



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

 **2019**

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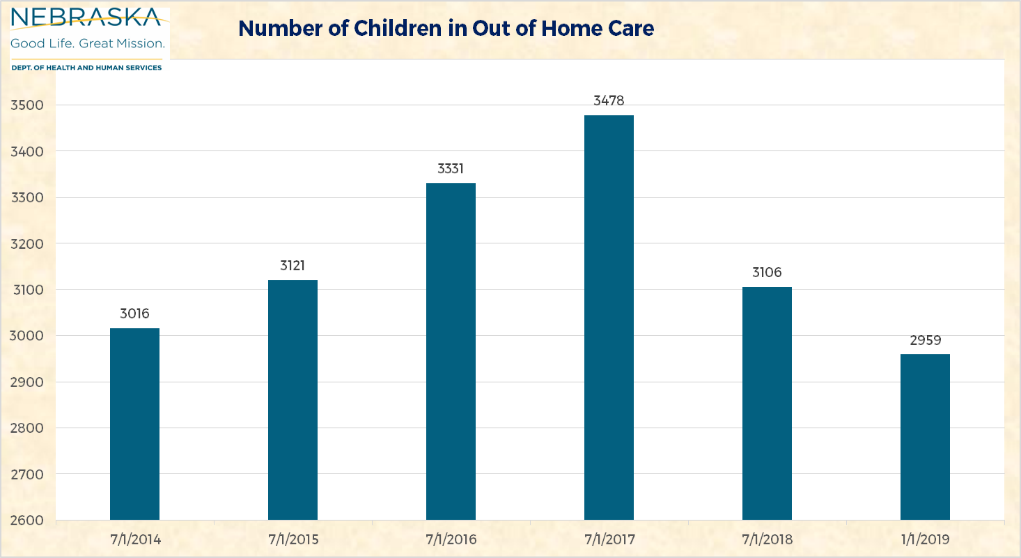
acronyms & TermS

|  |  |
| --- | --- |
| BH | Division of Behavioral Health |
| Case Manager | CFS Child & Family Services Specialist (CFSS) |
| CEBC | California Evidence-Based Clearinghouse[[1]](#footnote-1) |
| CFS or Division | Division of Children & Family Services |
| CFSP | Child & Family Services Plan[[2]](#footnote-2) |
| CQI | Continuous Quality Improvement |
| Department | Nebraska Department of Health & 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[[3]](#footnote-3) |
| FFT | Functional Family Therapy |
| HFA | Healthy Families America |
| MIECHV | Maternal, Infant & Early Childhood Home Visiting[[4]](#footnote-4) |
| MST | Multisystemic Therapy |
| PCIT | Parent & Child Interaction Therapy |
| PH | Division of Public Health |
| Plan | Nebraska’s 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 |

FORward

The Nebraska Department of Health and Human Service’s (DHHS) mission is to “Help people live better lives.”

To help people live better lives, the DHHS Division of Children and Family Services (CFS) will employ the Family First Prevention Services Act (FFPSA) to grow and improve prevention services for families, providing more comprehensive, evidence-based services to children in their own homes, with their family, with reduced levels of secondary trauma.



Over the past several years, CFS has committed to a cultural shift that focuses 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%. Further, 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%. Implementation of FFPSA will help further the Nebraska’s efforts to serve more families in the home with improved preventative, evidenced-based programs.

Excludes youth placed in Youth Residential Treatment Centers (YRTC)

Implementation of FFPSA 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*, families in rural and frontier areas of the state face a lack of social service resources. Access to substance abuse and specialized mental health services are notable challenges. 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 supports and encourages innovation. FFPSA is a monumental opportunity through which federal funding will help support existing and new prevention efforts and drive improved outcomes for the families CFS serves. This new opportunity requires a commitment by Nebraska’s child welfare system to embrace an improved way of working with families.

