at the conclusion of the full adversary hearing, the court shall order the return of the child to the parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession from whom the child is removed unless the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that: … (g-1) In a suit filed under Section 262.101 or 262.105, if the court does not order the return of the child under Subsection (g) and finds that another parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession did not cause the immediate danger to the physical health or safety of the child or was not the perpetrator of the neglect or abuse alleged in the suit, the court shall order possession of the child by that person unless the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that, specific to each person entitled to possession: (1)the person cannot be located after the exercise of due diligence by the Department of Family and Protective

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
abilities to avoid a substantial risk of physical harm, to engage in independent activities, either alone or with other children, shall not be a basis for the juvenile court to exercise jurisdiction under subdivision (3)(a) of section 43-247 or to terminate parental rights under section 43-292. (2) For purposes of this section, independent activities include, but are not limited to: (a) Traveling, including, but not limited to, by walking, running, or bicycling, to and from school or nearby commercial or recreational facilities; (b) Playing outdoors; (c) Remaining unattended in a motor vehicle, unless it is in conditions likely to cause serious harm that have not been mitigated by reasonable precautionary measures; or (d) Remaining at home unattended for a reasonable amount of time, provided the person has made provisions for any reasonably foreseeable emergencies that may arise. 43-292 Subject to section 6 of this act, the ~~The~~ court may terminate all parental rights… (3) The parents, being financially able, have willfully neglected to provide the juvenile with the necessary subsistence, education, or other care necessary for	Services, or the person is unable or unwilling to take possession of the child; or (2) reasonable efforts have been made to enable the person 's possession of the child, but possession by that person presents a continuing danger to the physical health or safety of the child caused by an act or failure to act of the person, including a danger that the child would be a victim of trafficking under Section 20A.02 or 20A.03, Penal Code. (h) In a suit filed under Section 262.101 or 262.105, if the court finds sufficient evidence to make the applicable finding under Subsection (g) or (g-1) [~~satisfy a person of ordinary prudence and caution that there is a continuing danger to the physical health or safety of the child and for the child to remain in the home is contrary to the welfare of the child~~], the court shall issue an appropriate temporary order under Chapter 105. --- (n) If the [~~The~~] court does not order possession of [~~shall place~~] a child by a [~~removed from the child 's custodial parent with the child 's noncustodial~~] parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession under Subsection (g) or (g-1), the court shall place the child [~~or~~] with a relative of the child [~~if placement with the noncustodial parent is inappropriate,~~] unless the court finds that the placement with [~~the noncustodial parent or~~] a relative is not in the best interest of the child.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
his or her health, safety ~~morals~~, or welfare or have neglected to pay for such subsistence, education, or other care when legal custody of the juvenile is lodged with others and such payment ordered by the court; (4) The parents are unfit by reason of debauchery, habitual use of intoxicating liquor or narcotic drugs, or repeated lewd and lascivious behavior, which conduct is found by the court to be seriously detrimental to the health, safety ~~morals~~, or well-being of the juvenile; 43-2,129 Sections 43-245 to 43-2,129 and section 6 of this act shall be known and may be cited as the Nebraska Juvenile Code.	(q) On receipt of a written request for possession of the child from a parent, managing conservator, possessory conservator, guardian, caretaker, or custodian entitled to possession of the child who was not located before the adversary hearing, the Department of Family and Protective Services shall notify the court and request a hearing to determine whether the parent, managing conservator, possessory conservator, guardian, caretaker, or custodian is entitled to possession of the child under Subsection (g-1). SECTION 8. Section 263.002, Family Code, is amended by amending Subsection (c) and adding Subsection (d) to read as follows: (c) At each permanency hearing before the final order, the court shall review the placement of each child in the temporary managing conservatorship of the department who has not been returned to the child ’s home. At the end of the hearing, the court shall order the department to return the child to the child ’s parent or parents unless the court finds, with respect to each parent, that: (1) there is a continuing danger to the physical health or safety of the child; and (2) returning the child to the child ’s parent or parents [~~The court shall make a finding on whether returning the child to the child ’s home is safe and appropriate, whether the return~~

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	~~is in the best interest of the child, and whether it~~] is contrary to the welfare of the child [~~for the child to return home~~]. (d) This section does not prohibit the court from rendering an order under Section 263.403. SECTION 9. Section 263.401, Family Code, is amended by adding Subsection (b-3) to read as follows: (b-3) A court shall find under Subsection (b) that extraordinary circumstances necessitate the child remaining in the temporary managing conservatorship of the department if: (1) a parent of a child has made a good faith effort to successfully complete the service plan but needs additional time; and (2) on completion of the service plan the court intends to order the child returned to the parent. SECTION 10 Subchapter E, Chapter 263, Family Code, is amended by adding Section 263.4011 to read as follows: Sec. 263.4011. RENDERING FINAL ORDER; EXTENSION. (a) On timely commencement of the trial on the merits under Section 263.401, the court shall render a final order not later than the 90th day after the date the trial commences. (b)The 90-day period for rendering a final order under Subsection (a) is not tolled for any recess during the trial. (c) The court may extend the 90-day period under Subsection (a) for the period the court determines necessary if, after a hearing, the court finds good cause for the extension. If the

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	court grants a good cause extension under this subsection, the court shall render a written order specifying: (1) the grounds on which the extension is granted; and (2) the length of the extension. (d) A party may file a mandamus proceeding if the court fails to render a final order within the time required by this section. SECTION 11. Section 263.403 (a-1), Family Code, is amended to read as follows: (a-1) Unless the court has granted an extension under Section 263.401(b), the department or the parent may request the court to retain jurisdiction for an additional six months as necessary for a parent to complete the remaining requirements under [~~in~~] a service plan [~~and specified~~] in a transition monitored return under Subsection (a)(2)(B) [~~the temporary order that are mandatory for the child 's return~~]. SECTION 12. Section 264.203, Family Code, is amended to read as follows: Sec. 264.203. REQUIRED PARTICIPATION. (a) The department may file a suit requesting [~~Except as provided by Subsection (d),~~] the court to render a temporary [~~on request of the department may~~] order requiring the parent, managing conservator, guardian, or other member of the [~~subject~~] child 's household to:

