Nebraska Children's Commission

Twenty-second Meeting
April 15, 2014
9:00 AM – 12:00 PM
Country Inn & Suites, Omaha Room
5353 North 27th Street, Lincoln, NE

Call to Order

Karen Authier called the meeting to order at 9:05 a.m. and noted that the Open Meetings Act information was posted in the room as required by state law.

Roll Call

Commission Members present: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Norman Langemach, Andrea Miller, David Newell, John Northrop, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab.

Commission Members absent: Janteice Holston and Jennifer Nelson.

Ex Officio Members present: Senator Kathy Campbell, Thomas Pristow, Julie Rogers, and Kerry Winterer.

Ex Officio Members absent: Ellen Brokofsky, Senator Colby Coash, Senator Jeremy Nordquist, Hon. Linda Porter, and Vicky Weisz.

Also in attendance: Bethany Connor and Leesa Sorensen from the Nebraska Children's Commission.

Approval of Agenda

A motion was made by Mary Jo Pankoke to approve the agenda, as written. The motion was seconded by John Northrup. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Norman Langemach, Andrea Miller, David Newell, John Northrop, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab. Voting no: none. Janteice Holston and Jennifer Nelson were absent. Motion carried.

Approval of March 18, 2014, Minutes

A motion was made by Susan Staab to approve the minutes of the March 18, 2014, meeting with revisions. Susan noted that on page 4 under the Community Ownership presentation Susan was noted as being both present and absent for the vote. The motion to approve the minutes with revisions was seconded by John Northrup. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Norman

Langemach, Andrea Miller, David Newell, John Northrop, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab. Voting no: none. Janteice Holston and Jennifer Nelson were absent. Motion carried.

Chairperson's Report

Karen Authier provided a brief chair's report. Karen then asked Leesa Sorensen to give an update on the Nebraska Children's Commission website. Leesa indicated that the website was currently under design and that Commission members would be notified once the website was available. Karen then reminded Commission members of the need to re-apply to be on the Commission. She also noted that Jennifer Nelson had indicated that she would not be seeking another term on the Commission and that Candy would be looking for a co-chair for the Psychotropic Medications Committee. Karen then addressed the issue that came up as new business at the March meeting regarding looking for more efficient ways to conduct the monthly meetings including considering a consent agenda. Karen asked that Commission members provide additional input and that she and Beth Baxter would be discussing the suggestions to try and find a solution.

Karen then reviewed the issues that would be covered in the agenda for the day. She noted that Bethany was available to be a resource to the committees and reviewed the role of the policy analyst that was outlined in LB269. Karen concluded her remarks by providing an update on the June meeting and the Phase II planning. Karen noted that Deb Burnight would be coming to the meeting to facilitate the Phase II discussion and review with the Commission the progress that has been made. Karen informed Commission members that there was an issue with needing a new contract because of the Commission's move from DHHS to the Foster Care Review Office.

At the conclusion of Karen's remarks Beth Baxter made a motion to approve the issuance of a new contract to Deb Burnight to continue the facilitation of Phase II of the statewide strategic plan. The motion was seconded by Susan Staab. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Norman Langemach, Andrea Miller, David Newell, John Northrop, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab. Voting no: none. Janteice Holston and Jennifer Nelson were absent. Motion carried.

Community Ownership of Child Well-being

Mary Jo Pankoke gave Commission members an overview of the work that was done to create the Model for Community Ownership of Child Well-being. Mary Jo emphasized the needs for having a successful community collaborative including having data collected and available, having a backbone organization, having a broad base of public and private stakeholders from a wide variety of systems and sectors, and having a common vision. Mary Jo offered to answer any questions Commission members might have on the model.

Mary Jo Pankoke then made a motion to adopt the Community Ownership of Child Well-being model as presented by the Community Ownership workgroup. The motion was seconded by Susan Staab. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy

Kennedy-Goergen, Kim Hawekotte, Gene Klein, Martin Klein, Norman Langemach, Andrea Miller, David Newell, John Northrop, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab. Voting no: none. Janteice Holston and Jennifer Nelson were absent. Motion carried.

Young Adult Voluntary Services and Support Committee Report

Mary Jo Pankoke and Nathan Busch provided an update on the Bridges to Independence program. There has been a delay in the implementation of the program. Nathan noted that the regulations for the program were developed and went through the formal process in October of 2013. It was noted that the regulations are currently on the Governor's desk for signature. The regulations must be signed by the Governor before DHHS can receive Federal approval to implement the program. It was noted that private partners are currently covering the cost of the program until the federal waiver or state funds are put into place.

Mary Jo also noted that the committee had two open representative positions and provided a membership application form to Commission members. The committee is currently looking for a young adult currently or previously in foster care. This position may be filled on a rotating basis by members of Project Everlast or a similar youth support or advocacy group. The committee is also looking for a representative of a child welfare service agency. Applications are due by noon on May 14, 2014.

Legislative Update

Bethany Connor provided Commission members with a list of Legislative Bills. Bethany gave a brief overview of the bills related to Alternative Response (LB853), Lead Agency (LB660), Juvenile Justice (LB464) and Psychology Internships (LB901). Bethany also provided a list of Legislative Resolutions of Interest and highlighted LR530 (Interim study to examine existing and proposed programs, policies, administrative rules, and statutes that impact the financial stability of working families in Nebraska) and LR533 (Interim study to assess the enrollment of former foster youth in the new Medicaid category for youth formerly in foster care up to age 26 in Nebraska under the new federal Patient Protection and Affordable Care Act).

Senator Campbell then made a few comments. Senator Campbell reminded everyone that bills that did not advance from this session would need to be reintroduced in the next session in order to be considered. She also highlighted LR422 (Provide the Health and Human Services Committee, in cooperation with the Banking, Commerce and Insurance Committee, be designated to develop policy recommendations towards transformation of Nebraska's health care system); LR552 (Interim study to examine Nebraska's juvenile courts, especially juvenile courts within Douglas County); and LR580 (Interim study to examine the reform effort of Nebraska's behavioral health system). Senator Campbell also encouraged the Children's Commission members to begin thinking about legislation that the Commission may want to draft and introduce in the next session related to the strategic plan.

IT Work Group Report
David Newell gave a brief update on the work the IT work group has been doing. David noted that the whole population discussion would take place on May 2 and would be a continuation of the work that was done earlier in the year. The other effort the group was working on was to identify data that might be needed by the other Children's Commission work groups.

Monthly Glance at Child Welfare System
Bethany Connor provided a *SAMPLE Monthly Glance at Nebraska's Child Welfare and Juvenile Justice Systems* document to help the Children's Commission begin to monitor the type of information needed to clearly and thoroughly analyze progress on child welfare indicators as required by LB821. Bethany noted that the sample was just for discussion purposes to begin the monitoring process. Bethany also provided a list of readily available information for Commission members to consider. Commission members were asked to provide input on other data elements they might like to see.

- Kim Hawekotte indicated that it would be nice to have monthly indicators that could be tied to implementation of the Alternative Response and Bridge to Independence programs.
- Senator Campbell indicated that it might be nice to have year to year data and a trend line and information on where money is being spent.
- Julie Rogers indicated that YRTC placements; information from the Barriers to Permanency project; and information on cross-over youth might also be helpful.
- David Newell suggested looking at data in a more systemic way.
- Susan Staab noted that it would be nice to know the number of available foster homes.
- Becky Sorensen asked for data on which calls are sent on from the hotline.
- Kim Hawekotte suggested having data on mediation and facilitation.

Commission members and committee/work group leaders were encouraged to contact Bethany to discuss any additional data elements they thought might be helpful. It was also noted that the IT work group is trying to identify data elements that are needed but are not readily available.

Alternative Response Evaluation Update
Michelle Graef and Katherine Sorenson provided an updated on the evaluation plan for the Alternative Response process. It was noted that the evaluation plan will be finalized in May or July. The evaluation process is subject to federal approval on the terms and conditions of the evaluation. The evaluators will be working on a variety of different aspects including community readiness; funding commitment; training; fidelity to the model; and efforts to overcome barriers and the steps taken to correct issues. An outcome report is expected in the Spring of 2017 with a final report due the end of 2019.

Foster Care Reimbursement Rate Committee Report
Peg Harriott provided a written progress report on the work of the Foster Care Reimbursement Rate Committee. Peg noted that the Level of Care work group has completed most of the work

on the Nebraska Caregiver Responsibilities tool. The work group is still working on the definition and process for respite care and determining how travel should be compensated for urban and rural areas.

The Foster Care Reimbursement Rate committee reviewed the July 1 implementation plan for DHHS, NFC and Probation. The committee also began the process of reviewing draft recommendations that will be presented to the Children's Commission at the May meeting. Peg noted that some of the work was still pending due to the lack of agency support rates from DHHS. Peg noted that the May 6 meeting would be used to review agency support rates and the final recommendations. Agency support rates were due from Thomas Pristow on April 28, 2014.

Peg reported that the committee currently had three open positions that needed to be filled. Peg provided a membership application form to Commission members. The positions that are open are:

- A child welfare agency that contracts directly with foster parents (SESA only);
- A representative from an advocacy organization, the singular focus of which is issues impacting children; and
- A foster parent who contracts with a child welfare agency.

DHHS Report

Thomas Pristow indicated that he did not have anything to add regarding the Foster Care Reimbursement Rate committee or the Alternative Response presentation. He noted that there was nothing more to add as a DHHS report.

Juvenile Services (OJS) Committee Report

Martin Klein provided a written report on the activities of the Juvenile Services (OJS) Committee meeting on April 8, 2014. The committee is working to further develop the Phase I Strategic Recommendations issued in December 2013. The committee received updates on the provisions in LB464 as it progressed to final reading and on a planning grant that has been received to expand in-home services. The committee also received an update from Cindy Gans, Community Based Aid Administrator for the Crime Commission on the 2014 community based aid program.

The committee began looking at the recommendations related to Community-based programs in a more in-depth manner. The committee referred back to design work that had been created in Phase I planning to determine what types of services are needed at every area of involvement in the juvenile justice system. The committee looked at and further developed the Continuum of Service chart and began discussing service design according to the eight evidence-based principles: Assess Risk and Needs; Build Motivation; Target Interventions (Including Treatment and Sanctions) Based on Risk and Needs; Use Cognitive Behavioral Techniques to Teach and Practice New Skills; Increase Positive Reinforcement; Engage Ongoing Support in Natural Communities; Measure Relevant Processes/Practices; and Provide Measurement Feedback.

The committee will continue its discussions, development, and information gathering on Community-based programs at the next meeting which is scheduled for May 13, 2014.

System of Care Planning Grant Update
Beth Baxter and Sheri Dawson provided information on the System of Care plan. The information packet included the system of care planning grant timeline and a copy of the working draft of the strategic plan. It was noted that a meeting would be held on May 14 to review the plan. Commission members were asked to provide feedback on the draft plan by April 25, 2014.

Family Organizations Presentation
Due to time constraints, Candy Kennedy-Goergen was asked if she would be willing to postpone her presentation to a later meeting. Candy agreed to do the presentation at a future Commission meeting.

New Business
Marty Klein informed Commission members that he had accepted a job with the US Attorney's office in Lincoln, Nebraska as a special assistant US Attorney. Due to his job change, Marty resigned his position as a member of the Nebraska Children's Commission. Marty indicated that his resignation from the Commission would be effective after the Juvenile Services (OJS) committee meeting on May 13.

Next Meeting Date
The next meeting is Tuesday, May 20, 2014, 9:00am-12:00pm. Country Inns & Suites – Omaha Room, 5353 N. 27th Street, Lincoln, NE

Adjourn
A motion was made by Mary Jo Pankoke to adjourn the meeting, seconded by Andrea Miller. The meeting adjourned at 11:48 am.

Nebraska Children's Commission
103rd Legislature 2nd Session List Legislative Resolutions of Interest
May 20, 2014

Goal: Encourage timely access to effective services through community ownership of child-wellbeing

LR530	Nordquist	Health and Human Services	Interim study to examine existing and proposed programs, policies, administrative rules, and statutes that impact the financial stability of working families in Nebraska
LR532	Davis	Education	Interim study to examine utilization of federal school breakfast and lunch programs and the impact of new federal options on Nebraska
LR539	Campbell	Health and Human Services	Interim study to examine whether the maximum payment rate in the Aid to Dependent Children program, is adequate to meet the goals of the Temporary Assistance for Needy Families program, including keeping children in their own home
LR547	Smith	Business and Labor	Interim study to examine issues surrounding labor shortage areas in the state and opportunities available to Nebraska's future workforce
LR559	Mello	Health and Human Services	Interim study to examine issues surrounding the Medicaid Reform Council
LR565	Gloor	Health and Human Services	Interim study to examine whether adding antidepressant, antipsychotic, and anticonvulsant drugs to the Medicaid preferred drug list would be of benefit to Nebraska Medicaid or Nebraska Medicaid clients
LR601	Davis	Health and Human Services	Interim study to examine the impact of implementing, and the impact of failing to implement, Medicaid expansion in Nebraska

Goal: Support a family driven, child focused and flexible system of care through transparent system collaboration with shared partnerships and ownership

LR533	Crawford	Health and Human Services	Interim study to assess the enrollment of former foster youth in the new Medicaid category for youth formerly in foster care up to age 26 in Nebraska under the new federal Patient Protection and Affordable Care Act
LR535	Mello	Appropriations	Interim study to conduct a comprehensive review of the structure of health and human services functions currently administered by the Department of Health and Human Services
LR536	Adams	Executive Board	Interim study to examine the process of creating legislative task forces, committees, and

			commissions
LR540	Campbell	Health and Human Services	Interim study to examine the treatment and services for people dually diagnosed with I/DD and MI or I/DD and behavioral health problems
LR541	Campbell	Health and Human Services	Interim study to examine the implementation of educational stability plans for children in foster care under the federal Fostering Connections to Success and Increasing Adoptions Act of 2008
LR548	Coash	Judiciary	Interim study to assess how the State of Nebraska can improve the coordination and provision of child welfare services for Native American children and families
LR568	Kolowski	Education	Interim study to examine options for the creation of a Nebraska educational trust fund for the purpose of stabilizing the availability of state aid to education when there is a significant decline in state sales and income tax revenue
LR573	Hadley	Revenue	Interim study to examine Nebraska's state aid programs to cities, counties, and other political subdivisions
LR580	Campbell	Health and Human Services	Interim study to examine the reform effort of Nebraska's behavioral health system
LR583	Crawford	Health and Human Services	Interim study to assess the behavioral health and mental health needs of Nebraska's K-12 students and available resources to meet those needs

Goal: Utilize technological solutions to information exchange and ensure measured results across systems of care

LR508	Mello	Education	Interim study to examine issues surrounding the Nebraska P-16 Initiative organized and managed by the University of Nebraska
LR576	Campbell	Health and Human Services	Interim study to examine the current status of the sharing of electronic health records and health information exchanges in Nebraska
LR586	Howard	Health and Human Services	Interim study to gather information and make recommendations to craft policy to support and continue electronic health records exchanges and health information initiatives
LR588	Howard	Education	Interim study to examine the establishment of an early childhood data governance entity

Nebraska Children's Commission
103rd Legislature 2nd Session List Legislative Resolutions of Interest
May 20, 2014

Goal: Foster a consistent, stable, skilled workforce serving children and families.

LR518	Haar	Health and Human Services	Interim study to examine the need to craft a policy to ensure that women who choose to give birth at home are adequately supported by trained health care professionals
LR519	Scheer	Education	Interim study to evaluate current course offering for high school students in Nebraska
LR525	Bolz	Education	Interim study to examine the skills gap in Nebraska's workforce and to identify options for workforce education
LR526	Haar	Education	Interim study to examine options to provide incentives for professional growth and development of teachers as the means to increased student achievement and success in Nebraska public schools
LR529	Nordquist	Appropriations	Interim study to examine the adequacy of provider rates to meet the needs of Nebraskans with disabilities and the providers of services
LR542	Campbell	Judiciary	Interim study to examine issues regarding the current guardian ad litem system
LR552	Ashford	Judiciary	Interim study to examine Nebraska's juvenile courts, especially juvenile courts within Douglas County
LR587	Howard	Health and Human Services	Interim study to gather information and make recommendations to craft policy to support the creation of a sustainable community health workforce in Nebraska
LR592	McGill	Health and Human Services	Interim study to examine various methods of behavioral health workforce development

Master w/ motion notes

May 16, 2014

Karen Authier, Chairperson
Nebraska Children's Commission

Dear Karen Authier,

Legislative Bill 530 from the 2013 Legislative Session requires the Nebraska Children's Commission to provide to the Department of Health and Human Services and the Health and Human Services Committee of the Legislature a final report including final recommendations regarding the adaptation or continuation of the implementation of a statewide standardized level of care assessment.

As noted in the reports provided previously, the Foster Care Reimbursement Rate Committee has been working for several months to enhance the level of care assessment tool and scoring sheet; develop financially feasible foster parent and agency support rates; and craft thoughtful final recommendations. As you know, the Foster Care Reimbursement Rate Committee and the Level of Care work group have dedicated countless hours to help design the process outlined in the attached documents.

The committee has included the following documents for the Nebraska Children's Commission's consideration:

- Foster Care Reimbursement Rate Committee Recommendations Document
- Nebraska Caregiver Responsibilities (NCR) Assessment Tool
- Nebraska Caregiver Responsibilities Summary and Level of Parenting

The Foster Care Reimbursement Rate Committee believes that the enclosed recommendations provide a good framework for achieving the LB530 (2013) express intent:

- to ensure that fair rates continue into the future to stem attrition of foster parents and to recruit, support, and maintain high-quality foster parents"
- "foster care reimbursement rates accurately reflect the cost of raising the child in the care of the state"
- "to ensure that contracted foster care provider agencies do not pay increased rates out of budgets determined in contracts with the Department of Health and Human Services prior to any changes in rates."
- "to maintain comparable foster care reimbursement rates to ensure retention and recruitment of high-quality foster parents and to ensure that foster children's best interests are served".
- to have funds appropriated to permanently replace the bridge foster care funding and provide the necessary additional funds to bring foster care reimbursement rates in compliance with the recommendations of the research and study completed by the Foster Care Reimbursement Rate Committee in 2012.

I would like to personally thank DHHS and the many organizations and individuals who worked so tirelessly to collaborate on this important effort.

Respectfully,

Peg Harriott
Chairperson
Foster Care Reimbursement Rate Committee

Foster Care Reimbursement Rate Committee
Final Recommendations Document
May 16, 2014

Final Recommendations:

A. Recommend changes and decisions for all aspects of foster care rate changes support the express intent of LB530 (2013)
   a. "to ensure that fair rates continue into the future to stem attrition of foster parents and to recruit, support, and maintain high-quality foster parents"
   b. "foster care reimbursement rates accurately reflect the cost of raising the child in the care of the state"
   c. "to ensure that contracted foster care provider agencies do not pay increased rates out of budgets determined in contracts with the Department of Health and Human Services prior to any changes in rates."
   d. "to maintain comparable foster care reimbursement rates to ensure retention and recruitment of high-quality foster parents and to ensure that foster children's best interests are served".
   e. to have funds appropriated to permanently replace the bridge foster care funding and provide the necessary additional funds to bring foster care reimbursement rates in compliance with the recommendations of the research and study completed by the Foster Care Reimbursement Rate Committee in 2012.
   [Approved April 1, 2014]

B. Recommend the Nebraska Children's Commission continue to monitor the progress of the work being done by the Department of Health and Human Services (DHHS), NFC, the Foster Care Reimbursement Rate Committee, and other related industry groups to ensure that: base rates; level of parenting rates; and Child Placement Agency rates are established and implemented:
   a. in accordance with the intent of LB530
   b. in a timely manner so that training and communication about the new rates and rate establishment process can be adequately administered to all affected parties.
   [Approved April 1, 2014]

C. Recommend the implementation of the Nebraska Caregiver Responsibilities (NCR) tool for all youth placed July 1, 2014, or after. As the NCR is a newly developed tool, DHHS and NFC may override the NCR tool administration results if determined to be in the child's best interest.
   [Approved April 1, 2014]

D. Recommend the adjustments highlighted in red on the NCR tool be made prior to implementation (attachment).
   [Approved May 6, 2014]

E. Recommend the Nebraska Children's Commission require the development of a **solid training, quality assurance and communication plan** to support the implementation of the NCR tool and the change in foster parent rates and agency provider rates. Training, quality assurance and communication plans will need to be developed and implemented by DHHS and NFC. It is recommended that the initial Level of Care subcommittee report be used as a reference when developing the training and quality assurance plan.
   [Approved May 6, 2014]

F. To assure equity for foster parents and agencies in the Eastern Region of the state, the Foster Care Rate Committee recommends that the July 1st contract DHHS has with NFC (which includes foster care

2014

services) accounts for the impact of the new foster care rates (foster parent and agency rates) and any increases are not taken out of the NFC budget determined in contracts with DHHS prior to any changes in rates.
[Approved May 16, 2014]

G. Recommend the implementation of the base rates effective July 1, 2014, as set forth in Legislative Bill 530 (LB530) from the 2013 Legislative Session.

Age	Daily	Monthly	Annual
0-5	$ 20.00	$608.33	$7,300.00
6-11	$ 23.00	$699.58	$8,395.00
12-18	$ 25.00	$760.42	$9,125.00

H. Recommend the following rates for the parenting levels of care using the NCR tool:

Age	Essential Parenting	Enhanced Parenting	Intensive Parenting
0-5	$ 20.00	*$27.50*	*$35.00*
6-11	$ 23.00	*$30.50*	*$38.00*
12-18	$ 25.00	*$32.50*	*$40.00*

I. Recommend a Pre-Assessment Rate for children brand new to the system:

Age	Daily
0-5	*$ 25.00*
6-11	*$ 28.00*
12-18	*$ 30.00*

J. Recommend DHHS and NFC implement, at a minimum, the committee's recommended "grandfathering" rate process to create a transitional implementation period for the new foster parent rates (base rate and level of parenting rate) to allow foster parents who may receive a decreased rate for children placed with them prior to 7/1/2014 time to budget for the rate changes.
[Approved May 6, 2014]

To recognize the importance of a stable payment to foster parents to ensure that families are able to budget for needs while caring for foster children, and to establish an equitable transition to the rates that become effective July 1, 2014, foster care payments made on or after July 1, 2014 will be calculated as follows:

If a child was in a foster care home on June 30, 2014, the foster parent(s) will receive the higher of:

- the payment amount in effect on June 30, 2014 (inclusive of the stipend amount); or
- the Foster Care Reimbursement Base Rates effective July 1, 2014 (see rates above).

