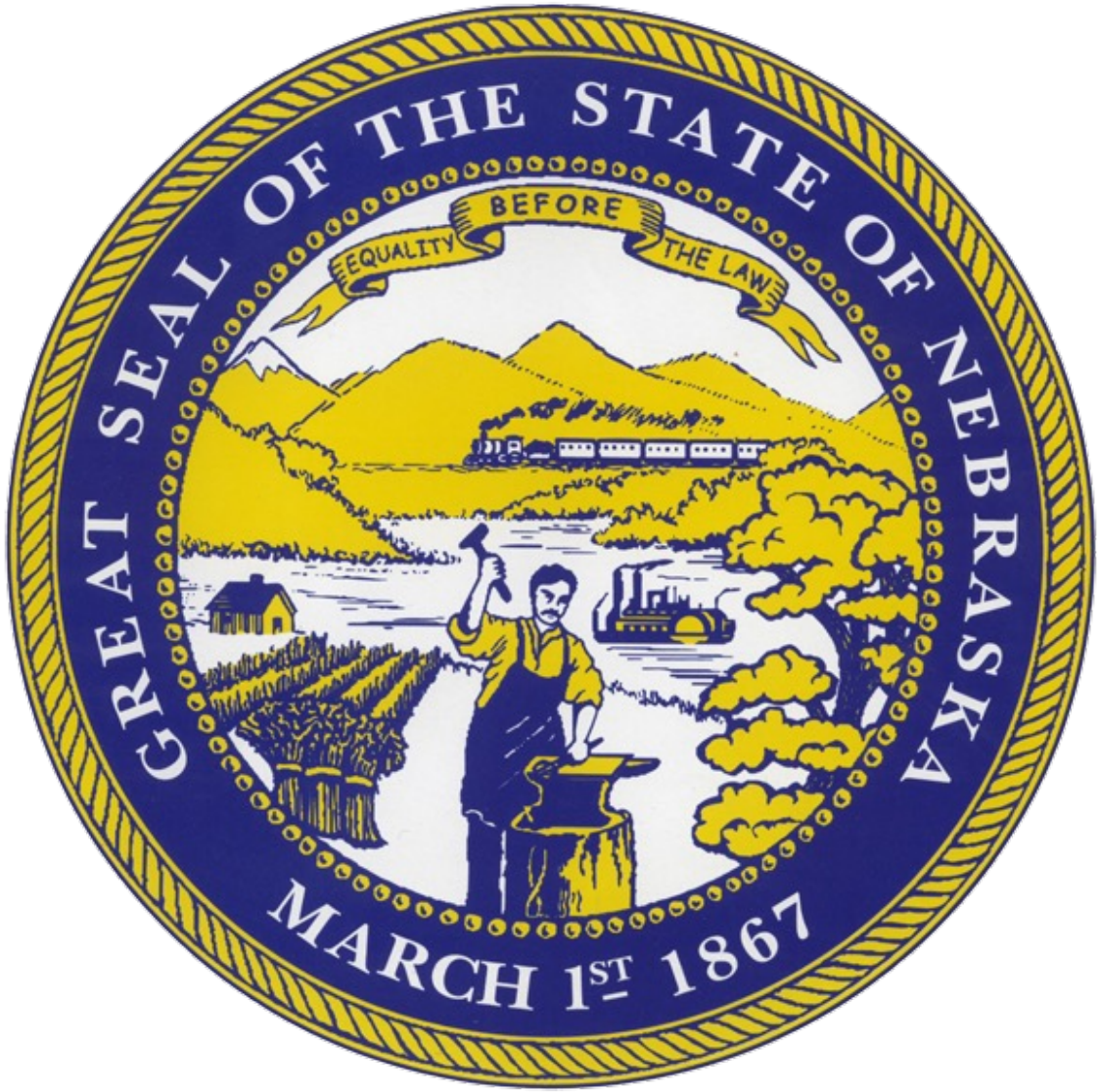
Nebraska LB 1173

Reimagining Child and Family Well-Being in Nebraska



Agenda

I. Call to Order
II. Approval of Previous Month
    a. Minutes
    b. Status Report
III. Finance, David Destefano
IV. TSG Presentation on Themes, John Stephen
V. Case Study: Behavioral Health, John Stephen
VI. Future State of Data, Greg Brockmeier
VII. Discussion: Community Forum Schedule, Alger Studstill
    a. North Platte (August 1)
    b. Lincoln (September 6)
    c. Scottsbluff (October 18)