SERVICE DESCRIPTION AND OVERSIGHT

**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, as identified in the Performance Improvement Plan).
* 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 age 1 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 studied by the Nebraska Foster Care Review Office.[[5]](#footnote-5) This study included analysis of point-in-time data from December 31, 2018. On this date, of the 4,200 children in out-of-home care, 226 were previously state wards who had 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, and many of these homes are no longer a permanent option.
* For dually-involved youth in care, 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**](http://www.fcro.nebraska.gov/pdf/FCRO-Reports/2019-q1-quarterly-report.pdf).

# 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 – meaning who is eligible for Family First services – is to define the families currently served by CFS who meet the requirements of FFPSA.

Nebraska’s Definition of Candidacy:

*Children and youth at imminent risk of entering foster care, as defined by Nebraska Revised Statute 71-1901, but who can remain safely in the child’s home or kinship/relative home as long as Title IV-E prevention services 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 with their following an out-of-home placement;*
3. *the subject of a case filed in juvenile court and is mentally ill and dangerous, as defined by Nebraska Revised Statute 43-247 (3)I;*
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. *presenting 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 identification of families at high risk of maltreatment, and ensures interventions meet the needs and strengths of families. Families involved in 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 will offer FFPSA prevention services to families involved with CFS prior to October 1, 2019, as well as new families, who meet the definition of candidacy and are in need of such services (**Attachment A**).[[6]](#footnote-6)

Nebraska is statutorily required to provide post-adoption and post-guardianship support and services to families meeting the criteria of: a) having a current adoption/guardianship assistance agreement with CFS for a child who was a state ward, b) a child whose adoption/guardianship arrangement is at risk of disruption or dissolution and would result in a foster care placement, or c) any family who adopted a child or became a guardian of a child and is currently residing in the State of Nebraska.

CFS provides post-adoption services through an external contractor. 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.

### 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 previously. Key information such as outcomes, target population, child welfare relevance, and Medicaid eligibility were identified for each program.

CFS proposes a service array that demonstrates a high level of evidence according to the ratings from the California Evidence Based Clearinghouse (CEBC) and predicted federal clearinghouse rated as promising, supported, or well-supported:

* *Promising.* A program has results or outcomes of at least one study determined to be well designed andwell executed, as rated by an independent review and utilized some form of control group.
* *Supported*. A program has results or outcomes of at least one study that show it to bewell designed and well executed, as rated by an independent systematic review. Additionally, the study involved a rigorous random controlled trial,was carried out in a usual care-of-practice setting, and has a sustained effect for at least 6 months beyond the end of service.
* *Well-Supported*. A program has results or outcomes of at least two studies that show it to bewell designed and well executed as rated by an independent systematic review. Additionally, the studies involved a rigorous random controlled trial (or, if not available, a study using a rigorous quasi-experimental research design),were carried out in a usual care-of-practice setting, and have a sustained effect for at least 12 months beyond the end of service (as demonstrated by at least one study).

The workgroups considered programs not currently established in Nebraska. The workgroups began researching geographic access and capacity for programs within the State 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.

To prepare for FFPSA implementation on October 1, 2019, CFS issued a Request for Qualifications (RFQ) for evidence-based [In-Home Parenting Skills Services](http://das.nebraska.gov/materiel/purchasing/RFQ%20100779-Z6/100779%20Z6.html) and [Substance Abuse and Mental Health Services](http://das.nebraska.gov/materiel/purchasing/RFQ%20100799%20Z6/100799%20Z6.html) in May 2019. Submissions included key program information such as geographic access, capacity and fidelity to model. Providers were required to show they have trained staff and can immediately offer EBP services to families. For contracts beginning October 1, 2019, RFQs submittals were due by June 30, 2019. The RFQ process will be continuous, allowing providers to submit new or additional proposals, as they implement new programs. CFS will amend its Plan as new programming is available.

CFS is submitting this initial Plan with the inclusion of six programs that are 1) rated on the federal clearinghouse, 2) currently available in Nebraska, and 3) included in contracts awarded based on the RFQ. CFS is including Family Centered Treatment (FCT), an existing CFS contracted program. Transitional payments for FCT are also requested, 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 that six of the ten programs are available in the State. Of those six programs, five are included in this Plan. Of those 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 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, Healthy Families America (HFA), which is neither Medicaid funded nor eligible. Approximately 80% of all children CFS works with in an ongoing services case have Medicaid insurance.