The foster care payment rate determined under this method will be in effect from July 1, 2014 to January 31, 2015, and the foster parent will not receive a reduction in payment during this period. However, during this period the child's

caregiver needs will be reassessed using the Nebraska Caregiver Responsibilities (NCR) tool, as appropriate, and rates may be increased based on the level of parenting needed.

For a child who has yet to be assessed, who is placed in a foster home on or after July 1, 2014, the foster parent will be paid the pre-assessment rate (as noted above) for no more than 30 days. During this 30 day period, the NCR tool will be completed. Upon the completion of the NCR tool, the parent will be paid the determined level of parenting rate plus the Foster Care Reimbursement Base Rate effective July 1, 2014 (see rates above).

For a child who is placed in a foster home on or after July 1, 2014, who is able to be assessed using the NCR tool prior to the placement, the determined level of parenting rate will be implemented. This rate will be paid in addition to the Foster Care Reimbursement Base Rate effective July 1, 2014 (see rates above).

For all children experiencing a status change on or after July 1, 2014, (i.e. – change in placement or change in level of parenting needs) the NCR tool will be completed and the determined level of parenting rate will be implemented. This rate will be paid in addition to the Foster Care Reimbursement Base Rate effective July 1, 2014 (see rates above).
[January 7, 2014]

K. Recommend that respite costs be addressed as follows:

Development of a respite care plan is the joint responsibility of DHHS/Agency Supported Foster Care provider and the foster parents. Respite is included in the foster parent maintenance payment and any costs associated with the respite care plan are the responsibility of the foster parent.
[Approved May 16, 2014]

L. Recommend that transportation costs for foster parents and agency support services be reimbursed in line with the 2014 DHHS Administrative Memo on Transportation* as follows:

a. **Foster Parents:** Foster parents are responsible for the first 100 miles per month of direct transportation for foster children in their home and are eligible for reimbursement for all miles beyond the initial 100 miles.

b. **Agency Supported Foster Care Providers:** to compensate for the additional mileage and travel time required to support foster parents outside metropolitan areas, implement a payment of $0.56/mile for distances over 50 miles roundtrip from the agency satellite office or foster care program site to the ASFC home. When travel of over 50 miles roundtrip occurs, a payment of $18.00/hr windshield/travel time will also be available.

use federal mileage rate

*Note: The 2014 DHHS Administrative Memo on Transportation will be issued in the near future and will replace Title 479 2-002.03E1, Administrative Memo #1-3-14-2005.
[Approved May 16, 2014]

M. Recommend that the base rate, level of parenting rate, and agency supportive rate added together create minimum foster care reimbursement rates but that no maximum rates are established. This allows DHHS and NFC to meet the needs of children with unexpected and unusual circumstances.
[Approved May 6, 2014]

N. Support the plan to "unbundle" foster care rates to allow for the tracking of Title IV-E expenses and in accordance the Nebraska's IV-E waiver plan. The "unbundling" should not result in a decrease in foster parent or foster care agency rates overall. DHHS must provide necessary financial data to foster care agencies and NFC to support the completion of an A-133 annual audit when $500,000 or more of federal funding is received. [Approved May 6, 2014]

O. Recommend the following rates for Agency Support Rates effective July 1, 2014:

Level	Daily Rate paid to Agency to support foster parent
Essential	$21.76
Enhanced	$28.17
Intensive	$38.76

Pre-Assessment: The pre-assessment rate is $21.76 for a 30 day or less pre-assessment period for those children new to the system.

Rural: To compensate for the additional mileage and travel time required to support foster parents outside metropolitan areas, implement a payment of $0.56/mile for distances over 50 miles roundtrip from the agency satellite office or foster care program site to the ASFC home. When travel of over 50 miles roundtrip occurs, a payment of $18.00/hr windshield/travel time will also be available. [Approved May 16, 2014]

P. Recommend the Nebraska Children's Commission and the Foster Care Reimbursement Rate Committee continue to monitor the impact and effectiveness of the new foster care rates (foster parent and foster care agency). Recommend that by July 1, 2015 a written report be submitted by DHHS and NFC that provides summary data and outlines the role and effectiveness of the level of care tool (NCR) to include:

a. Analysis of the Nebraska Caregiver Responsibilities tool to include: total number of tools completed; % in each category (essential, enhanced, intensive); % LOC1, LOC2, LOC3; intersection between frequency of review and score.
b. Analysis of the assessment process to include answering the following questions:
    i. Does the CANS gather the necessary information to identify the needs of the child and the resources needed as identified in the eight domains of the NCR?
    ii. Does the SDM provide adequate information to identify the needs of the child as they relate to the eight domains of the NCR?
    iii. Is the CANS needed given the information provided by SDM?
    iv. Does the NCR adequately identify the skills and responsibilities of the foster parent(s)?
    v. Does the NCR adequately ensure the child's needs are being met?
    vi. Does the NCR meet the needs of DHHS, Probation and the NFC?
    vii. Does the NCR meet the needs of Child Placing Agencies?
    viii. How does the NCR impact subsidies?
    ix. Do the current rates work and are they reasonable?
c. Lessons learned, trends identified and recommendations for future consideration

[Approved May 6, 2014]

ability to do overrides - need report

Data Collection

Nebraska Caregiver Responsibilities
(NCR)

Child's Name:_____ Child's Master Case #_____

Today's Date:_____ Last Assessment Date:_____ Previous Score:_____

Assessment Type:

- ☐ Initial
- ☐ Request of Foster Parent
- ☐ Change of Placement
- ☐ Reassessment (6 months from date of previous tool)
- ☐ Request of Agency/Department
- ☐ Permanency Plan Change
- ☐ Change of Child Circumstance

Worker Completing Tool:_____ Service Area:_____

Caregiver(s):_____

Child Placing Agency:_____ CPA Worker:_____

The Nebraska Caregiver Responsibility document is to be completed within the **first 30 days of a child's placement in out-of-home care or when there are changes that may impact the responsibilities of the caregiver as defined above.**

Forms should be filled out during a face-to-face meeting with the foster parent, the assigned worker, and the child placing agency worker (if applicable). Foster parents and the child placing agency worker (if applicable) should receive copies of the tool.

The first level (L1) is considered essential for all placements and the minimum expectation of all caregivers. **For each of the responsibilities, indicate the level of service currently required to meet the needs of the child (based on results of SDM and CANS). The focus is on the caregiver's responsibilities, not on the child's behaviors.** Each level is inclusive of the previous one. Outline caregiver responsibilities in the box provided for any area checked at a 2 or higher.

LOC 1 Medical/Physical Health & Well-Being		
L1	Caregiver arranges and participates, as appropriate in routine medical and dental appointments; Provides basic healthcare and responds to illness or injury; administers prescribed medications; maintains health records; shares developmentally appropriate health information with child.	

	Definition: Caregiver follows established policies to ensure child's physical health needs are met by providing basic healthcare and response to illness or injury. Caregiver contributes to ongoing efforts to meet the child's needs, by arranging, transporting and participating in doctor's appointments that is reflected in required ongoing documentation. Caregiver will administer medications as prescribed, keep a medication log of all prescribed and over-the-counter medication, understand the medications administered, and submit the medication log monthly.	
L2	Caregiver arranges and participates with additional visits with medical specialists, assists with treatment and monitoring of specific health concerns, and provides periodic management of personal care needs. Examples may include treating and monitoring severe cases of asthma, physical disabilities, and pregnant/parenting teens. Definition: Additional health concerns must be documented and caregiver's role in meeting these additional needs will be reflected in the child's case plan and/or treatment plan. Caregiver will transport and participate in additional medical appointments, including monthly medication management, physical or occupational therapy appointments, and monitor health concerns as determined by case professionals.	
L3	Caregiver provides hands-on specialized interventions to manage the child's chronic health and/or personal care needs. Examples include using feeding tubes, physical therapy, or managing HIV/AIDS. Definition: Any specialized interventions provided by the caregiver should be reflected in the child's case plan and/or treatment plan. Case management records should include narrative as to the training and/or certification of the caregiver to provide specialized levels of intervention specific to the child's heath needs. Caregiver will provide specific documentation of specialized interventions utilized to manage chronic health and/or personal care needs.	
Outline the caregiver responsibilities:		

LOC 2 Family Relationships/Cultural Identity		
L1	Caregiver supports efforts to maintain connections to primary family including siblings and extended family, and/or other significant people as outlined in the case plan; prepares and helps child with visits and other contacts; shares information and pictures as appropriate; supports the parents and helps the child to form a healthy view of his/her family. Definition: Caregiver follows established visitation plan and supports ongoing child-parent and sibling contact as outlined in case plan. Caregiver provides opportunities for	

	the child to participate in culturally relevant experiences and activities. Caregiver works with parents and youth in ongoing development of youth's life book.	
L2	Caregiver arranges and supervises ongoing contact between child and primary family and/or other significant people or teaches parenting strategies to other caregivers as outlined in the case plan. Definition: Caregiver provides and facilitates parenting time in accordance with the established parenting time plan and case plan. Caregiver provides regular instruction to parent outlining parenting strategies. This feedback must be reflected in Caregiver's required ongoing documentation.	
L3	Caregiver works with primary family to co-parent child, sharing parenting responsibilities, OR supports parent who is caring for child AND works with parent to coordinate attending meetings AND appointments together. Examples include attending meetings with doctors, specialists, educators, and therapists together. Definition: Caregiver partners and collaborates with parents to ensure both caregiver and parent attends child's appointments and activities. Caregiver allows parental interaction in the foster home and provides support to the parent while the child is in the parent's home. Caregiver allows the parent to participate in daily routine of the child in the foster home (i.e. dinner, bedtime routine, morning routine). Documentation should illustrate caregiver's efforts to engage parent and shows examples of a transfer of learning to the parent.	
Outline the caregiver responsibilities:		

LOC 3	**Supervision/Structure/Behavioral & Emotional**	
L1	Caregiver provides routine direct care and supervision of the child, assists child in learning appropriate self-control and problem solving strategies; utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change, adapts schedule or home environment to accommodate or redirect occasional outbursts. Definition: Caregiver provides age and developmentally appropriate supervision, structure, and behavioral and/or emotional support. Caregiver utilizes constructive discipline practices that are fair and reasonable and are logically connected to the behavior in need of change. Caregiver can provide examples of strategies and interventions implemented.	
L2	Caregiver works with other professionals to develop, implement and monitor specialized behavior management or intervention strategies to address ongoing	

	behaviors that interfere with successful living as determined by the family team. Definition: Caregiver provides beyond age and developmentally appropriate supervision, structure, and behavioral and/or emotional support in accordance with a formal treatment or behavioral management plan as identified by the child's needs. Caregiver can provide examples of strategies and interventions implemented.	
L3	Caregiver provides direct care and supervision that involves the provision of highly structured Interventions such as using specialized equipment and/or techniques and treatment regiments on a constant basis. Examples of specialized equipment include using alarms, single bedrooms modified for treatment purposes, or using adaptive communication systems, etc.; works with other professionals to develop, implement and monitor strategies to intervene with behaviors that put the child or others in imminent danger or at immediate risk of serious harm. Definition: Caregiver follows established treatment plan to ensure child's safety and well-being. Treatment plan requires immediate and ongoing (more than once daily) monitoring and interaction. Strategies and interventions are developed in accordance with treatment plan and in consultation with case manager and must be followed to ensure child's immediate and ongoing safety and well-being. If plan is not followed child is at risk of imminent danger. Caregiver maintains frequent contact with mental health professionals and actively participates in services and monitoring. Caregiver can provide examples of therapeutic interventions and demonstrates ongoing monitoring.	
Outline the caregiver responsibilities:		

LOC 4	**Education/Cognitive Development**	
L1	Caregiver provides developmentally appropriate learning experiences for the child noting progress and special needs; assures school or early intervention participation as appropriate; supports the child's educational activities; addresses cognitive and other educational concerns as they arise, participation in the IEP development and review. Definition: Caregiver ensures child meets established education goals. Routine educational support includes structured homework routine and help with homework; maintaining regular, ongoing contact with school to ensure age-appropriate performance and progress. This includes participation in regularly scheduled parent-teacher conferences with the parents (as appropriate). For non-school age children, the caregiver will ensure the child is working on developmental goals (i.e. colors, ABCs, counting, etc.)	

L2	Caregiver maintains increased involvement with school staff to address specific educational needs that require close home/school communication for the child to make progress AND responds to educational personnel to provide at-home supervision when necessary; or works with others to implement program to assist youth in alternative education or job training. Definition: Educational goals may include both school-based as well as job training goals (for older youth). Caregiver implements monitoring in the home to reflect established learning plan objectives or collaborates with professionals to ensure child's educational goals are met. Caregiver provides examples of efforts to support education. Caregiver provides support and structure for child if suspended or expelled from school.	
L3	Caregiver works with school staff to administer a specialized educational program AND carries out a comprehensive home/school program (more than helping with homework) during or after school hours. Definition: Caregiver implements interventions per an established alternative education plan, IEP or 504 plan which involves specialized activities and/or strategies outside of the educational setting. Implementation of this plan requires regular communication with school and is not considered routine educational support. Caregiver may require specialized training or certification in order to meet the child's educational and cognitive needs.	
	Outline the caregiver responsibilities:	

LOC 5	**Socialization/Age-Appropriate Expectations**	
L1	Caregiver works with others to ensure child's successful participation in community activities; ensures opportunities for child to form healthy, developmentally appropriate relationships with peers and other community members, and uses everyday experiences to help child learn and develop appropriate social skills. Definition: Caregiver encourages and provides opportunities for child to participate in age-appropriate peer activities at least once per week. Caregiver can give examples of the child's participation the activity. Caregiver transports to activity if needed. Caregiver monitors negative peer interactions. Examples may include: school-based activities, sports, community-based activities, etc.	
L2	Caregiver provides additional guidance to the child to enable the child's successful participation in Community and enrichment activities AND provides assistance with planning and adapting activities AND participates with child when needed. Examples include shadowing, coaching social skills, sharing specific intervention strategies with other responsible adults, etc.	

	Definition: Caregiver's intervention and participation further ensures child's participation in the activity. The child may not be able to participate without adult support. Caregiver can give examples of the child's participation in the activity.	
L3	Caregiver provides ongoing, one-to-one supervision and instruction (beyond what would be age appropriate) to ensure the child's participation in community and enrichment activities AND caregiver is required to participate in or attend most community activities with other responsible adults, etc. Definition: Caregiver must participate and fully supervise child during all community and enrichment activities. Participation in the community and enrichment activities provides a normalized child experience. Caregiver can provide examples of child's normalized involvement in the activity.	
	Outline the caregiver responsibilities:	

LOC 6	**Support/Nurturance/Well-Being**	
L1	Caregiver provides nurturing and caring to build the child's self-esteem; engages the child in constructive, positive family living experiences; maintains a safe home environment with developmentally appropriate toys and activities; provides for the child's basic needs and arranges for counseling or other mental health services as needed. Definition: Caregiver meets child's established basic needs to assure well-being. Caregiver understands and responds to the child's needs specific to removal from their home. Caregiver transports and participates in mental health services as needed.	
L2	Caregiver consults with mental health professionals to implement specific strategies of interacting with the child in a therapeutic manner to promote emotional well-being, healing and understanding, and a sense of safety on a daily basis. Definition: Caregiver follows established treatment plan to ensure child's safety and well-being are addressed. Strategies and interventions are developed in accordance with the treatment plan and in consultation with case manager. Caregiver has regular contact with mental health professionals and participates in mental health services for the child. Caregiver can provide examples of therapeutic interventions and demonstrates ongoing monitoring.	
L3	Caregiver works with services and programs to implement intensive child-specific in-home strategies of interacting in a therapeutic manner to promote emotional well-being, healing, and understanding, and sense of safety on a constant basis.	

	Definition: Treatment plan requires immediate and ongoing (more than once daily) monitoring and interaction. Therapeutic strategies and interventions are developed in accordance with treatment plan and in consultation with case management staff and must be followed to ensure the child's well-being. If plan is not followed child is at risk of imminent danger. Caregiver maintains frequent contact with mental health professionals and actively participates in services and monitoring. Caregiver can provide examples of therapeutic interventions and demonstrates ongoing monitoring.	
	Outline the caregiver responsibilities:	

LOC 7	**Placement Stability**	
L1	Caregiver maintains open communication with the child welfare team about the child's progress and adjustment to placement and participates in team meetings, court hearings, case plan development, respite care, and a support plan. Definition: Caregiver works to ensure placement stability. Caregiver communicates openly and regularly with case manager, provides required monthly documentation and participates in family team meetings. Caregiver must actively participate in developing a support plan to eliminate placement disruption.	
L2	The child's/youth's needs require caregiver expertise that is developed through fostering experience, participation in support group and/or mentor support, and consistent relevant in-service training. Definition: Caregiver must utilize specialized knowledge, skills, and abilities to maintain child's placement. Child's needs warrant specialized knowledge, skills, and abilities. Interventions provided by caregiver must be in collaboration and consultation with other professions and case managers. Caregiver should provide examples of their specialized knowledge, skill, and abilities to ensure placement and participation in in-service training.	
L3	The child's/youth's needs require daily or weekly involvement/participation by the caregiver with intensive in-home services as defined in case plan and/or treatment team. Definition: Caregiver must collaborate with external supports in order to maintain placement. These external supports provide intensive interventions within the caregiver's home, without which child could not safety be maintained. Interventions must be selected and implemented in collaboration with the case manager. Caregiver collaborates with intensive service interventions and demonstrates specialized knowledge, skills, and abilities to maintain child's placement. Caregiver provides	

	examples of their role in the intensive in-home service provision. Caregiver may require additional training to eliminate placement disruption.	
	Outline the caregiver responsibilities:	

LOC 8	**Transition To Permanency and/or Independent Living**	
L1	Caregiver provides routine ongoing efforts to work with biological family and/or other significant adults to facilitate successful transition home or into another permanent placement. Caregiver provides routine assistance in the on-going development of the child/youth life book. Definition: Caregiver collaborates with case manager and other community resources to ensure child's permanency goal is met. Caregiver works with youth in ongoing development of youth's life book in preparation for permanency. Caregiver addresses developmentally appropriate daily life skills with the child.	
L2	Caregiver actively provides age-appropriate adult living preparation and life skills training for child/youth age 8 and above, as outlined in the written independent living plan and determined through completion of the Ansell Casey Life Skills Assessment. For those youth available for adoption or guardianship who have spent a significant portion of their life in out of home care, the caregiver (with direction from their agency and in accordance with the case plan), actively participates in finding them a permanent home including working with team members, potential adoptive parents, therapists and specialists to ensure they achieve permanency. Definition: For children 8 and above caregiver develops and monitors daily life skills activities. Caregiver assists the youth in completing the Ansell Casey Life Skills Assessment and uses the results to inform daily activities that promote development of independent living skills. Caregiver also supports efforts to maintain family relationships where appropriate. For children with goals of adoption and guardianship, the Caregiver regularly collaborates with the permanency staff to ensure child's permanency goals are met. If the caregiver will be providing permanency for the child, the caregiver is actively participating in adoption preparation activities. (examples include training, support group, mentor support, respite care) Caregiver can provide examples of ongoing efforts to ensure permanency.	
L3	Caregiver supports active participation of youth age 14 or above in services to facilitate transition to independent living. Services including but not limited to assistance with finances, money management, permanence, education, self-care, housing, transportation, employment, community resources and lifetime family connectedness. Definition: Caregiver partners with independent living resources to ensure youth is	

	prepared for transition to independent living. Caregiver provides assistance and interventions on an ongoing basis and in accordance with established IL plan (for youth over age 15). Caregiver demonstrates role in preparing youth for independent living by providing concrete examples of provided intervention and child's skill acquisition.	
	Outline the caregiver responsibilities:	

Respite processes and payment should be discussed with the child's caseworker and/or your agency representative.

Transportation: Foster parents are responsible for the first 100 miles per month of direct transportation for foster children in their home and are eligible for reimbursement for all miles beyond the initial 100 miles. (Insert 2014 DHHS Administrative Memo ####, previously Title 479 2-002.03E1, Administrative Memo #1-3-14-2005).

Liability Insurance: Federal and state law mandate liability coverage for Foster Parents. For more information speak with your child's caseworker and/or agency representative (Program Memo-Protection and Safety- #1-2001).

SIGNATURES:

Youth:_____ Date:_____

NAME:_____ NAME: _____
Foster Parent Foster Parent

DATE: _____ DATE: _____

NAME: _____ NAME: _____
CFS Worker CFS Supervisor

DATE:_____ DATE:_____

NAME: _____ NAME: _____
CPA Representative (if involved) Other Participant

DATE:_____ DATE:_____

Nebraska Caregiver Responsibilities
Summary and Level of Parenting

Child's Name: _____ Child's Master Case #_____

Today's Date: _____ Last Assessment Date: _____ Previous Score: _____

Assessment Type:

- ☐ Initial
- ☐ Reassessment (6 months from date of previous tool)
- ☐ Request of Foster Parent
- ☐ Request of Agency/Department
- ☐ Change of Placement
- ☐ Permanency Plan Change
- ☐ Change of Child Circumstance

Worker Completing Tool: _____ Service Area: _____

Caregiver(s): _____

Child Placing Agency: _____ CPA Worker: _____

Circle the Age Range of the Child: 0-5 6-11 12-18

Take the scores for each of the LOC categories on the Nebraska Caregiver Responsibilities tool and record them below:

LEVEL OF CARE (LOC)	SCORE
LOC 1: **Medical/Physical Health & Well-Being**	
LOC 2: Family Relationships/Cultural Identity	
LOC 3: **Supervision/Structure/Behavioral & Emotional**	
LOC 4: Education/Cognitive Development	
LOC 5: Socialization/Age-Appropriate Expectations	
LOC 6: Support/Nurturance/Well-Being	
LOC 7: **Placement Stability**	
LOC 8 Transition To Permanency and/or Independent Living	
TOTAL LOC SCORE	

Circle the scores for LOC 1, 3 and 7. Add these three scores together to determine the weighted score.

Weighted Score: _____

Record the Total LOC Score from page 1: _____

Using the Total LOC Score above, determine what column to reference below. Once a column has been chosen, use the weighted score to determine Level of Parenting required.

