THE STEPHEN GROUP

SDM Design and Technical Assistance Project

Final Report

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I. Summary Findings and Key Recommendations

Findings

Nebraska has significantly decreased its child removal rate over the last eight years, despite the increase in new cases in the number of children served. The state has done this by increasing the number and percentage of children served in-home. This is entirely in alignment with the goal of keeping families together by delivering the appropriate services in a timely fashion.

The Strategic Decision Making (SDM) tools that Nebraska implemented in 2012 have been critical to this effort – allowing the Division of Children and Family Services (DCFS) to identify when the Department case workers need to intervene and when it is no longer necessary due to the achievement of safety and the mitigation of risk. The tools provide a means to assess and document safety and the level of risk in a household throughout DCFS' interventions and assist in the decision to close a case (i.e., closure of an in-home case, reunification) in a consistent and uniform manner.

Nebraska has implemented best-practice national SDM tools and fidelity to these tools remains high. Staff are well-trained on use of SDM tools. There are, however, opportunities to improve timeliness of tool completion and increase use of mobile technology in completing critical assessments.

Nebraska's Hotline effectively screens out the nearly two-thirds of intakes that do not meet state criteria, but opportunities exist to refer more individuals to Alternative Response and community resources, to ensure timely and appropriate service to allow families to stay intact. Consequently, the number of unsubstantiated calls from the Hotline to caseworkers is lower than the national average.

DCFS identified improvements to the Intake Assessment and Safety Assessment to sharpen the identification of safety factors, which will improve the quality of casework. Hotline staff are well-trained on the intake assessment SDM tool.

While Hotline staff are well-trained in SDM tools, DCFS supervisors have not been trained on how to supervise staff using these tools and may not have internalized the same importance of timeliness and fidelity to the tools. This represents a gap in ensuring consistency across staff engagement with families.

DCFS' decision to implement the Safety Organized Practice (SOP) model aligns well with and reinforces SDM. The case practice structure benefits to build a best-practice structure to improve outcomes and will help to ensure compliance with the newly implemented federal Family First Prevention Services Act (FFPSA) of 2018.

While the assessment finds no significant misuse of the Family Strengths and Needs Assessment (FSNA) tool, there is no process to analyze how FSNA works to inform the case plan and services and if the result was a good case outcome. The represents a missed opportunity for DCFS to utilize a continuous improvement function to drive performance and quality.

There are situations where workers take case actions counter to the SDM tools. While this is not unique to Nebraska, it can result in poorer outcomes for children and families, undermine the important goal of consistency statewide for all cases, and expose DCFS to risk.

Additionally, gaps in stakeholder knowledge about the safety and risk paradigm used by DCFS and the SDM tools more generally result in challenges for DCFS and potential disagreements about case decision-making. This can foster an erosion of the agency's credibility and drive calls for change that can destabilize performance enhancements, which can set back important steps for quality improvement.

In related findings, TSG notes that there are many opportunities to improve collaboration between DCFS and the Division of Medicaid and Long-Term Services, as well as Medicaid managed care organizations, to meet the behavioral health needs of children in Nebraska's care. In addition, suicide assessment and prevention remain a significant priority for Nebraska, as case workers are trained on the use of a suicide assessment tool. Finally, the Comprehensive Addiction and Recovery Act (CARA) has the potential to affect Nebraska's Hotline operation and caseworker caseload, but it remains too early to assess the impact.

Key Recommendations

Nebraska's DCFS Hotline has made significant strides since the implementation of SDM. However, there are a number of opportunities for improvement which can move the state into a lead position nationally for child protection intake services.

In order to ensure that Nebraska continues to enhance its SDM system using best practices, DCFS should engage the National Council on Crime and Delinquency/Children's Research Center (NCCD) to:

1. Re-evaluate implementation of the SDM system;
2. Conduct a recalibration exercise; retain the existing tools and consider adding additional available tools; and,
3. Modify existing tools to address concerns identified by staff.

These steps will ensure that the state is up-to-date and allow the sharing of critical knowledge that can assist in the improvement of other state systems as well.

While SDM has delivered improvements to date, DCFS should continuously focus on implementing it in the most effective manner possible, to ensure that it is delivering best practices. However, that process should work in a manner that does not overwhelm staff. DCFS should select an SDM project management team that can manage the SDM model revisions that will assume internal coordination and efficient use of time.

DCFS may want to adopt updated case and service plans, and also an improved template for court room testimony and DCFS should work to review and implement these through SOP or NCCD. This is an area that will improve integration of the tools with key planning and reporting documents used in case decision making and can also reduce caseworker burden by improving the translation of tool findings to these documents.

One immediate recommendation is that DCFS should review the timeliness of SDM tool completion, especially the Safety and Risk Assessments, and ensure supervisors are looking at aware of this issue and develop accountability mechanisms for staff to remain faithful to the model for implementation, which will deliver more consistent results. DCFS should implement monitoring protocols and use appropriate performance dashboards to ensure review of situations where case action is taken counter to the SDM tools and corrective action is quickly utilized to realign action in accordance with the practice model.