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Nebraska Title IV-E Prevention Services** | | | | | | | |
|  | **Evidence Based Program** | **Target Population in Years** | **Average Length of Service[[7]](#footnote-7)** | **Outcomes (CEBC)[[8]](#footnote-8)** | **Title IV-E Clearinghouse Rating** | **CEBC Rating** | **Requesting Transitional Payments[[9]](#footnote-9)** |
| **In-Home Parenting** | 1. 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, healthy child development, enhanced family functioning, increased protective factors, reduced risk | Well-supported | Well-supported | n/a |
| **Mental Health** |  | | | | | | |
| 2. Family Centered Treatment | Children 0-17 and their caregivers | 6 months | Family stability, increased family functioning in the critical areas contributing to increased risk of family dissolution, increased effective coping, reduced harmful or hurtful behaviors, build upon strengths to sustain changes made | Not yet rated | Promising | yes |
| 3. Functional Family Therapy | Children 11-18 | 3 months | Eliminated youth referral problems (e.g., delinquency, oppositional behaviors, violence, substance use), improved prosocial behaviors (e.g., school attendance), improved family and individual skills | Well-supported | Supported | n/a |
| 4. Multisystemic Therapy | Children 12-17 and their caregivers | 3-5 months | Youth: Reduced behavior problems  Caregiver: increased ability to address parenting difficulties and empower youth | Well-supported | Well-supported | n/a |
| 5. 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 |
| 6. 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 |

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**In-Home Parenting Skills Programs**

**Program 1: *Healthy Families America***

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

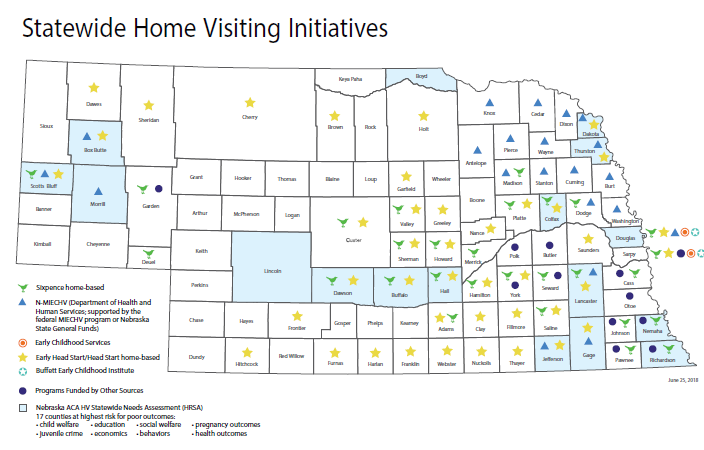
“Evidence-based home visiting has been proven effective through decades of research and data to reduce risk of child maltreatment and improve health and self-sufficiency of vulnerable families who participate. Families build personal relationships and receive education and referral services, leading 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.”

Through the adaptation approach, HFA is available to eligible families with children up to 24 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 24 months.

HFA is well aligned with FFPSA and well suited for the State’s needs. 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 age 1 or younger.

The DHHS Division of Public Health (PH) receives federal Maternal, Infant & Early Childhood Home Visiting Program (MIECHV)[[10]](#footnote-10) 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 working with PH to determine how to leverage existing funds and expand services 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 service capacity and number of potential referrals. Nebraska expects additional sites will continue to reply to the RFQ and expand the reach of HFA. A site requesting to use the HFA Child Welfare Adaptation has to submit a detailed implementation plan to HFA National for approval.

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

#### Program 2: *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 FCT 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 involvement. CFS is working with another part of the state to increase the number of families served with FCT in the pilot phase. This area was chosen due to lack of available 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 and strong family engagement, and by addressing the underlying trauma that has historically led the family to unsafe behaviors.

