

**NEBRASKA**

Good Life. Great Mission.



# **Nebraska's Five-Year Title IV-E Prevention Program Plan 2019**



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## ACRONYMS & TERMS

BH	Division of Behavioral Health
Case Manager	CFS Child & Family Services Specialist (CFSS)
CEBC	California Evidence-Based Clearinghouse <sup>1</sup>
CFS	Division of Children & Family Services
CFSP	Child and Family Services Plan <sup>2</sup>
CQI	Continuous Quality Improvement
Department	Nebraska Department of Health and Human Services
EBP	Evidence-Based Practice
FCT	Family Centered Treatment
Family First or FFPSA	Family First Prevention Services Act
Federal Clearinghouse	Title IV-E Prevention Services Clearinghouse <sup>3</sup>
FFT	Functional Family Therapy
HFA	Healthy Families America
MIECHV	Maternal, Infant & Early Childhood Home Visiting <sup>4</sup>
MST	Multisystemic Therapy
PCIT	Parent and Child Interaction Therapy
PH	Division of Public Health
Plan	Nebraska Five-Year Title IV-E Prevention Program Plan
PPI	Provider Performance Improvement
RFP	Request for Proposal
RFQ	Request for Qualifications
SDM	Structured Decision Making
SOP	Safety Organized Practice
SACWIS	State Automated Child Welfare Information System
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy

<sup>1</sup> <https://www.cebc4cw.org/>

<sup>2</sup> <https://www.acf.hhs.gov/cb/programs/state-tribal-cfsp>

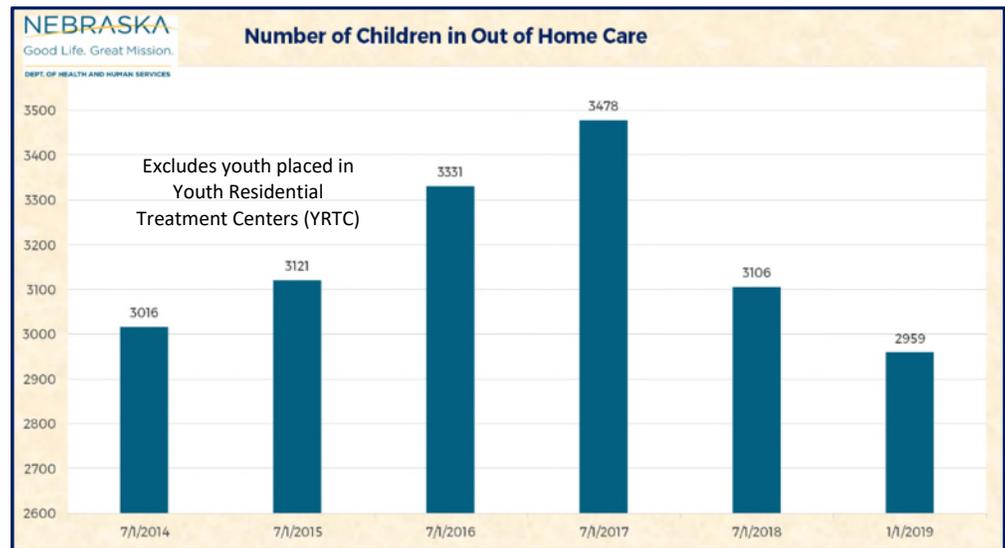
<sup>3</sup> Title IV- E Prevention Services Clearinghouse was established by the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS); <https://preventionservices.abtsites.com/>

<sup>4</sup> <https://www.acf.hhs.gov/ecd/home-visiting>

## FORWARD

The Nebraska Department of Health and Human Service's mission is to "Help people live better lives". The vision of the Division of Children and Family Services is that "CFS will utilize the Family First Prevention Services Act (FFPSA) to improve prevention services and remove fewer youth from the parental home, while providing more comprehensive, evidence-based services to children in their own homes, with their family, with reduced levels of secondary trauma. Families will progress more efficiently and more timely within CFS. CFS will have a reduction in the turnover rate of case managers and ensure staff are supported and satisfied, while continuing to be proficient at their work, engage with a family so their voice and choice is considered and that families will have the same case manager through the life of the case as often as possible. To achieve this vision, CFS will have improved collaboration, information sharing, continuity and performance within CFS, with the families we work with, and all parties within the Nebraska child welfare system."

The past several years, CFS committed to a cultural shift that focused on serving families through *prevention* rather than *intervention*. From 2017-2019, CFS safely reduced the number of children in out-of-home care by 15%. For children in out-of-home care since 2014, CFS has increased use of relative/kinship resource homes by 12% and decreased congregate care placements by almost 3%. Implementing FFPSA is important in helping further the Department and Division's efforts to serve more families in the home with improved preventative evidenced-based programs.



Implementation of FFPSA prevention services program aligns with Nebraska's *Performance Improvement Plan (PIP) Goal #5* which is to enhance current service array to ensure appropriate and individualized services are accessible. As noted in the Nebraska PIP, *Item 29: Array of Services* is an area needing improvement due to challenges in accessing services in the rural and frontier areas of the state. Additionally, this area needs improvement related to challenges in accessing substance abuse and specialized mental health services to address trauma and other factors. Nebraska expects implementing this Plan will not only improve in home service quality

and array of available services, but will reduce the demand for foster care services that are often not readily available, particularly in the rural Nebraska.

The Division is working to ensure that execution of Family First is not only trouble-free, but also supports and encourages innovation. FFPSA is a monumental opportunity in which federal funding will help support existing prevention efforts and most importantly improved outcomes for the families CFS serves. However, at the same time, this new opportunity requires a commitment by Nebraska's child welfare system to adjust to an improved way of working with families, by partnering with them to address the challenges they face and prevent it from turning into a crisis or worse.

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## SERVICE DESCRIPTION AND OVERSIGHT

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### Nebraska's Landscape

Program and population data from CFS shows:

- Approximately 22,845 children are involved in an investigation; 11,246 children receive services and 2,454 children enter foster care (based upon 2016 data).
- The majority of children enter foster care due to neglect.
- From 2015-2017, of all accepted intakes for abuse/neglect, 37% included a child age 0-5 years.
- From 2015-2017, 45% of children removed from the home were ages 0-5 years.
  - In 2017, of the total children ages 0-5 who entered out-of-home care, 47% were 1 year of age or younger.
- Approximately 46% of children who enter out-of-home care ages 0-5 have at least one parent who was previously in the state's custody.
- In July 2018, 40% of all the children involved in an ongoing services case had a parent who was also involved with CFS as a child.
- Parental substance abuse is a contributing factor for approximately 50% or more of children who enter out-of-home care.
- As of January 2019, approximately 60% of all children served are in out-of-home care and 40% are in-home.

Re-entry into foster care after adoption or guardianship dissolution was recently a special study by the Nebraska Foster Care Review Office.<sup>5</sup> This study included analysis of point in time data

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<sup>5</sup> The Nebraska Foster Care Review Office Quarterly Report; March 1, 2019; [www.fcro.nebraska.gov](http://www.fcro.nebraska.gov)

from December 31, 2018. On this date, of the 4,200 children in out-of-home care, 226 were previously state wards and exited state care to “permanent” homes through either adoption or guardianship. Analysis of this sample showed:

- 4.3% of the child welfare population were previously placed in permanent homes through adoption or guardianship, and many of these homes are no longer a permanent option.
- For dually-involved youth in care on 12/31/2018, 14.5% were previously adopted or placed in a guardianship, which is substantially higher than the proportion of kids solely involved with child welfare or juvenile justice. Dually-involved youth have both an active child welfare and juvenile justice case.
- Nearly all children who re-entered care did so during the early teenage years.

This report states, “Better preparing adoptive parents and guardians for the teenage years and ensuring families in need have access to behavioral health services outside of the child welfare system may reduce re-entry and assist all families”. Including this population of youth in the Nebraska definition of candidacy will assist with in these efforts. The full Nebraska Foster Care Review Office Quarterly Report issued March 1, 2019, is found [here](#).