In order to emphasize the well-being of families, DCFS should improve the linkage between DCFS and available resources for families such as Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families (TANF), Women, Infants, and Children (WIC), Medicaid, and other community supports. Awareness of these resources and a connection to these programs will be beneficial not only to Hotline staff, but also investigation and ongoing caseworkers who continually assess family needs and may want to include these other resources in the care plan development. This should be done also in concert with an outreach and education campaign for the reporting community, so that they are aware of the difference between poverty and abuse/neglect, and that it may be more appropriate to refer families to these community resources instead of calling the hotline to make an allegation of abuse/neglect.

Training is a critical component to implementation of SDM. There are a number of areas where training would benefit Hotline and front line staff to better support families and to reduce unsubstantiated claims. These training opportunities include:

- Utilizing training for Motivational Interviewing and Alternative Response, which will produce more robust engagement with reporters and families and will work to identify resources for those families whose needs do not fully align with child protective services;
- Expanding training on SAMHSA tools and resources for suicide prevention; and
- Building understanding of resources available for substance abuse through CARA and about including data in the case file to support future decision making,

In addition, DFCS should continue to train Hotline staff and caseworkers about CARA resources, create a routine report of CARA-related intakes for management review with data-rich analysis of CARA-related trends so management can stay appraised of the situation and act swiftly if state response is needed, and develop a CARA decision making and process map, based on Nebraska's CARA Implementation Plan, to be shared with birthing hospitals, stakeholders, and Hotline staff.

In addition to programmatic and training enhancements, DCFS should look to improve IT capabilities to support Hotline staff and give them more decision support tools, as well as to allow them to provide more data to caseworkers for referrals.

These enhancements should include an improved data sharing agreement with the Department of Medicaid, including a field in N-FOCUS, to allow Hotline staff to know immediately whether a child receives Medicaid services and what Health Plan that child is enrolled, or if a child is enrolled in CHIP.

DCFS should also work with NCCD and add additional fields to SDM Assessment tools that will help to identify other safety factors that will support caseworks if the case is referred. Other states, for example, have added questions to SDM tools relating to substance abuse and domestic violence. The SDM tools "other" category is broad and not descriptive enough to identify issues related to substance abuse and domestic violence and NCCD has already assisted other states in revamping their tools to address this same issue and Nebraska should take advantage of these changes in revamping its tools.

Finally, DCFS should prioritize a robust stakeholder engagement plan about the SDM tools generally, and modifications anticipated, specifically. This will help them understand how SDM works to deliver

consistent, quality services, while also giving groups the chance to offer meaningful feedback about improvements.

II. Background

The Nebraska Department of Health and Human Services (DHHS), Division of Child and Family Services (DCFS) has a mission to provide the least disruptive services when needed, for only as long as needed, to give children the opportunity to succeed as adults, help the elderly and disabled live with dignity and respect, and help families care for themselves. DCFS has prioritized the outcomes of improved child safety, well-being, and family functioning.

In 2012, DCFS contracted with the National Council on Crime and Delinquency Children Research Center (NCCD/CRC) to customize and implement the Structured Decision Making® (SDM) assessment system for all phases of its Child Protective Services (CPS) program to improve the quality and consistency of decision-making and better achieve agency goals and outcomes. SDM is an Evidence-Based Practice at all stages of child/family casework and is used in over 25 states and several countries.

Since the implementation of SDM in 2012, DCFS staff have consistently identified issues regarding the SDM process and tools. More recently, issues have included but are not limited to questions and/or policy interpretations with the SDM Intake Screening tool (also known as the "Hotline"), the Initial Safety Assessment, the utility of the Family Strengths and Needs Assessment (FSNA), and the Reunification Assessment. These issues require NCCD/CRC attention, change, and/or policy clarification.

DCFS contracted with The Stephen Group (TSG) to perform a targeted assessment of the SDM-related concerns, impact, and field experience with the SDM instruments. In addition, DCFS requested that TSG examine related topics including the needs of a child/youth removed from their homes that are in need of behavioral health or substance use disorder services and access to these services through linkages with the Division of Developmental Disabilities, Division of Medicaid and MCOs serving child welfare-eligible children and youth in Nebraska through Nebraska's Heritage Health Medicaid managed care plans. Finally, TSG was asked to review whether the SDM tools were sufficient to assess the risk of suicide, as well any suggested improvements to the process used by the Hotline related to reports received pursuant to the Comprehensive Addiction and Recovery Act (CARA).

TSG's research was informed by the DCFS scope of work and DCFS leadership priorities, and included the following:

- Focus groups with management staff
- Focus groups with investigative caseworkers and supervisors
- Interviews with DHHS partner divisions
- Data analysis
- Literature review of relevant past reports and other documents
- Interviews with NCCD/CRC

This report assesses the areas of concern prioritized by DCFS and recommends strategies for improvement related to the SDM tools and process, and related issues. The information and recommendations made in

this report focus on assisting DCFS in achieving the systemic improvement in child safety, well-being, and family functioning they have prioritized.

III. Structured Decision Making in Nebraska Child Welfare

The Nebraska Division of Family and Child Services effectively implemented the best practice Structured Decision Making System® in 2012. The SDM System is a product of the National Council on Crime and Delinquency Children's Research Center (NCCD/CRC). All of the tools are research-based, and the Risk Assessment tools are actuarially sound (using their robust national database to create models that predict risk). The suite of instruments that DCFS implemented and continues to use are reflected in Figure 1.