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(1) participate in the services for which the department makes a referral or services the department provides or purchases for: (A) alleviating the effects of the abuse or neglect that has occurred; [~~or~~] (B) reducing a continuing danger to the physical health or safety of the child caused by an act or failure to act of the parent, managing conservator, guardian, or other member of the child's household [~~the reasonable likelihood that the child may be abused or neglected in the immediate or foreseeable future~~]; or (C) reducing a substantial risk of abuse or neglect caused by an act or failure to act of the parent, managing conservator, guardian, or member of the child 's household; and (2) permit the child and any siblings of the child to receive the services. (b) A suit requesting an order under this section may be filed in a court with jurisdiction to hear the suit in the county in which the child is located [~~The department may request the court to order the parent, managing conservator, guardian, or other member of the child 's household to participate in the services whether the child resides in the home or has been removed from the home~~]. (c) Except as otherwise provided by this subchapter, the suit is governed by the Texas Rules of Civil Procedure applicable

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	to the filing of an original lawsuit [~~If the person ordered to participate in the services fails to follow the court 's order, the court may impose appropriate sanctions in order to protect the health and safety of the child, including the removal of the child as specified by Chapter 262~~]. (d) The petition shall be supported by a sworn affidavit by a person based on personal knowledge and stating facts sufficient to support a finding that: (1) the child has been a victim of abuse or neglect or is at substantial risk of abuse or neglect; and (2) there is a continuing danger to the physical health or safety of the child caused by an act or failure to act of the parent, managing conservator, guardian, or other member of the child 's household unless that person participates in services requested by the department [~~If the court does not order the person to participate, the court in writing shall specify the reasons for not ordering participation~~]. (e) In a suit filed under this section, the court may render a temporary restraining order as provided by Section 105.001. (f) The court shall hold a hearing on the petition not later than the 14th day after the date the petition is filed unless the court finds good cause for extending that date for not more than 14 days. (g) The court shall appoint an attorney ad litem to represent the interests of the child immediately after the filing but

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	before the hearing to ensure adequate representation of the child. The attorney ad litem for the child shall have the powers and duties of an attorney ad litem for a child under Chapter 107. (h) The court shall appoint an attorney ad litem to represent the interests of a parent for whom participation in services is being requested immediately after the filing but before the hearing to ensure adequate representation of the parent. The attorney ad litem for the parent shall have the powers and duties of an attorney ad litem for a parent under Section 107.0131. (i) Before commencement of the hearing, the court shall inform each parent of: (1) the parent ’s right to be represented by an attorney; and (2) for a parent who is indigent and appears in opposition to the motion, the parent ’s right to a court-appointed attorney. (j) If a parent claims indigence, the court shall require the parent to complete and file with the court an affidavit of indigence. The court may consider additional evidence to determine whether the parent is indigent, including evidence relating to the parent ’s income, source of income, assets, property ownership, benefits paid in accordance with a federal, state, or local public assistance program,

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	outstanding obligations, and necessary expenses and the number and ages of the parent ’s dependents. If the court determines the parent is indigent, the attorney ad litem appointed to represent the interests of the parent may continue the representation. If the court determines the parent is not indigent, the court shall discharge the attorney ad litem from the appointment after the hearing and shall order the parent to pay the cost of the attorney ad litem ’s representation. (k) The court may, for good cause shown, postpone any subsequent proceedings for not more than seven days after the date of the attorney ad litem ’s discharge to allow the parent to hire an attorney or to provide the parent ’s attorney time to prepare for the subsequent proceeding. (l) An order may be rendered under this section only after notice and hearing. (m) At the conclusion of the hearing, the court shall deny the petition unless the court finds sufficient evidence to satisfy a person of ordinary prudence and caution that: (1) abuse or neglect has occurred or there is a substantial risk of abuse or neglect or continuing danger to the physical health or safety of the child caused by an act or failure to act of the parent, managing conservator, guardian, or other member of the child ’s household; and

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(2) services are necessary to ensure the physical health or safety of the child. (n) If the court renders an order granting the petition, the court shall: (1) state its findings in the order; (2) make appropriate temporary orders under Chapter 105 necessary to ensure the safety of the child; and (3) order the participation in specific services narrowly tailored to address the findings made by the court under Subsection (m). (o) If the court finds that a parent, managing conservator, guardian, or other member of the child 's household did not cause the continuing danger to the physical health or safety of the child or the substantial risk of abuse or neglect, or was not the perpetrator of the abuse or neglect alleged, the court may not require that person to participate in services ordered under Subsection (n). (p) Not later than the 90th day after the date the court renders an order under this section, the court shall hold a hearing to review the status of each person required to participate in the services and the child and the services provided, purchased, or referred. The court shall set subsequent review hearings every 90 days to review the continued need for the order.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(q) An order rendered under this section expires on the 180th day after the date the order is signed unless the court extends the order as provided by Subsection (r) or (s). (r) The court may extend an order rendered under this section on a showing by the department of a continuing need for the order, after notice and hearing. Except as provided by Subsection (s), the court may extend the order only one time for not more than 180 days. (s) The court may extend an order rendered under this section for not more than an additional 180 days only if: (1) the court finds that: (A) the extension is necessary to allow the person required to participate in services under the plan of service time to complete those services; (B) the department made a good faith effort to timely provide the services to the person; (C) the person made a good faith effort to complete the services; and (D) the completion of the services is necessary to ensure the physical health and safety of the child; and (2) the extension is requested by the person or the person ’s attorney.

Nebraska LB42 Change provisions relating to child abuse and neglect under the Child Protection and Family Safety Act and the Nebraska Juvenile Code	**Texas HB567** Relating to the procedures and grounds for terminating the parent-child relationship, for taking possession of a child, and for certain hearings in a suit affecting the parent-child relationship involving the Department of Family and Protective Services.
	(t) At any time, a person affected by the order may request the court to terminate the order. The court shall terminate the order on finding the order is no longer needed. SECTION 13. The following provisions of the Family Code are repealed: (1) Section 262.113; (2) Section 262.1131; and (3) Sections 262.201(b) and (j)