## Definition of Candidacy

Developing a clear scope for Nebraska’s children and families in need of Family First prevention services is a critical task for CFS, its partners and stakeholders. Nebraska’s approach to candidacy is to define the families currently served meeting the requirements of FFPSA.

### Nebraska’s Definition of Candidacy is:

*“Children and youth identified as being a candidate for foster care are those at imminent risk of entering foster care, as defined by Nebraska Revised Statute 71-1901, but can remain safely in the child’s home or kinship/relative home as long as Title IV-E prevention services are necessary to prevent entry into the foster care system are provided. This includes but is not limited to those children and youth who are:*

1. *residing in a family home accepted for assessment, or with an , ongoing services case including non-court and court involved families where the child may be a state ward;*
2. *reunified following an out-of-home placement;*
3. *the subject of a case filed in juvenile court as being mentally ill and dangerous as defined by Nebraska Revised Statute 43-247 (3)(c);*
4. *pre- or post-natal infants and/or children of an eligible pregnant/parenting foster youth in foster care;*

5. *at risk of an adoption or guardianship disruption or dissolution that would result in a foster care placement;*
6. *with extraordinary needs and whose parents/caretakers are unable to secure assistance for them;*
7. *involved with juvenile probation and living in the parental/caretaker home.*

Nebraska's candidacy definition, allows a child to transition between traditional IV-E eligibility and FFPSA IV-E eligibility.

## Assessing Children and their Parents for Eligibility

CFS uses Structured Decision Making (SDM), a comprehensive case-management system for child welfare, to guide decision making. SDM is rated as a promising practice per the California Evidence-Based Clearinghouse for Child Welfare (CEBC). SDM assessments are used to guide decision making including to determine families at high risk of maltreatment and ensures interventions meet the needs and strengths of families. Accepted intakes of abuse or neglect receive this initial assessment. A family whose case does not close after the initial assessment, receives an ongoing services case. Nebraska intends to offer FFPSA prevention services to families involved with CFS prior to October 1, 2019, who meet the definition of candidacy and are in need of such services (**Attachment A**).<sup>6</sup>

Nebraska is statutorily required to provide post-adoption and post-guardianship support and services to families meeting the criteria of: having a current adoption assistance agreement or guardianship assistance agreement with CFS for a child who was a state ward, a child whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in a foster care placement or any family who has adopted a child or became a guardian of a child and is currently residing in the State of Nebraska. CFS has an external contractor that provides post-adoption services. Currently CFS is in the process of issuing a Request for Proposal (RFP) for post-adoption and post-guardianship services. The provider awarded this contract will provide intervention services to candidates at risk of an adoption/guardianship disruption. Referrals for these services can come from families, CFS, or other sources. The contractor will provide intervention services such as advocacy, intervention, crisis management, mental health referrals, respite care, training and education, support groups for parents and children, and mentoring. CFS will complete the FFPSA Foster Care Prevention Plan. If safety concerns are identified, the contractor must make a report to CFS Child Abuse and Neglect Hotline.

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<sup>6</sup> Please see *Attachment A: Standard Work Instruction for Foster Care Prevention Plan*, for regarding the policies and procedures for CFS staff regarding the FFPSA prevention program including determining candidacy and eligibility for FFPSA prevention programs and services.

## Program Selection

Program selection for this Plan has been a continuous process using data evaluation and program research. The process began through a CFS facilitated external stakeholder workgroup that helped identify existing evidence-based programs (EBPs) in Nebraska (*Attachment B*). The process was useful, given a complete scan of existing EBPs available in Nebraska had not been conducted. Key information such as, program overview, outcomes, target population, CEBC rating, predicted federal clearinghouse rating, child welfare relevance and Medicaid eligibility were identified for each program. Additionally, the workgroups considered programs not currently in Nebraska based on the needs assessment, but wanted. The workgroup began researching geographic access and capacity for programs within Nebraska and planned to conceptualize all relevant information into a map, so they could be better understand where service gaps existed and for what types of services and population.

Given the level of uncertainty caused by the delay of approved programs by the Children's Bureau and the importance for Nebraska to be prepared for implementation on October 1, 2019, CFS issued a Request for Qualifications (RFQ) for evidence-based [In-home Parenting Skills Services](#) and [Substance Abuse and Mental Health Services](#) in May 2019. A RFQ is a written solicitation utilized for obtaining qualification offers from providers for FFPSA-relevant evidence-based programs. This process provided CFS with the information needed and certainty of requirements for each EBP submitted e.g. geographic access and capacity, fidelity to model, etc. Part of the RFQ requirement is for providers to submit a proposal for EBPs in which they have trained staff and can *immediately* offer services to families given the short time frame for initial implementation. The RFQ process will be continuous, allowing to submit new, or additional proposals, as they implement new programs. CFS will amend its Plan accordingly.

RFQs were requested to be submitted by June 30, 2019, for contracts beginning October 1, 2019. CFS is submitting this initial Plan with the inclusion of programs that are *1) rated on the federal clearinghouse, 2) currently implemented in Nebraska and 3) providers were awarded a contract based on the RFQ*. CFS is including Family Centered Treatment (FCT), since this is an existing CFS contracted program and also requesting transitional payments for FCT, as it has not yet been rated by the IV-E Clearinghouse. Given the costs associated with implementing or expanding EBPs, CFS has secured additional funding to assist these efforts.

Nebraska intends to submit an amended Plan in the near future requesting transitional payments for additional programs once the requirements outlined in ACYF-CB-19-06 have been received.

Of the ten prevention programs rated by the federal clearinghouse (kinship programs excluded), Nebraska discovered via a statewide scan, only six of the ten programs are available in the State. Of the six programs, five are included in this Plan. Of the five programs listed in this Plan, two are Medicaid funded and have specific codes for which they are billed. An additional two programs are Medicaid insurance eligible, meaning Nebraska Medicaid does not

have specific billing codes for these EBPs. This is likely due to providers using the EBP and billing with other codes, since providers do not bill by specific EBP. This leaves one program, HFA, which is neither Medicaid funded nor eligible. Additionally, approximately 80% of all children CFS works with in an ongoing services case have Medicaid insurance. As for parents, Nebraska is in the process of Medicaid expansion; post-Medicaid expansion it is estimated that 55% of parents CFS works with in an ongoing services case will qualify for Medicaid insurance. In concert with the requirements of ACYF-CB-PI-18-09 that at least 50% of IV-E spending be for well-supported EBPs, the '*Payor of last resort*' requirement becomes problematic for Nebraska, especially as a Medicaid-expansion state.

See Attachments Section for **Attachment III: *State Assurance of Trauma-Informed Delivery.***

**Nebraska Title IV-E Prevention Services**

	<b>EBP</b>	<b>Target Population in Years</b>	<b>Average Length of Service<sup>7</sup></b>	<b>Outcomes (CEBC?)<sup>8</sup></b>	<b>Title IV-E Clearinghouse Rating</b>	<b>CEBC Rating</b>	<b>Requesting Transitional Payments<sup>9</sup></b>
<b>In-Home Parenting</b>	Healthy Families America	Parents of children 0-5 (must be under 2 at time of referral)	Until child is 3, can be offered until age 5	Increased nurturing parent-child relationships, health child development, enhanced family functioning, increased protective factors, reduced risk	Well-supported	Well-supported	n/a
<b>Mental Health</b>	Family Centered Treatment	Children 0-17 and their caregivers	6 months	Family stability, increase family functioning in the critical areas contributing to increased risk of family dissolution, increase effective coping, reduce harmful or hurtful behaviors, build upon strengths to sustain changes made	Not yet rated	Promising	yes
	Functional Family Therapy	Children 11-18	3 months	Eliminate youth referral problems (i.e., delinquency, oppositional behaviors, violence, substance use), improve prosocial behaviors (i.e., school attendance), improve family and individual skills	Well-supported	Supported	n/a
	Multisystemic Therapy	Children 12-17 and their caregivers	3-5 months	Youth: Reduce behavior problems. Caregiver: increased ability to address parenting difficulties and empower youth.	Well-supported	Well-supported	n/a
	Parent and Child Interaction Therapy	Children 2-7 and their caregivers	4-5 months	Child: Increased parent-child closeness, decreased anger and frustration, increased self-esteem. Parent: Increased ability to comfort child, improved behavior management and communication with child.	Well-supported	Well-supported	n/a
	Trauma-Focused Cognitive Behavioral Therapy	Children 3-18 and their caregivers	3-5 months	Improved PTSD, depression, anxiety symptoms, reduced behavior problems, improved adaptive functioning improved parent skills, reduced parent distress.	Promising	Well-supported	n/a