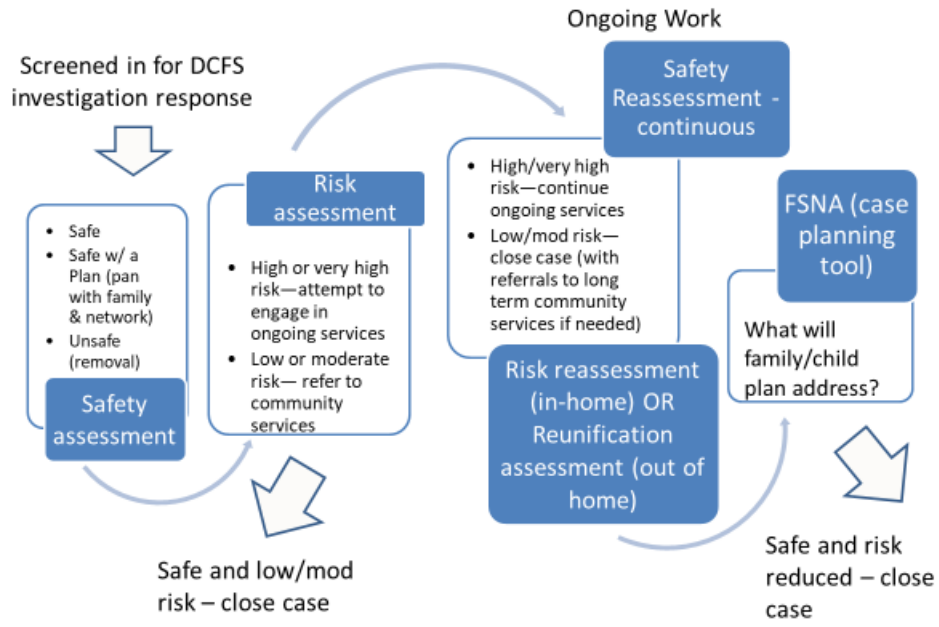
Figure 1. SDM Tools used in Nebraska Division of Children and Family Services, 2018.

Stage in Life of a Case	Tool	Requirement
Intake	Intake Screening (Hotline)	Performed by intake staff.
Initial Assessment	Safety Assessment	At first face-to-face contact with family, when a new allegation of abuse or neglect is received, when new information becomes available, or prior to recommending case closure.
	Assessment of Placement and Stability	When there is an investigation of alleged abuse/neglect, there are concerns regarding behaviors among children in a placement, and there are significant changes in a placement.
	Risk Assessment for Abuse/Neglect Cases	Upon conclusion of initial assessment and prior to decision to recommend ongoing services or to close the case (within 30 days).
	Prevention Assessment	Within 30 days of assignment to Lead Contractor or to ongoing services, prior to first case plan.
Ongoing Services Assessment	Prevention Assessment	For in-home cases: Within 30 days of assignment to Lead Contractor or to ongoing services, prior to first case plan. For out-of-home cases: Prior to completing initial assessment and making decision to transfer to ongoing services or close case.
	Safety Assessment	Whenever new information becomes available and prior to recommending case closure.
	Family Strengths and Needs Assessment (FSNA)	Prior to initial case plan (within 3- days of assignment to Lead Contractor or to ongoing services); every 3 months.
	Risk Re-Assessment	Every 3 months or 3 months following family reunification.
	Reunification Assessment	Every 3 months from initial case plan.
	Assessment of Placement Safety and Suitability	When there is an investigation of alleged abuse/neglect, there are concerns regarding behaviors among children in a placement, and there are significant changes in a placement impacting child safety.

Sources: NCCD/CRC, SDM procedures manuals for Nebraska.

The tools are designed to work together to assist a child welfare caseworker in making consistent evaluations of the family's safety and risk, which inform case decision-making (i.e., decisions to provide ongoing services, remove a child from the home, reunify a family, close a case) and service planning. Figure 2 shows the interaction of the core tools used to assess a family's safety and risk over the life of a case.

Figure 2. SDM System and Case Flow.



Source: NCCD/CRC, permission provided.

IV. Identified Staff Concerns about SDM

Since their implementation, DCFS leadership, administrators, managers, and caseworkers have identified questions and issues related to the SDM tools. Some of the more recent issues identified include:

- Intake Assessment/Safety Assessment: That the tools do not allow staff to identify substance abuse and domestic violence-related factors, which are increasing in the population served by DCFS.
- Family Strengths and Needs Assessment: That the tool is redundant and can be replaced by another instrument.
- The lack of alignment among Nebraska's court report and case plan templates, and the SDM tools.