#### Program 3: *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.

#### Program 4: *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 juvenile offenders and youth with either a substance use or behavioral health diagnosis. MST is rated well-supported on the IV-E Clearinghouse.

#### Program 5: *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.

#### Program 6: *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 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 Ministries in Douglas and Sarpy counties, comprising the CFS Eastern Service Area. As part of their contract, Saint Francis will deliver evidence-based models in compliance with FFPSA with at least 50% of all prevention service expenditures 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](http://dhhs.ne.gov/Pages/Eastern-Service-Area-Case-Management-Transition.aspx).

**Continuous Quality Improvement**

The CFS Continuous Quality Improvement (CQI) team will assess Family First Outcomes. The CQI team was established in 2012 and is comprised of team members with CFS protection and safety case management skills and experience, as well as knowledge of the Statewide Automated Child Welfare Information System (SACWIS) and provider performance. Nebraska’s CQI program is designed to enable both a qualitative and quantitative review process, providing support to continually improve case management practices and outcomes. In compliance with ACYF-CB-IM-12-07, the CFS CQI team provides support through a review process.

EVALUATION STRATEGY

## Evaluation Intent and Approach

Evidence-based interventions determined to be supported or promising by the IV-E Clearinghouse will be evaluated by CFS, or contracted vendor with evaluation expertize, with the exception of services that already encompass their own evaluation. An example of such program is Family Centered Treatment, which has an evaluation established through Indiana University, which will provide relevant documentation. Consistent with federal legislation and subsequent HHS guidance, the Department is requesting a waiver of evaluations requirements for its well-supported programs.

## Ability to Conduct an 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](https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/?hasBeenRedirected=1) to support the creation of the Nebraska Children and Families Foundation (NCFF). Designated to act as the lead agency for the Community Based Child Abuse Prevention Fund, NCFF has managed numerous targeted prevention initiatives across the state through the use braided public and private funds.

Nebraska CFS and NCFF 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](https://rootedinrelationships.org/file_download/inline/31217928-f140-4230-8ece-2e9d5cc041d7), as well as on the [NCFF website](https://www.nebraskachildren.org/what-we-do/prevent-child-abuse-nebraska/child-abuse-prevention-fund-board.html). Evaluation is an ever-evolving 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.

EVALUATION WAIVER

The Department 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.

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

cONSULTATION and COORDINATION

## How CFS Consulted with Other Agencies to Develop Continuum of Care

CFS held an external stakeholder meeting in June of 2018 inviting child welfare stakeholders to participate in an implementation workgroup. The Prevention Services and Programs Plan Committee was established to develop this Plan. Stakeholders include those representing the Nebraska Legislature, legal community, service providers, tribal partners, managed care organizations, various community organizations, and representatives from other DHHS divisions. CFS co-lead this external workgroup with the Nebraska Children and Families Foundation (NCFF). As the Community-Based Child Abuse Prevention agency in Nebraska, NCFF 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](http://dhhs.ne.gov/Pages/Family-First.aspx).

This Plan was posted on the Department’s public website and widely distributed for input. 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 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.

DHHS is comprised of five divisions: CFS, Medicaid and Long-Term Care, Behavioral Health, Developmental Disabilities and Public Health. CFS engaged in internal planning for Family First on how to provide greater access to evidence-based prevention and treatment programs by better leveraging existing opportunities across DHHS.

CFS continues to work closely with providers and stakeholders to develop a continuum of care for children, parents and caregivers receiving prevention services.

CFS is also working with Juvenile Probation to provide education and communication between CFS and Probation officers working with youth who may be candidates for foster care. Combined efforts to assess needs and strengths of families will capitalize aide efforts in allowing 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 to prevent further involvement in either system.