Appendix D County Attorney Survey Results

LB 1173 Survey of County Attorneys

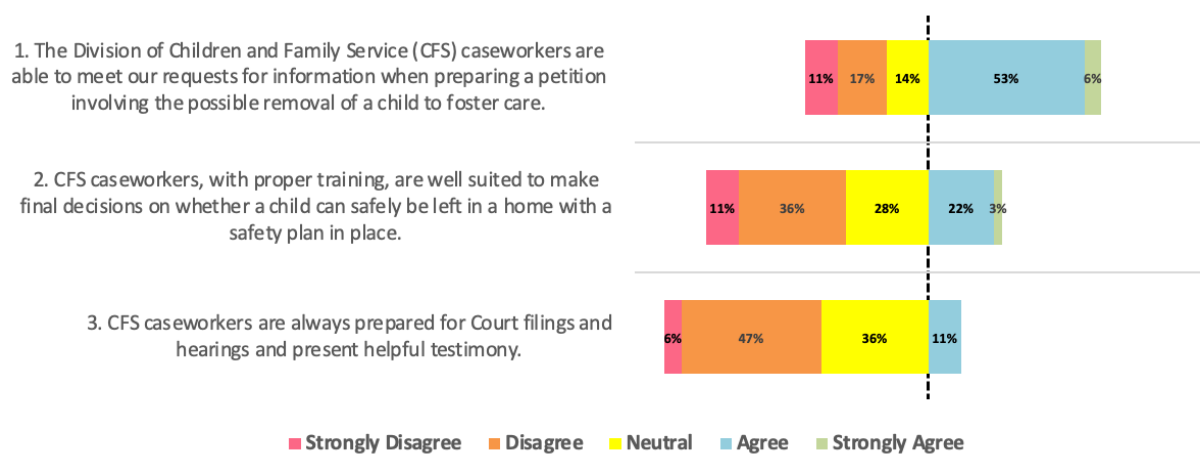
June to August 2023

Between the months of June through August 2023, Nebraska County Attorneys were surveyed as part of the LB 1173 process to re-imagine child welfare in Nebraska and design a new and transformative Child Welfare Practice Model. The survey's questions focused on issues involving CFS casework and court preparation, CASA and GAL case involvement, the process related to petitions for removal, services and coordination, foster parent participation, CFS decision making and discretion, training and understanding and permanency and collaboration.

The survey was forwarded by The Stephen Group to county attorneys statewide and there were 36 responses. We would like to specifically recognize and thank Lancaster County Attorneys Christopher Turner and Christopher Reid for their assistance in helping with the distribution of this survey.

The survey results are as follows:

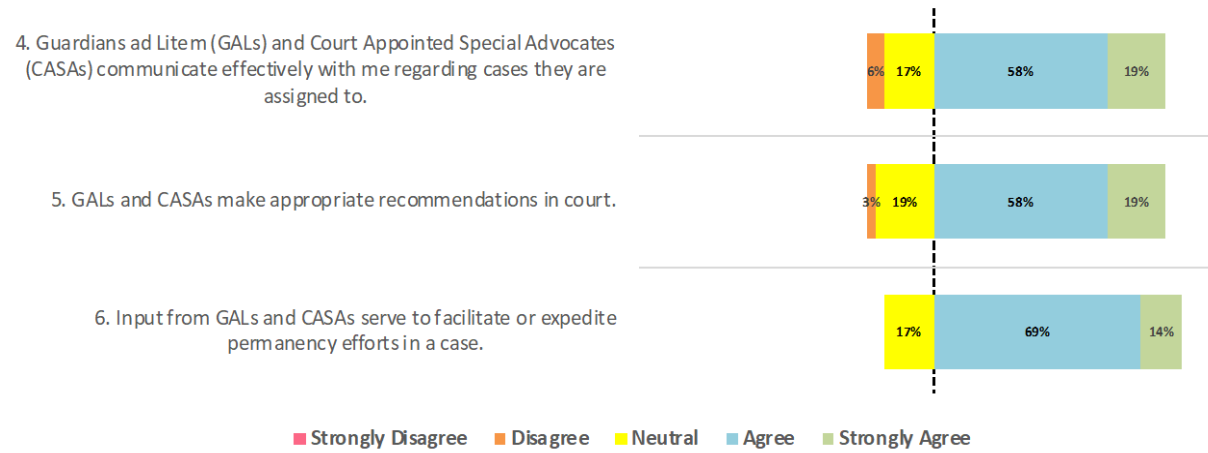
CFS Casework and Court Preparation



The results show majority of county attorneys believe that CFS caseworkers are able to meet their requests for information in preparing petitions for removal, but there is strong disagreement that CFS caseworkers are prepared for court and, even with

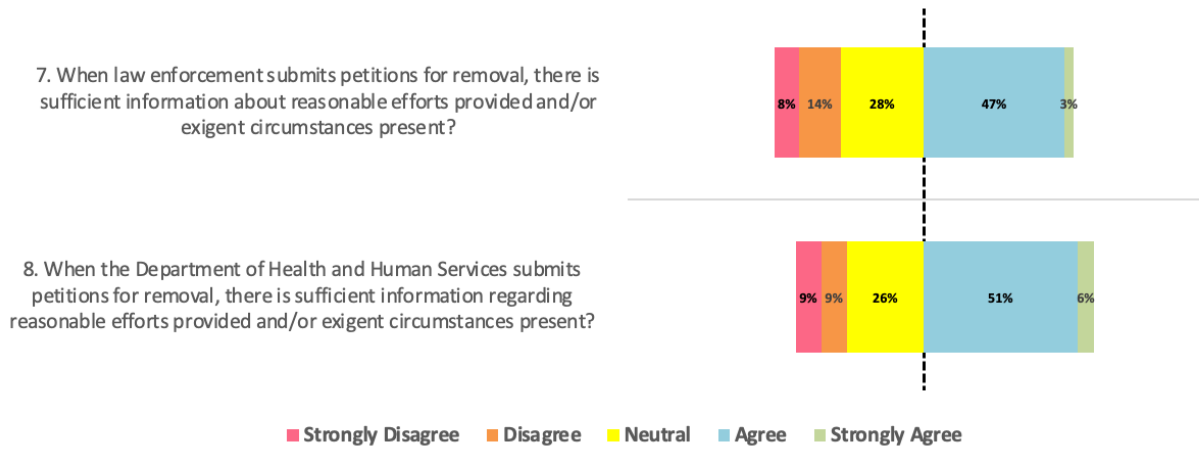
proper training are well suited to make final decisions on whether a child can safely be left in a home with a safety plan in place.