<sup>7</sup> Average length of service obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/>

<sup>8</sup> Outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; <https://www.cebc4cw.org/>

<sup>9</sup> ACYF-CB-PI-18-09-06; Transitional Payments for the Title IV-E Prevention and Family Services and Programs; <https://www.cwla.org/wp-content/uploads/2019/07/ACYF-CB-PI-18-09-Attachment-A.pdf>

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## In-Home Parenting Skills Programs

### *Healthy Families America*

Implementing Health Families America (HFA), specifically the Child Welfare Adaptation, is a part of the proposed 2019-2020 Department's Business Plan:

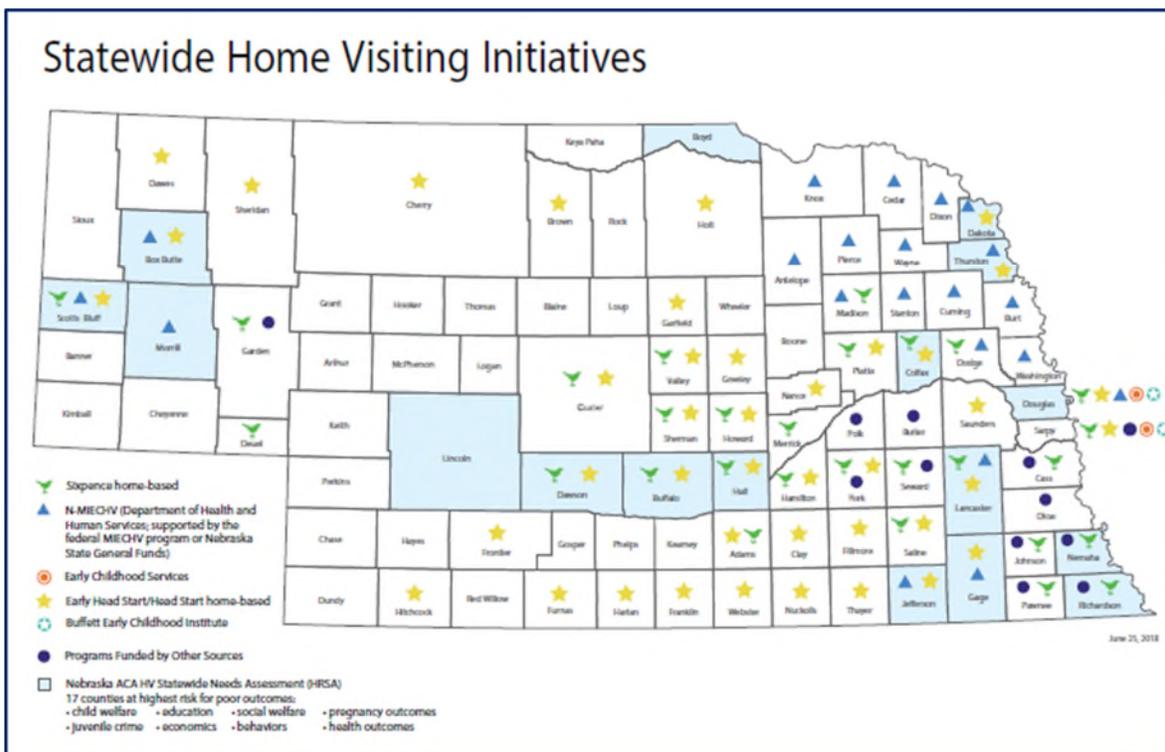
“Evidence-based home visiting has been proven effective through decades of research and data to reduce risk of child maltreatment and improve health and self-sufficiency of vulnerable families who participate. Families build personal relationships and receive education and referral services, leading to decreased infant mortality rates, increased positive parenting skills, and decreased child abuse and neglect.

“One such evidence-based home visiting program in Nebraska is the Healthy Families America model. The HFA model, since its inception, has been focused on the prevention of child abuse and neglect through a voluntary, strengths-based approach. The program best serves families who are high-risk and overburdened, including those who are involved in the child welfare system. HFA is designed to engage families as early as possible, during pregnancy or at the birth of a baby. For child welfare agencies, a challenge arises when families with older infants and toddlers are identified and are unavailable due to the age of a child. To address this existing gap in service, HFA created the Child Welfare Adaptation. “

The target population of HFA is to enroll families prenatally or within three months of birth; however with the adaptation, when referred from child welfare, families may be enrolled with a child up to twenty-four months of age. See **Attachment C** for a description of the HFA Child Welfare Adaptation. Per the federal clearinghouse, HFA was reviewed and rated well-supported with the extended enrollment to age twenty-four months.

Healthy Families America is a much needed child welfare prevention program. In Nebraska, 60% of children who enter foster care do so through neglect. Furthermore, almost half of *all* children who enter foster care are ages 0-5; the majority of which are 1 year of age or younger. By engaging families in preventative services such as HFA, Nebraska will address the generational cycle of child welfare involvement. HFA will also be utilized to serve pregnant and parenting youth in care.

The DHHS Division of Public Health (PH) receives federal Maternal, Infant & Early Childhood Home Visiting Program (MIECHV)<sup>10</sup> funds to implement the HFA home-visiting model. Through this funding, HFA is currently offered in 21 Nebraska counties. See *Statewide Home Visiting Initiatives* map below. CFS is been working with PH to determine how to leverage existing funds and expand locally funded slots as needed using FFPSA dollars. In collaboration, CFS and PH are working with one urban and one rural site to begin the child welfare adaptation. The sites were selected based on strong relationships between the local CFS office and the HFA site, as well as existing capacity and number of potential referrals. Additionally, Nebraska presumes additional sites will continue to reply to the RFQ. A site requesting to use the HFA Child Welfare Adaptation has to submit a detailed implementation plan to HFA National for approval.



<sup>10</sup> Health Resources & Services Administration, Maternal & Child Health, Home Visiting; <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>

## Behavioral Health Programs (*Mental Health and Substance Abuse*)

### *Family Centered Treatment*

Family Centered Treatment (FCT) is a model of intensive in-home treatment services for youth and families, using psychotherapy designed to reduce maltreatment, improve caretaking and coping skills, enhance family resiliency, develop healthy and nurturing relationships, and increase children's well-being through family value changes. The target population for CFS is *1) youth who have been placed out-of-home, have a mental health or serious emotional disturbance diagnosis, and have a permanency plan of reunification; or 2) families with a youth who is at risk of an out-of-home placement due to the youth's medical necessity for a higher level of care.* FCT is rated promising and high for child welfare relevance on the CEBC.

FCT was submitted to the federal clearinghouse for review (**Attachment D**) but has not yet been rated. **Attachment E** includes an executive summary of the research conducted on FCT from 2004-2019. **Attachment F**, *Checklist for Program or Service Designation for HHS Consideration*, as required by ACYF-CB-PI-9-06 for transitional payments is being reviewed by an independent evaluator. Upon receipt, Attachment F will be sent in to be included in this Plan.

FCT has had successful outcomes in several states and jurisdictions working with families who have had multi-generational system involvement. Instead of addressing the symptoms of a behavior and obtaining compliance with a family plan, FCT treats the systemic trauma a family may have experienced and the underlying cause. This aligns with the CFS goal of being trauma-informed. FCT was recently designated as a Trauma Treatment Practice by the National Child Trauma Stress Network.