Workgroup Member Roll Call

Statutory Member Roll Call

I. Director of Behavioral Health of the Division of Behavioral Health or the director's designee: Tony Green
II. Director of Children and Family Services of the Division of Children and Family Services or the director's designee: Dannette Smith
III. Director of Developmental Disabilities of the Division of Developmental Disabilities or the director's designee: Tony Green
IV. Director of Medicaid and Long-Term Care of the Division of Medicaid and Long-Term Care or the director's designee: Carisa Masek Schweitzer
V. Director of Public Health of the Division of Public Health or the director's designee: Charity Menefee
VI. Commissioner of Education or the commissioner's designee: Commissioner Deb Frison
VII. State Court Administrator: Corey Steel
VIII. Representative of the Supreme Court appointed by the Chief Justice: Corey Steel
IX. Representatives from each federally recognized Indian tribe within the State of Nebraska, appointed by each tribe's Tribal Council or Executive Committee:
    I. Miskoo Petite, Winnebago Tribe
    II. Danielle LaPointe, Santee Sioux Tribe
    III. Alexis Zendejas, Omaha Tribe
    IV. Stephanie Pospisil, Ponca Tribe

Approval of Minutes

Status Report Review

Housekeeping

I. If you haven't yet, please sign in. We will circulate the sign-in sheets.
II. Mics are throughout the room and will pick up side conversations, even whispers.
III. Identify yourself when speaking.

Finance

David Destefano
The Stephen Group

Current Use of Federal Funding

- Nebraska invests a high percentage of state funds in the provision of Child Welfare-related services
- Significant opportunity to leverage additional federal funding and reinvest in front-end services
- Finance plan focused on four primary objectives
  - Title IV-E maximization
  - Cross-system collaboration & leveraging
  - Payment rates and contracts
  - Performance based contracting

- *Source: *ChildTrends* based on 2018 data

	US Average % of Total Funding	NE Reported (2018) % of Total Funding	Standard Deviation from National Mean
Federal Title IV-E	24.74%	16.42%	-0.82
Federal Title IV-B	1.60%	1.21%	-0.41
Federal Medicaid	3.07%	0.00%	-0.62
Federal SSBG	4.68%	0.00%	-1.08
Federal TANF	9.12%	1.79%	-0.77
Other Federal Sources	0.75%	Not Reported by NE	N/A
TOTAL FEDERAL	**43.95%**	**19.42%**	**-1.52**
Other (offsets, in-kind, and private dollars)	**0.82%**	**Not Reported by NE**	**N/A**
TOTAL STATE AND LOCAL	**55.23%**	**80.58%**	**1.73**

Title IV-E Maximization Objective 1

- Recommendations designed to improve the Title IV-E penetration rate and state's ability to claim federal reimbursement
  1. Work with federal legislative representatives to pursue change to Title IV-E lookback (AFDC) amount
     - Long term agenda across states and from advocates
  2. Licensing of relative caregivers / kinship homes
     - Change to general mindset regarding licensing of relatives
     - Regulation change(s) to streamline licensing requirements for relative/kinship homes
       - Waiver to non-safety related standards federally allowed
       - Continue to incentivize licensing of licensing relative/kinship homes (incentive to homes only).
       - Funding to address safety concerns / home repairs
       - Pay for childcare during training for licensing relative/kinship
       - Training modifications to expedite licensing relative/kinship homes.

Title IV-E Maximization Objective 1

3. Claiming for children placed through Letters of Agreement
4. Change to agency contracts
    - Relative/kinship home specific contract requirements for agencies
    - Specific language related to licensing homes (give some language about approved waivers for a reason why the home can't or won't become licensed)
    - Reduce administrative rate for non-licensed homes or create an increase for licensed homes
        - ➢ Potential technology change (Nfocus) to establish pay differentials
5. Rate setting to ensure appropriate payment
    - Both maintenance and administrative costs (residential and CPAs)
    - May require statute change

Title IV-E Maximization Objective 1

6. Improve eligibility-related documentation
    - Court order language
        - ➢ Judicial outreach and training
    - Caseworker documentation
        - ➢ Opening packet
7. Shared Living Providers
    - Only send youth to SLPs who are DD Eligible (unlicensed)
    - Specialized License SLPs

- Eligible and claimable target
    1. Children and youth eligible: 36.3% (12-month average)
    2. Current children and youth claimable: 18.8% (12-month average)
    3. 5% increase to penetration rate could increase claiming for foster and relative homes by $500k+ annually
    4. Ability to reinvest $200-$300k of state general funds into supports and/or front-end programming

Title IV-E Maximization Objective 1

- Next steps
  1. Executive approval of recommendations (June 2023)
  2. Complete strategic plan detailing tasks for each recommendation (July 2023)
  3. Present final strategic plan to LB1173 workgroup (August 2023)

Cross-System Collaboration
Objective 2

- Coordination of services and claiming (blended and braided funding) across divisions
  1. Department of Juvenile Justice
     - Title IV-E claiming related to cross-over youth
     - Would require updates to the state's Title IV-E plan and Cost Allocation Plan
     - Administrative burden / cost to collect expenditure data, implement time study (Random Moment Sample), and calculate claim
     - Need to investigate and verify ROI
  2. Community pathway to Prevention
     - Identify community agency structure, develop contractual responsibilities, create cost estimates, and determine eligible expenses for reimbursement as a Title IV-E (FFPSA) administrative cost