Court Appointed Special Advocates and Guardians ad Litem Court Involvement



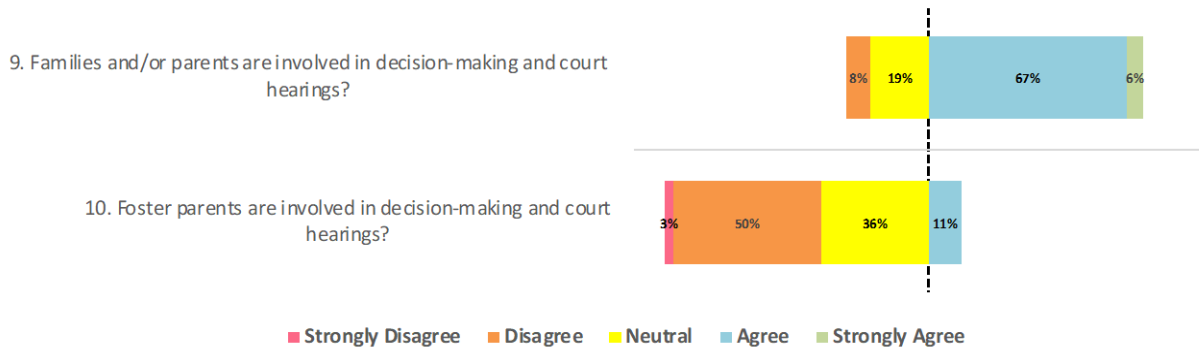
County attorneys strongly value the input, involvement and recommendations of GALs and CASA and believe overwhelmingly that they both serve to facilitate or expedite permanency efforts in a case.

Petitions for Removal



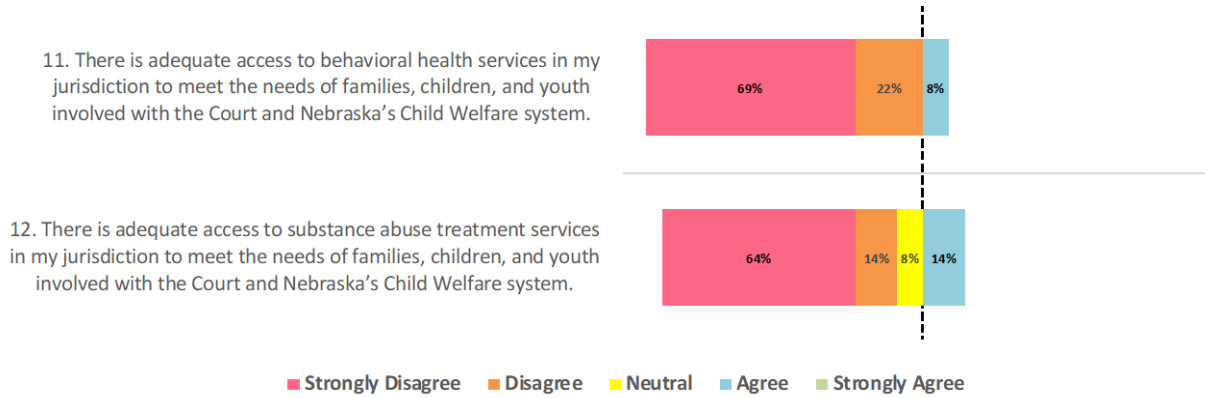
Largely county attorneys feel that petitions for removal contain sufficient information regarding reasonable efforts and exigent circumstances.

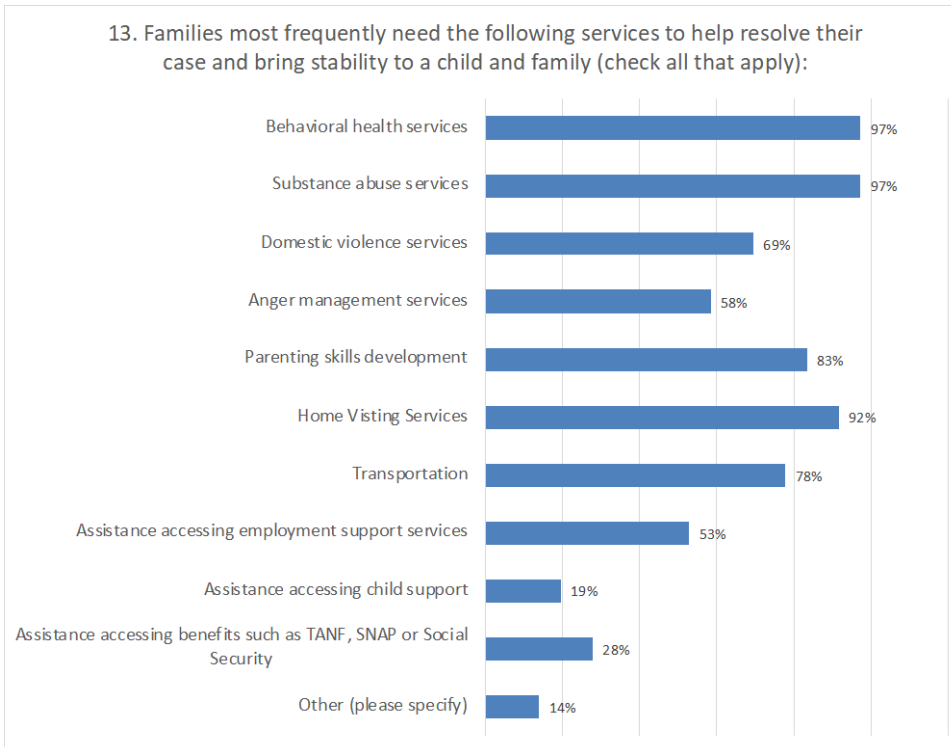
Birth and Foster Family Involvement in Court Hearings



County attorneys believe that families are involved in decision making and court hearings. Conversely, they feel foster parents are not.