A recent [report](https://voicesforchildren.com/wp-content/uploads/2019/07/RED-data-snapshot-1.pdf) by Voices for Children in Nebraska revealed equity issues in the State’s child welfare system. Data within this report show that a disproportionately high number of reports to the CFS Abuse and Neglect Hotline involving minority groups are substantiated and/or filed in Juvenile Court. Further, interventions are recommended at a higher rate for minority populations. In order to address this, Nebraska plans to engage with internal and external stakeholders to identify strategies to make the State’s child welfare system culturally sensitive and equitable for all families. CFS has begun working with Voices for Children to identify stakeholders for a committee which will develop a plan aimed at reducing the overrepresentation of minority populations within CFS.

## 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 utilizing prevention services to assist families experiencing multiple crises in order to keep families from entering further into the child welfare system. Services currently funded by family support, including Parent Child Interaction Therapy, 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 be provided to help adoptive families be more prepared to meet the needs of their children and equipped with resources and tools to prevent disruptions or dissolutions of adoptions and guardianships.

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. Family Support Service will be used in conjunction with FFPSA services to enhance assistance to families.

[Bring Up Nebraska](http://www.bringupnebraska.org/)[[11]](#footnote-11) is a statewide prevention initiative designed to give community partners the ability to develop long-term plans using the latest strategies to prevent life’s challenges from becoming a crisis for many Nebraska families and children. The Family First and Bring Up Nebraska initiatives align to create a comprehensive approach to supporting the well-being of children and families.

CHILD WELFARE WORKFORCE SUPPORT

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 to ensure CCFL is knowledgeable and equipped to provide new worker training related to FFPSA. All new staff who attend CFS new worker training are provided with several different trauma-informed trainings.

A description of these trainings are as follows:

**Training: Introduction to Trauma Informed Care**

*Topic Area*: Understanding, recognizing and 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 and 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 is secondary trauma, 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*: 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.

CFS will assess the need for additional trainings each year as part of the required annual in-services training for staff.

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

CHILD WELFARE WORKFORCE TRAINING

CFS and CCFS provide new caseworkers training related to assessing a family’s needs for prevention services and accessing identified trauma-informed and evidence-based services. CFS workforce will be trained in Safety Organized Practice (SOP), to enhance family engagement. Training is provided on an ongoing basis for specific trauma-informed and evidenced-based services as they become available to each community.

CFS 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 the SACWIS system N-Focus.

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.

MONITORING CHILD SAFETY

As previously noted, CFS utilizes 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 strategies to engage children and families by identifying the concerns that brought the family to the attention of CFS. CFS uses SOP to identify services that address the safety and risk factors and assess the 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 and documented within 24 hours of first contact with the victim or identified child. 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 when there is not a current maltreatment alleged in the intake. 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 include coping skills, mental health, resource management, substance use and parenting skills. Regular assessment allows case managers to identify needs of the family that should be prioritized in the family’s case plan, will improve child safety, and will reduce risk of maltreatment by utilizing protective factors already existing in the family.

SDM Risk Re-Assessments are completed every 90 days for families with children in-home and participating in ongoing case services. 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 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](http://dhhs.ne.gov/DCFS%20PS%20admin%20memos/PSP%2034-2016%20Ongoing%20Case%20Management.pdf)[[12]](#footnote-12) and [here](http://dhhs.ne.gov/DCFS%20PS%20admin%20memos/admin%20memo%202-2018%20Initial%20Assessment.pdf)[[13]](#footnote-13).

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

Visits with children should be private face-to-face visits. These monthly visits provide information about the child’s safety, permanency and well-being and allow the child an opportunity to share information about what is working well, what are they worried about and what needs to happen next[[14]](#footnote-14) .