DCFS leadership also identified concerns related to the implementation, impact, and outcomes of the SDM tools, including but not limited to the following:

- General:
  - Lack of focus on child well-being.
  - Challenges with stakeholder understanding of SDM tools and the impact on case outcomes.
- Intake:
  - There are perceptions that the tool is "screening-in" too many cases and that certain cases that are closed quickly upon investigation, both of which result in use of resources which

could be targeted toward working with families where there are confirmed allegations of abuse and neglect.
    - Some portion of Hotline reports do not meet acceptance criteria, which could be prevented.
- Intake-related issues:
    - Comprehensive Addiction and Recovery Act (CARA): potential impact on the number of Hotline cases reported, substantiated, unsubstantiated, and impact on caseworker workload.
- Family Strengths and Needs Assessment (FSNA):
    - Appropriate use/misuse of the tool.
    - No one is analyzing how the FSNA informs the case plan and service use, and whether that results in good case outcomes.
- Instances in which case decisions do not align with recommendations of the tools:
    - In-Home Cases: Inappropriate case closing for high/very high risk cases where parents refuse services and leaving low-risk cases open.
    - Misuse/ignoring Reunification Assessment when tool says to close, but staff override
- Training:
    - Lack of supervisor training on SDM tools.
    - There is an opportunity to improve intake and caseworker staff skills to engage callers/parents/caregivers.
    - There is an opportunity to improve caseworker ease of use of data and access to data on the SDM tools.

While these are not exhaustive lists of the issues identified by staff related to the SDM tools and implementation, they demonstrate that staff are already very aware of some of the issues and challenges surrounding these tools and are evidence of the solution-focused culture at DHHS, which has already resulted in implementation of strategies to address some of these issues.

V. Scope and Approach

As a result of management and frontline staff feedback, DCFS is considering engaging NCCD to review the functioning of its SDM System and make modifications to its existing tools. Prior to doing so, DCFS contracted with The Stephen Group (TSG) to perform a targeted assessment of the SDM tools and processes, within a time period of 30 days. This assessment will be used to inform discussions with NCCD/CRC.

In addition, DCFS requested that TSG consider related topics including how well children/youth removed from their homes that are in need of behavioral health or substance use disorder services are able to access these services through Nebraska's Heritage Health Medicaid managed care plans, the impact of the federal CARA legislation on the DCFS Hotline and caseload, and intake procedures related to suicide.

TSG performed this targeted assessment based on the scope of work, and using the following methods:

- Meetings with DCFS leadership to obtain project scope and identify leadership concerns with regard to the SDM tools and process.
- Focus group meetings with management staff, caseworkers, and supervisors across multiple DHHS service areas.

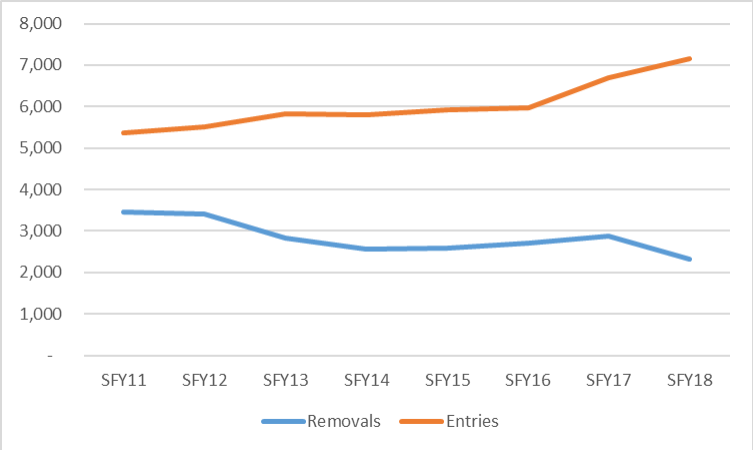
- Interviews with DHHS divisions including Division of Developmental Disabilities, Division of Behavioral Health, and Division of Medicaid and Long-term Care.
- Literature review of relevant reports and federal data.
- Interviews with NCCD/CRC.
- Data requests related to SDM, quality, and specific outcomes (see requested information in Appendix A).

VI. What We Found

Nebraska has significantly decreased its child removal rate over the last eight years, as shown in Figure 3 (a decrease of 32.7%), despite the increase in the number of children served in new cases. Nebraska has done so by increasing the share of children served in-home.

The SDM tools were implemented in 2012 and have been critical to this effort – allowing DCFS to identify when state's intervention is needed and when it is no longer necessary due to the achievement of safety and the mitigation of risk. The tools provide a means to regularly assess and document safety and the level of risk in a household throughout DCFS' interventions and assist in the decision to close a case (i.e., closure of an in-home case, reunification).

Figure 3. Number of New Intakes and Removals, SFY2011 – 2018.



Source: DCFS, October 2018.

1. Nebraska has implemented the full suite of SDM tools, which is a best practice.

Nebraska invested in the SDM tools across the entirety of its child welfare program. According to NCCD, the implementation of this suite of tools in Nebraska was based on the standard tool content and format, scoring models, policy and procedures manual, and statistical validation used in other states and customized for Nebraska.

These tools are designed by NCCD to complement one another and to be used in tandem. TSG finds that the value of a quality and high fidelity SDM system is to directly inform case practice throughout the life

of a case. Consistent integration of the SDM tools in practice leads to consistent casework, documentation, and decision-making, which is foundational to the achievement of positive outcomes for children/youth and families involved with the state's child welfare system.