Cross-System Collaboration Objective 2

3. Medicaid claiming for behavioral health and substance abuse services
    - Maximize Medicaid reimbursement for current services under FFPSA
    - Expand to encompass expansion of evidence-based (EB) services
    - Identify barriers to service provision and claiming within current structure
        - Provider capacity and capabilities - engaging providers willing to offer EB services
        - Funding for provider training and ramp-up to provide services
        - Ability to maintain fidelity to EB service while meeting Medicaid billing documentation requirements
        - Limitations to billing by existing CPT codes (is it sufficient to cover services)
    - Solutions to eliminate barriers for potential investigation
        - Expand Medicaid plan to include additional EB services
        - Establish in-lieu of services to encompass EB services
        - Waivers to allow EB documentation required for model fidelity to be accepted by Medicaid
4. Legal expenses for youth
    - Potential not yet discussed – for ongoing discussion with subgroup

Cross-System Collaboration Objective 2

5. Developmental Disabilities
    - Cross-system claiming for DD homes
    - Licensing related barriers to overcome
6. Education expenses
    - Establish cross-system ties and responsibilities especially as they relate to prevention activities
    - Develop strategies for cost sharing and claiming
    - Like with DJJ, this requires changes to state Title IV-E and cost allocation plans
7. Additional strategies
    - Federal grants to support EB service implementation and training
        - ➢ SAMHSA & Mental Health
        - ➢ Leverage TANF dollars
            - ✓ Significant surplus
            - ✓ Define how and where investment of TANF funds can create a return on ROI
            - ✓ Recent research has demonstrated that investment in concrete supports for families have created nearly a 3:1 return-on-investment

Cross-System Collaboration
Objective 2

- Next Steps
  1. Finalize and prioritize recommendations, submit for executive approval (July 2023)
  2. Establish implementation plan and tasks and submit strategic plan (August 2023)

Provider Rates and Contracts
Objectives 3 and 4

- Develop recommendations to complete rate review across services and departments
  1. Ensure rates are appropriate
  2. Consistency in rates to limit “cherry-picking” by providers
- Recommend strategies to capture costs, ensure eligible administrative costs are accounted for, and validate rates sufficient to support statewide service capacity
- Develop schedule for rate recalculation (biennial)
- Create recommendations for:
  1. Performance based contracting
  2. Parameters for shared risk
  3. Considerations and process for the development of agreed-upon outcome measures to be incentivized

Provider Rates and Contracts
Objectives 3 and 4

- Technology enhancements to support monitoring and reporting of performance and outcomes
  1. Daily cost tracking
  2. Service efficiencies
  3. Performance measures
  4. Contractual outcomes
- Next Steps
  1. Finalize and prioritize recommendations, submit for executive approval (July 2023)
  2. Establish implementation plan and tasks and submit strategic plan (August 2023)

Reduction to Out-of-Home Care Return on Investment

- Assumptions
  1. Total Reduction of 1,200 youth in OHC
  2. Reductions are straight-lined over 60-months
  3. Reductions occur from foster and relative placements
     - Always a core set of children needing more intensive placement options
  4. Based on total average claims
  5. Estimated cost savings per reduction of 20 children: $53,682
  6. 20% Penetration Rate
  7. Estimated federal share of claimed expenses: 45%
  8. Assumes no changes to penetration rate or other efforts to maximize Title IV-E reimbursement for out-of-home care

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

Reduction to Out-of-Home Care Return on Investment

- Ongoing annual savings: $38.6m
- State funds available for reinvestment annually: $34.7m

Themes

John Stephen

The Stephen Group

Common Themes From Stakeholders

- Lack of mental health and substance abuse services (especially in rural areas)
- Need robust community-based prevention system
- Build trust among all system players
- Listen to families - co-creation of plans of care
- Value lived experience
- Value peer support services
- Enhance support for social determinants of health (housing, transportation, food…)
- Involve schools in system re-design
- Technology enhancements needed to support caseworkers/interagency partners/providers
- Address placement challenges, especially with high needs and older youth
- Shared accountability across system
- Enhance foster parent capacity
- Structured and routine training for school system administrators/educators and mandatory reporters on alternatives to mandatory reporting/referral options
- Prioritize focus on outcomes rather than outputs
- Cultural/language gaps adversely impact family supports
- Invest in culturally appropriate/regionally equitable systems and services/need for more bilingual services, especially in rural areas of state
- Broader community support, resources and involvement for high-risk and special ed children and biological/foster families
- Improve relationship with providers, including fair and reasonable rate/performance-based system

Common Themes from Stakeholders (cont.)

- Alignment of agency resources (e.g., Medicaid, CFS, Education, Housing, Behavior Health, Developmental Disabilities, etc.)
- Workforce/turnover - Increase longevity, stability, decrease turnover, increase diversity of staff/better recruitment, support, professional development, training…
- Families kept together whenever safe to do so
- Poverty and lack of resources should not be grounds for removal
- Define key data and performance metrics across all systems and use them to drive innovation and change
- 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
- Improved coordination between tribal Child and Family agencies and the institutional system to foster better coordination of tribal children between the two systems
- Abuse/neglect reporting standards need reform - too easy to get families in the system over minor issues vs. helping mitigate reported issue

Common Themes from Stakeholders (cont.)