	Total Score 1-8	**Total Score 9-17**	**Total Score 18-23**	**Total Score 24**
Essential	Weighted score =3	Weighted score =3		
Enhanced		Weighted score =4-5	Weighted score =4-5	
Intensive		Weighted score =6-9	Weighted score =6-9	Weighted score =9

Level of Parenting: _____

NAME: _____

CFS Worker

NAME: _____

CFS Supervisor

DATE:_____

DATE:_____

Foster Care Reimbursement Rate Committee Nominations

Gregg Nicklas – Co-CEO of Christian Heritage (A child welfare agency that contracts directly with foster parents – SESA)

Sarah Forrest – Policy Coordinator – Voices for Children in Nebraska (An advocacy organization, the singular focus of which is issues impacting children)

Jodi Hitchler – Program Manager – CEDARS (A foster parent who contracts with a child welfare agency)

Bridges to Independence Committee Nominations

Betsy Vidlak – Director of Youth Programs, Community Action Partnership of Western Nebraska (child welfare service agency)

Andrew Paul – (young adult currently/previously in foster care)

2010-2011 NDE-DHHS STATE WARD STATISTICAL SNAPSHOT

Overview

The Nebraska Department of Health and Human Services (DHHS) and Nebraska Department of Education (NDE) collaboratively conducted a statistical snapshot of students, who are State wards attending school in Nebraska between the dates of July 1, 2010 and June 30, 2011. This baseline snapshot focuses on indicators of academic outcomes for all school-age State wards, 4 to 19 years of age, as identified in the DHHS N-FOCUS database. Education-related statewide aggregate data for that student data-set was generated through the NDE Nebraska Student and Staff Record System (NSSRS).

Aggregate data on indicators of academic outcomes for the matched State ward dataset was compared to the same data for public school students. The indicators of academic outcomes are listed under *"Education–Related Data"* below. Additionally, data for those indicators was broken down into the descriptive sub-categories listed under *"Education-Related Data - Descriptive Sub-Categories"*.

Education-Related Data

1. School Enrollment
2. Summary School Attendance
3. School Mobility
4. High School Graduation
5. Special Education Students
6. High Ability Learners
7. English Language Learners (ELL)
8. Migrant Students
9. Students Eligible for Free or Reduced Lunch
10. Homeless Students
11. Participation in Early Childhood Programs
12. Participation in Career Education
13. Academic Performance

Education-Related Data - Descriptive Sub-Categories

1. By Student Cohort
2. By Gender
3. By Type of School
4. By Grade Level
5. By Type of Adjudication
6. By Judicial District
7. By DHHS Service Area
8. By Type of Placement

Date: April 14, 2014
Source: Nebraska Department of Education (NDE) Committee on Education of Students in Out-of-Home Placements

School Enrollment

- Enrolled – 98.8% (5,701) of State wards, compared to 99.9% (302,697) of Non-wards
- Dropped Out of School - 3.2% (182) of State wards, compared to 0.4% (1,135) of Non-wards

Summary School Attendance

- Total Days Present and Absent - State wards were absent from school twice as many days (15.94 days) as Non-wards (7.76 days)

School Mobility

- Highly Mobile Students - 25.2% (1,455) of State wards were "highly mobile", compared to 4.2% (12,829) of Non-wards

High School Graduation

- 43.7% (284) of 12th Grade State wards graduated in 2010-2011, compared to 87.4% (19,455) of Non-ward peers

Special Education Students

- State wards are more than twice as likely to have received special education services (36.2% or 2,090), compared to Non-wards (16.6% or 50,296)
- Higher percentages of State wards are particularly evident under the following disability types:
  - Specific Learning Disability (10.9% or 627 State wards, compared to 5.2% or 15,855 Non-wards)
  - Behavioral Disorder (7.9% or 455 State wards, compared to 0.6% or 1,894 Non-wards)
  - Other Health Impairment (7% or 401 State wards, compared to 2.1% or 6,476 Non-wards)
  - Mental Handicap (3.8% or 217 State wards, compared to 1.3% or 3,917 Non-wards)

High Ability Learners

- 2.4% (138) of State wards, compared to 11.5% (34,734) of Non-wards

English Language Learners (ELL)

- 3.3% (190) of State wards, compared to 6.8% (20,698) of Non-wards

Migrant Students

- 0.6% (32) of State wards, compared to 1% (3,053) of Non-wards

Homeless Students

- 5.3% (306) of State wards, compared to 0.7% (2,149) of Non-wards

Participation in Early Childhood Programs

- 1.7% (96) of State wards, compared to 3.6% (10,967) of Non-wards

Participation in Career Education

- 29.7% (1,714) of State wards, compared to 28.9% (87,597) of Non-wards

Academic Performance

- State wards tend to have lower average assessment scores in math, reading and science than Non-ward counterparts

HISTORICAL SUMMARY OF NEBRASKA DEPARTMENT OF EDUCATION'S INITIATIVE ON EDUCATION OF STUDENTS IN OUT-OF-HOME PLACEMENTS: 1997 – 2013

Year	*Group / Chairperson*	*Purpose / Focus*	*Priority Areas / Activities*
Multi-Agency Task Force on Children in Out-of-Home Placements			
1997 to 2002	*Interim-Study and Advisory Group*, co-chaired by Senator Jessie Rasmussen and Dr. Marilyn Peterson	Education issues related to children and youth in out-of-home placements and development of *Rule 18: Interim-Program Schools in County Detention Homes, Institutions and Juvenile Emergency Shelters.*	▪ Development of *Rule 18* ▪ Standard Procedures for *PASS* Curriculum ▪ Academic Credits Earned in Interim-Program Schools that Public Schools will Accept ▪ Surrogate Parents for Education Decision-making
Juvenile Corrections Special Education Committee			
2002	*SEAC Committee*, chaired by Barbara Schliesser	Special education and related services for youth with disabilities in juvenile detention and correctional facilities.	▪ Exchange of Student Records ▪ Surrogate Parents for Education Decision-making ▪ *Rule 19*, School Residency and Enrollment
Ad Hoc Committee on Youth in Corrections			
2003 to 2004	*SEAC Committee*, chaired by Barbara Schliesser	***Expanded Focus:*** Regular and special education for children and youth in residential programs, emergency shelters, juvenile detention and correctional facilities.	▪ Resource Packet and Implementation of *Rule 18* ▪ Statewide Academic Assessment ▪ Individualized Education Plans (IEP) ▪ Academic Advancement Plans (AAP) ▪ Data Collection and Evaluation
Ad Hoc Committee on the Education of Children and Youth in Out-of-Home Placements			
2005 to 2007	*SEAC Committee*, chaired by Barbara Schliesser	***Expanded Focus:*** Multi-disciplinary approach to improving academic outcomes of students in out-of-home placements and their successful transition to public school or other education program through systems communication, coordination and collaboration.	▪ Resource Packet and *Rule 18* Implementation ▪ Systems Communication, Coordination and Collaboration ▪ Statewide Academic Assessment ▪ School-to-School Transition ▪ Data Collection and Evaluation ▪ Program Monitoring ▪ *Partnering4Students* Workshops ▪ NE Dept. of Corrections' Special Purpose School
Ad Hoc Committee on the Education of Children and Youth in Out-of-Home Placements And Interim-Program School and Special Purpose School Practitioners Group			
2008	*SEAC Committee* and *Practitioners Group*, chaired by Barbara Schliesser	***Expanded Focus:*** Multi-disciplinary approach to improving academic and vocational outcomes of students in out-of-home placements and successful transition to public school or other education program through systems communication, coordination and collaboration.	▪ Systems Communication, Coordination and Collaboration ▪ School-to-School Transition ▪ Academic Assessments and Student Engagement ▪ Data Collection and Evaluation ▪ Program Monitoring ▪ *Partnering4Students* Workshop ▪ NE Dept. of Corrections' Special Purpose School
SEAC Committee on Education of Students in Out-of-Home Placements			
2009 to 2011	*SEAC Committee*, chaired by an Executive Council	***Expanded Focus:*** Multi-disciplinary approach to improving academic and vocational outcomes of students in out-of-home placements and successful transition to public school or other education program as well as eventual transition into adulthood and independent living through post-secondary education and/or employment.	▪ Systems Communication, Coordination and Collaboration ▪ Development of *Systems Tool Kit* and *Partnering4Students* Website ▪ Academic Assessment and Student Engagement ▪ Student Transitions ▪ School Residency and Responsibility ▪ Academic Advancement Plan (AAP) System
NDE Committee on Education of Students in Out-of-Home Placements			
2012 to 2013	*SEAC Committee*, chaired by an Executive Council	Multi-disciplinary approach to improving academic and vocational outcomes of students in out-of-home placements and successful transition to public school or other education program as well as eventual transition into adulthood and independent living through post-secondary education and/or employment.	▪ Systems Communication, Coordination and Collaboration ▪ *Systems Tool Kit* and *Partnering4Student* Website ▪ Student Transitions ▪ Informational Advocacy ▪ Collaborations with *"Fostering Connections in Education" State Team* and *Probation-DHHS-NCJIS Information Sharing Task Force* ▪ Academic Advancement Plan (AAP) System

Date: December 10, 2013
Source: Nebraska Department of Education (NDE) Committee on Education of Students in Out-of-Home Placements

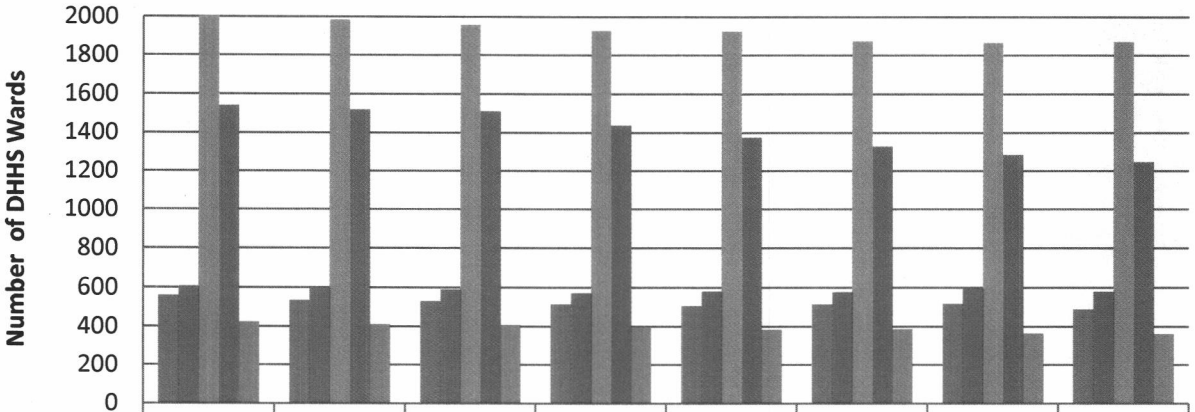
CURRENT INITIATIVES RELATED TO EDUCATION OF SYSTEMS-SUPPORTED STUDENTS

Initiatives	*Purpose*
NDE Committee on Education of Students in Out-of-Home Placements (OHP Committee)	• Advise and make recommendations to Nebraska Dept. of Education, SEAC, state and local agencies, policymakers and stakeholders regarding education of systems-supported students. • Primary venue for communication, coordination and collaboration among primary systems involved in education of systems-supported students. • Forum for identification and discussion of education-related issues, promising practices and protocols that promote school stability and improve academic and vocational outcomes for systems-supported students.
• Executive Council	o Provide leadership for OHP Committee and develop OHP Committee agendas.
• Transitions Work Group	o Promote communication, coordination and collaboration between schools to facilitate successful transition of systems-supported students: (1) from a facility-based school to public school or other education program; (2) from middle school to high school; and (3) from high school into post-secondary education and/or employment. o Promote student empowerment and family engagement in education during those transitions. o Promote communication, coordination and collaboration between schools through use of a web-based Academic Advancement Plans (AAP) System. o Promote professional development opportunities for educators in public schools about systems-supported students and trauma-informed care, in collaboration with other initiatives.
• Systems Work Group	o Promote communication, coordination and collaboration among primary systems involved in education of systems-supported students. o Promote cross-systems information sharing (aggregate data and student-specific information) related to education of systems-supported students, in collaboration with other initiatives. o Develop, maintain and promote the *Systems Tool Kit* posted on *Partnering4Students* website. o Promote training about education of systems-supported students for child welfare and juvenile/criminal justice staff, in collaboration with other initiatives. o Collaboration with judicial initiatives, policies and practices that support school stability and improve academic outcomes for systems-supported students. o Provide information for informed legislative, regulatory and policy level decision-making that supports school stability and improves academic outcomes for systems-supported students.
• Special Education Work Group	o Promote school stability and improved academic and vocational outcomes for systems-supported students with disabilities. o Promote data collection and cross-systems information sharing (aggregate data and student-specific information) related to education of systems-supported students with disabilities. o Promote parent involvement in education to support continued school engagement and academic achievement for systems-supported students with disabilities.
"Fostering Connections in Education" State Plan	• Develop and implement *State Action Plan* to improve cross-systems information sharing, school stability and academic outcomes for court-involved students.
• "Fostering Connections" Liaison Network	o Promote communication, coordination and collaboration on a student-specific basis through a network of liaisons representing the 36 largest school districts, ESUs, DHHS Service Areas, Probation Districts, Interim-Program Schools and Special Purpose Schools.
• Nebraska Supreme Court's Commission on Children in the Courts – Education Sub-Committee	o Promote judicial practices that support school stability and improve academic outcomes for court-involved students. o Adapt and implement the *Nebraska Juvenile Courts: Education Court Report* statewide. o Develop and implement "best Interest" considerations when a student's out-of-home placement results in a change in school attended.
Cross-Systems Information Sharing	• Promote aggregate data and student-specific information sharing among child welfare, juvenile justice and education systems, in collaboration with other initiatives.
• Nebraska Children's Commission – IT Work Group	o Promote data collection and cross-systems information sharing (aggregate data and student-specific information) related to systems-supported students.
• Probation-DHHS-NCJIS Information Sharing Task Force	o Develop and implement *Nebraska's Capstone Project* to enhance student-specific information sharing about cross-over youth between Probation, DHHS and schools.
• NDE-DHHS State Ward Statistical Snapshots	o Annually provide aggregate data regarding academic outcomes of school-age State wards.
• Academic Advancement Plan (AAP) System	o Facilitate student-specific information sharing between Interim-Program Schools, public schools and Special Purpose Schools through a web-based AAP Student Information System. o Provide a web-based platform for collaborative development of *Academic Advancement Plans* and continuation of education for students attending Interim-Program Schools.
Professional Development for OHP Educators	• Promote professional development opportunities for educators in Interim-Program Schools, Special Purpose Schools and alternative schools on effective instructional strategies.

Date: May 5, 2014
Source: Nebraska Department of Education (NDE) Committee on Education of Students in Out-of-Home Placements

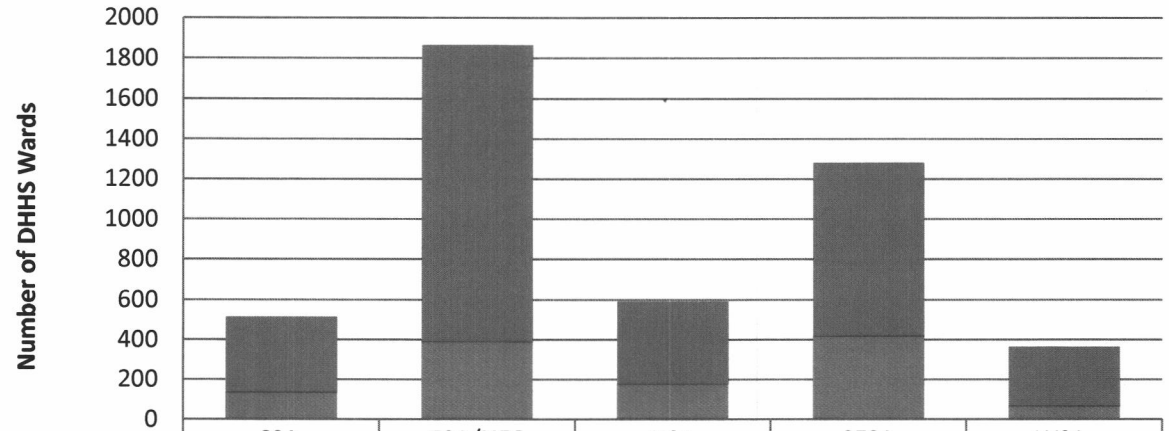
Nebraska Children's Commission
Monthly Glance at Nebraska's Child Welfare and Juvenile Justice System
May 20, 2014

DHHS State Wards by Service Area



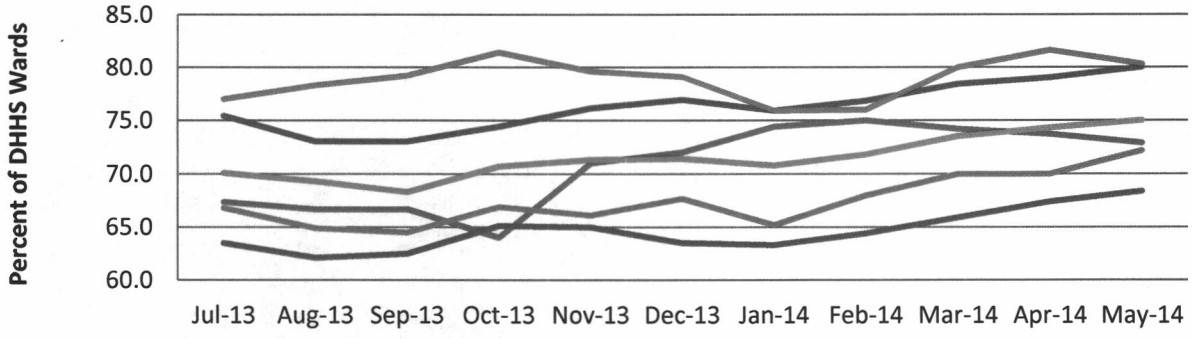
	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	March-14	Apr-14	May, 14
CSA	560	534	530	516	507	516	517	488
NSA	608	599	589	573	581	578	594	579
NFC/ESA	2013	1985	1,957	1,927	1,926	1,874	1,866	1,871
SESA	1541	1,520	1,511	1,438	1,374	1,327	1,283	1,246
WSA	424	411	408	399	384	386	365	361

DHHS Wards by Placement Status April 2014



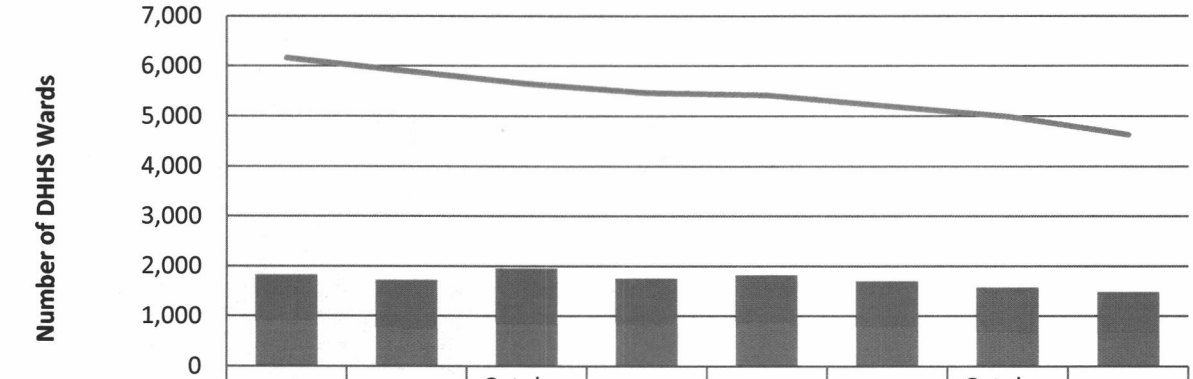
	CSA	ESA/NFC	NSA	SESA	WSA
Out of Home	381	1,475	416	865	298
In Home	136	391	178	418	67

Percent DHHS Wards in Out of Home Placements



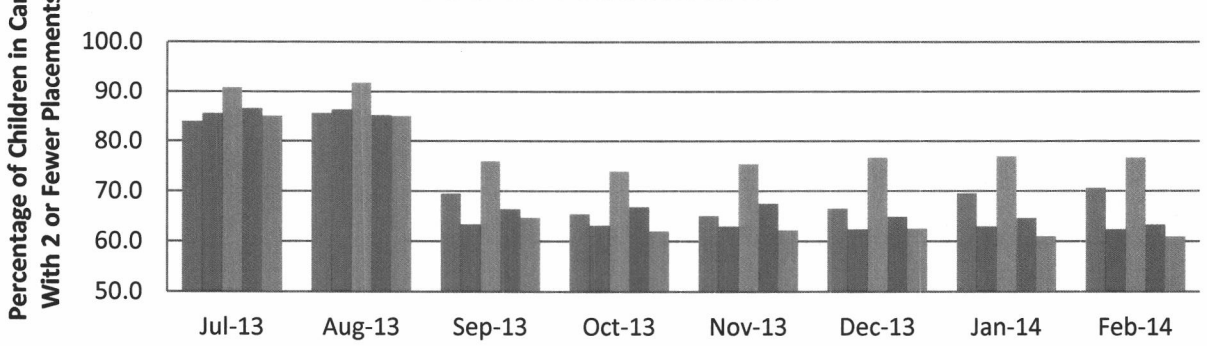
	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14
CSA	67.4	66.7	66.7	64.0	71.0	72.0	74.4	75.0	74.2	73.7	72.9
ESA/NFC	75.4	73.0	73.0	74.4	76.1	76.9	75.9	76.8	78.4	79.0	80.0
NSA	66.8	64.9	64.5	66.9	66.1	67.7	65.2	68.0	70.0	70.0	72.2
SESA	63.5	62.1	62.5	65.1	65.0	63.5	63.3	64.4	65.9	67.4	68.4
WSA	77.0	78.3	79.2	81.4	79.6	79.1	75.9	76.0	80.0	81.6	80.3
Statewide	70.1	69.3	68.3	70.7	71.3	71.4	70.8	71.8	73.5	74.3	75.0