Service Access and Coordination

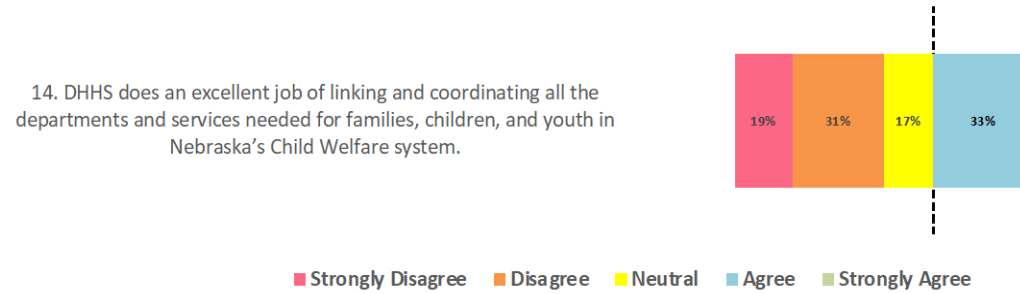




Other Responses:

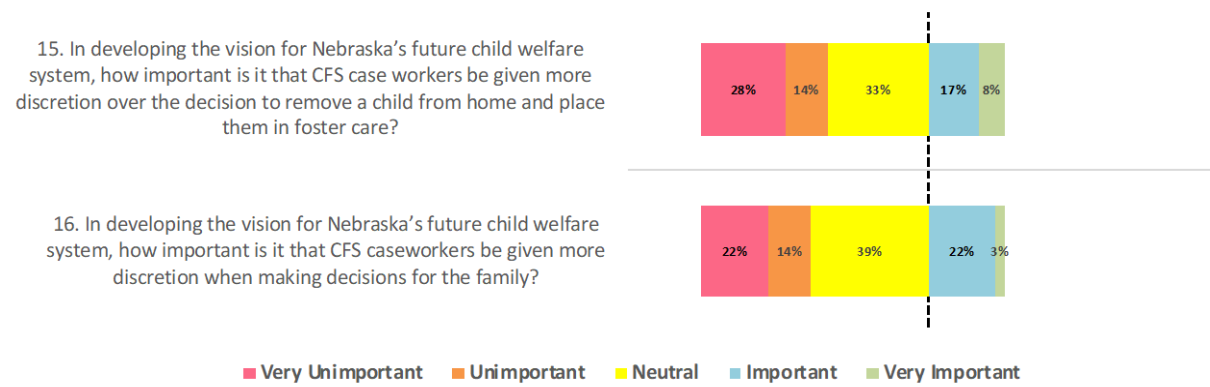
1. Drug and alcohol testing
2. Drug testing to ensure sobriety and/or aid parents in getting the level of counseling that is appropriate.

3. Housing
4. Professional mental health evaluation, such as parenting assessment and/or psych evaluations



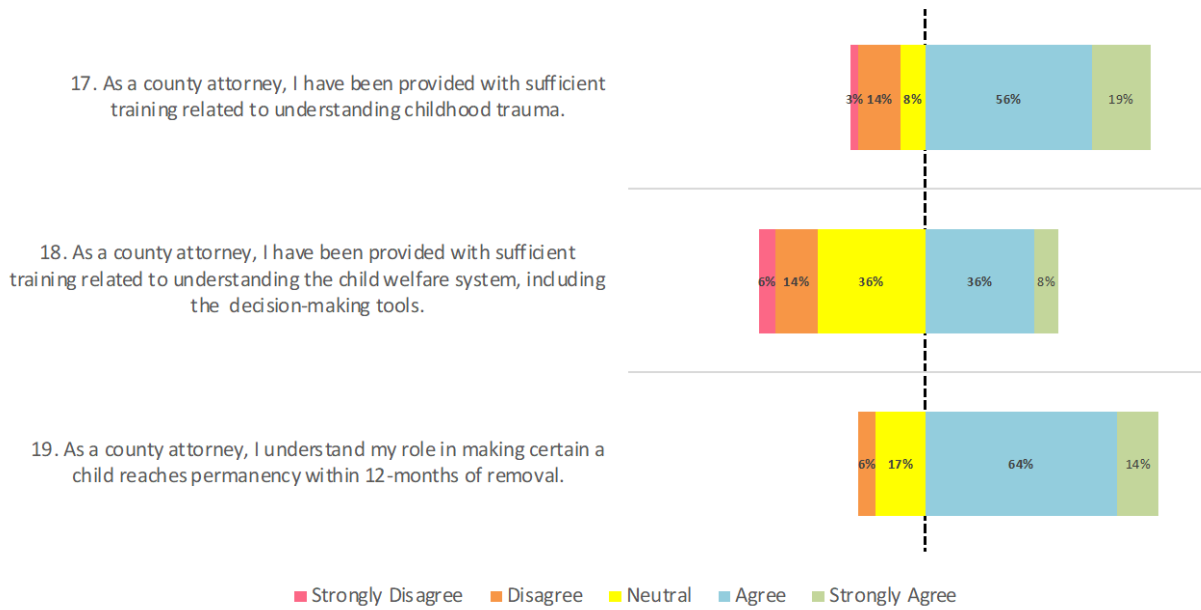
County attorneys overwhelmingly believe there is inadequate access to mental health and substance abuse services to meet the needs of families, children and youth. They have also identified behavioral health services, substance abuse services, parenting sill development, home visiting services, and transportation as significant areas of need to bring stability to a child and family. Additionally, the majority of county attorneys do not believe that DHHS does an excellent job in linking and coordinating all departments and services needed for families.

CFS Decision Making and Discretion



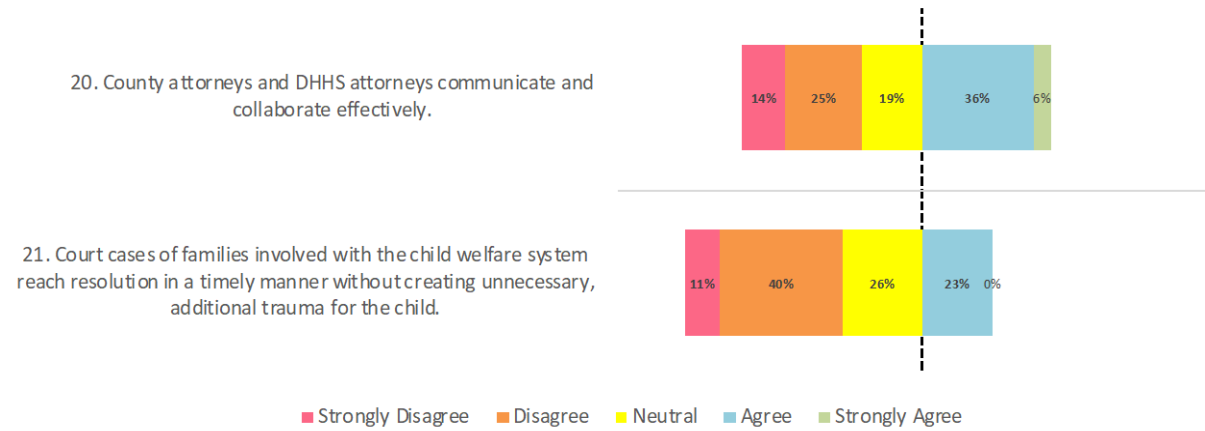
The vast majority of County Attorneys do not believe that CFS caseworkers should be given more discretion over the decision to remove children or in making decisions for the family.