CFS worked with the Behavioral Health Region and the Lincoln County Community Collaborative to pilot FCT in the North Platte-Lexington area and surrounding communities. The implementation process for FCT began in spring of 2017 and the first six families began the service in January 2019. To enhance sustainability, CFS worked with system partners in Medicaid and the Behavioral Health Region to create a blended funding model. The treatment services are billed to Medicaid or private insurance and the non-treatment services are paid by one of three organizations. CFS pays for families we are working with and the Behavioral Health Region pays the non-treatment costs for families that are not involved with CFS but do meet income eligibility. The Lincoln County Collaborative also agreed to build funding into their budget to pay for at least one family who may not have insurance coverage, meet behavioral health income criteria, or be involved with child welfare. This allows families to access the service regardless of what system they may or may not be involved in. CFS is working with another part of the state to include in the pilot in order to increase the number of families served with FCT. This area was chosen due to lack of in-home services and a high percentage of youth in out-of-home care.

CFS receives monthly fidelity data reports and meets weekly to discuss referrals with the provider awarded the contract to pilot FCT. FCT will positively impact families through the

thorough assessment process, strong family engagement, and addressing the underlying trauma that has historically led the family to unsafe behaviors.

### ***Functional Family Therapy***

Per the CEBC, Functional Family Therapy (FFT) is a family intervention program for dysfunctional youth with disruptive, externalizing problems. Target populations range from at-risk pre-adolescents to youth with moderate to severe problems such as conduct disorder, violent acting-out and substance abuse. FFT targets youth aged 11-18. FFT has been rated Well-Supported by the IV-E Clearinghouse.

### ***Multisystemic Therapy***

Per the CEBC, Multisystemic Therapy (MST) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The target population is 12-17 year olds who are at risk of out-of-home placement due to delinquent behavior. In Nebraska, MST is a Medicaid funded program and the target population is not only juvenile offenders but youth with either a substance use or behavioral health diagnosis. MST is rated Well-Supported on the IV-E Clearinghouse.

### ***Parent and Child Interaction Therapy***

Per the CEBC, Parent and Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children and their parents or caregivers focused on decreasing externalizing child behavior problems, increasing child social skills and cooperation, and improving the parent-child attachment relationship. The target population is children ages 2-7 years of age and their caretakers. PCIT is rated Well-Supported on the IV-E Clearinghouse.

### ***Trauma-Focused Cognitive Behavioral Therapy***

Per the CEBC, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. The target age is 3-18. TF-CBT is rated Well-Supported and High for child welfare relevance on the CEBC. TF-CBT is rated Promising on the IV-E Clearinghouse.

## **Improved Outcomes for Children & Families**

Each evidence-based program selected for this plan has intended outcomes (chart on page 11 of this Plan). CFS believes that Family First along with other current CFS initiatives will improve outcomes for Nebraska children and families.

The Division is in the process of implementing Safety Organized Practice (SOP). SOP is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief of SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children.

SOP aligns well with the Division's efforts towards emphasizing a family's voice and choice while involved with the child welfare system. CFS aims to improve its engagement with families served by ensuring their opinion is valued and they are empowered to make decisions for their family. CFS believes that implementing Family First, along with SOP and family voice and choice, will lead to better family engagement, improved workforce retention and better outcomes for families.

## Eastern Service Area Ongoing Case Management Contractor

The Division is transitioning ongoing case management services from PromiseShip to Saint Francis Nebraska in Douglas and Sarpy counties which is CFS' Eastern Service Area. As part of their contract, Saint Francis will deliver evidence-based models in compliance with FFPSA including that at least 50% of all prevention service expenditures shall be on well-supported programs. CFS continues to work closely with both PromiseShip and Saint Francis Ministries during this transition to ensure Family First readiness. More information on the *Eastern Service Area Case Management Transition* can be found [here](#).

## Continuous Quality Improvement

CFS is proud to have a fully functional and independent Continuous Quality Improvement (CQI) team of experts on staff serving our staff and children and families. The CQI team was established in 2012 and is comprised of not only team members with CFS protection and safety case management skills and experience, but also team members having analytical knowledge, SACWIS development, and provider performance and. Nebraska's CQI program is designed to enable both a qualitative and quantitative review process, providing insight and support to continually assess and improve case management practices and outcomes.

In current compliance and consistent with ACYF-CB-IM-12-07, the CFS CQI team provides support through a comprehensive review process including:

- CQI Structure
  - Statewide Quality Assurance (QA) program with independent oversight and dedicated staff.
  - Continual training of CQI staff occurs regularly and the CQI team is working with policy, training and administrators.
  - Written policies and procedures are being updated and produced where they do not currently exist.
- Quality Data Collection
  - Common data collection and measuring process statewide.
  - All CQI staff are trained and utilize the same QA Tools.
  - CFSR reviews are performed by the same staff and reported consistently.
  - 2<sup>nd</sup> level reviews occur on all processes to ensure consistent QA and learning opportunities.
- Case Record Review Data and Process
  - Quality unit is responsible for all case reviews.
  - Case review system has been developed to randomly select cases statewide, provide the CQI staff with the correct review questions and stores results in a non-editable location.
  - Case review system has been modified to allow for testing of specific CFSR questions by service area as needed and generate an email to the worker.
  - Inter-rater reliability testing is ongoing to ensure consistent scoring
- Analysis and Dissemination of Quality Data
  - Statewide case review system has been developed to review all cases selected for review.
  - Data is reported statewide and by service area.
  - An extensive array of performance reports are created and distributed at monthly CQI meeting.
- Feedback to Stakeholders
  - Results are used to inform training, policy, stakeholders, community partnerships and others as a means to identify and communicate improvement opportunities and areas of strength.
  - Supervisors and field staff understand how results link to daily casework practices; results are used by supervisors and field leadership to assess and improve practice.
  - First stage of CQI communications is monthly Statewide CQI meeting. Second stage of CQI communications is local CQI meetings. At the local level 4-6 areas of improvement have been selected and structured teams created to analyze the results and identify improvement opportunities.

The CFS CQI team is ready to begin the review process for families served through Family First. CFS CQI will draw upon the in-home experience learned from traditional response families, as well as the IV-E Waiver Alternative Response families, both of which have parallels with FFPSA eligibility. Analysis will include quantitative measures ranging from, basic counts arranged demographically and geographically, and measures of tendencies to assess case durations,

family risk or safety and frequencies of service provisions. The quantitative analysis will also include an in-depth review of outcomes in order that CFS can constantly assess the familial success of FFPSA, measured by traditional types of outcomes such as removal rates, re-entry, and recurrence of substantiated maltreatment. Finally, analytical reviews will include a corollary analysis to determine the accuracy to which CFS can predict outcomes based upon case characteristics as well as service provisions.

The CFS CQI team will also be performing numerous qualitative assessments ranging from targeted reviews such as correct and consistent determination of candidacy, accurate pregnant and/or parenting status, etc., to comprehensive CFSR reviews. FFPSA-eligible families will be categorized as in-home families as well as out-of-home, thus the CFSR random sampling selection process will include all FFPSA families in the PIP reviews. As with all reviews, aggregated results will be compiled and provided to all parties. Additionally, consistent with all reviews performed by the CQI team, administrators and supervisors will be notified for any reviewed case where safety concerns or case management deficiencies are identified so corrective action can be taken when necessary.

One of the important purposes of the CQI process is to determine if case management processes are in compliance with all state and federal requirements and in fidelity to the models from which programs were developed. Just as the Division does for existing in-home and out-of-home cases, CFS is in a position to perform sufficient analysis both through a sampling process, as well as in aggregate from intake through case closure. CFS continually assesses conformance to policy/fidelity and FFPSA-eligible families will be included and identifiable for specific reporting purposes.

Capturing and analyzing the information collected from the FFPSA reviews is the first step. CFS CQI is creating FFPSA performance and outcome dashboards, which will contain a wide cross-section of measurements, both qualitative and quantitative. The dashboards will present the information in both aggregate and arranged formats to provide the most value and insight into the analysis process. The data will be presented over time, both near-term and long-term, so CFS can quickly identify emerging trends.