Point in Time DHHS Ward Count with Entries and Exits



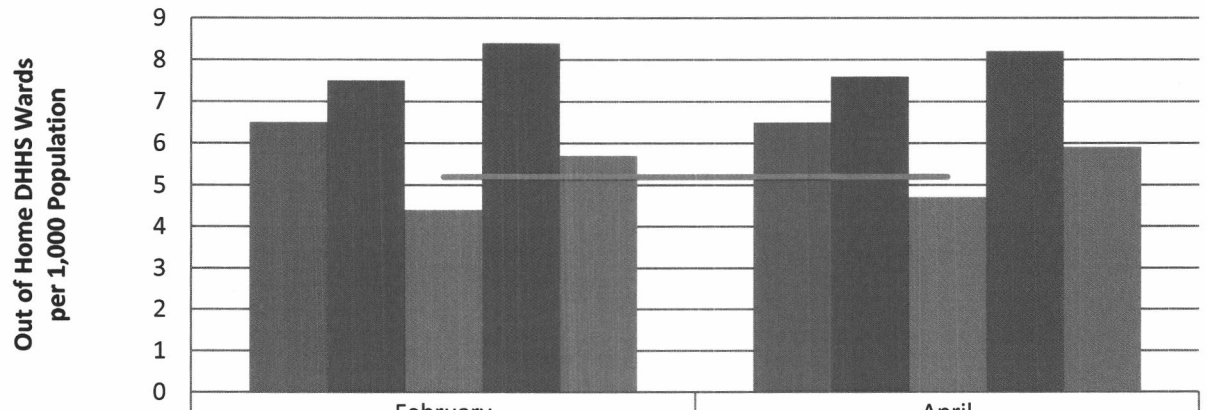
	April - June 2012	July - September 2012	October - December 2012	January - March 2013	April - June 2013	July - September 2013	October - Deceom ber 2013	January - March 2014
Ward Exits	939	965	1,097	902	942	929	912	833
Ward Entries	881	749	850	846	877	766	658	646
Total Wards	6,166	5,895	5,641	5,463	5,416	5,199	4,995	4,625

Children in Care for 12-14 Months with Two or Fewer Placements



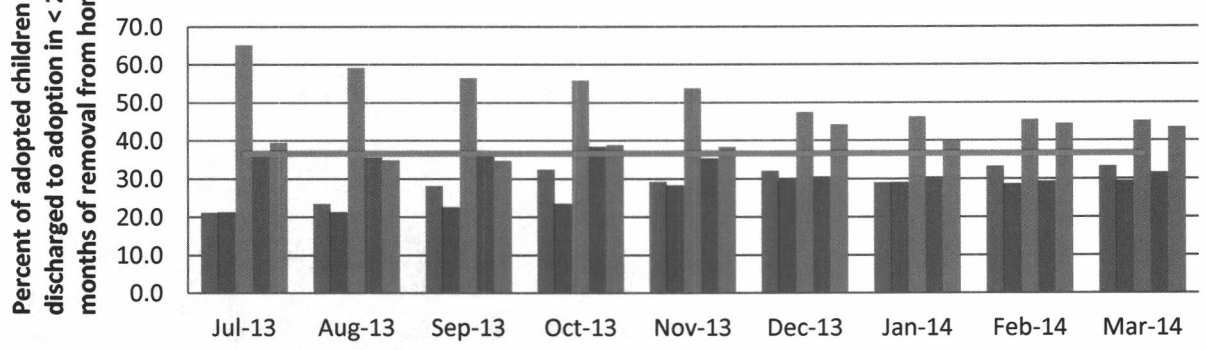
	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
CSA	84.0	85.6	69.5	65.4	65.1	66.5	69.5	70.6
ESA/NFC	85.6	86.4	63.4	63.2	63.0	62.4	63.0	62.4
NSA	90.8	91.8	76.0	74.0	75.5	76.7	77.0	76.7
SESA	86.6	85.2	66.4	66.8	67.5	64.9	64.6	63.3
WSA	85.0	85.0	64.7	62.0	62.2	62.5	61.0	60.9

Out of Home DHHS Wards per 1,000 Population



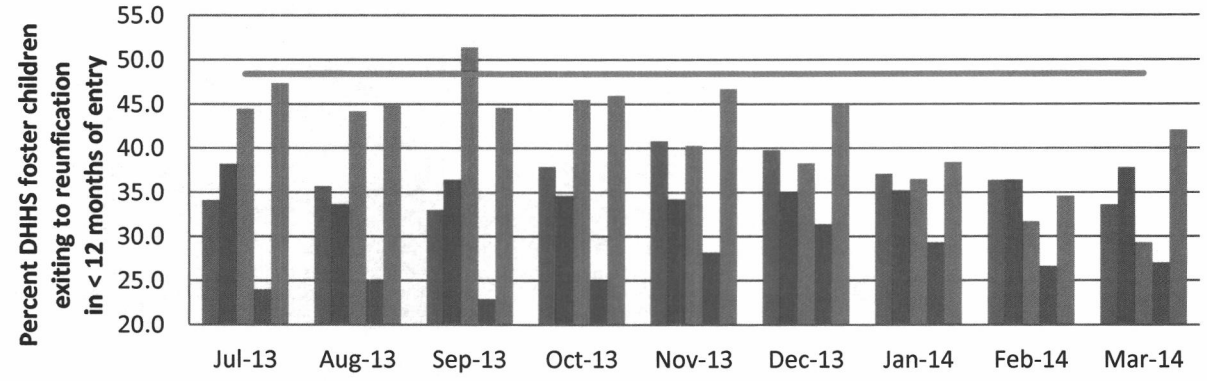
	February	April
CSA	6.5	6.5
ESA/NFC	7.5	7.6
NSA	4.4	4.7
SESA	8.4	8.2
WSA	5.7	5.9
Expected	5.2	5.2

Exits to Adoption in < 24 months



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
CSA	21.2	23.5	28.1	32.4	29.2	32.1	29.0	33.3	33.3
ESA/NFC	21.3	21.3	22.6	23.5	28.3	29.6	29.0	28.6	29.4
NSA	65.2	59.2	56.4	55.8	53.8	47.5	46.3	45.5	45.2
SESA	37.1	35.7	36.5	38.4	35.3	30.6	30.5	29.3	31.6
WSA	39.5	34.9	34.7	38.8	38.3	44.2	40.0	44.4	43.5
Target	36.6	36.6	36.6	36.6	36.6	36.6	36.6	36.6	36.6

Exits to Reunification in < 12 Months of Entry



	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
CSA	34.1	35.7	33.0	37.9	40.8	39.8	37.1	36.4	33.6
ESA/NFC	38.2	33.6	36.4	34.6	34.2	35.0	35.2	36.4	37.8
NSA	44.5	44.2	51.4	45.5	40.3	38.3	36.5	31.7	29.3
SESA	24.0	24.9	22.9	25.0	28.2	31.4	29.3	26.6	27.0
WSA	47.4	44.9	44.6	46.0	46.7	44.9	38.4	34.6	42.1
Target	48.4	48.4	48.4	48.4	48.4	48.4	48.4	48.4	48.4

Whole Population Indicators Planning Meeting

May 2, 2014

I. Introduction

Stakeholders met to continue the work started in December 17, 2013, to define "child-wellbeing" and select indicators to measure results of programs and systems aimed at improving child-wellbeing. The group defined "child-wellbeing" as a set of five outcomes measured by selected indicators. This document details the outcomes and indicators as well as the discussions held at the meeting.

The purpose of reaching agreement on population outcomes and indicators is to improve outcomes for Nebraska's children and families. The indicators inform decision making by highlighting the strengths and weaknesses of the state in serving its families.

Every community has the ability to identify and prioritize its own indicators. The indicators identified here are not meant to be limiting, but to provide a starting point for big picture thinking about how Nebraska can support children.

Whole Population Definitions

Outcomes are the conditions of well-being for children and families. The purpose of using population data is to improve outcomes for the target population. **Indicators** are the measurements that show whether a positive impact has been achieved. Under each outcome, the group identified a series of indicators. The group also identified data sets that would be helpful in measuring outcomes for children and families, but have not been fully developed.

There are four different criteria for choosing indicators. The first is **communication power.** Indicators need to be understandable to policy makers, stakeholders, and the public, with a common interpretation across all domains. The second is **proxy power.** Indicators need to bring along other measures with connections supported by research. An indicator that provides insight into related matters is more desirable than a less connected indicator. The third is **data power.** The indicator must be supported by established, reliable, and available data that is helpful at both the State and community level. Data must be easily obtained in a cost-effective manner. The fourth is **action power.** The indicator must be considered significant enough by the public and policy makers

to produce action within five years. The group considered all criteria in identifying indicators.

Outcomes

Stakeholders selected five outcomes for children and families at a meeting on December 17, 2013. The outcomes are:

- Children are safe.
- Children are healthy.
- Children are supported in quality environments.
- Children are ready for and succeed in school and beyond.
- Youth successfully transitioning into adulthood.

II. Indicators

A. Children are Safe

This outcome results in children who are free from harm including abuse and neglect in their homes. The trauma inflicted on abused and neglected children results in dramatically reduced outcomes and often creates a cycle of abuse and neglect that continues through generations. When communities monitor the safety of children, they can target their resources to families who need it most and end the cycle. To measure the safety of children, the group identified four key measures.

1. **Adverse childhood experiences (ACEs) data**

   This indicator encompasses several different aspects that all reflect the safety of children's homes. ACEs data reveal how many children have experienced stressors such as abuse, neglect, or exposure to intimate partner violence, substance abuse or mental illness.

2. **Rate of substantiated maltreatment reports and child abuse per 1,000 children**

   Measuring this rate allows communities to target programs and resources towards preventing child abuse and maltreatment, as well as trauma-informed care to support children. This indicator brings along several other measures as well. Where a family is struggling with abuse and maltreatment, there are often other underlying issues, such as mental health, substance abuse, or intimate partner violence.

3. **Rate of unintentional injury and death**

Unintentional injuries are the most fatal, but also the most preventable, injuries. Communities can target this rate with prevention and awareness programs.

4. Rate of children experiencing bullying

Children who experience bullying often have problems with substance use, mental health, poor academic performance and absenteeism. Children who bully engage in risky or violent behavior at a high rate and are more likely to be child abuse or intimate partner violence perpetrators as adults. There are a number of highly effective anti-bullying programs for a community or school to choose from to aid in preventing bullying.

B. Children are Healthy

This outcome results in children who start their lives healthy and continue to access health care throughout their childhood and youth. To measure this outcome, the group identified four key times within children's lives to monitor indicators: infancy, childhood, youth, and lifespan.

1. Infant mortality rate (Infancy)

Infant mortality rates bring along other indicators such as maternal health, access to medical care, and access to prenatal care.

2. Low birth weight (Infancy)

Children born at a healthy birth rate have better health outcomes. Low birth rates are often a result of poor prenatal care and prevention, and can result in poor health outcomes for children. This is another example of early prevention paying off in big results in the long term.

3. Obesity (Children)

Children who have access to a secure source of healthy food have lower rates of obesity. Obesity is often an indicator of food insecurity in families. The group stressed that obesity must be looked at as the outcome of a number of different indicators. Obesity can be caused by the metabolic effects of starvation or medication, food scarcity or insecurity, the "grocery gap" in lower income communities, and poverty. The solution to childhood obesity is not simply children decreasing caloric intake and increasing physical activity. When this rate is monitored and communities determine the underlying causes, obesity can be addressed and prevented while improving other outcomes.

4. **Rate of youth substance abuse/use (Youth)**

Youth who remain free from substances have improved social, physical, and economic outcomes. Use of substance can lead to contact with the penal system, health problems, and family dysfunction. This indicator can be influenced by community support and prevention programs. Each community will have different rates in substance prevalence, so by looking at this measure, communities can target the substances youth most commonly use.

5. **Depression rates (Youth)**

Depression is a powerful indicator because it brings along a number of other indicators. Youth who are depressed are at risk for substance abuse, poor academic performance, risky behavior, and self-harm. Monitoring the prevalence ensures that youth can receive needed treatment, since depression is often untreated due to a lack of resources.

6. **Access to health care (Life span)**

Healthy children and youth have accessible health care. There are a number of factors that can make health care unavailable to children and youth, such as distance and transportation, poverty, language barriers, and cultural practices. This indicator can make the source of the barrier to access clear so that families and children can obtain basic health care.

7. **Health insurance coverage rates (Life span)**

Children and youth with health insurance have better access to quality medical care. Some health insurance may even cover preventative services, which have an enormous impact on health. Children and youth without health insurance often only see a doctor when they are ill or injured, leaving little resources for preventative care. A special concern is ensuring youth aging out of the foster care system are enrolled in health insurance.

C. Children are Supported in Quality Environments

This outcome results in children growing up in supportive, safe communities and stable homes. Quality environments are physically safe and provide children with the security to develop emotionally and socially.

1. **Poverty rate**

The group was in agreement that the first indicator should be the poverty rate in the community. Communities with high poverty rates are often faced with high levels of violence, substance abuse, and undiagnosed or untreated mental illness. Outcomes for children are diminished as the cycle and effects of poverty continue through the transition into adulthood.

2. Areas of concentrated disadvantage

This measure is an index of five different pieces of Census data: 1) percent of individuals below the Federal Poverty Line, 2) percent of individuals on public assistance, 3) percent of female-headed households, 4) percent of individuals who are unemployed, and 5) percent less than eighteen years of age. There is a strong correlation between areas of concentrated disadvantage and racial/ethnic inequality.

3. Permanency and mobility of foster children

Children who have been removed from their homes should achieve permanency as soon as possible. Monitoring this measure can shed light on problems in the child welfare and juvenile justice system, whether it is inefficiencies in the court system, lack of needed services in the community, support to foster parents, or case management issues. Children who remain out of the home for a prolonged period of time, are repeatedly removed from and reunited with their caregivers, or experience a high number of placement changes experience dramatically diminished outcomes in almost all areas of their lives.

D. Children are Ready for and Succeed in School and Beyond

This outcome results in children who enter school prepared to excel and continue to achieve through their education to ensure readiness for post-secondary education or entry to the workforce.

1. 4^{th}, 8^{th}, 11^{th} grade proficiency

Math and reading proficiency scores at key points in children's development are predictors of future success. These scores can indicate how many children are prepared to excel in the next level of their education. Children who fall behind in these scores lack the necessary skills to take the next step in academic development. High scores let communities know that children are prepared for further education, and low scores indicate a need for programs to help students develop proficiency.

2. Quality early care and education enrollment and access

Early intervention is a key for successful students. The group agreed that the benefits of early childhood education outweigh any potential cost for services. However, communities must consider not just the enrollment, but also the access to the services. Some communities may not have available programs, and this indicator may help communities plan programs to help their families access this crucial service. Where programs are available but enrollment is low, these measures can shine a light on other struggles that families may have.

3. Mother's education level at birth

The education level attained by a mother at birth impacts children's outcomes. Children generally achieve better outcomes when their mothers have attained high school or post-secondary diplomas. This measure can be affected in the long term by targeting resources at young women with the goal of delaying pregnancy until after the completion of high school.

4. Truancy/suspension/expulsion and absenteeism

This measure will help communities effectively intervene in the lives of youth and prevent future contact with the adult criminal system. Children who struggle with behaviors in youth and are punished by the school system have an increased likelihood of contact with the juvenile court system and the adult criminal system. Youth who display difficult behaviors in school are often struggling with issues related to their homes and families, substance abuse, or undiagnosed/untreated mental health concerns.

E. Youth Successfully Transitioning to Adulthood

Healthy communities depend on a diverse and educated workforce. The group came to a quick consensus on three indicators, the high school graduation rate, juvenile violent crimes/arrests per 1,000 youths, and the rate of youth employment and enrollment in post-secondary education.

1. High School Graduation rate

Attaining a high school diploma impacts the course of a youth's career and post-secondary education. One attendee remarked that outcomes for youths who do not graduate high school within four years are significantly diminished. This information is easily attainable, can be clearly communicated to the public and policy makers, and can lead to action.

2. Juvenile Violent Crimes/Arrests per 1,000

This measure is an excellent predictor of future contact with the adult criminal system and will help communities allocate resources to prevention and diversion programs.

3. Employed or enrolled in post-secondary education

This measure is important to both youth and communities. Youth will experience diminished outcomes if they are not prepared to enter the workforce, and communities will struggle without a quality workforce. This information is available from youth surveys and is easy for communities to understand.

III. Data Development

There are a number of indicators that would be helpful in measuring children's outcomes, but are not currently being reliably measured or reported. The group identified several key items as data that would enhance the ability to measure outcomes in each category but still needs development.

A. Children are Safe

1. Adverse childhood experiences (ACEs)

The Center for Disease control provides data on ACEs, including on a statewide level, but there is still a need for ACEs data on a community/county level.

2. Violence rates

Data should be developed regarding the exposure of children to violence in the home. Law enforcement often has contact with homes experiencing violence in the community and may be a source for tracking this information.

B. Children are Healthy

1. Social development

Social development data would encompass a number of different factors. The group identified STD/STI rates and early sexual activity as factors that affect the outcomes of youths. There are a number of behaviors related to reproduction and sexuality that impact life outcomes. These behaviors have been difficult to measure due to the perception that the collection of this data will cause discomfort or controversy.

2. **Depression rates**

Depression rates in both youth and adults are important to outcomes. This data is not currently tracked and aggregated by county level.

3. **Mental health services access**

A significant challenge facing many Nebraskans is access to mental health services when they are needed. In many counties, the need is greater than the number of providers.

4. **Undiagnosed mental illness**

The group suggested a comparison of Center for Disease control prevalence rates compared to the number of actual mental health diagnoses to give an estimate of the number of Nebraskans with undiagnosed mental illnesses.

C. Children are Supported in Quality Environments

1. **Childhood exposure to violence in communities**

Many children live in unsafe communities due to gang or drug activity, and can be exposed to traumatic violent events. The rate of violence in communities can be tied with a lack of community engagement. The threat of violence in a community may lead parents to be afraid to allow children to play outside or at a community park, leading to a disengagement from the community.

2. **Rate or number of families experiencing homelessness.**

The current data on families experiencing homelessness reports only families who seek services. This number is believed to be small in comparison to the actual number of families experiencing homelessness.

3. **Percentage of adults with mental health diagnoses and children in the home**

Data exists for the number of adults with mental health needs, but there is no data source for the number of these adults with children in the home. Living in a home with a mentally ill adult is classified as an adverse childhood experience, and these numbers will allow a community to plan mental health supports for caregivers and children.

D. Children are Ready for and Successful in School and Beyond

1. **Readiness for school data as defined by Together for Kids and Families**

This is a strong indicator where it is available. This measure is tracked by public health, but not all communities have collected this information.

2. **Social and emotional development indicators**

While academics are important and more easily measured, the social and emotional development of children is also important. These indicators would help schools and communities target funding and programs that enrich these aspects of children's lives.

3. **Rate of participation in extracurricular activities**

There is not a current reliable source of extracurricular involvement of students. Participation in extracurricular activities is a protective factor that may help to mitigate the risk factors in a child's life. Most extracurricular activities are structured around athletic, artistic or intellectual interests, and provide social, emotional, physical or academic benefits.

E. Youth Successfully Transitioning to Adulthood

1. **Rate of youth experiencing homelessness**

Individuals and families experiencing homelessness are tracked only then they seek services. These rates are not disaggregated by age, so there is no clear data for this indicator. The lack of stable housing predicts other adverse outcomes, such as mental illness, substance abuse, and poverty.

IV. Next Steps

The next steps in this initiative will be to spread awareness of the outcomes and indicators with the ultimate goal of adoption by other agencies. Attendees will be presenting this information to other entities, including the Nebraska Children's Commission and the Prevention Partnership.

The purpose of these outcomes and indicators is to improve the well-being of children. Each individual community may choose different or additional priority indicators. The work of this group is meant to create a starting point in streamlining efforts for the common goal of creating a better, more effective support system for Nebraska's children and families.

Juvenile Services (OJS) Committee

Report to the Nebraska Children's Commission
April 15, 2014

Co-Chairperson: Ellen Brokofsky, Nebraska Children's Commission, State Probation Administrator – Administrative Office of the Courts and Probation

Co-Chairperson: Martin Klein, Nebraska Children's Commission, Deputy Hall County Attorney

Committee members:

- Kim Culp, Director -Douglas County Juvenile Assessment Center
- Barbara Fitzgerald, Coordinator - Yankee Hill Programs – Lincoln Public Schools
- Sarah Forrest, Policy Coordinator – Child Welfare and Juvenile Justice – Voices for Children
- Cindy Gans, Director of Community-Based Juvenile Services Aid – Nebraska Commission on Law Enforcement and Criminal Justice
- Judge Larry Gendler, Separate Juvenile Court Judge for Sarpy County, NE
- Kim Hawekotte, Director – Foster Care Review Office (former CEO – KVC Nebraska)
- Dr. Anne Hobbs, Director – Juvenile Justice Institute, University of Nebraska, Omaha
- Ron Johns, Administrator – Scotts Bluff County Detention Center
- Nick Juliano, Senior Director of Business Development – Boys Town
- Tina Marroquin, Lancaster County Attorney
- Mark Mason, Program Director - Nebraska Vocational Rehabilitation
- Jana Peterson, Facility Administrator – YRTC, Kearney
- Corey Steel, Assistant Deputy Administrator for Juvenile Services, Administrative Office of the Courts and Probation
- Monica Miles-Steffens, Executive Director – Nebraska Juvenile Justice association & Nebraska JDAI Statewide Coordinator
- Pastor Tony Sanders, CEO – Family First: A Call to Action
- Dalene Walker, Parent
- Dr. Ken Zoucha, Program Medical Director - Hastings Juvenile Chemical Dependency

Resources to the Committee:

- Sen. Kathy Campbell
- Sen. Colby Coash
- Doug Koebernick, Legislative Assistant for Senator Steve Lathrop
- Jerall Moreland, Assistant Ombudsman - Nebraska Ombudsman's Office
- Dr. Hank Robinson, Director of Research, Nebraska Department of Corrections
- Dan Scarborough,Facility Administrator – YRTC, Geneva

Meeting Dates:

January 14, 2014
March 11, 2014
April 8, 2014
May 13, 2014

Activities:

The Juvenile Services (OJS) Committee met on May 13, 2014, to further develop recommendations related to Community-based programs. The committee worked from the Proposed Nebraska Juvenile Justice System Continuum of Service matrix that was created during

Phase I planning. The committee discussed what types of services are needed during diversion and "pre-diversion". To inform the work and enhance discussion, Dr. Anne Hobbs, Director of the Juvenile Justice Institute, University of Nebraska, Omaha provided a presentation on State Wide Juvenile Diversion Survey Data. The presentation provided data from surveys that were completed by 17 directors, 28 county attorneys, (involving a total of 30 juvenile diversion programs). The survey looked at case filing before diversion; screening assessments and screening tools; and the use of assessment tools to determine the diversion plan. The survey also looked at diversion program funding and the amount being paid for individual diversion programming. The survey includes information on data needs and workforce development issues.

Dr. Hobbs also provided information on Nebraska Juvenile Diversion case closures. The data included percentages on the withdrawal of a youth's referral to a diversion program; declined admission to a diversion program; and a juvenile's failure to comply with program conditions.

The committee discussed the various aspects of diversion and pre-diversion; the survey results; and data provided. The committee also asked for clarification on a variety of issues. Dr. Hobbs collected a variety of suggestions from the committee and will be providing updates on the analysis of the data at a future meeting.