Further, TSG finds that the agency's decision to implement the Safety Organized Practice (SOP) model is a very positive case practice innovation that will reinforce the SDM system. According to the Academy for Professional Excellence at the San Diego State University School of Social Work, this model is based on the safety of the child in the family setting, and integrates several evidence-based and best practice approaches including:

- Structured Decision Making
- Solution-focused practice
- Signs of Safety
- Child and family engagement
- Risk and safety assessment research
- Trauma-informed practice
- Group Supervision and Interactional Supervision
- Appreciative Inquiry
- Motivational Interviewing
- Consultation and Information Sharing Framework
- Cultural Humility

The timing of DCFS' implementation of the SOP model in conjunction with DCFS' intention to adjust SDM assessment tools is fortuitous in light of the pending implementation of the Family First Prevention Services Act (FFPSA) of 2018.

The case practice integration of the SDM system within the SOP model should enhance Nebraska's ability to take full advantage of the opportunity for states to use Title IV-E funds for families at risk of entry into the foster care system, the provision of up to 12 months of mental health, substance abuse treatment, and in-home parenting training including parents, kinship, and caregivers based on trauma-informed plans of care (Section 50711) as well as the new limitation on the use of Title IV-E funds for only two weeks of group home placements unless the child is placed in a qualified residential treatment program (QRTP) that provides trauma informed treatment and specialized prenatal or parenting support or supervised living for youth over 18 years of age. The FFPSA permits states to delay the congregate care provisions for up to two years, but the state loses prevention services funding for the same period of time (Sections 50741, 50742, 50743, 50744, 50745, and 50746).

1a. Nebraska continues to require the use of all its current tools, including the Family Strengths and Needs Assessment (FSNA).

TSG assessed the value of management and staff experience with all of the SDM tools. Generally, TSG found in focus groups with leadership, management, and frontline staff that the DCFS staff culture at all levels of the organization to have a strong positive commitment to the SDM system, and the insights to identify issues and problems that could improve the effectiveness and efficiency of SDM system implementation. We found generally positive comments focused on ease of use and support of the decision-making logic of the instruments.

TSG asked management staff about all of the SDM tools identified in Figure 1. Overall, they indicated that staff like the tools and find them (especially the Safety and Risk Assessments) user friendly. The caseworkers interviewed generally shared this view. They noted that the tools help with documenting their reasoning and engaging families. In a caseworker/supervisor focus group, one participant indicated, "SDM was very exciting. It gives us evidence…when we go to court, which holds more weight."

TSG conducted additional research on utility of the Family Strengths and Needs Assessment (FSNA), which is used to inform the case plan due to specific issues raised with DCFS leadership. In a focus group of management staff, staff concerns about the FSNA tool were raised including that "There is not one person who likes it" and it has "No value." Management suggested that based on the timing of when the FSNA assessment is completed, it does not inform service planning and that other instruments might be simpler and more effective (such as the Protective Factors Questionnaire, which is used in the Alternative Response model). Also, there was a concern that the focus on needs related to safety was sometimes lost, and that caseworkers made referrals without seeing how the services apply to safety.

TSG validated these claims with NCCD, as well as DCFS caseworkers and supervisors. According to NCCD, the FSNA serves several purposes.

- It provides an objective means of consistently assessing a family's strengths and needs.
- It facilitates collaboration in the needs assessment and case planning processes.
- It provides a means of assessing a family's strengths and needs over time, which can demonstrate the progress a family has made.
- Data from FSNAs helps child welfare agencies identify the needs families have and develop services.

TSG convened a caseworker and supervisor focus group on October 9, 2018 specifically to ask about what was working well and not well with the FSNA. Staff indicated strengths that the FSNA promoted family engagement, lead to consistency between workers, gave staff the opportunity to engage in and document critical thinking, was helpful when passing on a case to another staff person, and that it was helpful with service planning and in making service referrals for families. They disputed the idea that the tool does not keep a focus on needs related to safety, indicating that the tool has a mechanism for staff to note whether a need is safety-related.

In terms of what was not working well, staff indicated that there is a challenge related to the independent living assessment within the child section in that it requires the caseworker to enter a score for the Ansel-Casey assessment, which is not required in in-home cases. Another complaint was that the tool is repetitive in nature, though staff appreciate the new copy-forward functionality in N-FOCUS.

TSG also explored the Protective Factors Questionnaire as an alternative to the FSNA. It is used as a pre- and post-assessment in the Alternative Response model. Staff felt the tool has a lot of questions and can be overwhelming or even irritating when done with families at the first meeting. They also identified some repetitiveness. TSG did not identify evidence that staff would prefer to substitute the Protective Factors Questionnaire for the FSNA.

1b. There are additional related tools Nebraska may consider adopting.

DCFS leadership asked TSG to identify whether "off-the-shelf" court reports and safety plans exist that are compatible with the SDM tools, as there may be opportunities to adopt new tools that reduce caseworker

burden by pre-populating information captured on the tools or better aligning with the tools. Here, there are opportunities for DCFS to adopt new safety and case plans. A new safety plan format has been incorporated by NCCD into the latest safety assessment tool and NCCD has worked with other states to develop a case plan with a better alignment to the tools. The SOP model should include a court report/testifying piece, so it may be unnecessary to engage NCCD for this tool.