The first step of the CQI process is to ensure the SACWIS can accurately identify and differentiate FFPSA families from other in-home and out-of-home cases. As such, work is already underway to ensure these families can be accurately identified, both in terms of determining families meeting the candidacy definition or pregnant/parenting eligible youth, as well as the types and ratings of programs being provided. The subsequent steps will be formalized as all the requirements are finalized and CFS implements FFSPA.

In addition to collecting and reviewing outcome data and case management adherence to policies and procedures, CFS CQI also has a team of professionals dedicated to monitoring provider performance. Quality of the services being provided to youth and families working with CFS is a critical component of success, most importantly the family's success. Accordingly, in 2016 and as an intervention for the IV-E waiver, CFS developed a continuous quality

improvement sub-program entitled Provider Performance Improvement (PPI). This team of specialists focus exclusively on monitoring the performance of providers CFS has contracted with to provide various services, such as foster care, visitation, in-home family, support, etc. This team assesses provider performance, including data from SACWIS, data loaded by the providers, data from on-site visits, and through consultation with the case manager and Resource Development teams in each of the service areas. Nearly all of this information is stored in a cloud-based system so providers have the same data as CFS in an attempt to be as transparent as possible.

Because the successful implementation and long-term execution of FFPSA is highly dependent on in-home service provisions, Nebraska is aware of the need to closely monitor and support the providers and execution of these services. Accordingly, CFS will be expanding the reach and design of the PPI program to include specific performance and process assessment processes to monitor fidelity, either directly or indirectly, for the FFPSA service array. This will be a highly collaborative process with data being collected both by CFS and by the providers. Outcome data will be derived directly from SACWIS, as will the aggregated frequencies of usage among other measures.

Through this approach, CFS will be able to effectively monitor internal performance, provider performance, and most importantly the outcomes experienced by the children and families.

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## EVALUATION STRATEGY

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### **Evaluation Intent and Approach**

Nebraska CFS will implement a well-designed and rigorous evaluation strategy for evidence-based interventions provided to foster care candidates or pregnant or parenting youth in foster care with the intent of reducing initial entry or re-entry to foster care. Evidence-based interventions determined to be supported or promising by the IV-E Clearinghouse will be formally and rigorously evaluated by CFS, with the exception of services that already encompass their own rigorous and well-designed evaluation. An example of such program is Family Centered Treatment, which has a rigorous and well-designed evaluation established through Indiana University, who will then provide CFS relevant documentation.

Consistent with federal legislation and subsequent HHS guidance, a waiver of this requirement is requested for evidence-based practices determined to be Well-Supported by the federal clearinghouse. When additional services are approved by the federal clearinghouse and are determined to be supported or promising, CFS leadership will determine if the internal capacity

is no longer enough to evaluate services and if there is a need to contract with an independent evaluator.

The Division understands the ongoing requirement to implement a plan for CQI with regard to the ongoing provision of these interventions. To accomplish this objective, CFS will utilize our PPI approach to CQI to examine all interventions provided to children, youth and families. CFS will compare statewide outcomes to national outcomes, to the extent data is available, in order to validate prevention services are offered in a quality manner consistent with the model and to ensure intended outcomes are achieved.

To facilitate the ability of CFS to complete process and outcome components of the evaluation, the ongoing use of fidelity tools by individual service providers will be contractually mandated. Provider compliance with fidelity requirements including use, completion and submission of monitoring tools will be monitored through comprehensive contract monitoring and CQI procedures, and also with the expansion of our Salesforce system. Data points will be entered by contracted providers to ensure fidelity measures are being met and maintained, and compared to the outcomes of the case on well-supported, supported and promising services.

## **Ability to Conduct a Comprehensive Evaluation of Prevention Programming**

The Division recognizes the value of working through communities to strengthen families so children can reach their full potential. In 1997, with input from Nebraskans across the state, CFS used funding from the [Family Preservation and Support Act](#) to support the creation of the Nebraska Children and Families Foundation (NCFE). Designated to act as the lead agency for the Community Based Child Abuse Prevention Fund, NCFE has managed numerous targeted prevention initiatives across the state through the use braided public and private funds.

Nebraska CFS and NCFE partner with the University of Nebraska to develop and implement evaluations of multiple prevention strategies within communities across Nebraska. Examples of such evaluations conducted through this process can be found [here](#) as well as the [NCFE website](#). Evaluation is an ever-evolving and continual process. FFPSA offers an opportunity for Nebraska to continue to improve upon alignment of effort, building upon a strong foundation of relationships at both the community and state levels in the collection and analysis of data, implementation of practices, and collective work toward identified results.

As a result, Nebraska does not need to “reinvent the wheel” as it relates to evaluation, but rather build upon the existing evaluation and CQI framework established to inform our work in community-driven, community-based prevention services, as well those services purchased to address the needs of families who are involved with the child welfare system. This includes strategies described above in the Continuous Quality Improvement section of this Plan.

### ***Internal Capacity***

Nebraska adopted and uses Provider Performance Improvement (PPI) as a data-driven decision-making process to help providers improve the performance of their adopted strategies and to improve the lives of children, families and their communities. CFS staff, consultants, and evaluators have worked with other state partners with aligned missions, to focus on community driven and state supported solutions.

Using the [Nebraska Evidence-Based Practices document](#), members from the FFPSA workgroup have been developing practice matrices to better understand the breadth of evidence-informed and evidence-based practices, along with the population that the practices were designed to support. **Attachment G** provides the grid that was created for this purpose. Completing this matrix is a step toward understanding the infrastructure required to support implementation and evaluation of selected evidence-based practices. Some considerations include, training or certification requirements of practitioners, ongoing support of a practitioner registries, assuring or monitoring fidelity, processes established for data collection, analysis, reporting, and ongoing improvement. This process furthered our understanding of evaluation-related strengths and gaps while informing the development of a comprehensive evaluation strategy and plan

Nebraska will work from the PPI framework, beginning with asking the three basic questions:

- How Much Did We Do?
- How Well Did We Do It?
- Is Anyone Better Off?

Nebraska will continue to build upon current work in areas of community collective impact, reviewing data across communities and across strategies as part of our decision-making and continuous improvement process. To this end, CFS will utilize an existing, well-established CQI system which produces comprehensive quality data and performance reports based upon qualitative and quantitative case reviews. These reports will be used along with the PPI framework to support cross-site evaluation of programming across the state.

### ***Evaluation Staff***

Nebraska CFS currently has a Research, Planning and Evaluation team to design, complete and communicate findings of data provided by contracted providers of Supported and Promising programs. Further, this team will collaborate with CFS CQI staff to integrate existing CQI strategies into the evaluation design and continuously monitor any prevention services determined to be Well-Supported by the federal clearinghouse.

The CFS internal program and CQI teams will be responsible for all aspects of the evaluation design and methodology. This team will support critical implementation activities, using theories of implementation to ensure prevention programming is implemented effectively.

They will also supplement continuous quality improvement activities by supporting cross-programmatic data analysis in partnership with the CQI team.

### ***Stakeholder Collaboration***

CFS will establish an external stakeholder workgroup focused on evaluation. This strategy will allow organizations providing the contracted prevention services to play an integral part of defining and implementing the evaluation design for the programs they provide. While it is being planned to maintain the evaluation of programs internally, Nebraska also recognizes there may be a need to collaborate externally for rigorous and well-designed evaluations, should our internal team not have the capacity to do this.

### ***Outcome Evaluation***

Outcomes will be monitored and reported through the use of administrative data maintained within the statewide data system, N-Focus. As with the process evaluation, CFS will collaborate with model developers to identify specific outcome measures which:

1. Align with the intended outcomes of each intervention approved through this Plan.
2. Assess the overall success of the prevention services selected and approved.
3. Determine the longitudinal impact of interventions provided to individual families and children.
4. Ensure alignment of services with, and availability to, specific target populations and identified needs.
5. Contribute to the continued development of a national body of evidence which supports the efficacy and impact of prevention services selected and implemented.

### ***Participation in Cross-Site Evaluation Activities***

In compliance with FFPSA, CFS will collaborate with any national cross-site evaluation activities implemented by the Administration for Children and Families.