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

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

PREVENTION CASELOADS

Caseload sizes for CFS staff with FFPSA eligible families will align with current caseload standards. The Department maintains strict case load standards for all CPS workers. CFS regularly oversees and monitors caseload standards through ongoing CQI practices. The below table contains operational definitions utilized for caseloads in accordance with Neb. Rev. Statute 68-1207. The current caseload ratio for all CPS workers are as follows:

|  |  |
| --- | --- |
| **Caseload Type** | **Caseload Standard** |
| Initial Assessment Cases | 1:12 families – urban  1:10 families – rural |
| Mixed – Initial Assessment Cases & On-Going Cases | 1:4 families for Initial Assessment  1:7 children out-of-home  1:3 non-court-involved families  *Total: 1:14* |
| On-Going – Court-Involved, **In-Home** Cases | 1:17 families |
| On-Going – Court-Involved, **Out-of-Home** Cases | 1:16 children |
| On-Going – Court-Involved, **Blended In-Home & Out-of-Home** | 1:10 Out-of-home wards  1:7 In-Home families  *Total: 1:17* |

assurance on prevention program reporting

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

future planning

Given the many components involved with implementation of FFPSA, Nebraska decided to focus on what can be successfully accomplished for the initial phase of implementation. Over the course of the next five years, CFS intends to use the information learned from the initial phase of implementation to drive later phases. Some future planning includes the following.

Nebraska decided to begin with a limiteddefinition of candidacy for the initial phase of implementation. However, after transitioning the current system to the changes required within FFPSA and evaluating how the system is functioning, Nebraska intends to **broaden the candidacy definition** further upstream towards primary prevention. This will allow Nebraska to provide additional resources to already strong community prevention efforts focused on supporting families prior to involvement with CFS.

In order to better understand the needs of these families, CFS staff are beginning to review child abuse/neglect **intakes that do not meet the standards to be accepted for an assessment**. This process began in June 2019 but will be an informative part in identifying the needs assessment and efforts to work with families in the least intrusive way and not creating a system that forces families into 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 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 be used for assessments and allows clinicians to serve families despite transportation challenges. This option for service delivery is still fairly new and some youth involved with child welfare are receiving services through Telehealth. CFS intends to work with partners in the Division of Medicaid and Long Term Care as well as EBP model developers to **expand 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](https://caimaps.info/caseyfamilynebraska?state=Nebraska&tab=nebraska), 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 a valuable resource in **identifying future services gap and community needs**.

Nebraska is excited to begin implementation of FFPSA on October 1, 2019. FFPSA supports Nebraska’s vision for moving the child welfare system to serving families through prevention rather than intervention. The State of Nebraska is proud to be one of the first states to implement Family First and looks forward to the renewed vision it offers for the child welfare system.

stAte contact

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ATTACHMENTS

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: 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

1. https://www.cebc4cw.org/ [↑](#footnote-ref-1)
2. https://www.acf.hhs.gov/cb/programs/state-tribal-cfsp [↑](#footnote-ref-2)
3. 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/ [↑](#footnote-ref-3)
4. https://www.acf.hhs.gov/ecd/home-visiting [↑](#footnote-ref-4)
5. The Nebraska Foster Care Review Office Quarterly Report; March 1, 2019; [www.fcro.nebraska.gov](http://www.fcro.nebraska.gov) [↑](#footnote-ref-5)
6. 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. [↑](#footnote-ref-6)
7. Average length of service obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; https://www.cebc4cw.org/ [↑](#footnote-ref-7)
8. Outcomes obtained from individual program profiles on the California Evidence-Based Clearinghouse for Child Welfare; https://www.cebc4cw.org/ [↑](#footnote-ref-8)
9. 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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   [↑](#footnote-ref-9)
10. Health Resources & Services Administration, Maternal & Child Health, Home Visiting; https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview [↑](#footnote-ref-10)
11. Bring Up Nebraska: A Community-Based Prevention Strategy; <http://www.bringupnebraska.org/> [↑](#footnote-ref-11)
12. Division of Children and Family Services, Protection and Safety Procedure #36-2016: *Ongoing Case Management*; effective 9/23/16 [↑](#footnote-ref-12)
13. Division of Children and Family Services, Protection and Safety Procedure #2-2018: *Initial Assessment*; effective 5/7/18 [↑](#footnote-ref-13)
14. Academy for Professional Excellence; *Safety Organized Practice*; https://theacademy.sdsu.edu/programs/cwds/sop/ [↑](#footnote-ref-14)