Nebraska Children's Commission
Foster Care Reimbursement Rate Committee
January 7, 2019
1:00 p.m. – 3:00 p.m.
Southeast Community College, Rooms V-103 & 104
8800 O Street, Lincoln, NE 68520

1. Call to Order

The Foster Care Reimbursement Rate Committee (FCRRC) Co-Chairs, Peg Harriott and Bill Williams, called the meeting to order at 1:08 p.m.

2. Roll Call

Committee Members present (10):

Jodie Austin	Bobby Loud (1:25)	Lana Temple-Plotz
Robin Chadwell	Felicia Nelsen	Bill Williams
Peg Harriott	Cindy Rudolph	
Dr. Anne Hobbs	Juliet Summers*	

Committee Members absent (5):

Phillip Burrell	Jessica Kroeker	Joan Schwan
Susan Henrie	Jackie Meyer	

Ex Officio Members present (5):

Olivia Biggs	Mike Puls	Kathleen Stolz
Rochelle Dotson	Kari Rumbaugh	

Ex Officio Members absent (2):

Jerrilyn Crankshaw	Jennifer Potterf

A quorum was established.

*Let it be noted for the record that Juliet Summers was appointed by Julia Tse as her temporary proxy

Guests in Attendance (4):

Amanda Felton	Nebraska Children's Commission
Chris Jones	Nebraska Children's Commission
Cristen White	PromiseShip
Lisa Story	Foster Parent/Nebraska Children's Commission

a. *Notice of Publication*
Recorder for the meeting, Amanda Felton, indicated that the notice of publication for this meeting was posted on the Nebraska Public Meetings Calendar and Nebraska Children's Commission website in accordance with the Nebraska Open Meetings Act. The publication would be kept as a permanent attachment with the meeting minutes.

b. *Announcement of the placement of Open Meetings Act information*
A copy of the Open Meetings Act was available for public inspection and was located at the sign-in table at the entrance of the meeting room.

3. Approval of Agenda

A motion was made by Jodie Austin to approve the agenda as presented. The motion was seconded by Anne Hobbs. No further discussion ensued. Roll Call vote as follows:

FOR (9):

Jodie Austin	Dr. Anne Hobbs	Juliet Summers*
Robin Chadwell	Felicia Nelsen	Lana Temple-Plotz
Peg Harriott	Cindy Rudolph	Bill Williams

AGAINST (0):

ABSTAINED (0):

ABSENT (6):

Phillip Burrell	Jessica Kroeker	Jackie Meyer
Susan Henrie	Bobby Loud	Joan Schwan

MOTION CARRIED

4. Approval of the Previous Meeting Minutes

Cindy Rudolph moved to approve the November 5, 2018 FCRRC meeting minutes as presented. Felicia Nelsen seconded the motion. There was no discussion. Roll Call vote as follows:

FOR (9):

Jodie Austin	Dr. Anne Hobbs	Juliet Summers*
Robin Chadwell	Felicia Nelsen	Lana Temple-Plotz
Peg Harriott	Cindy Rudolph	Bill Williams

AGAINST (0):

ABSTAINED (0):

ABSENT (6):

Phillip Burrell	Jessica Kroeker	Jackie Meyer
Susan Henrie	Bobby Loud	Joan Schwan

MOTION CARRIED

5. Co-Chair Report

Co-Chair Harriott noted that the group would be monitoring any proposed legislation regarding the future of the Commission, as it would affect the structure of and resources available to the Committee. Lana Temple-Plotz inquired as to how the Committee and/or members could assist in supporting the Commission through testimony or other means. Policy Analyst, Chris Jones, let members know that the Children's Commission would be meeting on the 23rd to work discuss the bill currently being drafted by Senator Bolz. Information would be shared to the subgroups once it became available.

6. Public Comment

The Co-Chairs invited any members of the public forward for comment. No public comment was given.

7. Department of Health and Human Services Update

Olivia Biggs, Program Specialist with the Division of Children and Family Services (DCFS), was invited forward to provide an update on the status of the current Adoption Subsidy Pilot occurring in the eastern service area. She shared that there had been 34 completed subsidy negotiations under the pilot. Biggs explained that while there was one subsidy negotiation with an outstanding barrier, the delay in adoption finalization was not due to the pilot. Complications had arose due to the child having high medical needs which required a subsidy higher than the rates provided under the current Nebraska Caregiver Responsibility (NCR) tool rates.