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## EVALUATION WAIVER

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CFS is requesting a waiver for the following programs and will follow established procedures to monitor, compile, assess and report fidelity and outcomes data as part of the ongoing effort to monitor the effectiveness of selected interventions.

- Healthy Families America
- Multisystemic Therapy
- Parent-Child Interaction Therapy
- Functional Family Therapy

These programs are rated as well-supported programs on the federal clearinghouse. CFS also meets the continuous quality improvement requirements of the Act as outlined in the above section of this Plan, *Continuous Quality Improvement*.

See Attachments Section for **Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice**.

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## CONSULTATION AND COORDINATION

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### **How CFS Consulted with other Agencies to Foster Continuum of Care**

CFS held an external stakeholder kick-off meeting in June of 2018 and all stakeholders were encouraged to participate in an implementation workgroup. The Prevention Services and Programs Plan Committee was established to develop this Plan. Stakeholders include those representing the legal & legislation sectors, service provider community, tribal partners, managed care organizations, various community organizations, and representatives from partner DHHS divisions, etc. CFS co-lead this external workgroup with the Nebraska Children and Families Foundation (NCFE). As the Community-Based Child Abuse Prevention agency in Nebraska, NCFE is a strong partner in the FFPSA planning given their expertise in community engagement and prevention portfolio. Committee meeting agendas, notes, and workgroup members can be found [here](#).

This Plan was posted on the Department's public website and distributed widely for input including with internal staff, stakeholders, tribal partners, and family organizations to garner family voice. Feedback and additions/corrections were requested to be sent to [DHHS.FamilyFirst@Nebraska.gov](mailto:DHHS.FamilyFirst@Nebraska.gov), the CFS global email address for any FFPSA related questions. CFS wanted to ensure family voice in this Plan. Feedback was received from youth and young adults as well as parents who have previously been involved with CFS. The youth and young adults indicated that intentional efforts to unify their family prior to being placed in out-of-home care as well as in-home therapeutic services would have, given the family an opportunity to address safety concerns without an out-of-home placement. Parents who have previous involvement with CFS, also identified trauma therapy as a method to keep children in their family's home rather than foster care. Services in this Plan such as Multi-Systemic Therapy, Family Centered Treatment and Trauma-Focused Cognitive Behavioral Therapy through FFPSA will allow for families to have an opportunity to participate in these services and address concerns of safety and risk with their children in their home.

CFS has met with tribal representatives to provide information regarding FFPSA and gain input and insight into how the implementation of FFPSA in Nebraska can support the unique cultural

needs of Native families. CFS will continue to partner with the tribes in identifying culturally-relevant evidence-based models relevant for FFPSA.

Additionally, a grant application has recently been submitted by the St. Monica's Life Changing Recovery for Women program, to implement a secondary residential substance abuse treatment program, dedicated to serving parenting American Indian women and their children. The name of this proposed program is Women are Sacred. This program would provide greater intensity of therapeutic and supportive services to children and families than traditional treatment programs in Nebraska. The target population would primarily be within child welfare with the goal of the program being to develop and maintain healthy relationships for children and families, with cultural responsiveness being the program's foundation. Should the grant application be approved, Women Are Sacred will utilize trauma-informed programming with western approaches to treatment such as Dialectic Behavioral Therapy and Trauma-Focused Cognitive Behavioral Therapy alongside traditional American Indian healing practices such as sweat lodges, cleansing and herbal medicine.

This program will also incorporate children and family therapy provided by a licensed therapist who is trained specifically to work with American Indian children and families. Culturally-focused parenting education and specialized programming that includes Child-Parent Psychotherapy and Parent-Child Interaction Therapy would also be provided. CFS and sister Division of Behavioral Health (BH) are in support of this grant application. Should it be approved and St. Monica's awarded the funding, CFS, BH, the Administrative Office of the Court and Probation and the Indian Center will collaborate with St. Monica's to ensure the goals of this project are met, share and analyze data, and work to further this program in the community.

The Nebraska Department of Health and Human Services not only includes CFS, but sister Divisions of Medicaid and Long-Term Care, Behavioral Health, Developmental Disabilities and Public Health. CFS began internal discussions during the Family First on how to provide greater access to FFPSA evidence-based prevention and treatment programs. Better leveraging the opportunities across DHHS will lead to better outcomes across the state, cohesion for families receiving services and expectations for services which will meet the needs of families with complex needs.

CFS has worked with the Division of Public Health in identifying in-home services overseen by their agency that are instrumental in preserving family stability. Furthermore, CFS has assembled a diverse and stakeholder group consisting of numerous statewide providers of child and family services, including community based organizations and providers of family preservation, behavioral health and substance abuse services. CFS will continue to work closely with all of these providers and stakeholders in order to foster a continuum of care for children, parents and caregivers receiving prevention services.

CFS has established a workgroup with the Division of Medicaid and the Managed Care Organizations (MCOs) specific to FFPSA readiness and implementation. CFS believes this will

improve uniformity when working with families in identifying the most appropriate services to meet the needs of children and families and ensuring funding for those services is provided by the appropriate entity. This workgroup aims to streamline services for families and provide education regarding the unique roles of CFS, the MCOs and Medicaid in the lives of the families involved in one or more of these systems.

Additionally, CFS is working with Juvenile Probation to provide education and communication between CFS CFSS and Probation officers working with youth who may be candidates for foster care. Working with Probation is critical, since youth involved with both systems are at a higher risk for being placed in out-of-home care. Combined efforts to assess needs and strengths of families will capitalize on strengths and address needs in order to allow youth to remain in the family home. The goal is to ensure appropriate, not duplicative, programs are provided to the juvenile and their family while maximizing the effectiveness of EBPs used by both to prevent further involvement in either system.

A recent [report](#) was produced by Voices for Children in Nebraska. This report highlighted that Nebraska struggles with identifying the difference between poverty and neglect (this mirrors a nationwide problem). Data within this report shows that although reports made to the CFS hotline involving white non-Hispanic children are higher than minority groups, the percentage of reports that are substantiated and/or filed in Juvenile Court reflects a higher overall percentage amongst minority youth in comparison to their white counterparts. Further, interventions are at a higher rate of being recommended within the minority populations. In order to address this, Nebraska plans to engage with internal and external stakeholders to identify strategies to make Nebraska's system culturally competent and equitable for all families. CFS Administration is in the process of working with Voices for Children to identify key stakeholders for a committee, to consult and collaborate on a plan to reduce the over representation of the minority population within CFS and to ensure services are equitable.

CFS is committed to ensuring the path to FFPSA is a collaborative effort drawing from the existing strengths in communities, service providers and other partners. Ensuring robust communication and a shared understanding is a critical component of remaking the service array to ensure positive outcomes during and after this transition.

## **How Family First Prevention Services will be Coordinated with Other IV-B Plan Services**

As outlined in Section 4 of the *CFSP: Promoting Safe and Stable Families*, Nebraska will continue to utilize services such as community response to assist families experiencing multiple crises to prevent them from moving further into the Child Welfare system in conjunction with FFPSA services for children at risk of entering foster care. Additionally, services provided by Family Support dollars to each Nebraska community supports the intended outcomes of FFPSA, including strengthening families and enhancing Protective Factors. Services such as Parent

Child Interaction Therapy is an EBP which is currently being funded by Family Support dollars throughout the State to support keeping families together. Other services funded by Family Support, such as Circle of Security Parenting, Lincoln Community Learning Centers, the Families and Schools Together (FAST) program, all outlined in the CFSP Section 4: *Promoting Safe and Stable Families, title IV-B, subpart 2*, can be utilized in conjunction with FFPSA services to better support families in improving safety for their children.

Adoption promotion and support services, described in *CFSP Section 4: Promoting Safe and Stable Families*, will also be provided with the intent adoptive families will be more prepared to meet the needs of their children long-term and be better equipped with resources and tools to prevent disruptions or dissolutions of adoptions and guardianships. The utilization of these services will directly impact families of children who may have otherwise been a candidate for foster care due to risk of an adoption or guardianship disruption.