In addition, NCCD reported to TSG that newer versions of the existing tools Nebraska uses may be available. For example, for the Risk Assessment, the most current version is a single stream of questions, rather than two indices, that still gets to the same conclusion, but with a reduced number of questions for the worker to answer. This is one example of efficiencies that can be gained by Nebraska in this update of its tools.

Recommendations:

- DCFS should establish a project management team to manage the SDM model revisions that will assure internal coordination, efficient use of time and resources, and achieve identified outcomes. This should include a work plan, with assigned tasks and due dates for each task.
- DCFS should develop a comprehensive scope of work draft document of the issues, concerns, specific tasks, expected outcomes, and timelines they want to discuss with NCCD/CRC before beginning a formal dialogue, draft contracts, and develop cost projections.
- DCFS should initiate dialogue with NCCD to re-evaluate implementation of the SDM system tied to the scope of work identified. TSG suggests negotiating on subject matter, deliverables, and cost based on an hourly/overhead/travel basis or a negotiated bundled rate.
- DCFS should work with NCCD to conduct a recalibration exercise for the entire SDM suite. According to NDDC, CRC has not conducted an updated risk validation and recalibration analysis for any of Nebraska's tools, which is recommended every five years. This is needed to ensure accuracy of the tools. TSG agrees that this would be a sound approach, but in order to minimize costs, DCFS should prioritize the Safety Assessment, Risk Assessment, and Reunification Assessment instruments based on the role they play in critical decision-making points in the course of an individual case.
- DCFS should retain use of the FSNA and address staff issues through training. TSG identified a wide range of opinions about the utility of the FSNA (difference of opinion between management and front-line staff). TSG suggests that DCFS discuss these concerns with CRC, with a focus on the role of the tool in the continuity of casework and related tools, review the policy and procedures related to the FSNA, and review the detailed content of current training materials related to the FSNA to clarify appropriate use and utility of the tool.
- DCFS should consider implementation of new safety and case plans and newer versions of the tools, which may reduce some duplication. DCFS staff have a high degree of fidelity to the SDM model with opportunities for continued improvement.

2. DCFS staff have a high degree of fidelity to the SDM model with opportunities for continued improvement.

Fidelity to the SDM model measures the degree to which staff use the tools as intended, which is linked to the outcomes of reliable and valid decision-making.

2a. Fidelity to the tools is high.

Two key external assessments found that DCFS was effectively implementing and managing the SDM system with high fidelity and adherence to the decision-making logic of each tool. NCCD/CRC found in a November 2016 audit of the intake tool that on almost all of the case reading questions designed to assess the quality of implementation, Nebraska DCFS workers scored 90% or better including:[1]

- 97% of cases screened in correctly
- 98% of identified safety threats correct
- 93% final risk level correct attained a 90% or better correct completion rate.[2]

The federal Administration for Children and Families found during its Child and Family Services Reviews (third round), that Nebraska has continuous quality improvement (CQI) processes in place to assess fidelity of its SDM tools, writing: "Nebraska utilizes various methodologies to asses Service Area and statewide SDM fidelity. Nebraska tests for accuracy of the item scores based on a comprehensive analysis of completed assessments. Case reviews are also completed to support SDM fidelity. Results from the fidelity reviews are discussed during the statewide CQI meetings and strategies are developed to address areas needing improvement."[3] In addition, ACF identified the DCFS continuous quality improvement approach was found to be "integral" in driving case practice.[4]

DCFS also conducts an internal analysis on the use of some of the SDM tools as part of its quality assurance activities. In a February 2018 review of 166 Hotline calls between October – December 2017, DCFS found:

- 99.4% - information gathered and documented was adequate to determine if the report met screening criteria
- 96.4% - closing status reason was correct based on the SDM Intake Tool
- 92.7% - staff displayed a courteous and professional tone
- 97% - CFSS staff used active listening

The report did identify opportunities for improvement such as improving documentation for overrides (correct at rate of 65%), improving action to address immediate safety concerns (72.7%), and engagement of law enforcement when an intake involves injuries to a child (76.9%).

In the most recent DCFS analysis available on the Safety Assessment, published in July 2017 (which reviewed 9,078 safety assessments completed for the purpose of Initial Assessment between 9/1/2016 and 5/31/2017), DCFS found evidence of improved fidelity of Safety Assessment scoring from the prior reporting period.

- 98% of the Safety Assessments with a final decision of "Unsafe" had supporting information
- 77% of the Safety Assessments with a final decision of "Safe" had supporting information.
- 68% of the Safety Assessments with a final decision of "Conditionally Safe" had supporting documentation.

While staff excel in documenting decisions where the finding is "Unsafe," opportunities exist to improve the documentation in cases with other final dispositions. While this could be a function of staff prioritization

[1] NCCD/CRC SDM Case Reading Report, 11/2016, p. 11.
[2] NCCD/CRC SDM Case Reading Report, 11/2016, p. 11.
[3] ACF, letter of 4/26/17, CFSR Review, Round 3, Statewide Assessment Report, p. 77.
[4] Nebraska, CFSR Final Report, p. 2.

and not a lack of understanding or training, this remains a performance issue to address to ensure the tools are used as intended during the investigation.