- Attention to substance exposed infant policy
- Zero to 5 year old reporting policy needs to be re-considered
- Need to adhere to current cross-over youth policy
- Review current CFS training model to ensure workers are receiving quality learning
- 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
- Legal and policy barriers: statutory and policy changes may be necessary
- Improved communication and coordination to best serve families at beginning of process
- Improved communication, coordination, and training on cross-over youth
- FFPSA planning needs to be aligned with overall prevention strategy
- Prioritize focus on outcomes rather than outputs
- Re-imagine supportive case work, where silos between families and case workers are broken down
- Trauma sensitivity in all services and supports
- Address significant service/support resources access in rural counties

Common Themes from Stakeholders (cont.)

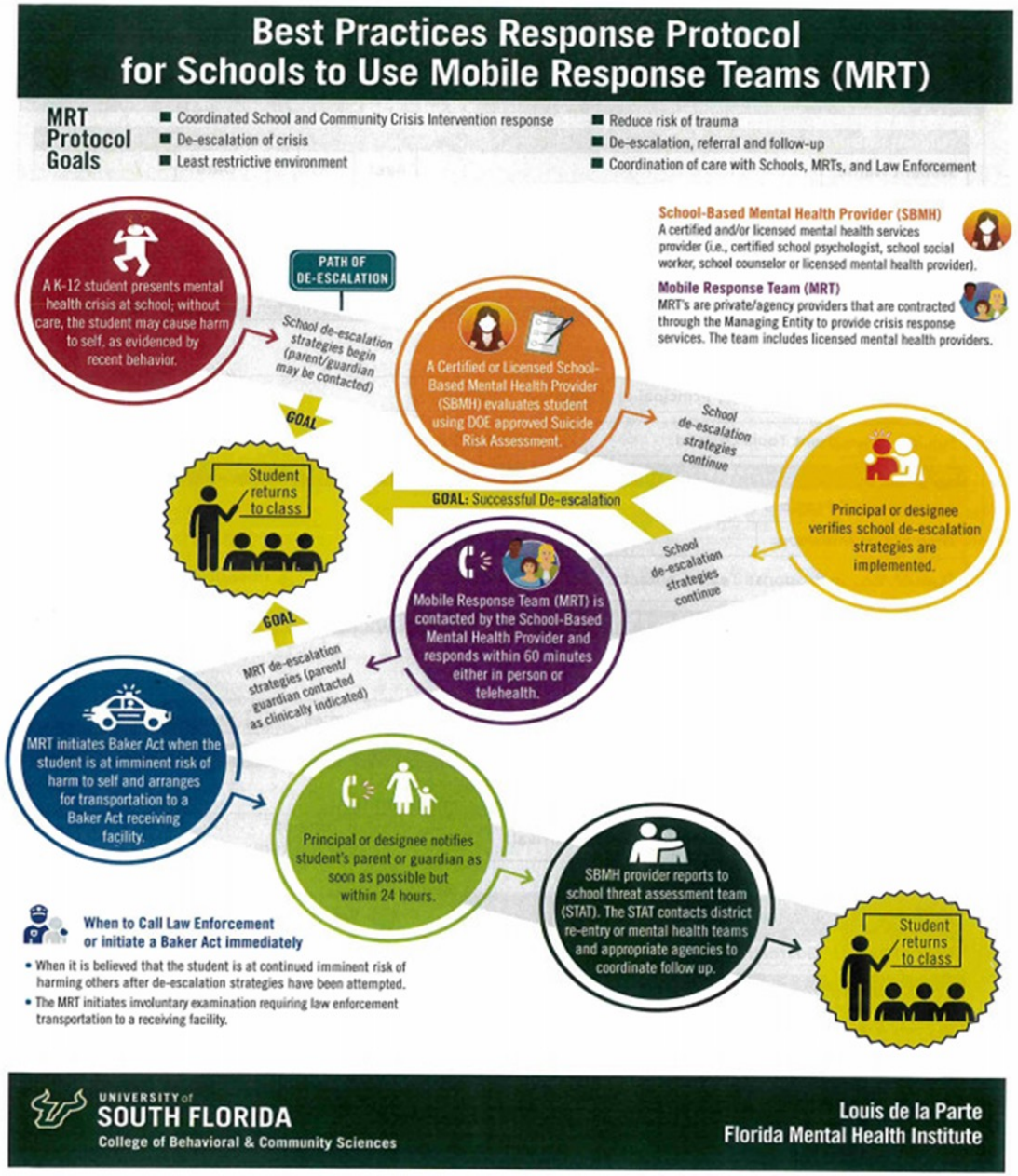
- County Attorney key intersectoral partner in LB 1173 efforts going forward
- More intensive case management for families with multigeneration experience in child welfare system
- Flexible services funding that: A) does not require individuals to be involved with the Child Welfare system to access, and, B) services can be sustained post system involvement to prevent return to the Child Welfare system
- Collaboration across agencies, including braided/flexible funding, data sharing/analytics; education system is a critical partner in making needed changes to Child Welfare system
- MCO's are an integral partner of DCFS including protocols for high needs cases and Child population health
- Regional behavioral health system is an integral partner of DCFS, including participation in future Community Pathway
- Youth Impact model in Douglas County with cross-over youth is a "best practice" model to look to in designing Multi Disciplinary Teams in court
- Judges/courts will need to be included in re-imaging well-being prevention efforts going forward and their acceptance of such a system going forward is a key ingredient to success
- CFS and JPO will need to understand the courts they are in and what judges will need to ensure a community pathway prevention model succeeds