As outlined in the *CFSP Section 4: Stephanie Tubbs Jones Child Welfare Services Program*, CFS will continue to utilize Family Support Services with goals designed to (1) *prevent or remedy abuse and neglect*; (2) *improve basic daily living and coping skills*; and/or (3) *better manage the home, income, and resources*. The Family Support Service Worker shall have knowledge of community and program resources and assist families with arranging for and obtaining: necessary medical care and treatment, appropriate support systems, and necessary training and education as identified in the service referral. Family Support Service promotes child and family well-being, enhances the protective factors through increased knowledge of parenting and child development, builds personal resilience by helping parent(s) and/or family members overcome obstacles, promotes meaningful social connections, provides concrete supports, and encourages social and emotional competence. Family Support Service will be used in conjunction with FFPSA services to enhance assistance to families.

This Plan is a complement to existing community-based prevention efforts which are designed to safely keep children and families out of the child welfare system. [Bring Up Nebraska](#)<sup>11</sup> is a statewide prevention initiative designed to give local community partnerships the ability to develop long-term plans using the latest strategies and data to prevent life's challenges from becoming a crisis for many Nebraska families and children. The Family First initiative and the Bring Up Nebraska initiative align to create a comprehensive approach to supporting the well-being of children and families.

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<sup>11</sup> Bring Up Nebraska: A Community-Based Prevention Strategy; <http://www.bringupnebraska.org/>

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## CHILD WELFARE WORKFORCE SUPPORT

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CFS partners with the University of Nebraska, Center for Children, Families and the Law (CCFL) to provide training for our workforce. This training helps to ensure staff are competent, skilled and professional when working within child welfare. CFS worked with CCFL to ensure they are knowledgeable and equipped to provide training on FFPSA within new worker training. All new staff who attend CFS new worker training are provided with several different trauma-informed trainings. Additionally, these trainings could be offered to staff as an in-service training as needed.

A description of these trainings are as follows:

**Training: Introduction to Trauma Informed Care**

*Topic Area:* understanding, recognizing & responding to the effects of all types of trauma; trauma-informed care

*Description:* Trainees learn the important concepts and practices related to trauma and trauma-informed care. Topics include: types of trauma in children, adolescents, and adults; typical trauma reactions in children; the five core principles of trauma-informed care; and the impact of trauma on the mind, body, and behavior.

**Training: Secondary Trauma**

*Topic Area:* understanding, recognizing & responding to the effects of all types of trauma; trauma-informed care

*Description:* Trainees learn about secondary trauma and its possible impact on workers. Topics include: what it is, how to recognize it, and protective strategies for self and others.

**Training: Trauma Review and Preparation**

*Topic Area:* trauma-informed care

*Description:* Trainees review the important concepts and practices related to trauma and trauma-informed care in preparation for application in the classroom. Topics include: review of core principles of trauma-informed care, awareness of impacts on traumatic stress, and what therapeutic services should be utilized for trauma.

**Training: Trauma Capable**

*Topic Area:* addressing trauma's consequences and facilitate healing

*Description:* Trainees continue to explore the important concepts and practices related to trauma and trauma-informed care. Topics include: understanding the CFSS' role in decreasing the impact of increased distress within the family system; Adverse Childhood Experiences (ACEs); resiliency; how trauma can affect safety, permanency, and well-being; core principles of trauma-informed care and how to respond effectively to traumatic reactions; what therapeutic services should be utilized for trauma; and referring to evidence-based, trauma-

focused treatment services. This course guides trainees beyond the philosophy of trauma informed care and moves towards application of evidence based trauma informed interventions to address the reactive and/or stress based behaviors they may encounter from individuals of all ages. By learning and implementing these interventions they will empower families and allow healing to begin.

The need for additional trainings each year as part of the required annual in-services training for staff will continue to be assessed following implementation of FFPSA. Further, field training specialists from CCFL, along with the Administrator and Program Specialist with CFS overseeing this Plan will provide ongoing support and guidance to the field.

For additional CFS training details, please see the following section.

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## CHILD WELFARE WORKFORCE TRAINING

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CFS will provide case management training during new worker training through CCFL and in-service training to caseworkers on how to assess what the child and families need for prevention services, and how to access and deliver the identified trauma-informed and evidence-based services. The CFS workforce will be trained in Safety Organized Practice (SOP), as this model enhances engagement and partnering with families. Staff will be better equipped to have conversations with families and ensuring voice and choice in prevention services.

Training will be provided on an ongoing basis for specific trauma-informed and evidenced-based services as they become available in each community. Training will take place in multiple modalities in the form of presentations from service providers, in-service trainings and webinars created as a collaboration with CCFL and CFS, and/or reference sheets for caseworkers to take into the field when working with families.

CFS uses the Structured Decision Making (SDM) case management model. SDM includes specific research based risk assessments. Throughout the life of the case, SDM assessments will consistently be used and will be completed at least every 90 days to assess for the ongoing need of services and/or if the services being provided, continue to be appropriate. SDM assessments guide important decisions such as when case closure is appropriate.

CCFS created FFPSA specific on-line training for all staff. Key topics included the purpose and goals of FFPSA, defining candidacy, evidence-based practices, and creating the prevention plan on our SACWIS system N-Focus. This training was followed-up with question & answer sessions for leadership in each service area. Additionally CFS has additional statewide webinars scheduled for all staff to do a question & answers.

For comprehensive information regarding CFS child welfare workforce training, please see the *Nebraska Training Plan 2020-2024* submitted with the Nebraska CFSP 2020-2024. These plans have been submitted to the Children's Bureau.

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## MONITORING CHILD SAFETY

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CFS uses Structured Decision Making (SDM) assessments and is in the process of implementing Safety Organized Practice (SOP) to assess and monitor the safety and risk of children and families. SOP uses a variety of tools available for CFS staff to utilize to engage children and families in identifying the needs that brought the family to the attention of CFS. It provides a way to focus services to address the identified safety and risk factors and to assess the child and family's perceptions of where they are in relation to mitigating the safety or risk issues.

SDM Safety Assessments are required in the initial assessment phase of a case, to be documented within 24 hours of first contact with the victim(s) or identified child(ren). Additionally, SDM Safety Assessments are required if there is a change in family conditions, the original safety decision changes, all victims or identified children were not initially interviewed and the original safety decision changes or when a recommendation is made to close an ongoing services case.

SDM Risk Assessment is completed for families where maltreatment has been alleged in the current intake. A SDM Prevention Assessment is completed for families where there is not current maltreatment alleged in the intake such as with dependency intakes. These SDM Assessments evaluate the family's risk or likelihood of future maltreatment.

The SDM Family Strengths and Needs Assessment (FSNA) is completed for each family throughout the life of the case. The SDM FSNA assesses areas of strength and need for the caregiver and child. Such areas of global functioning include coping skills, mental health, resource management, substance use, parenting skills, etc. Assessing each of these areas regularly allows case managers to identify areas of need for the family which should be prioritized in the family's case plan in order to improve child safety and reduce risk of maltreatment for the children as well as recognize and utilize protective factors already existing in the family.

SDM Risk Re-Assessments are completed every 90 days for families with children in home participating in an ongoing services case. The Risk Re-Assessment evaluates a family's progress towards meeting case plan goals and guides decision-making related to case closure. When an ongoing case is being considered for case closure based on the Risk Re-Assessment, a new safety assessment will be completed.

The CFS Policy Memo regarding these assessments can be found [here](#)<sup>12</sup> and [here](#)<sup>13</sup>. CFS is in the process of updating all of our policy memos including these.

In addition to regular SDM assessments, the CFSS is required to meet with families and children face-to-face at least monthly. These visits should occur in the family home or the home in which the child resides if they are placed out of the home and the case manager must obtain supervisor approval to conduct monthly face-to-face visits with a child outside of the home.

Visits with children should be private face-to-face visits. These monthly face-to-face visits provide valuable information about the child's safety, permanency and well-being and allow the child an opportunity to share information about "What is working well"; "What are they worried about"; and "What needs to happen next"<sup>14</sup> with the CFSS.