8. Nebraska Adoptive Parent Responsibility Tool

Biggs continued on to discuss the Nebraska Adoptive Parent Responsibility (NAPR) Tool. A small focus group comprised of DCFS staff and members of the Committee's Level of Care Workgroup partnered to review the draft NAPR tool. The goal was to create a document to ensure consistent negotiation parameters when establishing adoption subsidies. Lana Temple-Plotz highlighted the main alterations to the tool from the original Nebraska Caregiver Responsibility (NCR) tool. Changes included language changes throughout to replace foster care references with adoptive, references to rate methodology documents, alteration of the LOR 7 category to Family Stability, and suggested changes in the weighted scores. Temple-Plotz noted that additional review was to be completed in partnership with the Family Focused Treatment Association (FFTA).

Biggs noted that several potential adoptive parents within the pilot area had been given the draft tool for review, but had not yet completed the form with staff. Potential adoptive parents of "at risk" youth were also being provided a copy of the tool to familiarize them with the process should their youth receive a diagnosis post adoption. Further clarification was provided of the "at risk" category, explaining that it would be for a child who may be at risk of, but currently had no behavioral, emotional, physical or mental disability diagnosis. "At risk" youth would receive the base rate, while youth with a diagnosis would complete a NAPR tool to determine their stipend rate.

Additional work would be done over the next month to finalize the tool for approval at the March FCRRC meeting. Temple-Plotz reiterated the complications that occurred in stipend negotiations for youth who fall above the NCR standard due high medical needs. When this population of youth moved towards adoptive permanency, their homes saw a significant decrease in payment due to the fact that adoption subsidies were required to be less than the current NCR rates. Any questions or feedback prior to the next meeting could be provided to either Olivia Biggs or Lana Temple-Plotz.

9. Treatment Family Care Workgroup Update

The floor was given to Jodie Austin, Chair of the Treatment Family Care (TFC) Workgroup, to provide an update on their work. Austin directed members to the proposed service definition for TFC. Highlights discussed included the language aimed to ensure youth with Developmental and Intellectual Disorders would not be excluded from the service, alteration from a TFC parent to a TFC team member available to provide rehabilitative intervention at all times, language to encourage a co-parenting approach, and alteration of discharge language.

After lengthy discussion several minor amendments were proposed. **It was moved by Lana Temple-Plotz to approve the TFC Service Definition with the alterations noted in Attachment A. The motion was seconded by Bobby Loud. There was no further discussion.** Roll call vote as follows:

FOR (9):

Jodie Austin	Bobby Loud	Juliet Summers*
Robin Chadwell	Felicia Nelsen	Lana Temple-Plotz
Dr. Anne Hobbs	Cindy Rudolph	Bill Williams

AGAINST (0):

ABSTAINED (0):

ABSENT (6):

Phillip Burrell	Susan Henrie	Jackie Meyer
Peg Harriott	Jessica Kroeker	Joan Schwan

MOTION CARRIED

10. Planning for 2020 FCRRC Report

Co-Chair Harriett and Lana Temple-Plotz provided a historical overview of the FCRRC. Members were given a compendium of information to reference as work toward the 2020 report progressed. Members discussed the need to break down the work into smaller issues addressed in a workgroup setting. There was agreement in the need for several previously formed workgroups such as base rate, foster parent survey, and the level of responsibility workgroups. Given the recent mention of agency rates within the 2018 audit of program 354, it was also suggested to have a workgroup aimed specifically at the administrative and support payments for child placing agencies.

Based on the earlier discussion of youth with needs that fall outside of the current NCR tool, the Level or Responsibility (LOR) workgroup was charged with examining the potential of creating a fourth level of responsibility. Examples of youth served at this level included those who were medically fragile or who were eligible for developmental disability aid but were not receiving services or funding due to waitlists.

11. Review of Assignments/Action Plan

The Committee Co-Chairs reviewed the decisions and items to address when moving forward. Below is a list of the final assignments/action plans.