The committee will be using notes from the discussion to inform future discussions about Community-based programs and to make recommendations about state funding.

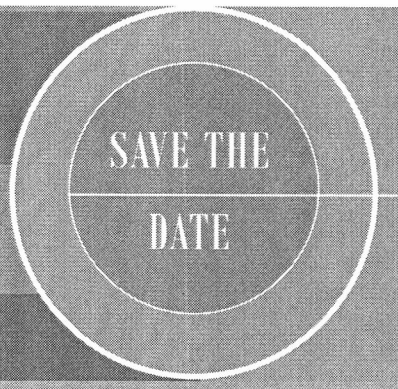
Project Reports

The Juvenile Services (OJS) committee added a new feature to the monthly meeting agenda. Committee members have been asked to share information about projects they are currently working on that relate to youth in the juvenile justice system. The committee received information this month from Nick Juliano on cross-over youth and from Kim Hawekotte on the Out-of Home Placement committee.

Membership Update:

At the conclusion of the meeting, Marty Klein resigned his position as co-chairperson of the committee. The committee discussed the need to identify another co-chairperson. The committee tabled this discussion until the June meeting.

The committee has also invited Sheri Dawson from DHHS to attend the June or July meeting. The committee has asked DHHS to identify someone who can attend the meeting as a resource person from DHHS behavioral health.

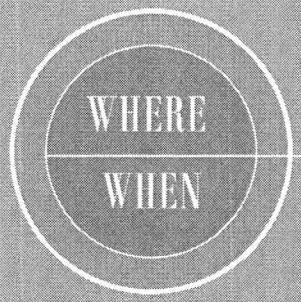


Enhancing Juvenile Justice In-home Interventions: Regional Introduction and Planning Meetings

Nebraska Juvenile Probation and the Juvenile Justice Court Improvement Project/Through the Eyes of the Child Initiative have been working with a private foundation to provide the funds for infrastructure development, training, and accreditation to implement Multisystemic Therapy (MST), Functional Family Therapy (FFT), and Boys Town's Intensive Family Preservation Services across the state. MST and FFT have a significant body of evaluation research indicating that their interventions reduce re-offending and other anti-social behaviors of youth in juvenile justice systems. Boys Town has preliminary data that suggests their intervention also reduces offending.

We will be assessing community and provider interest/capacity across the state to develop a comprehensive plan for implementation of these services. Please join us for a regional meeting in your area where you will learn about the different interventions from leaders from MST Services, FFT LLC, and Boys Town. These speakers will provide an overview of their models for the first two hours of the meeting. Immediately following the two-hour overview, providers will remain for more details about the models including therapist requirements, training plans, etc. Finally, a *Request for Interest and Qualifications* process will be described. The information provided by providers (providers will have several weeks to complete this information) will help inform the comprehensive plan.

For questions, please contact Vicky Weisz (vweisz1@unl.edu) or Melissa Townsend (melissa.townsend@unl.edu).



June 2: Norfolk (pm session)
June 3: Lincoln (am session)
June 4: Omaha (am session)

June 16: Scottsbluff (pm session)
June 17: North Platte (am session)
June 18: Kearney (am session)

Register NOW!

(http://ccfl.unl.edu/registration/event.php?id=5682166)

Sponsored by Juvenile Probation, Juvenile Justice Court Improvement Project/Through the Eyes of the Child Initiative

State Wide Juvenile Diversion Survey Data

UNL Law/Psychology

&

UNO Juvenile Justice Institute

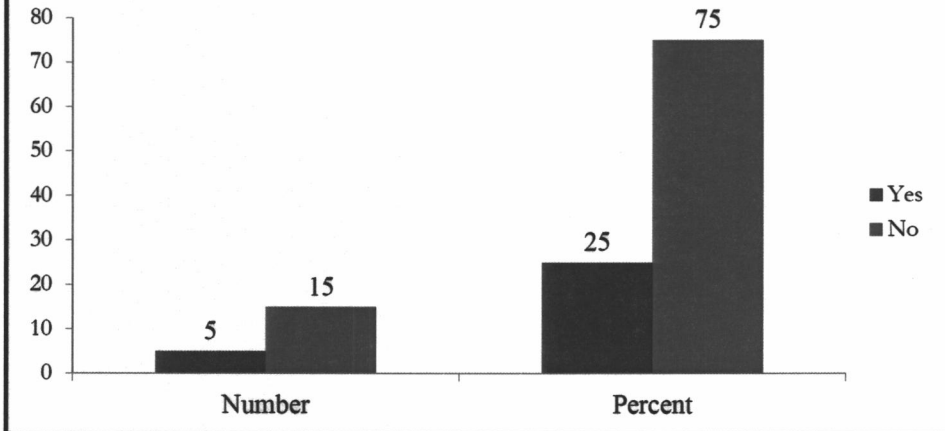
Description of Sample

- 3 Staff Responses
- 17 Director Responses
- 28 County Attorney Responses

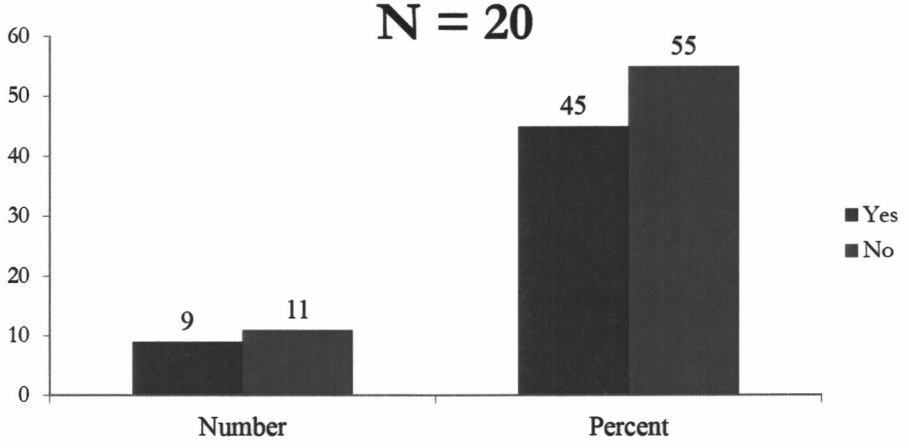
- Staff collapsed with Directors
- 30 Juvenile Diversion Programs Represented
  - 13 Did not list a Diversion Program

Staff and Directors

Are cases filed before diversion? N= 20



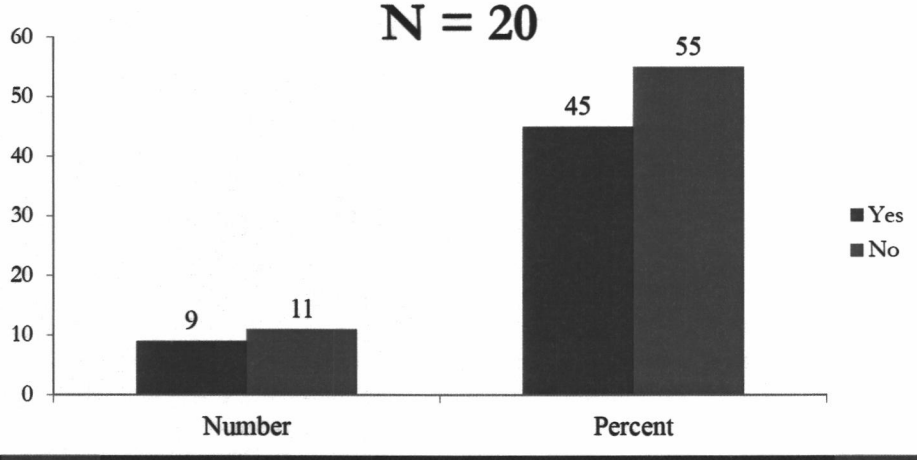
Is a screening assessment completed?
N = 20



Tools for Screening

- Of the 9:
  - 1 used MYSI-2 and YLS/CMI
  - 2 used Nebraska Youth Screen
  - 6 used an informal assessment

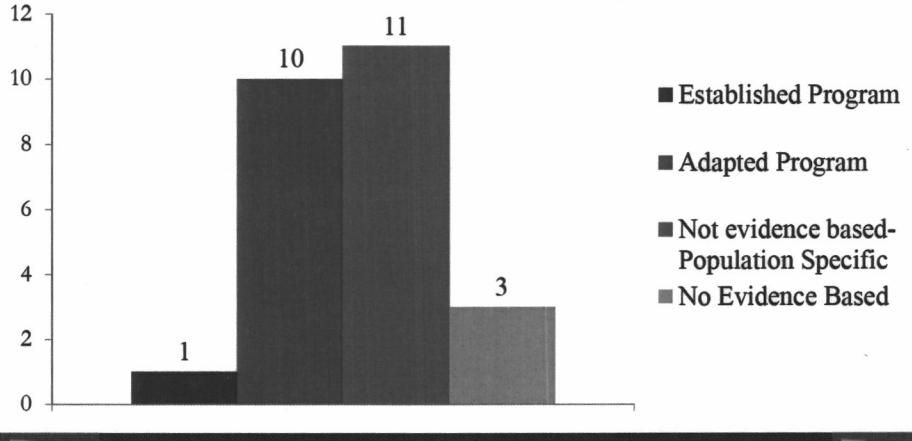
Use of Assessment Tool to Determine Diversion Plan N = 20



Tools for Assessment

- All 9 used some combination of SASSI, YLS, MAYS/I, Nebraska Youth Screen, Nebraska Youth Survey, YLS-CMI, and the SSI

Evidence Based Programs
N = 20 (Multiple Responses)



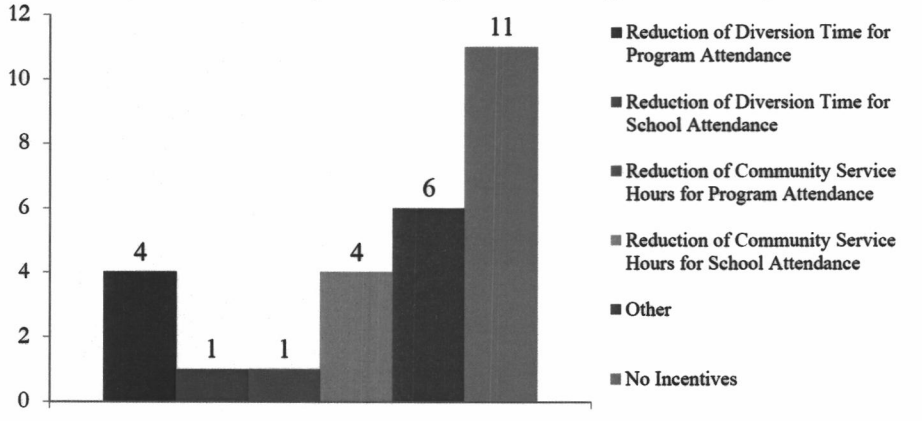
Established Programs Used

- No programs named
- Adapted Programs – Class Action

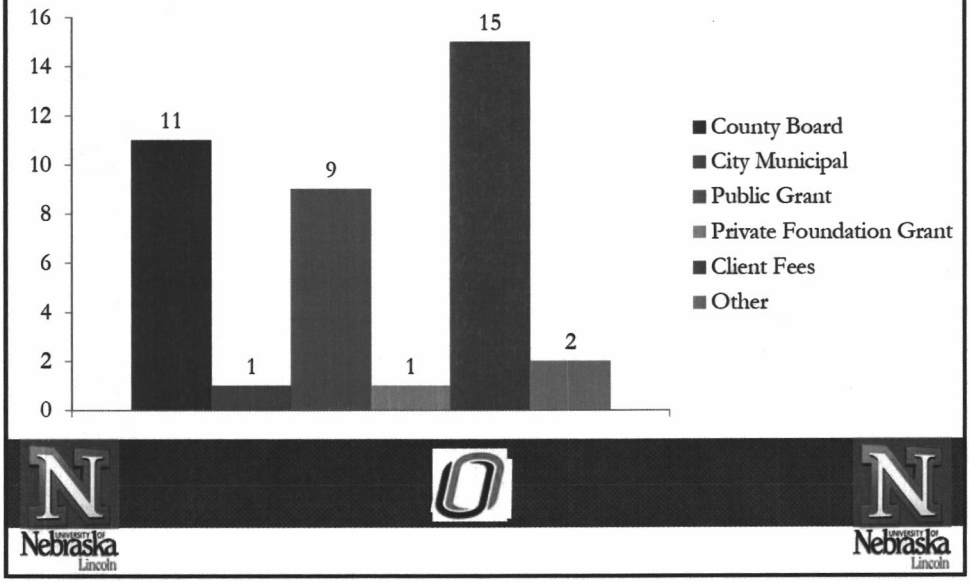
Adapted Programs Used

Class Action	Responsible Behavior Workbooks
Young Women's Class	Why Try?
Young Men's Class	Upward Movement
Victim Impact Panel	40 Development Assets
Teen Court	3rd Millennium
Power of Parents	Strengthening Families
Power of Youth	Community Referral
Real Colors	

Incentives
N = 20 (Multiple Responses)

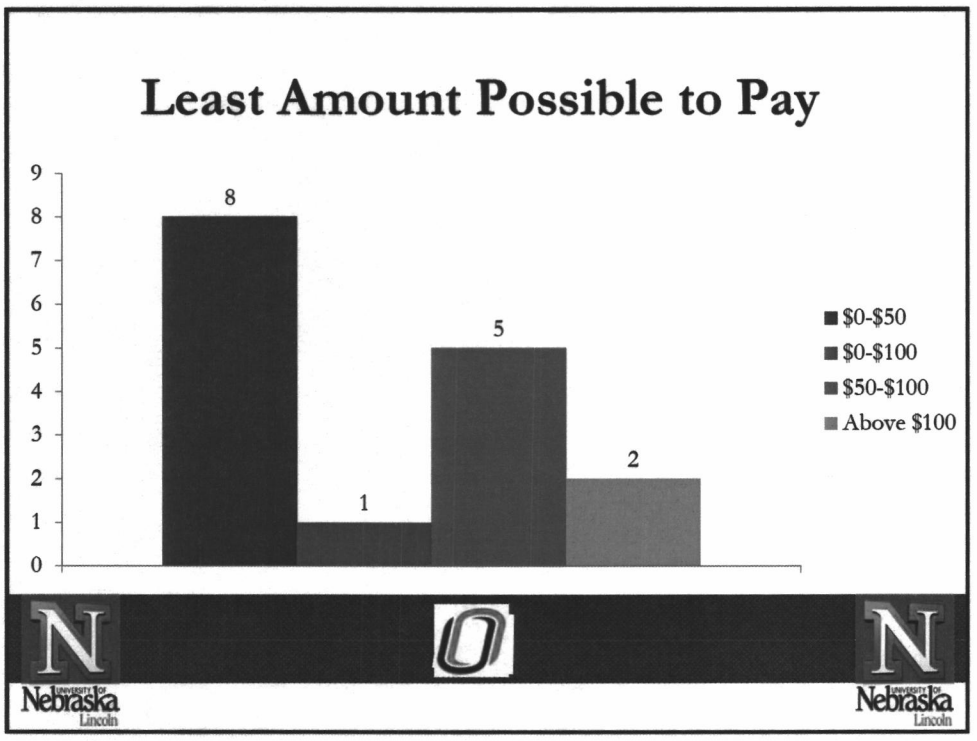


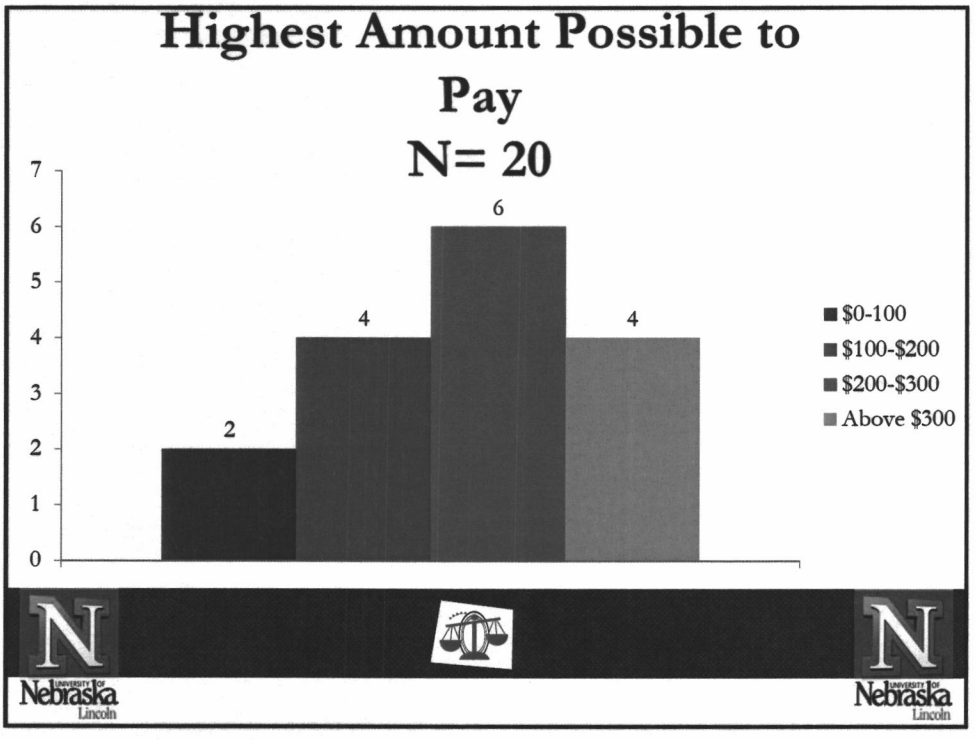
Diversion Program Funding

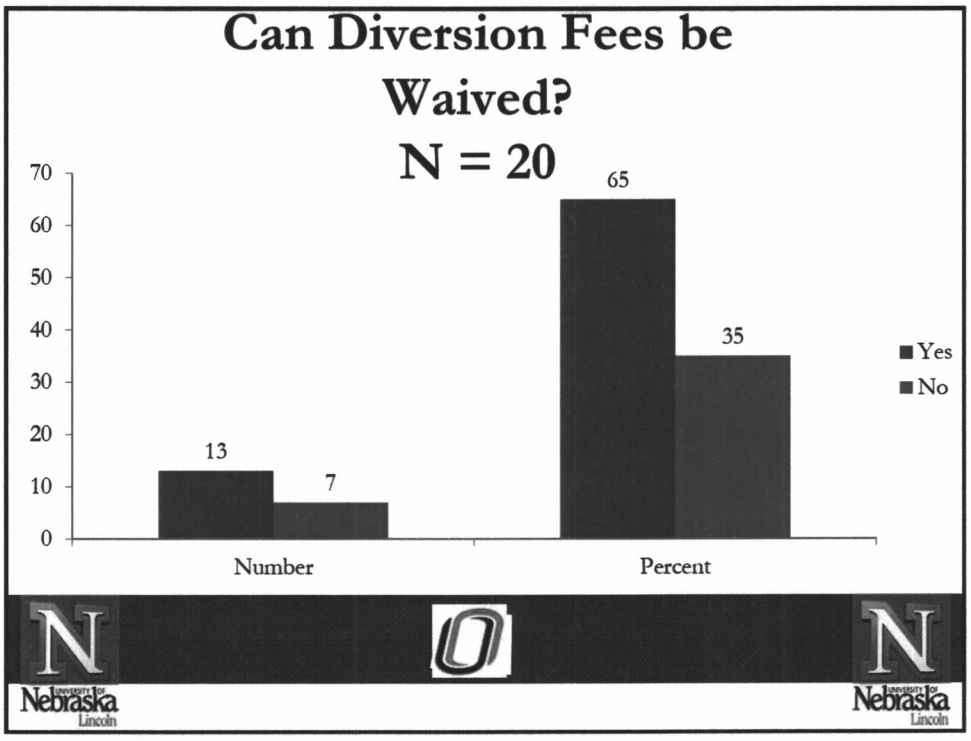


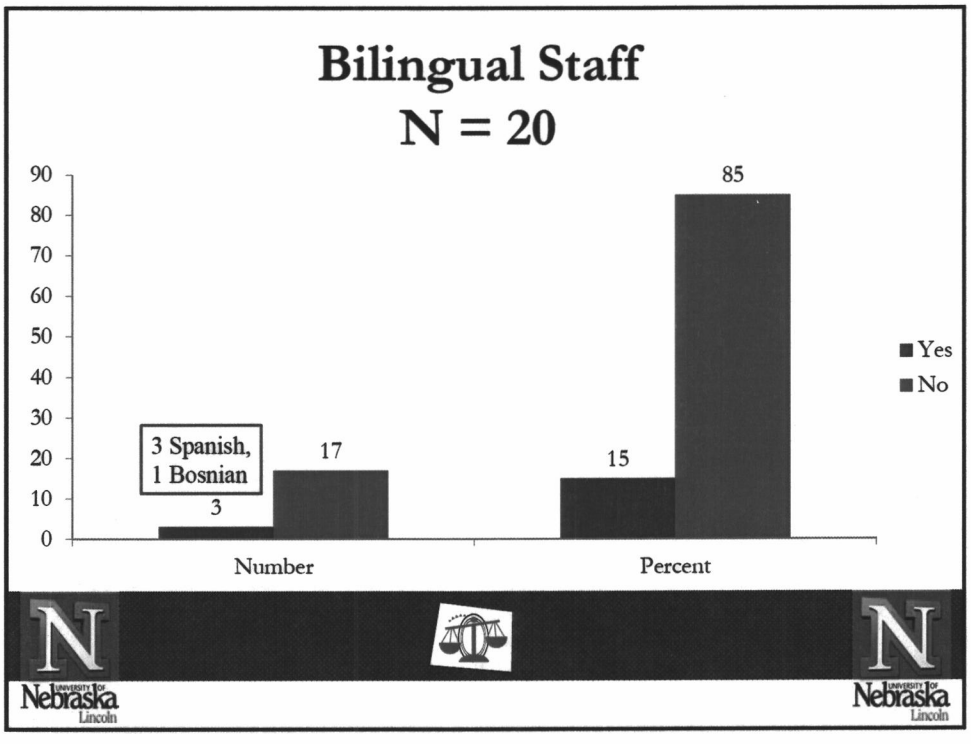
Incentives – Other

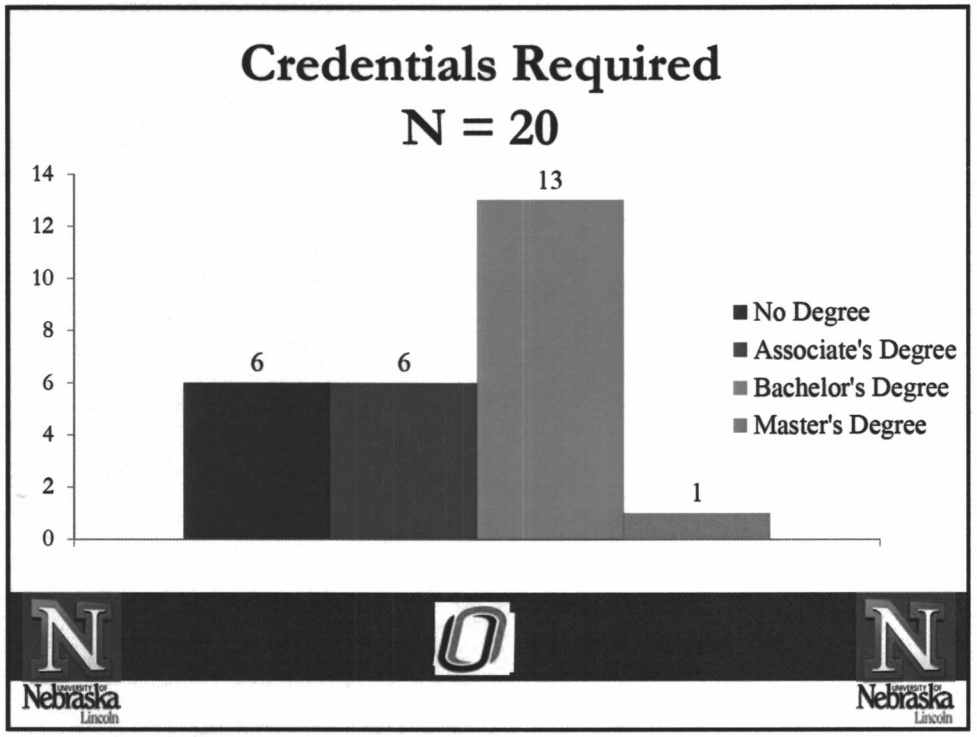
- Crime Commission County Aid
- State Funded Grants