Attorney Training and Understanding



County Attorneys believe they have had sufficient training to understand childhood trauma and in understanding their role in helping a child reach permanency, but the majority do agree that they need more training related to understanding the child welfare system and its decision tools.

Collaboration and Permanency



County Attorneys overwhelmingly believe there is not enough collaboration with DHHS attorneys, and that cases do not reach permanency in a timely manner.

Comments and Clarifications

Please clarify any of your prior responses or offer any additional comments you think are relevant:

1.	#1. DHHS does not recommend removal from home on a new filing/initial removal. They used to, but it is my understanding they do not write affidavits per DHHS policy and need supervisor or admin approval in order to do so. #2. The key being "with proper training". #4. I consistently and regularly get more information from the CASA and/or GAL before getting it from the DHHS worker, if I even get the information from the DHHS worker at all. Oftentimes, as county attorney I am the LAST person to get information. #8. It is DHHS policy to NOT submit petitions for removal. I have seen it done in cases with a newborn whose sibling is already a ward of the state, but that is rare. I have received more affidavits in support of removal from health care professionals than I have received from DHHS. #14. In my experience, communication is poor between DHHS and other agencies (especially probation). Both agencies always want to say it's the other agency's responsibility. #15. Discretion or authority? Currently DHHS workers have no authority to removal a child from the home and place in foster care (this is assuming a "first" removal, not removing a child who is already a ward of the state from the parental home on an emergency basis). DHHS discourages law enforcement from exercising their statutory authority to remove children from the home, so granting them any statutory authority likely wouldn't result in additional removals. #16. The way this question is worded makes it difficult to answer. DHHS implements services and pays for them when it wants to (i.e., according to their policy), but requires court orders to provide other services (drug testing). I don't think the answer is granting DHHS more discretion because I think the discretion will ultimately be interpreted as a reason to further restrict and narrow the services it feels like offering or implementing. #20. My county doesn't have a DHHS attorney present at all hearings, which I don't believe is necessary anyway. However, the times DHHS attorneys have become involved, they communicate well even if our positions on certain issues differ. #21 When children are available for adoption/guardianship, it takes DHHS too long to prepare the adoption/guardianship packets. Additional comments: Communication from DHHS workers needs significant improvement.
2.	I wish they would make better use of calendar invites that include zoom links for family team meetings, as opposed to having to search through tons of emails to locate. Also, the CAO corrects the assigned attorney on cases and DHHS continues to subsequently send reports to the wrong attorney. This results sometimes in reports not being received by the correct attorney ahead of hearings. It also mean sometimes the report does not reach the attorney in time for the hearing.
3.	I think the questions about GALS and CASAS should have been split. I find GALS very helpful and very good at communicating. CASAS are not always as helpful, generally if I have issues with CASA it is because the specific worker lacks and understanding of the law (such as parental preference, minimal parenting standards etc). Caseworker preparation and testifying is very dependent on the individual worker. Some workers are always prepared and provide good testimony. Others are rarely prepared and thus rarely provide helpful testimony.

4.	I have had the pleasure of working with amazing CFSS, and some that are less than stellar. I think more training on the impact of trauma and lack of permanency on children is needed for the County Attorneys, and ESPECIALLY for judges. I also think it is critical that we provide better training on exception hearings and effective/efficient ways to use them, and more training with ICWA/NICWIC. I have sought further education in juvenile law that has been critical for me to do a good job as county attorney in rural/Greater Nebraska, but that does not necessarily overcome other structural barriers, which include lack of services in the areas or the barriers to reunification caused by distance to access services.
5.	As a county attorney, I did not receive appropriate juvenile justice/child welfare training until well after my first few years of practice. Even then, I had to seek out additional training, and the trainings provided by the NECAA were lacking in appropriate procedural as well as trauma informed advocacy material.
6.	We are struggling with DHHS in Western Nebraska. I believe a lot of the issues are related to caseworkers being understaffed and overworked and lack of services in the area, but the decision making I've seen out of DHHS lately has been extremely concerning.
7.	The DHHS hotline has, for over a year, screened several VERY concerning cases as "does not meet" or "information only"--one of the biggest challenges we face is the hotline not screening properly. Also, we struggle with families who have voluntary cases, but then ghost DHHS and DHHS closes (per their protocols) and then not having eyes on family, but DHHS is unable to provide legal documentation or recommend removal/filing.
8.	It all depends on the caseworker. Some are very competent and efficient. Some are not. Caseworkers are often hampered in their efforts by decisions or policies made by higher-ups.
9.	When the State closed the Regional Centers and touted community based services as the new panacea they should have helped cultivate those services. Instead, they just walked away leaving communities to try to put a patchwork of services together. While Lincoln and Omaha may be able to access services Western Nebraska can not. Without community based services no one in the Child Welfare system can do their jobs. There is not enough counselors to help addicts and mentally ill people in the communities. The DHHS and Legislature need to work with colleges throughout the State to cultivate more mental health professionals to aid people. They need to cultivate new and better crisis facilities throughout the State. They need to cultivate new and better long-term mental health facilities.
10.	I did struggle to answer many of the questions. Some of my "neutral" responses were because it just depended on several factors. For example, I did not understand what was meant by giving HHS workers more discretion. Frequently their discretion is hampered by their own policies, and sometimes is hampered by me filing things because I disagree. So I would support some policy HHS policy changes that would give them more true discretion, but I am not going to support changes that give them "discretion" by limiting my ability to file when I disagree with HHS policy. Other times I put "Neutral" because "sometimes" and "it depends on the officer/CFS" weren't options. Some officers explain exigent circumstances, some don't. Most CFS are fairly competent, but some are not.
11.	DHHS often approaches removal situations from a financial perspective and it seems that they are concerned more with saving money than they are with child safety. I believe more discretion to CFS will only make the problems worse. We need more services in rural Nebraska.
12.	I have an excellent working relationship with the DHHS supervisors and caseworkers and my jurisdiction is small enough that I know each caseworker by name and they feel comfortable reaching out to me with issues/questions. We also have monthly meetings to discuss open/active cases and DHHS is involved in our