2b. Timeliness of Tool Completion is an area where focused improvement is needed.

An area where DCFS staff improvement is needed is in the timeliness of SDM tool completion. Figure 4 shows the timeliness of completion of critical SDM tools used in the initial investigation of a case, for a three-month snapshot.

Figure 4. Timely Completion of Select SDM Tools, June – August 2018.

	Central	Eastern	Northern	Southeast	Western	State
Safety Assessments in Ready for Review in 24 Hours						
Actual	228	419	229	400	74	1,350
Required	280	925	332	563	235	2,335
Percent	81.4%	45.3%	69%	71.0%	31.5%	57.8%
Risk/Prevention Assessment in Final Status in 30 Days						
Actual	138	414	152	308	100	1,112
Required	177	674	186	387	178	1,602
Percent	78.0%	61.4%	81.7%	79.6%	56.2%	69.4%

Source: DCFS, October 2018. (Note: For the Timely Completion of Select SDM Tools, the data on priority level are not available)

Although still not in compliance with policy, this is an area where recent performance has been improving. DCFS has made progress in the average number of days to the initial risk assessment, as shown in Figure 5.

Figure 5. Average Days to Initial Risk Assessment, FY 2016 – 2018.

Priority/Risk Level	2016	2017	2018
Priority 1	97.4	58.7	29.4
Priority 2	89.0	60.2	30.5
Priority 3	80.1	57.2	30.0
Total	**87.0**	**59.0**	**30.2**

Source: DCFS, October 2018.

For the initial FSNA completion, the statewide mean days to completion was 65.56. This is consistent across regions except the Central Region, which averages 35.9.

Figure 6. FSNA Average Days to Completion of First FSNA.

Region	Average Days
Central	35.9
Eastern	69.3
Southeast	74.6
Western	61.2
Northern	67.3
Statewide	**65.6**

Source: DCFS, October 2018. Note: Date range for data not provided.

Recommendation:

- DCFS leadership should establish clear performance goals for each region and the state for the timeliness of each tool and hold regional management accountable for these goals. These targets should be built into the training for the tools.

3. While generally effective, opportunities to improve training on the SDM tools exist.

The primary training on SDM occurs as part of the 14-week new caseworker training model and is delivered by the University of Nebraska's Center on Child, Families, and the Law (CCFL). Generally, focus group comments specific to SDM training were positive. Staff felt they received adequate preparation to use the tools effectively in the field and that desk aides were very effective in resolving questions as they occurred. The fidelity data previously provided validates the effectiveness of the SDM training.

Gaps identified in the new caseworker training include a lack of Motivational Interviewing training and Alternative Response Training.

- Motivational Interviewing training is a critical tool in family engagement. It can improve the quality of information gleaned by staff in the Hotline, during investigations, and in on-going casework (both in-home and out-of-home). Caseworker use of the SDM tools is enhanced with more accurate and complete information obtained during casework. Motivational Interviewing skills training is offered for all DCFS supervisors and caseworkers as an in-service (after initial training).
- Alternative Response training is currently under development. This model represents an opportunity for the state to serve more families outside of the traditional in-home and out-of-home (court) model. This model is well-suited for families whose needs do not align directly with the criteria for traditional child welfare services. This gap is in the process of being addressed; there is a new caseworker module under development and a training for existing workers is under consideration.

Outside of caseworker training, a major gap related to the SDM tools is the lack of supervisor SDM training. Supervisors received training on SDM from the worker perspective (how to use the tools) but have not received training on how to manage to the tools or how to manage staff in using the safety/risk paradigm.

DCFS is aware of this gap and has included a training plan for supervisors as part of its Child and Family Services Review Round 3 Program Improvement Plan for FY2018.

Recommendations:

- DCFS should use the revision of the SDM tools as an opportunity to conduct refresher training for staff on all of the SDM tools. This training could address the timeliness issues and documentation issues identified internally by DCFS in its own assessments, as well as those identified by TSG.
- DCFS should include a CCFL representative in SDM modernization project meetings, to assist in developing new curricula.
- DCFS should consider requiring Motivational Interviewing training in the 14-week new caseworker training.

4. Opportunities to improve technology use related to the SDM tools exist.

Caseworkers relayed to TSG that DCFS has made IT-related improvements for caseworkers such as carry-forward functionality in N-FOCUS, which decreases administrative burden for staff by reducing the need to retype the information on multiple screens.

Staff identified that they do not currently use their phones or other mobile devices in the field when completing SDM documentation requirements. While internet connectivity may be an issue in certain parts of the state, the development of smart phone capability for caseworkers to complete SDM documentation requirements using mobile devices would further increase efficiency in the field and could help to address the lack of timeliness of completion of certain assessments.

Recommendation:

- Discuss options with NCCD to use mobile devices to complete SDM assessments.

5. The Intake Assessment and Hotline Process significantly reduces the number of intakes, resulting in fewer investigations.