- Formation/continuation of four workgroups in preparation of the 2020 report
    - Base Rate and Foster Parent Survey Workgroup
        - This group would examine the USDA rates and determine if a change is necessary for the previous base rate recommendation. They will also work to replicate the survey completed in 2016 to get input from foster parents on the NCR tool.
    - Agency Administration and Support Rate Workgroup
        - This group would research and recommend rates for child placing agencies.
    - Level of Responsibility Workgroup
        - This group would create recommendations for a fourth level of care within the NCR tool.
    - LOR/TFC Rates Workgroup
        - This workgroup would create rate structure recommendations for the proposed fourth level of responsibility within the NCR tool and for the proposed TFC service definition.
- Correspondence would be sent out to members asking for them to designate the workgroups they wish to participate in.
- Workgroups would aim to meet monthly, with joint meetings occurring with the full FCRRC every other month.

12. New Business

There was no new business.

13. Upcoming Meeting Planning

The Co-Chairs reminded members of the future Committee meeting dates which were:

- March 3, 2019
- May 6, 2019
- July 1, 2019
- September, 2019 (Date TBD)
- November 4, 2019

14. Adjourn

The meeting was adjourned at 3:07 p.m.

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Treatment Family Care Workgroup Recommended Changes to DHHS Therapeutic Foster Care Service Definition

Service Name	Treatment Family Care (TFC)
Setting	Treatment Family Care home
Facility License	The community based agency that operates the TFC program as required by Department of Public Health; and the individual treatment family care homes as licensed by ~~Children and Family Services~~ the Department Health and Human Services.
Basic Definition	TFC is an all-inclusive rehabilitative model of care that provides intensive care for youth provided by trained and supported treatment parents. TFC must be a community based behavioral health program under the clinical direction of a psychiatrist, psychologist, or LIMHP. TFC is a Medicaid eligible, highly supportive, and individualized approach serving ~~Medicaid eligible~~ youth ages 20 and younger who have a history of trauma in addition to complex mental health or substance use disorder that are causing functional impairment. ~~TFC is available to c~~Children and youth with co-occurring developmental or intellectual disabilities, or who are medically fragile are included. The youth have a history of psychiatric residential or inpatient treatment, or have been unsuccessful in remaining at home with outpatient services, and are clinically identified as requiring out of home treatment at the TFC level. This level of care will address the symptoms that affect the daily functioning of the youth and prevent further regression. This service requires intensive involvement and frequent contact between members of the treatment team. It is intended to provide a high degree of structure and supervision.
Service Expectations	• An Initial Diagnostic Interview (IDI) will be completed prior to the beginning of treatment and will identify TFC as the level of care needed. This IDI will serve as the initial treatment plan for the youth until a comprehensive treatment plan is developed. • The discharge plan is to be defined at intake and is reviewed and updated at each 30 day treatment team meeting, or sooner, as clinically indicated. • Utilization of a team approach to decision making is used in this program. • The treatment team will develop the comprehensive treatment plan within 30 days of admission. • Treatment shall address the mental health/substance use and bio psychosocial issues that have contributed to the youth's need. • The treatment plan will identify goals, objectives, and interventions necessary to improve or prevent regression in the mental health status of the youth. • Ongoing treatment meetings will be held at a minimum of every 30 days until treatment services are no longer necessary or the youth is no longer demonstrating benefit from this level of treatment. • In cases where parental rights are intact and the permanency plan is reunification, the reunifying family is the parent. In cases where reunification is not the permanency plan, the reunifying family is identified as the home with which the youth will