	monthly LB1184 meetings. If I didn't have this relationship with the workers/supervisors I don't think my answers would have been as positive as I know there are issues in other jurisdictions.
13.	If a CFS has the appropriate training, I agree that discretion is important. I also think that the "tools" sometimes cover the issues in the family and that reunification is not always the answer or keeping the kids at home is not always the best option. Overall, my CFS workers in my area prepare for Court and are ready to give responses. The majority of the workers will keep me in the loop of information that is important in the cases. I struggle with the ones that are the exception. I do have a handful of workers that do not prepare, do not seem to understand they are to advocate for kids over parents, and focus too much on family voice and choice when it may be to the detriment of the child's well-being. Very recently, services have begun to disappear and are not as readily available in our area for mental health and substance abuse. There is a long wait-list for these services at times and there is a wait-list for visit workers, in-home family services and overall support services for families. We have a few providers to do psychological evaluations and parenting assessments and one is basically retired so getting access to these evaluations has been much more difficult in the last year or so.
14.	I answered neutral to Number 19. I certainly understand the County Attorney's role to help a child reach permanency after an extended time in foster care, however, my reading of 19 is that it is an incorrect statement of Nebraska's law. The law does not require permanency after 12 months of foster care or any specific set time. Instead, parental rights can be terminated after 15 months of foster care, or if other circumstances that are harmful to the child exist, and it is in the child's best interests to terminate. I am well aware of my role and obligation to argue for permanency to the court after 15 months of foster care when it appears that termination of parental rights is in the child's best interest. However, I do not have an obligation to make "certain" that a child has permanency within 12 months of foster care as there is no basis in the law for that claim.
15.	All of my answers depend on who the caseworker and/or GAL are. If I have a good worker and a good GAL, the cases move appropriately and the communication is good. When I have a bad worker or GAL the cases require my attention beyond a prosecutor's role in order to move the case forward. I am concerned about the number of cases that are voluntary or AR that are never discussed with the prosecutor. We have workers that are not familiar with these families or the services in the area, yet they are making decisions on these families with no input from anyone in the community. If I didn't constantly monitor intakes and follow up with DHHS, numerous children and families who need assistance would fall through the cracks. I am also increasingly concerned about the legal advice provided to these workers. Our local DHHS attorney has no courtroom experience and no juvenile law experience. Her involvement causes roadblocks in cases that do not need to be there and she holds up cases with unrealistic expectations.
16.	Our current system regularly prioritizes the welfare and rights of parents above the welfare and rights of children.
17.	I answered the questions involving CFS workers being "given more discretion over the decision to remove a child" with the belief that this really means DHHS Admin making policy re: removal vs. allowing law-enforcement/co atty/judges. I believe that would lead to greater numbers of children remaining in imminent risk of abuse. If the questions really means that the CFS working with the family actually has discretion (without DHHS Admin policy telling them to never consider removal) utilizing their training, education, and experience - then I would support .
18.	Communication of information with all parties is the key and timely availability of services.
19.	Over the years, DHHS has implemented policies based on cost reduction, rather than policies which focus on the risk of harm to the child. Risk of harm is often treated as whether or not the child is at immediate

	risk of physical harm, but routinely ignores the evidence that persistent, long-term neglect is and can just as damaging as immediate physical abuse toward a child. Many of the people involved in these decision making processes have never lived through the circumstances, neglect, and related issues that many children have to endure. The policies in place which seek to divert referrals for review are not rooted in the best interest of the children, but instead are rooted in the best interest of DHHS' pocketbook.
20.	There is an increasing breakdown in relations and communications between DHHS and the county attorney's office. At times it appears as if DHHS intentionally withholds information from the county attorney.
21.	In my service area there are one or two good caseworkers. The rest have no idea what services are offered in my community. They also have no ability to make decisions or advocate for kids and families. Everything has to be run by a supervisor who does not know what is going on. My county continually gets bumped to another service area and we have on call workers who refuse to come out because it is too far. The workers are rude and act like their job is an inconvenience. Getting any information out of all but a couple workers is next to impossible. Many times they block law enforcement from portions of their investigation and I have no one to write an affidavit to remove. They do everything possible to keep cases out of court so they have no oversight. I am not informed when a voluntary or AR case is open or closed. They refuse to provide information on AR cases at the 1184 meetings so my community members think those kids are falling off the radar. The last 1184 meeting a worker told a foster mother what was discussed at the meeting causing her to threaten to sue an agency. That agency now does not want to participate in the 1184 meetings causing a huge gap of information. The workers who are good are getting burned out because the bad workers can do nothing and get away with it while the good workers get in trouble for things that aren't their fault. Every time I turn around there are new DHHS policies that they refuse to explain and there is no way to look them up to find out if they even exit. The DHHS attorneys back the department no matter what without even looking into the information. The attorney in my area doesn't even show up to court for hearings and we have numerous issues with her that go unaddressed. We do not have CASAs but our GALs are generally well trained and do a good job. There is one or two that have issues but the judges know who to appoint to avoid issues.