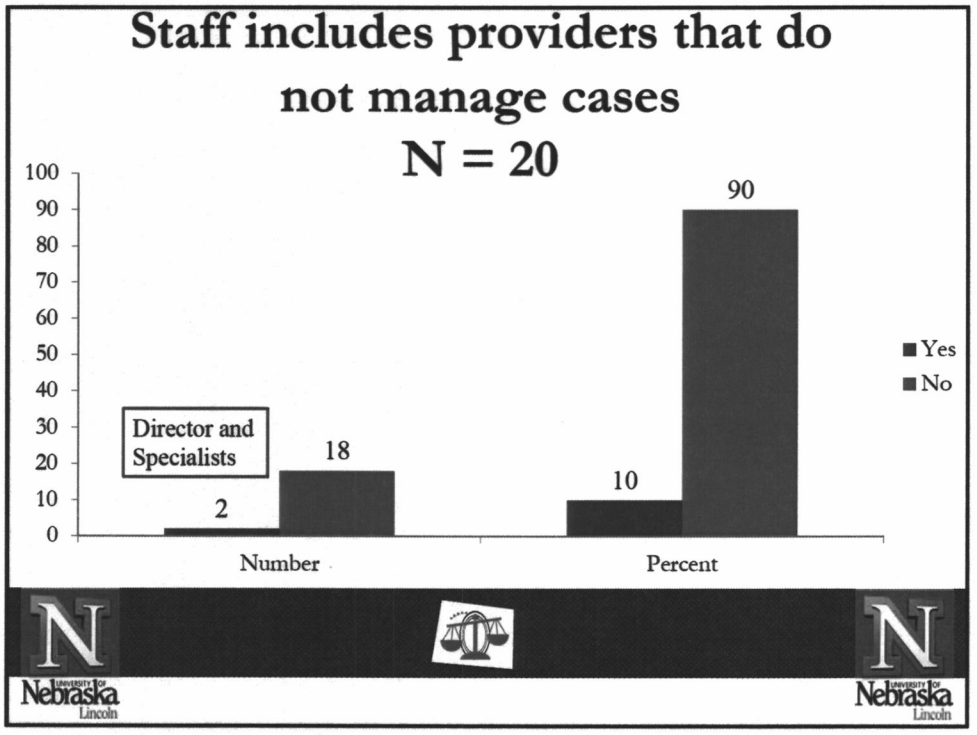

Least Amount Possible to Pay
9
8
7
6
5
4
3
2
1
0
8
1
5
2
$0-$50
$0-$100
$50-$100
Above $100

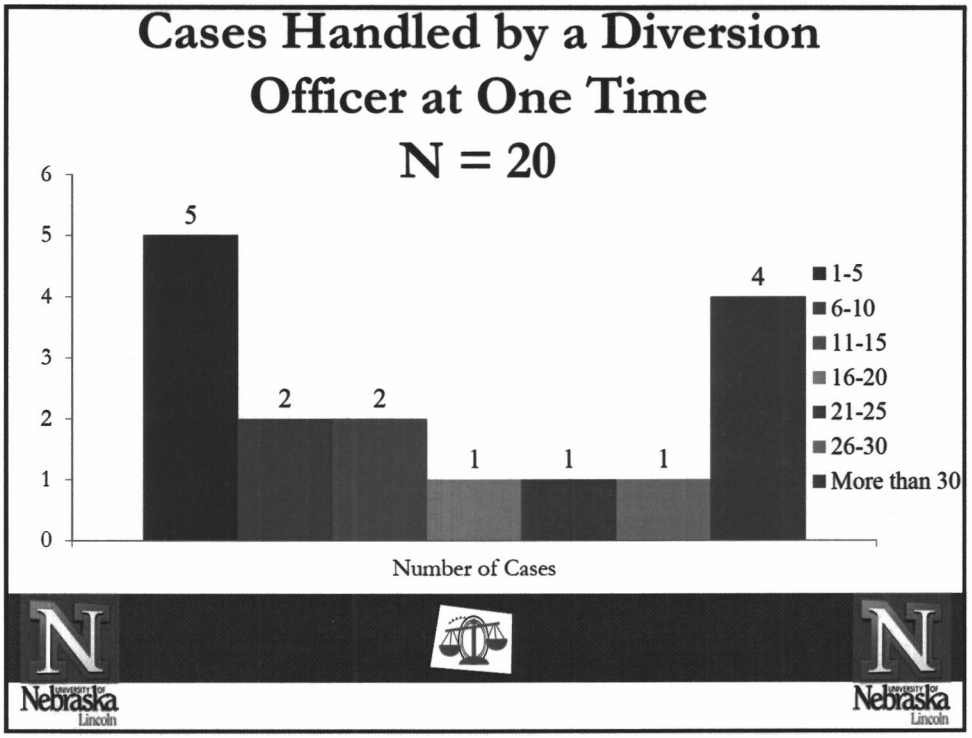

Highest Amount Possible to Pay
N= 20
7
6
5
4
3
2
1
0
2
4
6
4
$0-100
$100-$200
$200-$300
Above $300

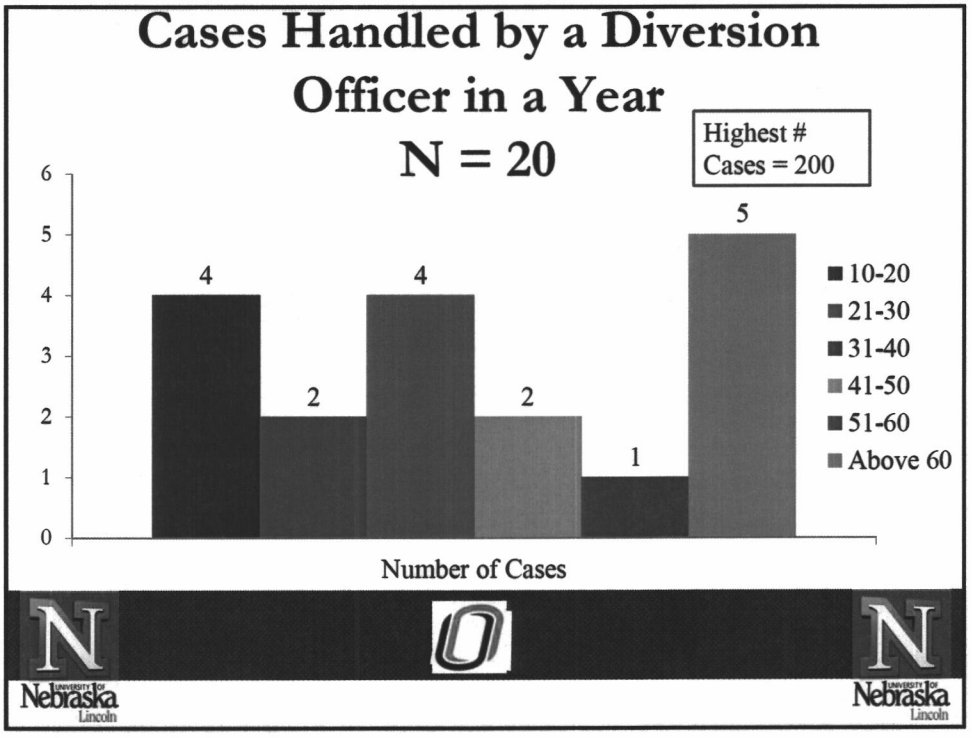

Can Diversion Fees be Waived?
N = 20
70
60
50
40
30
20
10
0
13
7
65
35
Number
Percent
Yes
No
University of Nebraska Lincoln
University of Nebraska Lincoln

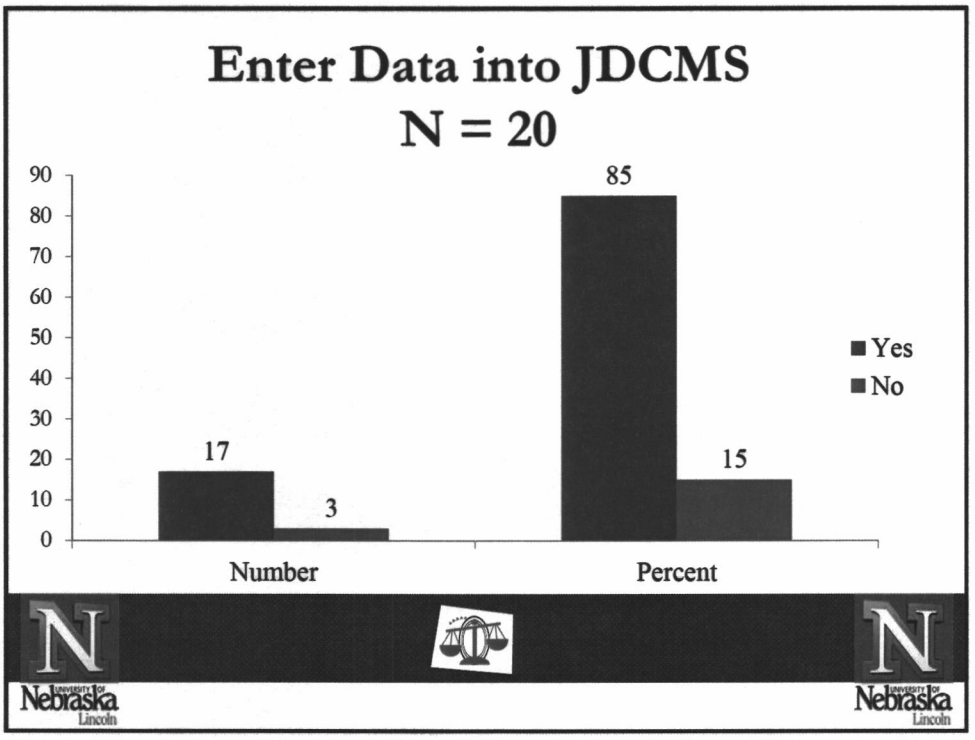

Bilingual Staff
N = 20
90
80
70
60
50
40
30
20
10
0
3 Spanish,
1 Bosnian
3
17
15
85
Number
Percent
Yes
No
University of Nebraska Lincoln
University of Nebraska Lincoln

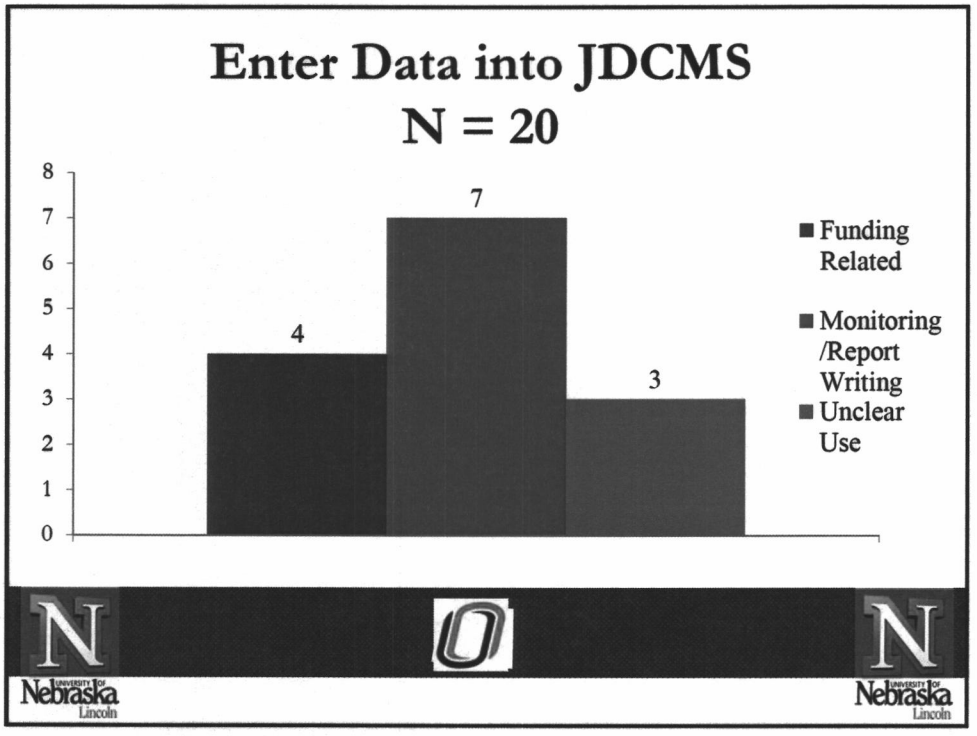

Credentials Required
N = 20
14
12
10
8
6
4
2
0
6
6
13
1
No Degree
Associate's Degree
Bachelor's Degree
Master's Degree


Staff includes providers that do not manage cases
N = 20
100
90
80
70
60
50
40
30
20
10
0
Director and Specialists
2
18
10
90
Number
Percent
Yes
No


Cases Handled by a Diversion Officer at One Time
N = 20
6
5
4
3
2
1
0
5
2
2
1
1
1
4
1-5
6-10
11-15
16-20
21-25
26-30
More than 30
Number of Cases
Nebraska
Lincoln
Nebraska
Lincoln


Cases Handled by a Diversion Officer in a Year
N = 20
Highest # Cases = 200
6
5
4
3
2
1
0
4
2
4
2
1
5
10-20
21-30
31-40
41-50
51-60
Above 60
Number of Cases
Nebraska
Lincoln
Nebraska
Lincoln

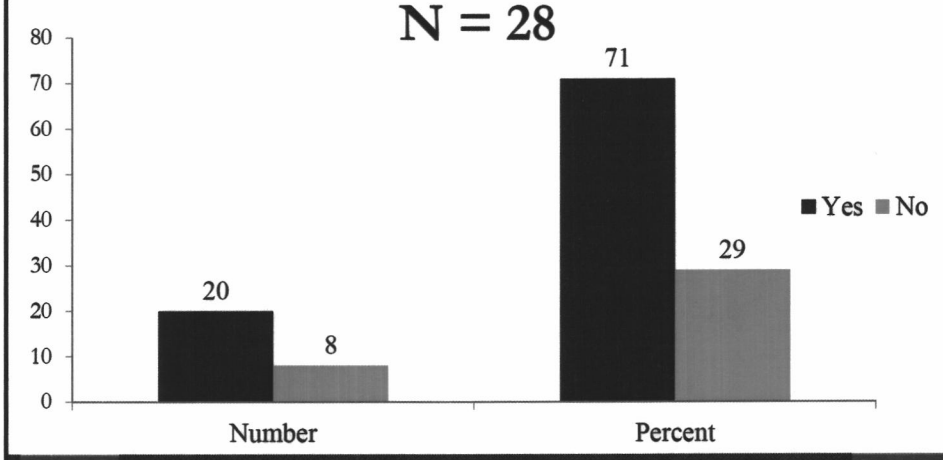

Enter Data into JDCMS
N = 20
90
80
70
60
50
40
30
20
10
0
17
3
85
15
Number
Percent
Yes
No


Enter Data into JDCMS
N = 20
8
7
6
5
4
3
2
1
0
4
7
3
Funding Related
Monitoring /Report Writing
Unclear Use

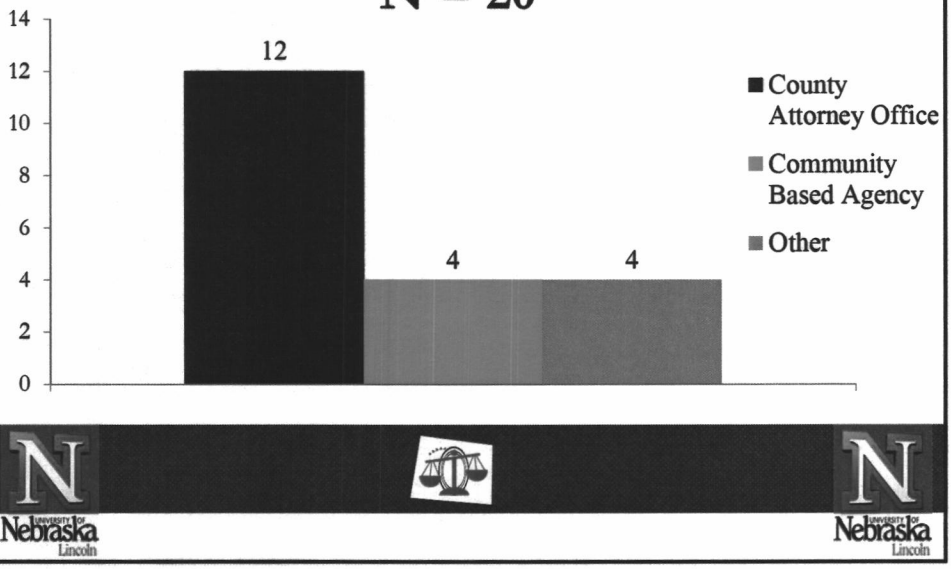
County Attorneys

Does Your County Offer a Juvenile Diversion Program?

N = 28

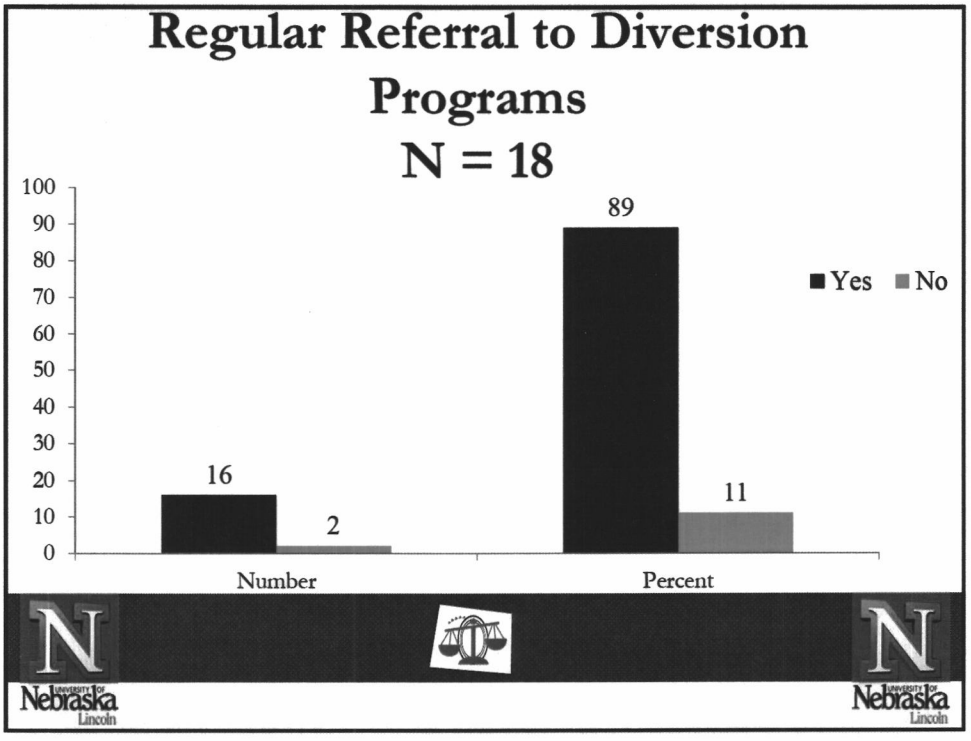


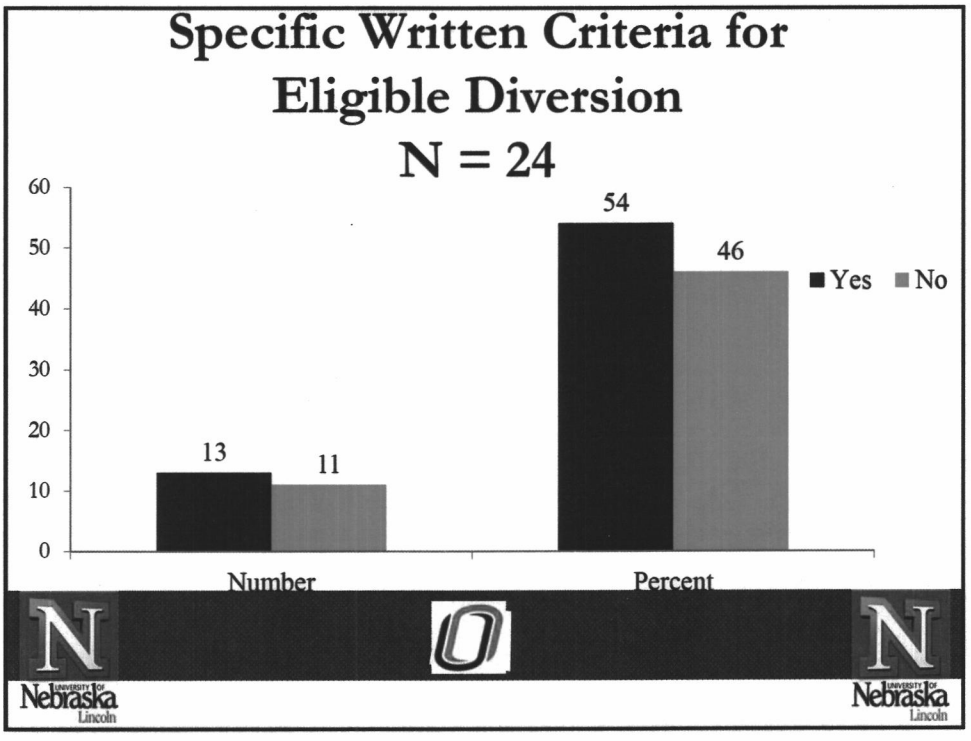
What is the Base of the Diversion Program?
N = 20