Case Study: Behavioral Health

John Stephen
The Stephen Group

State Best Practices in Children's Behavioral Health Response

Florida Mobile Response System


Best Practices Response Protocol
for Schools to Use Mobile Response Teams (MRT)
MRT Protocol Goals
Coordinated School and Community Crisis Intervention response
De-escalation of crisis
Least restrictive environment
Reduce risk of trauma
De-escalation, referral and follow-up
Coordination of care with Schools, MRTs, and Law Enforcement
School-Based Mental Health Provider (SBMH)
A certified and/or licensed mental health services provider (i.e., certified school psychologist, school social worker, school counselor or licensed mental health provider).
Mobile Response Team (MRT)
MRT's are private/agency providers that are contracted through the Managing Entity to provide crisis response services. The team includes licensed mental health providers.
A K-12 student presents mental health crisis at school; without care, the student may cause harm to self, as evidenced by recent behavior.
PATH OF DE-ESCALATION
School de-escalation strategies begin (parent/guardian may be contacted)
A Certified or Licensed School-Based Mental Health Provider (SBMH) evaluates student using DOE approved Suicide Risk Assessment.
School de-escalation strategies continue
Principal or designee verifies school de-escalation strategies are implemented.
School de-escalation strategies continue
Mobile Response Team (MRT) is contacted by the School-Based Mental Health Provider and responds within 60 minutes either in person or telehealth.
MRT de-escalation strategies (parent/guardian contacted as clinically indicated)
MRT initiates Baker Act when the student is at imminent risk of harm to self and arranges for transportation to a Baker Act receiving facility.
Principal or designee notifies student's parent or guardian as soon as possible but within 24 hours.
SBMH provider reports to school threat assessment team (STAT). The STAT contacts district re-entry or mental health teams and appropriate agencies to coordinate follow up.
Student returns to class
GOAL
Student returns to class
GOAL: Successful De-escalation
GOAL
When to Call Law Enforcement or initiate a Baker Act immediately
• When it is believed that the student is at continued imminent risk of harming others after de-escalation strategies have been attempted.
• The MRT initiates involuntary examination requiring law enforcement transportation to a receiving facility.
UNIVERSITY of SOUTH FLORIDA
College of Behavioral & Community Sciences
Louis de la Parte
Florida Mental Health Institute

Features	MRT	CAT	FIT	FACT
Purpose	Mobile Response Teams (MRT) provide on-demand crisis intervention services in any setting in which a behavioral health crisis occurs in order to lessen trauma; prevent suicide; conduct an independent assessment; divert from emergency departments; psychiatric hospitalization; and from juvenile justice or criminal justice settings.	Community Action Treatment (CAT) Teams provide community based behavioral health services using team approach to comprehensively address the needs of the youth and their family. CAT is an effective alternative to out-of-home placement for children with serious behavioral health conditions.	Family Intensive Treatment (FIT) Teams provide early assessment and intensive team-based, family-focused services to families in the child welfare system with parental substance abuse. Collaborate with child welfare professionals to promote child safety.	Florida Assertive Community Treatment (FACT) teams use a multidisciplinary, recovery-oriented approach to assist individuals with serious mental illness living in the community and prevent recurrent hospitalization or incarceration.
Ages served	All ages	Youth ages 11-21 and their families	Adults	Adults
Target population	Anyone in behavioral health crisis	Youth who are at risk for out-of-home care; have 2 or more psychiatric hospitalizations; have multiple episodes with law enforcement; have a history of extreme school related issues	Parents (and families) involved in the child welfare system who have parental substance abuse.	Adults with serious, persistent mental illness
Service location	Anywhere – schools, community, in-home, and hospitals	Home, School, Office	Home, Community, Office	Home, Community, Office
24/7 operation	24/7 operation. Goal of 60 minute response.	On-call after hours	On-call after hours	On-call after hours
Typical length of service	Up to 3 days of follow up from the crisis	9-12 months	9-12 months	12 months +
Key partners and stakeholders	Law enforcement, school systems, 211 centers	Schools, Community Providers, Child Welfare	Child Welfare, Community Providers	Community Providers, Law Enforcement, Housing Services, Medical Professionals