Appendix E - Comparison Matrix of the Nebraska DCFS 2017, 2018 and 2022 Proposed Policy Regarding Drug Testing

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
1. The CFS Specialist will utilize the results of the Structured Decision Making (SDM) Assessments, reports from Law Enforcement and the UNCOPE tool to determine if: • There are any individuals within the family who may need further evaluation regarding the individual's substance use; or • Information exists that demonstrates that an individual is abusing substances. An evaluation of the individual's substance use may be necessary to determine the extent of the use and any treatment recommendations. • The CFS Specialist must identify a clear purpose for using drug testing **Determining Whom to Test:** Given the limitations of drug testing, the CFS Specialist should base decisions on which individuals to test using information from the safety	1. During the Initial Assessment or Ongoing case management, when it is determined that substance use is a contributing factor related to a SDM@ Safety Threat or contributing factor to the SDM@ Risk Assessment or SDM @Risk Reassessment level of high or very high risk, the CFS Specialist will refer the parent(s) or caregiver(s) for a substance use disorder evaluation. a. The CFS Specialist or designee will assist the parent or caregiver to arrange for an evaluation. b. The CFS Specialist will work with the parent or caregiver to follow any recommendations provided from the evaluation. c. When drug testing is recommended as part of substance abuse treatment, drug testing should be arranged by the treatment provider	1. A report concerning abuse or neglect due to substance use allegations of a parent/caregiver has been reported to and received by Nebraska's Child Abuse and Neglect hotline. The report has been accepted by the hotline for an initial assessment. • The Safety Assessment will be completed. During the Safety Assessment, the substance use screening tool (TAPS) will be offered to the parent/caregiver to complete with the assistance of the CFSS. If the parent/caregiver declines the offer to complete the TAPS tool, proceed with the rest of the steps in this process. 2. As part of the Safety Assessment, CFSS will observe the parent/caregiver, children, and surroundings to look

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
assessment, risk or prevention assessment and family assessment. Other considerations may involve mothers of babies who were identified at birth as having been prenatally exposed to drugs. The CFS Specialist will also consider recommendations from the substance abuse evaluation or orders from the court. Drug testing is a service available for court and non-court involved cases. **Detection:** CFS Specialist completes initial screening. Confirmatory tests are used for further analysis of a sample, to confirm a positive or sometimes, negative result. **Probation:** When an individual is on Probation and the Office of Probation is conducting drug tests, the CFS Specialist must work with the parent to obtain a Release of Information or a court order for the results and documentation of any drug tests conducted by Probation. CFS should not authorize additional drug testing unless it is court ordered or the individual will not consent to the Release of Information. **Authorizing Drug Testing:**	and the individual. Medicaid, private insurance or the individual is responsible for the costs of any recommended drug testing. **Court Ordered Testing:** If the court orders drug testing, the CFS Specialist will comply, but will notify the CFS Supervisor and provide the CFS Supervisor with copies of the petition that brought the child into care; the court order; and the case plan and court report. a. The CFS Supervisor will review the information to determine if DHHS Legal staff need to be notified for possible reconsideration or appeal: i. In certain cases, i.e. 3(a) No Fault and 3(c) cases where substance use is not cited as a safety concern in the Petition, CFS attorneys may file a Motion to Reconsider and argue to the Court that drug testing should not be required.	for signs and symptoms of specific drug use, and how it affects parenting, as trained. CFSS will reference the CFS-approved mobile tools accessible in the field regarding signs and symptoms of specific substance use. 3. The CFSS will assess the appropriateness of offering a drug/alcohol test to the parent/caregiver **<u>after</u>** the CFSS has done the following during the Safety Assessment: • Had the parent/caregiver complete the TAPS tool (if they choose); • Observed for signs and symptoms of drug use; • Utilized CFS-approved tools for signs and symptoms of drug use; • Obtained collateral information (when appropriate); and, • Contacted a CFS Lead Worker for support or consultation. 4. If the CFSS assesses it is appropriate to offer a drug test, the CFSS will

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
The CFS Specialist will create a Service Referral that specifies the length and frequency of drug testing. The CFS Specialist will need to check with the DCFS Contracted Drug Testing providers to determine which provider(s) are able to provide the type and frequency of testing needed. Drug testing will not be conducted with parent(s) who admit to use unless there is additional information in which the use of substances other than what is disclosed is suspected that would impact the safety of the child. DCFS contract providers of drug tests will report the following to the CFS Specialist by the end of the next business day, in writing, unless otherwise directed in the service referral. **Addressing Results of Drug Tests:** The CFS Specialist will report all drug test results (positive & negative), self-disclosures, refusals and no shows to the court. Unless there is a court order authorizing the release of the results to other parties, the results of the drug test will be shared with the	b. If an Order for drug testing is under Appeal or Reconsideration, the original Court Order for drug testing remains valid and must be honored until the Court rules on the Appeal or the motion to reconsider. c. When the Court orders drug testing to be completed on a parent or caregiver and it is not a part of the substance abuse treatment recommendations and CFS is ordered to pay then the CFS Specialist will submit an authorization for drug testing. **Authorizing Court Ordered Drug Testing:** The CFS Specialist or designee will create a Service Referral specifying the length and frequency and the specific drug(s) for which the testing is ordered and will provide the parent or caregiver a list of the contracted providers for the service and the parent may select the provider. **Addressing Results of Drug Tests:** The results of all drug tests including those performed by treatment providers, probation, self-disclosures,	contact their CFS Supervisor or the on-call CFS Supervisor (CFSSS), discuss the situation, and the CFSSS will make the final determination regarding a drug test being offered to the parent/caregiver. CFS Administration will be available for a consult if needed by the CFSSS. • If the CFSSS does not agree with offering a drug test, the CFSS will continue the SDM assessment process, as trained, to determine safety. • With CFSSS verbal approval, the CFSS will offer the parent/caregiver a drug/alcohol test. Testing allows CFS to assess and identify red flags to determine the possible need for a substance use evaluation or subsequent treatment. • If the parent agrees to take the drug test, CFSS will contact the identified drug testing contracted

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
court, the county attorney and the attorney for the parent who was tested.	refusals and 'no shows', will be reported to the Court, the county attorney, the attorney for the parent or caregiver and any other party for whom there is a Court Order authorizing the release of the results. These results will be shared in the court report unless otherwise indicated by the court order.	provider. A test will be done, and preliminary results received. • If the parent/caregiver disagrees with completing a drug/alcohol test, the CFSS will document this and follow the SDM assessment process, as trained, to determine safety. • Note: If the parent/caregiver already completes substance use testing for Adult Probation, work with the parent/caregiver to coordinate testing through this entity, if possible, within the time frames needed by CFS, so duplicate testing is not done. Releases of information signed by the parent/caregiver will likely be required by the entity. • If a safety plan is developed with the family network, identified CFS-approved

Prior Protocol #17-2016	Current Protocol Update #3-2018	Proposed Pilot (11/2022)
		educational material will be provided to the family network identified as a support, to understand and recognize signs, symptoms, and behaviors of substance use. • Depending on the results of the TAPS tool and how that corresponds to the TAPS recommendations, complete a service referral for a substance use evaluation. ***SOP doesn't address who receives the results of testing***