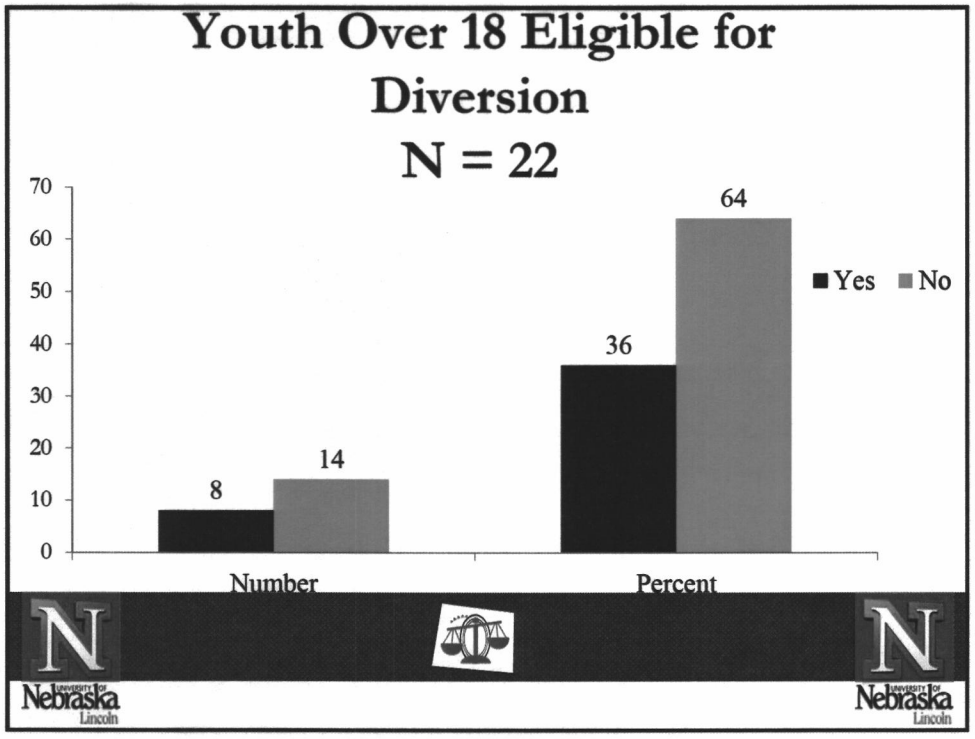


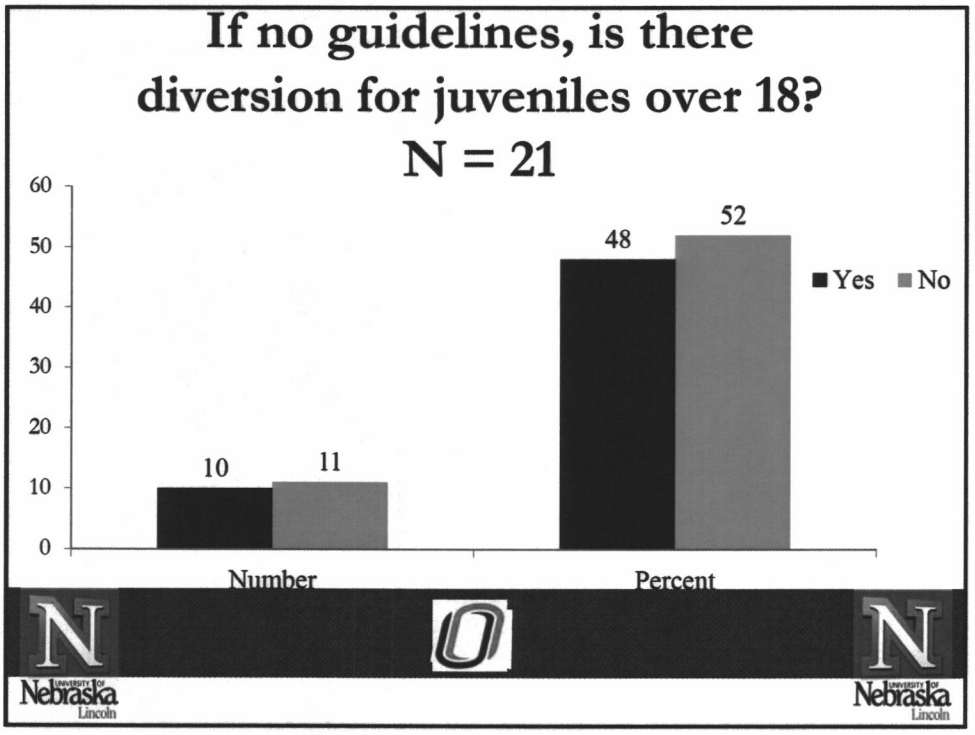
Diversion Program Base – Other

- Multi-County
- Juvenile Assessment Center
- Lutheran Family Services
- County Extension Service Office


Regular Referral to Diversion Programs
N = 18
100
90
80
70
60
50
40
30
20
10
0
16
2
89
11
Yes
No
Number
Percent
University of Nebraska Lincoln
University of Nebraska Lincoln

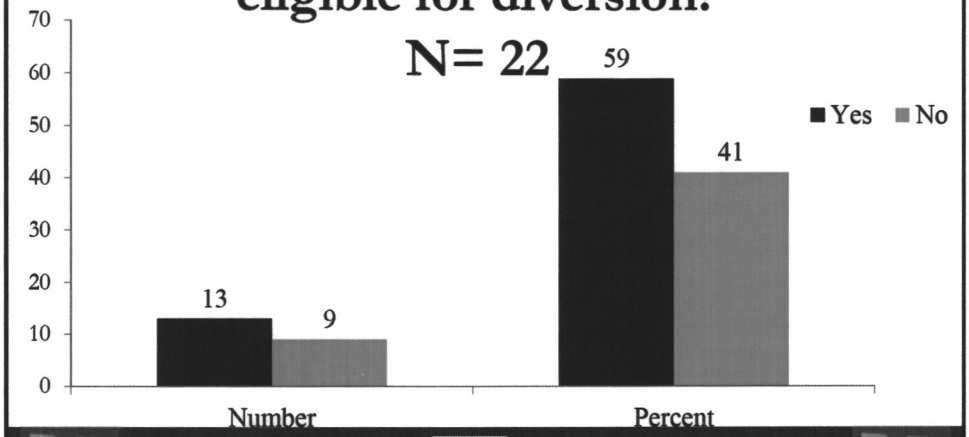

Specific Written Criteria for Eligible Diversion
N = 24
60
50
40
30
20
10
0
13
11
54
46
Yes
No
Number
Percent
University of Nebraska Lincoln
University of Nebraska Lincoln


Youth Over 18 Eligible for Diversion
N = 22
70
60
50
40
30
20
10
0
8
14
36
64
Yes
No
Number
Percent
Nebraska
Lincoln


If no guidelines, is there diversion for juveniles over 18?
N = 21
60
50
40
30
20
10
0
10
11
48
52
Yes
No
Number
Percent
Nebraska
Lincoln

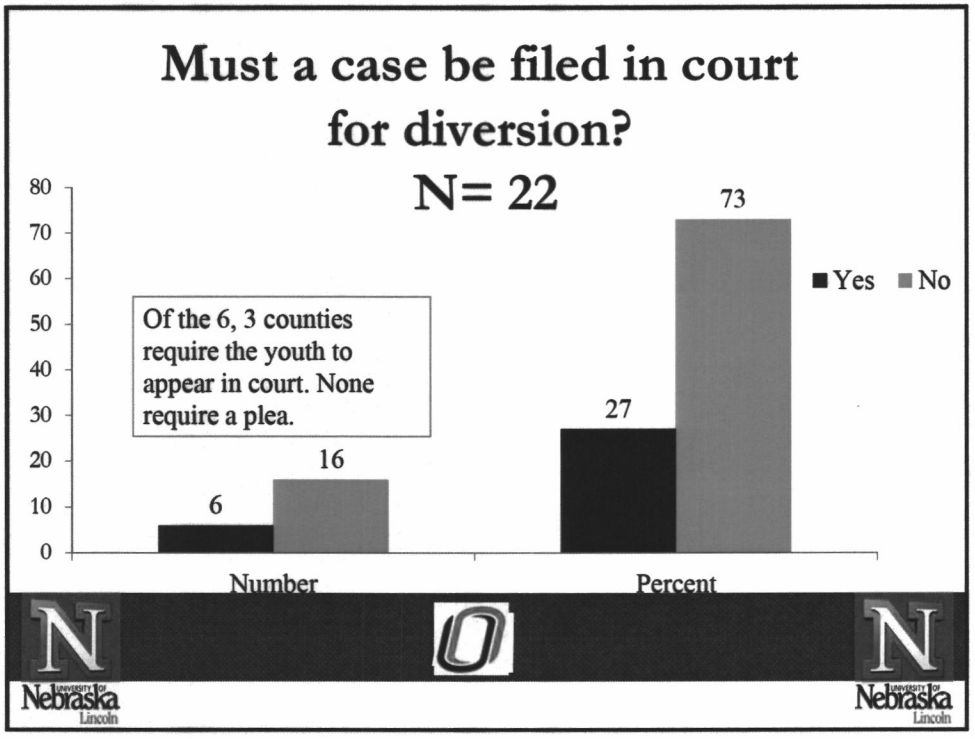
Are there specific non-felony offenses that should not be eligible for diversion?

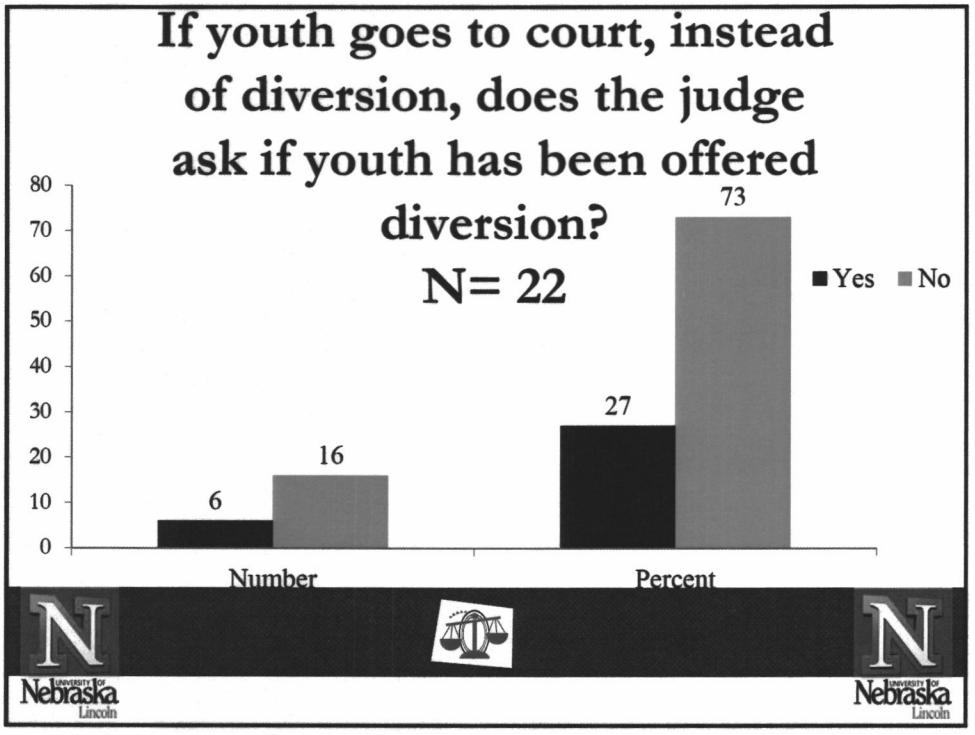
N= 22



What are these non-felony offenses?

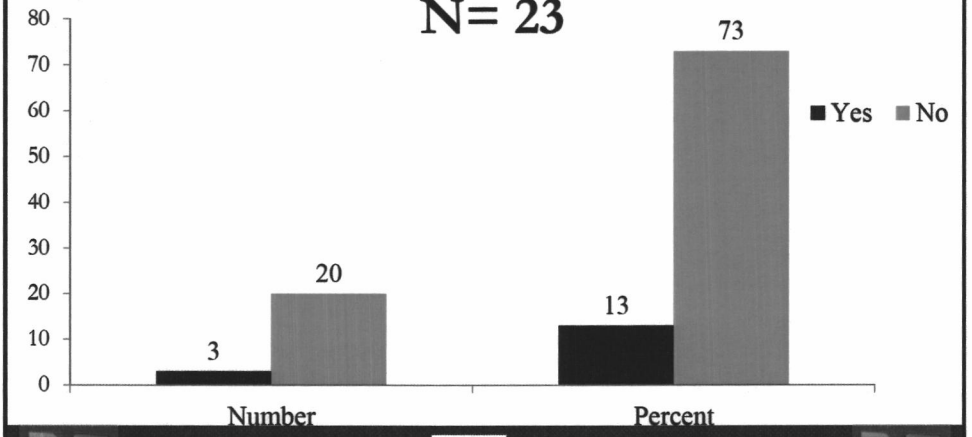
- Assault (2)
- Drug Offense (1)
- DUI (5)
- Misdemeanor Sexual Assault (3)


Must a case be filed in court for diversion?
N= 22
80
70
60
50
40
30
20
10
0
73
27
16
6
Yes
No
Of the 6, 3 counties require the youth to appear in court. None require a plea.
Number
Percent
Nebraska
Lincoln


If youth goes to court, instead of diversion, does the judge ask if youth has been offered diversion?
N= 22
80
70
60
50
40
30
20
10
0
73
27
16
6
Yes
No
Number
Percent
Nebraska
Lincoln

Does part of CA's budget fund diversion programs?

N= 23



UNL Law and Psychology Program

&

UNO Juvenile Justice Institute

Nebraska Juvenile Justice Association

Diversion Data

Nebraska System of Care
Strategic Plan Overview

Overview

The Planning Process

Planning for Nebraska's System of Care involved a comprehensive, highly participatory statewide process, featuring youth, family members and system representatives. Planning centered around eleven (11) planning groups that were formed and facilitated beginning in December 2013 and extending through April 2014. These groups include 10 Core Strategy Teams and an overarching Project Management Team. All teams included system, youth and family partners working together.

The Core Strategy Teams (CSTs) were organized around content areas and the Project Management Team (PMT) was responsible for project oversight and development of this consolidated statewide plan based on recommendations from each of the other planning groups. While this participatory process was highly intensive in terms of complexity and overall level of effort, this model was chosen in order to promote wide-ranging participation and ownership of identified issues. The participatory planning process emphasized culturally and regionally relevant and sustainable strategies and engagement of local experts (including those with lived experience), resources and supports instead of reliance on centralized experts, resources or efforts that would have led to top-down, generic strategies.

The 10 CSTs were facilitated by planning Co-Chairs. The Co-Chairs for each CST included a system partner and a family partner who were recruited based on their experience with the topic area, systems and stakeholders involved in the planning process as well as their willingness to serve, in volunteer capacity, as facilitator. The CST structure resulted in 10 sets of content-specific recommendations for enhancing Systems of Care. The Project Management Team then reviewed, analyzed and consolidated these recommendations.

In addition, a series of youth forums were held across the state to bring youth voice to the planning process.

Population of Focus

The population of focus for Nebraska's System of Care (SOC) planning efforts is defined, inclusively, as: *Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska's child-serving systems.*

Vision, Mission and Values

Vision

Nebraska's Vision describes our hopes and intentions for Systems of Care for children and youth and their families in the next three to five years – our Vision reminds us why this effort is important.

Vision: *Nebraska children, young adults and families of all cultures are able to access an integrated system of care that supports them to reach their full potential holistically (health, home, purpose and community) while in school, living in a home and community that supports strong family connections and in their transition to adulthood.*

Mission

The Mission of the Nebraska System of Care Partnership guides our efforts by describing (1) what the System of Care does; (2) who it does it for; and (3) how it does what it does.

Mission: *Nebraska's child and family serving systems of care will improve access to appropriate and timely community-based care that is family-driven and youth-guided, embodies the cultural and linguistic values of the individuals and families being served and improves their clinical, behavioral, social, and educational outcomes and eliminates fragmented approaches to meeting need. Child and family-serving systems will achieve this change through transparent system collaboration with partnerships and shared ownership involving individuals and families as full partners.*

Values

Our Values and Principles are the foundation for our System of Care; everything we do can be measured against these core values.

Values: *Youth guided; family driven; strength-based; individualized; culturally & linguistically competent; evidence-based; high quality; accessible; integrated; cost-effective; data informed.*

Organization of the Strategic Plan

Goals

The Project Management Team (PMT) considered all of the input from the CST planning process and identified 9 goals that will organize our plan to enhance systems of care for children, youth and their families across Nebraska:

1. Develop, implement and sustain system of care infrastructure, inclusive of policy, regulatory and financing, at regional, tribal and state levels.
2. Build a sustainable statewide infrastructure for a youth network and family network representative of the population of Nebraska to empower all youth and family voice, outreach, education, advocacy and leadership opportunities.
3. Ensure a full service array of culturally-based, research-based practices, featuring High Fidelity Wraparound principles/philosophy, is available to children and families across the state of Nebraska.
4. Integrate services for multi-system youth across all child-serving systems.

5. Build, or enhance, the community-based crisis continuum.
6. Build an integrated cross-system, collaborative prevention and early intervention system including physical and behavioral health, child welfare and education.
7. Develop policies that promote flexible funding through multiple strategies.
8. Promote and support Cultural and Linguistic Competence (CLC/CLAS) in all aspects of the system of care.
9. Implement a participatory continuous quality improvement (CQI) process in which all SOC plan goals and strategies are systematically monitored and changes are made as needed to improve outcomes.

Framework

Nebraska has adopted the overarching framework of five core areas of focus identified by Beth Stroul and Robert Friedman (2011)[1] as a way to organize the system of care strategic plan. Strategies to achieve each of the 9 goals are organized according to these 5 areas. They are:

1. Implementing Policy, Administrative, and Regulatory Changes
2. Developing Services and Supports based on the SOC Approach
3. Creating Financing Mechanisms
4. Providing Training, TA, and Coaching
5. Generating Support

Strategies

Nebraska is a diverse and complex state; the strategic plan reflects this diversity as many strategies and activities require state, regional and local level actions that need to be addressed. Like any strategic plan, it is a work in progress and subject to continuous review and improvement.

Key Elements of the Plan

Governance, Oversight and Accountability

Establish a governance structure to facilitate implementation and accountability. In order to ensure the best chance for implementation, a governance and oversight group will be established representing key systems (e.g., behavioral health, child welfare juvenile justice and education) and with authority to make decisions.

Establish regional, local and tribal governance. Recognizing that implementation must happen at the local, regional and tribal level, it is crucial to support implementation of local leadership teams including

[1] Stroul, B. A., & Friedman, R. M. (2011). Issue brief: Strategies for expanding the system of care approach. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

youth and family leaders, child-serving organizations along with system leaders, as the locus of accountability for SOC efforts.

Youth and Family Involvement and Leadership

Fund, expand and sustain youth and family networks and organizations across Nebraska. The planning process highlighted the critical importance of expanding, strengthening and sustaining a coalition of youth and family organizations and advocates across Nebraska.

Cross-system training. Expand training for youth and families to ensure that comprehensive, cross-system training is accessible in all regions of the state to give youth and families information and skills to fully participate in systems of care.

Financing Strategies

Understand funding streams. Identify opportunities within each system (federal, state, tribal and private partner) to using Medicaid and other resources to increase flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development initiatives.

Understand expenditures and profiles of need. Implement a pilot project to understand and prioritize financial needs tracking high utilizers across systems.

Maximize flexibility through integration. Explore options for using cross-system braided funding approaches for flexible service funding.

Services and Supports

Identify and address barriers. Review policy and regulations to identify barriers to effective collaboration and/or development of a single services plan for youth and families across systems.

Systems guided by Wraparound principles. Incorporate Wraparound principles into expectations for service provision, including contractual language to promote accountability.

Access to High Fidelity Wraparound. Ensure that within each region/county/tribe there is access to Wraparound planning as well as access to person-centered planning, family-focused and evidence based services and supports.

Crisis continuum. Build a statewide crisis continuum that includes brief out-of-home options for children and youth in crisis such as crisis residential, respite, therapeutic foster care, and emergency shelter options. Also explore a dedicated on-call team serving children, youth and their families across systems.

Workforce Development. Ensure cross-system competencies across relevant domains including trauma-informed, CLAS and family-driven care. Ensure cross-system statewide training in both High Fidelity Wraparound and Wraparound-informed care.

Integration across systems

Identify and address barriers. Review policy and regulations to identify barriers to effective cross-system collaboration and coordination in care planning and provision of services.

Coordinated access, screening and assessment. Explore options to identify and agree upon a shared screening and assessment framework (e.g., CANS) in the context of interagency coordinated funding. Identify opportunities to promote coordination and eliminate duplication of services and processes across systems.

Culturally and Linguistically Responsive Services and Systems

Formalize CLS / CLAS in policy. Develop policies, rules, procedures that support CLC, implement CLAS standards, and address disparities.

Workforce development. Implement statewide, cross-system training in CLC/CLAS and its relevance to disparities in outreach, access and outcomes among youth and families involved with the child-serving systems.

Culturally responsive care. Develop and build on standards and successful efforts to ensure that all plans developed with youth and families are individualized to their unique culture, beliefs and values.

Prevention and Early Intervention

Integration. Build an integrated prevention and early intervention system including physical and behavioral health, child welfare and education.

Training. Design, implement cross-system training in prevention and early intervention, emphasizing mental health promotion, resilience and trauma-informed practices.

Data-Informed Decision Making / Continuous Quality Improvement

Shared, cross-system screening and assessment. System partners will identify and agree upon a shared screening and assessment framework. (e.g., CANS) to support understanding of appropriateness of level of care determinations and service utilization.