NJ System of Care

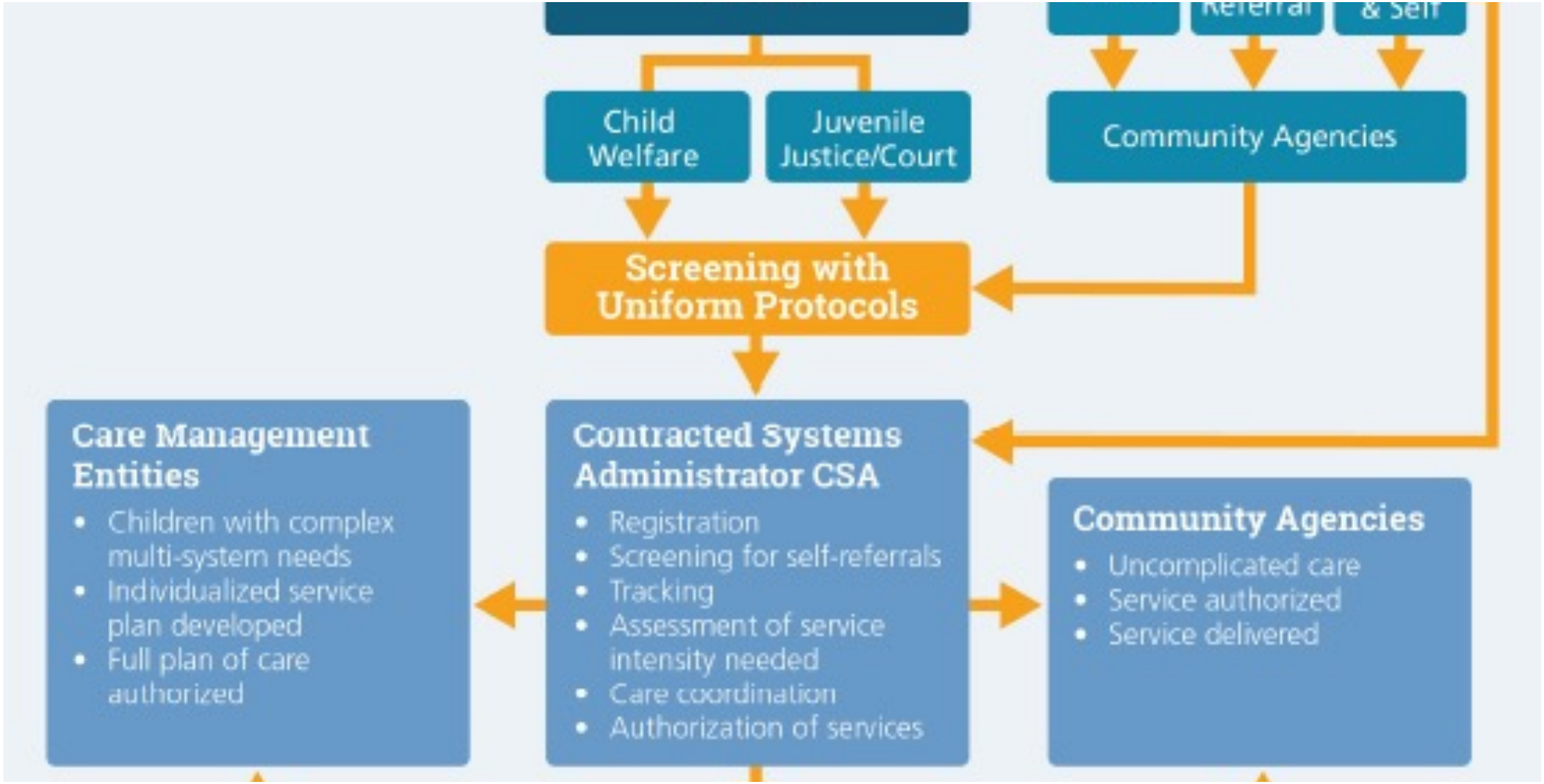
The New Jersey Children's System of Care (the System)—a division of the New Jersey Department of Children and Families (DCF)—manages a statewide children's behavioral health system delivering clinical services, concrete resources, and social supports through tiered care management. Rooted in systems of care theory, the System's design differs from other models in its contracting structure, funding sources, eligibility criteria, and investment in empowering children, families, and communities.

The System launched in 2001 spurred by political pressure to increase access to children's behavioral health services. The impetus for reform arose from a grassroots movement organized by parents of children struggling with behavioral health challenges. These parents successfully lobbied the state legislature to invest in more efficient ways for parents and children to voluntarily access services. The System's origin in parents' advocacy influenced its design and implementation in at least three important ways.

First, parents' success persuading the Legislature to pursue reform catalyzed a significant investment of state funds blended with New Jersey's Medicaid program. Most of the System's distinguishing characteristics depend on this state funding.

Second, because the grassroots movement focused on parents voluntarily seeking care for their children, the System's design focuses on facilitating access through voluntary engagement. So, while the State's investment enhanced family support services to some extent, it primarily improved care and service coordination.