Treatment Family Care Workgroup Recommended Changes to DHHS Therapeutic Foster Care Service Definition

	experience permanency. When the youth enters TFC without an identified reunifying home upon discharge, one of the goals of the plan must be to develop that resource while TFC is being provided. • The treatment team will consist of the youth, TFC parents, licensed clinician, agency staff, reunifying family, and other support networks deemed appropriate to the treatment review and planning process. • Clinical expectations include: 1) oversight of the treatment plan, 2) collaboration with formal and informal networks, 3) provision of treatment and rehabilitative interventions, 4) ongoing assessment of the youth to determine progress in the treatment, 5) regular review, and updating, if necessary, of the diagnosis and treatment interventions. • A licensed clinician provides treatment services in the youth's home, the TFC home and/or in the community. Clinical services are provided for the youth, the reunifying family, and the TFC parents as deemed appropriate in the treatment plan. The frequency of this service is to be no less than weekly for each or as otherwise defined by the treatment plan and endorsed by the clinical supervisor. Frequency of services can be titrated as needed during the termination phase of treatment. • The licensed clinician will also serve as the liaison for communication and a treatment consultant for all treatment team members. • The licensed clinician will provide the reunifying family and the t TFC parent(s) assistance in understanding clinical issues that impact the youth. • A TFC member will be available to provide rehabilitative intervention for the youth. • The clinical director or the licensed clinician will be available to provide crisis intervention to support all members of the treatment team at all times. • The reunifying family is involved, as clinically appropriate, and is active in service decisions for the youth. • The service is all inclusive and will be reimbursed at a daily rate for treatment services in the TFC home. • The following criteria must be met for a client's admission to a TFC program: o The need for TFC must be identified on an Initial Diagnostic Interview based on the following criteria: The client must have sufficient need for active treatment at the time of intake to justify the expenditure of the client/family's and program's time, energy, and resources; Of all reasonable options for active treatment available to the client, active treatment in this program must prevent placement in a more restrictive setting and be reasonably expected to improve the client's condition; o The proposed or revised treatment plan must be the most efficient and appropriate use of the program to meet the client/family's particular needs; o The plan must address active and ongoing involvement of the family in care provision; and o The program is designed to meet the needs of clients age 20 and younger. • The community based behavioral health program that operates the TFC program, and trains and supports the TFC family, provides a 20 hour initial training on mental health and substance use disorders, including the effects of trauma on youth, suicide prevention, emotional and behavioral interventions, in addition to training topics required by the agency.

	• It is the responsibility of the TFC parent(s) to attain 12 additional training hours per year to be determined and approved by the agency which the program is operated out of. • In addition to the biological, adoptive or guardianship children, the TFC parent(s) will have no more than two ~~TFC~~ youth receiving TFC treatment residing in their home at a time (special consideration is given to sibling groups). • The TFC program shall have a director and an adequate number of non-licensed staff to provide administration, training, and any additional support of the TFC program. • Length of service is individualized according to the needs of the youth. • When TFC treatment is complete, the youth will be discharged from ~~the~~ TFC ~~home~~ treatment.
Staffing	• Licensed Program Clinical Director (psychiatrist, psychologist or LIMHP) • Licensed and/or provisionally licensed clinician • Child placing agency staff ~~and the~~ • TFC parents
Hours of Operation	• 24/7 with the availability of clinical assistance.
Desired Individual Outcome	• The youth has met the treatment plan goals and objectives. • The condition that brought the child to this treatment level is stabilized, and the child is able to successfully maintain at home and in the community in the absence of the supportive services and interventions provided in the TFC home. • The youth has support systems secured to help maintain safety and stability at home and in the community.
Admission guidelines	All of the following guidelines are required to be met: • The youth has a current edition DSM diagnoses for a disorder that is causing functional impairment requiring TFC level of intervention. • The youth has been unsuccessful in a lower intensity of services and/or is clinically identified as requiring TFC care treatment to prevent regression and improve symptoms and functioning. • The youth has a history of psychiatric residential or inpatient treatment or is at risk of requiring a higher level of care in the absence of this program. And one or more of the following: • The youth is experiencing or is at risk for self-harming, aggressive, or destructive behaviors • The youth has a significant history of trauma Excluding factors include the following: truancy and law violations in the absence of other symptoms.
Continued stay guidelines	• The youth is making progress toward the goals but has not made sufficient progress to consider discharge; and/or • There is sufficient clinical information to show that TFC level of care continues to be the least restrictive level of care that can meet the individual needs of the youth.

Discharge Criteria	• The youth no longer meets admission criteria or meets criteria for a more or less intense level of service; • And one of the following: o Youth has not benefited from the TFC program and there is not a reasonable expectation of further progress at this level of care. o The youth has met the goals of TFC and can be safely discharged from treatment.