The CFSS has monthly face-to-face visits with both parents of all children involved in the case and these visits should occur in the family home at least every other month. During these visits there should be discussion regarding child safety and risk factors, areas of strength and need for the family and parents, the effectiveness of services being provided to improve safety for the family and decrease risk level and should be an opportunity for parents to express concerns or give input regarding their case. The CFSS will discuss the SOP Danger or Harm Statements identified by CFS and the family. These statements will provide a focus to the family and CFS on the areas of concern related to safety and risk. These statements clearly identify what the worry is about, what actions need to happen to mitigate the worry and how long the action needs to be demonstrated.

The CFS Standard Work Instruction regarding monthly face-to-face contact with families is included as **Attachment H**.

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## PREVENTION CASELOADS

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Caseload sizes for CFSS with FFPSA eligible families will align with current caseload sizes. These are as follows:

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<sup>12</sup> Division of Children and Family Services, Protection and Safety Procedure #36-2016: *Ongoing Case Management*; effective 9/23/16

<sup>13</sup> Division of Children and Family Services, Protection and Safety Procedure #2-2018: *Initial Assessment*; effective 5/7/18

<sup>14</sup> Academy for Professional Excellence; *Safety Organized Practice*; <https://theacademy.sdsu.edu/programs/cwds/sop/>

Initial Assessment only caseloads, which are defined as “active, open child abuse/neglect investigations conducted by Initial Assessment Workers,” have a caseload standard of 1:12 families in urban areas and 1:10 families in rural areas. This does not mean the case manager can be assigned 10 or 12 new cases each month unless all 10 or 12 cases from the previous month are closed. This is a rolling number. Cases assigned the previous month are carrier over and counted toward the total number of 10 or 12 cases.

Mixed Caseloads which includes Initial Assessment and On-Going cases, have a caseload standard of 1:7 Children out of Home, in which one child is counted as one case, 1:3 families in home, in which one family is counted as one case, and 1:4 Families for Initial Assessment in which one family is counted as one case. This is for a total of 14 assigned cases. For On-going case management, this includes In-Home or Out-of-Home cases and Voluntary or Court-involved cases.

On-Going In-Home Caseloads of children who are in the family home and have not been removed have a standard caseload of 1:17 families. These cases include ICPC (Interstate Compact on the Placement of Children) and Court Supervision cases, open and active voluntary cases with children placed in the home who have never been removed and are not Court involved as well as open and active Court involved families with the children in a planned permanent home or in the family home. This caseload size includes children who are still in CFS custody and are Court involved. A planned permanent home will be defined as a home which will provide permanency for a child, this includes:

1. Child returns from out-of-home care and resides with a parent
2. Child resides in a pre-adoptive placement with a signed adoptive placement agreement
3. Child's permanency plan is guardianship and child lives with identified guardian

On-Going Mixed Caseloads which is defined as families with one or more wards in home and one or more wards out of home within the same family has a standard caseload of 1:10 wards who are placed out of the home, in which each ward counts as one case, and 1:7 families with children in the home in which each family counts as one case for a total of 1:17 total caseload. For example, if a case manager has a family assigned to them with one ward placed out of the family home and one ward placed in the family home, this family would count as two cases. This caseload size includes open and active Court involved children and only counts wards; this does not involve non-ward siblings.

On-Going Out-of-Home Caseloads of children who are placed out of the family home has a standard caseload of 1:16 children. These are Court involved and non-Court involved cases where children are placed formally out of the parental/guardian home. This includes Approved Informal Living Arrangements (AILA). For this standard caseload count, each child placed outside the home is counted as one case.

CFS has a [\*Children and Family Services Caseload Status Report\*](#) that illustrates the current caseloads of CFS CFSS and PromiseShip staff. Case counts are limited to staff with one or more

assigned case. Report calculations are based on the Child Welfare League of America (CWLA)<sup>15</sup> Caseload recommendations. The data is expressed as an average of the indicated month. CFS Supervisors have access to this report and frequently reference it when making case assignment determinations per the procedure in the local office. Keeping within caseload limits is prioritized when assigning new cases transferring from Initial Assessment to Ongoing Case management or re-assigning cases due to a vacancy.

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## ASSURANCE ON PREVENTION PROGRAM REPORTING

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

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## FUTURE PLANNING

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Given the many components entailed with implementation on October 1<sup>st</sup>, Nebraska has determined it will focus on what can be successfully accomplished by then in this Plan for the initial phase of implementation. However, over the course of the next five years, Nebraska intends to continue research, data collection, and stakeholder workgroups and use the information learned from the initial phase of implementation to drive later phases. Some future planning includes the following.

As mentioned previously, Nebraska decided to begin with a modest candidacy definition for the initial phase of implementation. However, after some time transitioning the current system to the changes required within FFPSA and evaluating how the system is functioning, Nebraska intends to push the candidacy definition further upstream into primary prevention. This will allow us to provide additional infrastructure and sustainability to already strong community prevention efforts and focus on supporting families prior to involvement with CFS. In order to better understand the needs of these families, CFS Central Office Program staff are beginning to review child abuse/neglect intakes that do not meet definition to be accepted for an assessment. Data will be collected from these intakes such as if a warm handoff was completed such as to a community partner and gaps in service array. This process is in the beginning stages just beginning in June 2019 but will be an informative part of the needs assessment and efforts

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<sup>15</sup> Child Welfare League of America, *Direct Service Workers' Recommendations for Child Welfare Financing and System Reform*; January 2012; <https://www.cwla.org/wp-content/uploads/2014/05/DirectServiceWEB.pdf>

to work with families in the least intrusive way and not unintentionally creating a system that forces families into formal involvement with the CFS in order to receive needed services.

The complexities of sustaining evidence-based practices are magnified in Nebraska's rural areas. As is described in detail in Nebraska's Child and Family Services Plan (CFSP), effective January 1, 2017, Nebraska Medicaid allowed several services to be delivered through means of Telehealth so families could access the medically necessary services to address physical and behavioral health needs. Telehealth can also be used for assessments and evaluations as well and allows clinicians to serve families despite transportation challenges. This option for service delivery is still fairly new; however, some youth involved with child welfare are receiving services through Telehealth. CFS intends to strategically work with partners in the Division of Medicaid as well as the EBP model developers in expanding the use of Telehealth for services while still maintaining fidelity to the model.

Additionally, Nebraska is awaiting the official release this summer of the [Nebraska Community Opportunity Map](#), launched by Casey Family Programs in 2018. Per the website, the map is "designed to empower people working in and with communities across the state by providing easily accessible, timely, relevant, and high-quality data." The map provides information relevant to the safety and well-being of children and families. This interactive map will be an additional valuable resource in future planning of services gap analysis and community needs.

Nebraska is excited begin implementation on October 1, 2019, while simultaneously continuing research, innovation and using the FFPSA to help shape the future of Nebraska's families. FFPSA supports Nebraska's vision for moving the child welfare system to serving families through prevention and shifting from intervention. The state of Nebraska is proud to be one of the first states to implement Family First and look forward to the renewed vision it offers for the child welfare system.

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## STATE CONTACT

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## ATTACHMENTS

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Attachment A: CFS Standard Work Instruction for Foster Care Prevention Plan

Attachment B: Draft Nebraska Evidence-Based Programs

Attachment C: Healthy Families America Child Welfare Adaptation

Attachment D: Letter from Family Centered Treatment (FCT) Foundation's Executive Director

Attachment E: Research Publications, Independent Reports and Published Articles Regarding FCT 2004-2019

Attachment F: Transitional Payment Checklist: Family Centered Treatment (ACYF-CB-PI-19-06 Attachment B)

- *Note: Attachment F will be sent in to be included with this Plan once received from the independent evaluator.*

Attachment G: Nebraska's Plan for Supporting EBP's with Infrastructure and Evaluation

Attachment H: CFS Standard Work Instruction for Mandatory Monthly Visits

Attachment I: State Title IV-E Prevention Program Reporting Assurance

Attachment II: State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Attachment III: State Assurance of Trauma-Informed Service-Delivery

Attachment IV: State Annual Maintenance of Effort (MOE) Report