Finally, parents' role in creating the System led the State to embed structural elements that empower families' voices at both the case and systems level.


Child Welfare
Juvenile Justice/Court
Community Agencies
Screening with Uniform Protocols
Care Management Entities
• Children with complex multi-system needs
• Individualized service plan developed
• Full plan of care authorized
Contracted Systems Administrator CSA
• Registration
• Screening for self-referrals
• Tracking
• Assessment of service intensity needed
• Care coordination
• Authorization of services
Community Agencies
• Uncomplicated care
• Service authorized
• Service delivered

Role of the state

- Setting vision and policy for system of care
- Setting data collection priorities
- Using data to refine service array
- Establishing clinical criteria for each service
- Contract management and service line manager
- Rate setting, new services (via notice of funds availability), funding priorities
- Defining new service and population rules, requirements, and criteria, ensuring compliance with statutes and regulations

Role of PerformCare

- Providing access to care 24/7/365 as a single point of contact for families
- Developing and enhancing electronic medical record
- Data collection, reporting, and trending
- Independent clinical decision-making to authorize services
- Provider training, communication, technical support
- Leveraging funding streams to maximize services and availability of Federal Funding Participation
- Rapid implementations that ensure capacity for new services and populations

Washington: WISe Program: Wrap Around with Intensive Services

- **Genesis:** Result of TR v Dreyfus CW related lawsuit/Settlement Agreement: Requires System of Care
- **Governance Structure:** Multi-Systemic: DSHS, HCA/Medicaid; Child Serving agencies; family members; Lived Experience; Peer Youth and Parents
- **Covered Population:** All Medicaid eligible children and youth, including CW
- **WISe Access/Provider Agencies:** qualified community behavioral health child/youth serving organizations contracted with Managed Care organizations and/or HCA/Medicaid FFS contractor (Mobile/Crisis Intervention paid FFS
- **Required WISe Provider Services:** CANS assessment; Intensive Care Coordination, and Mobile/Crisis Intervention – all other BH services provided through MCOs
- **Statewide Coverage:** currently 79 WISe providers statewide; at least one in each county (39)
- **Clinical Eligibility:** EPSDT screened for Medical Necessity; WISe screened for Intensive Services

Washington: WISe Program: Wrap Around with Intensive Services (cont.)

- **WISe eligibility screening and WISe Plan Development:** CANS on a state wide, multi-system basis including Medicaid Managed Care Plans; Child Family Team develops the Services Plan
- **WRAP Fidelity Standards:** National Wraparound Initiative: Portland State School of Social Work
- **WISe Access Protocol:** Access: inform, identify, and screen eligible youth, including self-referrals; Plan and Provide WISe services to the children/youth meeting WISe medical necessity screening requirements based on CANS assessment; Provide continuity of care for eligible children/youth, including Transition youth, with MCOs or FFS providers.
- **WISe Service Delivery, Policy, Procedures, and Resources Manual:** https://www.hca.wa.gov/assets/billers-and-providers/wise-wraparound-intensive-services-manual.pdf
- **WISe Data Reports:** https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/wraparound-intensive-services-wise

Virginia: Children's Services Act: Community Based System of Care

- **Genesis:** § 2.2-5201: It is the intention of this law to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families. (Updated in 2018; originally passed in 1993)
- **Governance: State Executive Council**: One member of the House of Delegates; One member of the Senate; the Commissioners of Health, of Behavioral Health and Developmental Services, and of Social Services; the Superintendent of Public Instruction; the Executive Secretary of the Virginia Supreme Court; the Director of the Department of Juvenile Justice; the Director of the Department of Medical Assistance Services; a juvenile and domestic relations district court ex officio nonvoting member; the chairman of the state and local advisory team; five local government representatives chosen from members of a county board of supervisors or a city council and a county administrator or city; two private provider representatives; and parent representative.

Virginia: Children's Services Act: Community Based System of Care (cont.)

- **Office of Children's Services** administers the CSA and facilitates the work of the State Executive Council; assures High Fidelity of the Wrap Around model; provides CANS training and certification; and statewide data management and reporting. (Established by the Act)
- **Financing Model:** Blended Funding: Medicaid; Social Services: IV-E; Special education/DOE; Juvenile Justice; Behavioral Health & Developmental Services: a single state pool of funds to purchase services for at- risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams (FAPT) who plan and oversee services to youth.
- **Covered Population:** Children who are "abused or neglected" as defined in COV § 63.2-100/"Child Welfare; and "Children in need of services" as defined in COV § 16.1-228.
- **CSA eligibility screening and CSA Plan Development:** CANS on a state wide, multi-system basis including Medicaid Managed Care Plans and providers; local FAPT teams develops the Services Plan.

Virginia: Children's Services Act: Community Based System of Care (cont.)