Expand use of measurement to support decision-making. Identify opportunities to incorporate measurement and evaluation in all child-serving systems, provider contracts and state/regional processes including procurement, training, and implementation of services and supports.

Build local capacity. Support the formation of local continuous quality improvement (CQI) teams /workgroups and support training and TA as necessary.

Nebraska System of Care Planning Project
Strategic Plan Review

Stakeholders across Nebraska developed a Strategic Plan for a System of Care (SOC) that will lead to better outcomes for Nebraska youth and families. Thank you for your time in reviewing the plan. Your answers (anonymous if you wish) and comments to the survey that follows will support the continued development and sustainability of Nebraska's SOC and assist us in making the plan even better.

Name (Optional) _____

As a stakeholder, with which group do you most identify when thinking about Nebraska's SOC? (✓Select all that apply)

☐System Partner

☐Family Partner

☐Youth/Young Adult Partner

☐Other (Please Specify)

_____

REVIEW DIRECTIONS

1. The following pages list the key elements as they relate to the goals of Nebraska's Strategic Plan. You are asked to complete survey questions related to strategies supporting these elements as you rotate (take these pages with you) around the review stations. Use Nebraska's *Strategic Plan* (included in your program) to review and discuss the listed strategies within your review group and then answer the survey question following each key element by checking the box that most represents your view. Your candid comments and recommendations in the spaces provided will be welcomed and appreciated!

2. Turn in this review document at the end of your last review session. You may give it to your last review leader or drop it in the box marked "Review/Survey Here" as you leave today's SOC Town Hall.

Thank you for your valued contributions and commitment to

Nebraska's System of Care!

Key Elements of the Plan

Goal #1: Governance, Oversight and Accountability

Establish a governance structure to facilitate implementation and accountability. In order to ensure the best chance for implementation, a governance and oversight group will be established representing key systems (e.g., behavioral health, child welfare juvenile justice and education) and with authority to make decisions.

Establish regional, local and tribal governance. Recognizing that implementation must happen at the local, regional and tribal level, it is crucial to support implementation of local leadership teams including youth and family leaders, child-serving organizations along with system leaders, as the locus of accountability for SOC efforts.

Do the strategies listed in the Strategic Plan support this key element?

Governance, Oversight and Accountability	**Yes**	**No**	**I don't have enough information to respond.**

If you selected no, what revisions would you recommend for consideration?

Goal #2: Youth and Family Involvement and Leadership

Fund, expand and sustain youth and family networks and organizations across Nebraska. The planning process highlighted the critical importance of expanding, strengthening and sustaining a coalition of youth and family organizations and advocates across Nebraska.

Cross-system training. Expand training for youth and families to ensure that comprehensive, cross-system training is accessible in all regions of the state to give youth and families information and skills to fully participate in systems of care.

Do the strategies listed in the Strategic Plan support this key element?

Youth and Family Involvement and Leadership	**Yes**	**No**	**I don't have enough information to respond.**

If you selected no, what revisions would you recommend for consideration?

Goals #3 and #5: Services and Supports

Identify and address barriers. Review policy and regulations to identify barriers to effective collaboration and/or development of a single services plan for youth and families across systems.

Systems guided by Wraparound principles. Incorporate Wraparound principles into expectations for service provision, including contractual language to promote accountability.

Access to High Fidelity Wraparound. Ensure that within each region/county/tribe there is access to Wraparound planning as well as access to person-centered planning, family-focused and evidence based services and supports.

Crisis continuum. Build a statewide crisis continuum that includes brief out-of-home options for children and youth in crisis such as crisis residential, respite, therapeutic foster care, and emergency shelter options. Also explore a dedicated on-call team serving children, youth and their families across systems.

Workforce Development. Ensure cross-system competencies across relevant domains including trauma-informed, CLAS and family-driven care. Ensure cross-system statewide training in both High Fidelity Wraparound and Wraparound-informed care.

Do the strategies listed in the Strategic Plan support this key element?

Services and Supports	Yes	No	I don't have enough information to respond.

If you selected no, what revisions would you recommend for consideration?

Goal #4: Integration Across Systems

Identify and address barriers. Review policy and regulations to identify barriers to effective cross-system collaboration and coordination in care planning and provision of services.

Coordinated access, screening and assessment. Explore options to identify and agree upon a shared screening and assessment framework (e.g., CANS) in the context of interagency coordinated funding. Identify opportunities to promote coordination and eliminate duplication of services and processes across systems.

Do the strategies listed in the Strategic Plan support this key element?

Integration Across Systems	Yes	No	I don't have enough information to respond.

If you selected no, what revisions would you recommend for consideration?

Goal #6: Prevention and Early Intervention

Integration. Build an integrated prevention and early intervention system including physical and behavioral health, child welfare and education.

Training. Design, implement cross-system training in prevention and early intervention, emphasizing mental health promotion, resilience and trauma-informed practices.

Do the strategies listed in the Strategic Plan support this key element?

Prevention and Early Intervention	**Yes**	**No**	**I don't have enough information to respond.**

If you selected no, what revisions would you recommend for consideration?

Goal #7: Financing Strategies

Understand funding streams. Identify opportunities within each system (federal, state, tribal and private partner) to using Medicaid and other resources to increase flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development initiatives.

Understand expenditures and profiles of need. Implement a pilot project to understand and prioritize financial needs tracking high utilizers across systems.

Maximize flexibility through integration. Explore options for using cross-system braided funding approaches for flexible service funding.

Do the strategies listed in the Strategic Plan support this key element?

Financing Strategies	**Yes**	**No**	**I don't have enough information to respond.**

If you selected no, what revisions would you recommend for consideration?

Goal #8: Culturally and Linguistically Responsive Services and Systems

Formalize CLS / CLAS in policy. Develop policies, rules, procedures that support CLC, implement CLAS standards, and address disparities.

Workforce development. Implement statewide, cross-system training in CLC/CLAS and its relevance to disparities in outreach, access and outcomes among youth and families involved with the child-serving systems.

Culturally responsive care. Develop and build on standards and successful efforts to ensure that all plans developed with youth and families are individualized to their unique culture, beliefs and values.

Do the strategies listed in the Strategic Plan support this key element?

	Yes	No	I don't have enough information to respond.
Culturally & Linguistically Responsive Services & Systems			

If you selected no, what revisions would you recommend for consideration?

Goal #9: Data-Informed Decision Making / Continuous Quality Improvement

Shared, cross-system screening and assessment. System partners will identify and agree upon a shared screening and assessment framework. (e.g., CANS) to support understanding of appropriateness of LOC determinations and service utilization.

Expand use of measurement to support decision-making. Identify opportunities to incorporate measurement and evaluation in all child-serving systems, provider contracts and state/regional processes including procurement, training, and implementation of services and supports.

Build local capacity. Support the formation of local continuous quality improvement (CQI) teams /workgroups and support training and TA as necessary.

Do the strategies listed in the Strategic Plan support this key element?

	Yes	No	I don't have enough information to respond.
Data-Informed Decision Making & Continuous Quality Improvement			

If you selected no, what revisions would you recommend for consideration?

Draft Strategic Plan

Vision: *Nebraska children, young adults and families of all cultures are able to access an integrated system of care that supports them to reach their full potential holistically (health, home, purpose and community) while in school, living in a home and community that supports strong family connections and in their transition to adulthood.*

Mission: *Nebraska's child and family serving systems of care will improve access to appropriate and timely community-based care that is family-driven and youth-guided, embodies the cultural and linguistic values of the individuals and families being served and improves their clinical, behavioral, social, and educational outcomes and eliminates fragmented approaches to meeting need. Child and family-serving systems will achieve this change through transparent system collaboration with partnerships and shared ownership involving individuals and families as full partners.*

Values: *Youth guided; family driven; strength-based; individualized; culturally & linguistically competent; evidence-based; high quality; accessible; integrated; cost-effective; data informed.*

Goals

The Project Management Team (PMT) considered all of the input from the CST planning process and identified 9 goals that will organize our plan to enhance systems of care for children, youth and their families across Nebraska:

1. Develop, implement and sustain system of care infrastructure, inclusive of policy, regulatory and financing, at regional, tribal and state levels.
2. Build a sustainable statewide infrastructure for a youth network and family network representative of the population of Nebraska to empower all youth and family voice, outreach, education, advocacy and leadership opportunities.
3. Ensure a full service array of culturally based, research-based practices, featuring High Fidelity Wraparound principles/philosophy, is available to children and families across the state of Nebraska.
4. Integrate services for multi-system youth across all child-serving systems.
5. Build, or enhance, the community-based crisis continuum.
6. Build an integrated cross-system, collaborative prevention and early intervention system including physical and behavioral health, child welfare and education.
7. Develop policies that promote flexible funding through multiple strategies.
8. Promote and support Cultural and Linguistic Competence (CLC/CLAS) in all aspects of the system of care.
9. Implement a participatory continuous quality improvement (CQI) process in which all SOC plan goals and strategies are systematically monitored and changes are made as needed to improve outcomes.

Functional Outcomes and Indicators

- Children and Youth will live at home.
  - Decrease utilization of long-term out of home placements
  - Increase use of residential alternatives such as evidence based practices (e.g. HFW), short term crisis, respite, and related supports
  - Children and Youth will experience improved stability in living situation
- Children and Youth will have improved wellness and mental health
  - Children and Youth will report improved coping skills
  - Children and Youth will report improved social connectedness
  - Children and Youth will report increased ability to overcome behavioral health needs
- Children and Youth will function successfully in the community
  - Children and Youth will attend school and graduate
  - Young adults will succeed in employment
  - Children and Youth will engage in pro-social activities
  - Children and Youth will experience more positive relationships with family, friends and others
  - Children and Youth will have effective support networks
  - Children and Youth will experience decreased substance use

Framework

Nebraska has adopted the overarching framework of five core areas of focus identified by Beth Stroul and Robert Friedman (2011)[1] as a way to organize the system of care strategic plan. They are:

1. Implementing Policy, Administrative, and Regulatory Changes
2. Developing Services and Supports based on the SOC Approach
3. Creating Financing Mechanisms
4. Providing Training, Technical Assistance, and Coaching
5. Generating Support

Strategies

The following strategies have been developed by the state-level Project Management Team (PMT) and Core Strategy Teams. Nebraska is a diverse and complex state; these strategies reflect this diversity as many strategies and activities require state, regional, tribal and local level

[1] Stroul, B. A., & Friedman, R. M. (2011). Issue brief: Strategies for expanding the system of care approach. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

actions that need to be addressed. Like any strategic plan, these strategies are a work in progress and subject to continuous review and improvement.

Important Note

Throughout the plan, some strategies are repeated for more than one goal.

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN DRAFT 5.14.14					
GOALS	**Strategies Needed to Complete Goals**				
	(A) Implementing Policy, Administrative, and Regulatory Changes	(B) Developing Services and Supports Based on the SOC Approach	(C) Creating Financing Mechanisms	(D) Providing Training, TA, and Coaching	(E) Generating Support
	Strategies	**Strategies**	**Strategies**	**Strategies**	**Strategies**
GOAL # 1 **Develop, implement and sustain System of Care infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and state levels.**	1. A.1. System partners will develop a governance structure for locus of accountability and implementation at the state level. 1. A.2. A System of Care (SOC) Leadership Team, inclusive of youth, family, and system partners will be formed and tasked with pursuing dissemination and implementation of this strategic plan. 1. A.3. The SOC Leadership	1. B.1. The SOC Leadership Team will work with regional and tribal leadership teams to explore ways to integrate the multiple SOC strategies across systems.	1. C.1. The SOC Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives. 1. C.2. The SOC Leadership Team will explore and develop guidelines for expense reimbursement	1. D.1. The SOC Leadership Team will support the development of cross-system training for the workforce of all providers and systems (including behavioral health, child welfare, juvenile justice, courts and education) and will identify resources to support the training throughout the state. 1. D.2. The SOC Leadership Team will develop guidelines that support organizations with	1. E.1. The SOC Leadership Team will ensure that all key stakeholders are informed and knowledgeable about the NE SOC.

	Team will identify and review regulations and other barriers that prevent effective collaboration and/or development of a single services plan for youth and families across systems. 1. A.4. The SOC Leadership Team will support regional and tribal implementation of leadership teams including youth and family leaders, child-serving organizations along with system leaders, as the locus of accountability for SOC efforts. 1. A.5. The SOC Leadership Team will ensure that SOC-related practice are clearly stated and disseminated across the state and will assist regions in interpreting and implementing SOC in ways that build on each region's strengths.		and/or other supports needed to assure youth and family participation in SOC.	recruitment and retention of the workforce.	
GOAL # 2 **Build a sustainable statewide infrastructure for a youth network and family network**	2. A.1. The System of Care (SOC) Leadership Team will develop strategies to support youth and family members' involvement and voice as equal partners in state, regional and tribal	2. B.1. The SOC Leadership Team will identify strategies to fund, expand and sustain youth and family organizations in Nebraska	2. C.1. (Same as 1.C.1.) The SOC Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within	2. D.1. Working with family organizations, the SOC Leadership Team will expand training for youth and families to ensure that comprehensive, cross-system training is accessible	2. D.1. The SOC Leadership Team will work with Regions and existing family organizations to ensure that families, youth and other key stakeholders are informed about the value of

representative of the population of Nebraska to empower youth and family voice, outreach, education, advocacy and leadership opportunities.	planning regarding SOC and child and family serving systems.	2. B.2. The SOC Leadership Team will develop and support family organizations within each tribal nation and community in Nebraska. 2. B.3. The SOC Leadership Team will explore recommendations to strengthen and support a coalition of existing youth and family organizations and advocates across Nebraska.	funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives. 2. C.2. The SOC Leadership Team will work with Medicaid and other systems to pursue specific funding for youth and family peer support and related activities. *Systems will assist families and youth financially to be involved.	in all regions of the state to meet the needs of family and youth of all cultures. 2. D.2. The SOC Leadership Team will develop or identify a process for identifying and increasing state-level family and youth leader position(s) to serve as a liaison between state agencies and systems and the youth and family network(s). 2. D.3. The SOC Leadership Team will develop training/education and technical assistance that includes youth and families as participants and trainers alongside professionals. 2. D.4. The SOC Leadership Team will develop guidelines for state best practices for youth involvement, leadership and youth-driven services.	youth and family voice and leadership.
GOAL # 3 **Ensure a full service array of culturally based, research-based and promising practices,**	3. A.1. (Same as 1.A.3.) The System of Care (SOC) Leadership Team will identify and review regulations or other barriers that prevent effective collaboration and/or development of a	3. B.1. The SOC Leadership Team will explore school-based and school-linked services including screening, assessment and referral protocols and comprehensive whole school environmental	3. C.1. The SOC Leadership Team will explore policy and administrative options for using Medicaid, and other resources, to increase flexibility.	3. D.1. The SOC Leadership Team will develop statewide, cross-system competencies for training of workforce. 3. D.2. The SOC Leadership Team will ensure	3. E.1. The SOC Leadership Team will ensure the development and implementation of a statewide communications plan to inform key stakeholders about SOC, evidence-based services

featuring High Fidelity Wraparound principles/philosophy, is available to children and families across the state of Nebraska.	single services plan for youth and families across systems. 3. A.2. The SOC Leadership will ensure Wraparound Principles are incorporated into expectations for service provision, including contractual language to promote accountability.	interventions. 3. B.2. The SOC Leadership Team will work to ensure that within each region/county/tribe there is access to Wraparound planning as well as access to person-centered planning, family-focused and evidence based services and supports.		development of a cross-system curricula and training system including trauma-informed, Culturally and Linguistically Appropriate Services (CLAS) and family-driven training across systems. 3. D.3. The SOC Leadership Team will ensure development of cross-system competencies across relevant domains including trauma-informed, Culturally and Linguistically Appropriate Services (CLAS) and family-driven care. 3. D.4. The SOC Leadership Team will ensure cross-system statewide training in both High Fidelity Wraparound and Wraparound Principles.	and supports and Wraparound Principles.
GOAL # 4 **Integrate services for multi-system youth across all child-serving systems.**	4. A.1. The System of Care (SOC) Leadership Team will explore regulations, licensing and policy requirements that prevent the development of a single services plan for youth and families across systems in order to change those policies. 4. A.2. The SOC Leadership	4. B.1. The SOC Leadership Team will work with child-serving systems to explore options to identify and agree upon a shared screening and assessment framework in the context of interagency coordinated funding. 4. B.2. The SOC Leadership Team will identify	4. C.1. (Same as 1.C.1.) The SOC Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives.	4. D.1. The SOC Leadership Team will identify, and work towards coordination of training activities across child-serving systems and establish joint curricula and training that supports cross-system work.	4. E.1. The SOC Leadership Team will work to ensure a statewide communications plan that informs youth and families of available services and supports across all child-serving systems.

	Team will identify and develop strategies to address requirements regarding confidentiality issues that inhibit collaboration. 4. A.3. The SOC Leadership Team will work with regions and tribes to identify and establish mechanisms for regional and tribal SOCs to identify and monitor effectiveness for youth involved in multiple systems.	opportunities to promote coordination and eliminate duplication of services and processes across systems.	4. C.2. The SOC Leadership Team will implement a pilot project to understand and prioritize financial needs tracking high utilizers across systems.		
GOAL # 5 **Build, or enhance, the community-based crisis continuum.**	5. A.1. The System of Care (SOC) Leadership Team will explore regulations, licensing and policy requirements that are relevant to the development of an integrated cross-system crisis continuum.	5. B.1. The SOC Leadership Team will explore and identify requirements to build a statewide crisis continuum that includes brief out-of-home options for children and youth in crisis such as crisis residential, respite, therapeutic foster care, and emergency shelter options. Also explore a dedicated on-call team serving children, youth and their families across systems.	5. C.1. The SOC Leadership Team will identify options for using cross-system braided funding approaches to support a cross-system, community-based crisis continuum.	5. D.1. The SOC Leadership Team will ensure trauma-informed training across systems.	5. E.1. The SOC Leadership Team will ensure that a communications plan addresses crisis and understanding of issues related to the importance of quick, community-based response and stabilization.
GOAL # 6 **Build an integrated prevention and**	6. A.1. (Same as 1.C.1.) The System of Care (SOC) Leadership Team will identify opportunities with	6. B.1. The SOC Leadership Team will explore and identify requirements to build a statewide	6. C.1. The SOC Leadership Team will identify opportunities in each system for funding a	6. D.1. The SOC Leadership Team will ensure training in the area of prevention and early intervention takes	6. E.1. The SOC Leadership Team will ensure that the communications plan addresses the importance

early intervention system including physical and behavioral health, child welfare and education.	each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives.	prevention and early intervention system that emphasizes mental health promotion and resilience and is trauma-informed. 6. B.2. The SOC Leadership Team will explore and identify requirements to build a statewide prevention and early intervention system that emphasizes suicide prevention.	collaborative prevention and early intervention system.	place across systems.	of prevention and early intervention.
GOAL # 7 **Develop policies that promote flexible funding through multiple strategies.**	7. A.1. (Same as 1.C.1.) The System of Care (SOC) Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives.		7. C.1. The SOC Leadership Team will explore policy and administrative options for using Medicaid and other resources to increase flexibility. 7. C.2. The SOC Leadership Team will explore options for using cross-system braided funding approaches for flexible service funding. 7. C.3. The SOC Leadership Team will explore the feasibility of an integrated data system to facilitate situational analysis. 7. C.4. (Same as 4.C.2.) The SOC Leadership Team will implement a pilot project to understand and prioritize		

			financial needs tracking high utilizers across systems.		
GOAL # 8 **Promote and support Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS) in all aspects of the System of Care. .**	8. A.1. The System of care (SOC) Leadership Team will review and make recommendations regarding recruitment, hiring and retention practices to ensure a workforce that is culturally and linguistically representative of the communities being served. 8.A.2 The SOC Leadership Team will ensure that data regarding outreach, access, outcomes and disparities among culturally and linguistically diverse groups are used in making policy, administrative and regulatory decisions. 8. A.3. The SOC Leadership Team will develop policies, rules, procedures that support Cultural and Linguistic Competence (CLC) and implement Culturally and Linguistically Appropriate Services (CLAS) standards, and address disparities.	8. B.1. The SOC Leadership Team will review current practice and make recommendations regarding the use of culturally and linguistically relevant outreach materials, services and supports. 8. B.2. The SOC Leadership Team will develop/build on standards to ensure that all plans developed with youth and families are individualized to their unique culture, beliefs and values.	8. C.1. (Same as 1.C.1.) The SOC Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives.	8. D.1. The SOC Leadership Team will work to ensure the development and implementation of cross-system learning opportunities for key staff and stakeholders (including youth, family and system partners) to learn about **Cultural** and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS) and relevance to disparities in outreach, access and outcomes among youth and families involved with the child-serving systems. 8. D.2. The SOC Leadership Team will ensure development of a statewide, cross-system "competency worksheet", emphasizing Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS) for organizations to incorporate into training and evaluation practices.	8. E.1. The SOC Leadership Team will ensure communications are appropriate across regions/counties with diverse linguistic characteristics including their primary language, literacy skills and disability status. 8. E.2. The SOC Leadership Team will develop a Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS) component to social marketing and communication plan to emphasize understanding of the cultural issues related to service and include linguistic ability to communicate. 8. E.3. The SOC Leadership Team will ensure messaging campaigns consider the cultural communities' preferred language, medium, messenger and style.

GOAL # 9 **Implement a participatory Continuous Quality Improvement (CQI) process in which all System of Care (SOC) plan goals and strategies are systematically monitored and changes are made as needed to improve outcomes.**	9. A.1. The System of Care (SOC) Leadership Team will identify opportunities to incorporate measurement and evaluation in all child-serving systems, provider contracts and state/regional/tribal processes including procurement, training, and implementation of services and supports. 9. A.2. The SOC Leadership Team will engage regional, tribal and local entities to participate in the development and implementation of state and local monitoring and evaluation planning. 9. A.3. The SOC Leadership Team system partners will identify and agree upon a shared screening and assessment framework to support understanding of appropriateness of level of care determinations and service utilization.	9. B.1. The SOC Leadership Team will encourage the development and implementation of monitoring strategies for services and supports. 9. B.2. The SOC Leadership Team will explore the implementation of accountability standards for providers and state partners across systems.	9. C.1. The SOC Leadership Team will work to identify funding options for fiscally sustaining evaluation activities.	9. D.1. The SOC Leadership Team will develop and/or enhance the formation of local continuous quality improvement (CQI) teams /workgroups and support training and technical assistance as necessary.	9. E.1. The SOC Leadership Team will ensure that partners are knowledgeable about how data can be effectively used to guide decision-making. 9. E.2. The SOC Leadership Team will utilize data in social marketing efforts.