- **Local FAPT/Family Assessment Planning Team Composition:** Local Community Services Boards; JJ Court Services; DOH; DSS Child Welfare; local school division; family members/representatives; operate under High Fidelity Wraparound model
- **FAPT Fidelity Standards:** National Wraparound Initiative: Portland State School of Social Work
- **CSA Values:** All families have strengths; Families are the experts on themselves; Families deserve to be treated with dignity and respect; Families can make well-informed decisions about themselves and their children; Family voice and choice is a trauma-informed approach to service engagement; Families are shaped by their rich and unique histories and cultural backgrounds; Outcomes improve when families are involved in decision-making; A FAPT team that genuinely includes youth and family is often more capable of creative and high-quality decision-making than individuals or groups of professionals alone.
- 2022 Outcomes Indicators Report: https://www.csa.virginia.gov/content/doc/CSA_Performance_Measures_Outcome_Indicators_Report_FY2022.pdf

Youth Peer Support Models

- In **Michigan**, peer support is expanded to include youth and young adults with serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of Non-Judgmental Support, Connection through Lived Experience, and Supporting Self-Advocacy. These activities increase hope, confidence, self-advocacy skills, and decision-making abilities. Youth Peer Support Specialists promote hope and acceptance by sharing their story of lived experience to reduce stigma and increase youth voice and ownership in services. Services are funded by Medicaid as part of Michigan's Early Periodic Screening Diagnosis and Treatment State Plan.
- In **New Hampshire**, the Family Wraparound program funds both family and youth peer specialists to work as part of the interdisciplinary team assigned to assist a family. The Family Peer Support Specialist (FPSS) brings a "lived experience" as a person who has been or is a parent of a child with mental health challenges and needs. A FPSS will provide coaching, education, information, mentoring, and/or support and encouragement to family members to ensure their voice is heard and to help caregivers participate as "full partners" in the Wraparound Process.
- **Alleghany County, Pennsylvania** has developed several strategies to engage youth in system improvement efforts. The Youth Support Partners (YSPs) have been in foster care, juvenile probation, or mental health services. They are full-time, salaried staff with benefits

Closed Loop Referral Navigation

In 2020, the **Florida Department of Children and Families** (DCF) launched MyFloridaMyFamily. , a web-based application that provides real-time geolocated information to child protection investigators, child welfare case managers, and the public at large identifying available child and family supports across several service domains. Through the portal, a family in need can access the location, contact information, eligibility criteria, and cost for services through local providers meeting needs related to behavioral health, food, housing, tangible goods, transportation, healthcare, finances, legal issues, education, employment, and personal care.

DCF implemented MyFloridaMyFamily as part of the Governor's Faith and Community Based Initiative, focusing on improving child and family wellbeing by leveraging existing faith and community-based programs.

In March 2022, Florida's First Lady and DCF announced the launch of Hope Florida-A Pathway to Prosperity. Hope Florida expands upon the web based MyFloridaMyFamily portal with care navigators who the State tasks with developing individualized pathways to "prosperity, economic self-sufficiency and hope." The navigators—accessible through a statewide hotline (the "hope line")—work with clients to identify goals and barriers, develop a plan to achieve self-sufficiency, and connect with local service providers. A navigator refers the client to providers of behavioral health, concrete resources, and social supports within their local community. Florida has trained care navigators in Motivational Interviewing to equip them with the skills necessary to guide each client to the successful completion of their plan.

Additional Resources

- https://www.casey.org/resources/field-questions/all-questions/

(Link to Casey's public briefs re: questions from the field – searchable by topic)

- https://www.casey.org/nj-mobile-response-stabilization-services/

(NJ's mobile response model)

- https://www.casey.org/telehealth-strategy-brief/

(Telehealth strategies re: your reference today to access to mental health services in rural NE)

- https://www.casey.org/can-you-tell-us-about-a-few-agencies-that-have-systems-of-care/

(Systems of Care developed in response to meeting mental health needs in child welfare systems)

Future State of Data

Greg Brockmeier

CFS Deputy Director Analytics, Planning and Evaluation

Child Welfare Data – Future State

CFS Case Managers, Supervisors, Administrators

- Realtime Data Available at their finger-tips
  - Dashboards
  - Backlogs
  - Performance
- Available within the case management system

Data Sharing/Inter-Connectivity between systems

- DHHS (CFS, Medicaid, Behavioral Health, Public Health, etc.)
- Other Government Agencies (Courts, Probation, Dept. of Ed, etc.)
- Service Providers
- Community Agencies

https://www.casey.org/data-sharing-implementation/

Child Welfare Data – Future State

Expanded Use of Modern Tools for Business Intelligence/Analytics (e.g., Tableau)

- Key Performance Indicators
  - Drill downs for regions and staff
- Data Driven Decision

https://www.childwelfare.gov/topics/management/info-systems/program-improvement/

- Predictive Analytics

https://www.childwelfare.gov/topics/management/info-systems/predictive/

Publicly Available Data/Dashboards

- Historical and Recent Data
  - State/Regional Performance Measures
  - Statistics
  - Florida Example:

https://www.myflfamilies.com/services/child-family

Community Forum Schedule

Alger Studstill

CFS Deputy Director