TSG was asked to examine the Hotline intake tools and process, in order to assess Nebraska's effectiveness and efficiency, relative to other states. There was concern that Nebraska may be expending too many resources on cases that could be "Screened out," that could be redirected toward serving families where allegations of abuse and neglect are confirmed. To accomplish this task, TSG requested a variety of Hotline data (see Appendix A), including the number of calls accepted and not accepted, and compared this data to other states.

Data for the FY 2016-2018[5] indicates that approximately two-thirds of all calls are screened out, with an increasing trend (see Figures 7 and 8).

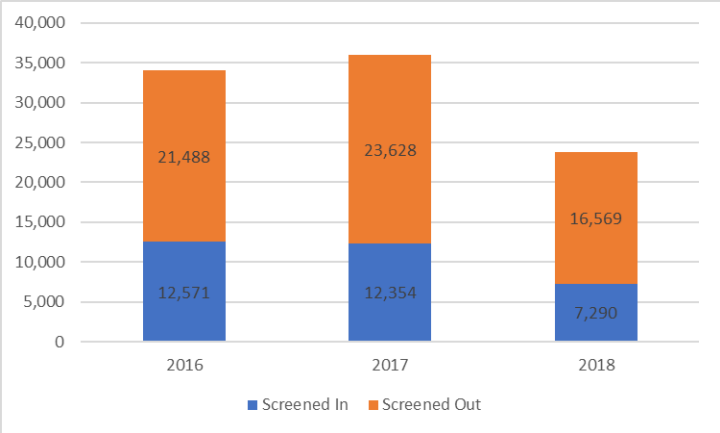
[5] 2018 data is year to date

Figure 7. Intake Disposition, 2016 – 2018 (to date).

	2016	2017	2018
Screened In	12,571	12,354	7,290
Screened Out	21,488	23,628	16,569
Total	**34,059**	**35,982**	**23,859**
Screened In	36.9%	34.3%	30.6%
Screened Out	**63.1%**	**65.7%**	**69.4%**

*FY2018 is year to date. Source: DCFS, October 2018.

Figure 8. Screened out and Screened in Cases, 2016 – 2018.



Source: DCFS, October 2018.

Even though the screening process allows for a systematic, evidence-based tool to be used in assessing which intakes to accept and not to accept, the process of screening cases out requires significant staff resources. According to Hotline officials, in addition to time spent with a caller, staff often make collateral calls during the course of assessing a given intake. Through these efforts, many intakes are "Screened Out."

Figure 9 shows the reason for intakes that are "Screened Out." The largest reason for screened out calls by far is the "Does Not Meet the Definition" (82%). This suggests a need to educate the general public about policy and definitions as a strategy to reduce intakes that are not accepted.

Figure 9. Screened Out Intakes, by Disposition, 2016 – 2018 (to date).

	Number			Percent		
Disposition for Screened Out Intakes	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
Does Not Meet Definition	17,788	19,464	13,665	82.8%	82.4%	82.5%
Law Enforcement	1,127	1,330	1,129	5.2%	5.6%	6.8%
Multiple Reporter	1,948	1,968	1,140	9.1%	8.3%	6.9%
Placement Concerns	533	761	540	2.5%	3.2%	3.3%
Referred for Service	0	1	0	0.0%	0.0%	0.0%
Unable to Identify	89	101	74	0.4%	0.4%	0.4%
Open Intake	3	3	21	0.0%	0.0%	0.1%
Grand Total	**21,488**	**23,628**	**16,569**			

Source: DCFS, October 2018.

Of the cases that are screened out, in some instances, an over-ride is used. Figure 10 shows the types of over-ride used, by "Screened Out" reason.

Figure 10. Screened Out Cases by Reason and Type of Override Used.

Disposition for Screened Out Intakes	2016	2017	2018
Screened Out			
Does Not Meet Definition	**17,788**	**19,464**	**13,665**
Discretionary Override	1.2%	1.1%	0.8%
Policy Override	5.4%	5.3%	3.3%
No Override	93.3%	93.5%	95.9%
Law Enforcement	**1,127**	**1,330**	**1,129**
Discretionary Override	1.6%	2.3%	1.9%
Policy Override	92.1%	91.4%	91.1%
No Override	6.3%	6.3%	7.0%
Multiple Reporter	**1,948**	**1,968**	**1,140**
Discretionary Override	0.6%	0.8%	0.4%
Policy Override	10.3%	7.0%	8.6%
No Override	89.1%	92.2%	91.1%
Placement Concerns	**533**	**761**	**540**
Discretionary Override	0.4%	0.3%	0.6%
Policy Override	1.1%	3.0%	2.4%
No Override	98.5%	96.7%	97.0%
Referred for Service	**0**	**1**	**0**
No Override	0.0%	100.0%	0.0%
Unable to Identify	**89**	**101**	**74**
Discretionary Override	2.2%	3.0%	0.0%
Policy Override	7.9%	10.9%	6.8%
No Override	89.9%	86.1%	93.2%
Open Intake	**3**	**3**	**21**
Discretionary Override	0.0%	33.3%	0.0%
No Override	100.0%	66.7%	47.6%
No Override Info Documented	0.0%	0.0%	52.4%
Grand Total	**21,488**	**23,628**	**16,569**

*FY2018 is year-to-date. Source: DCFS, October 2018.

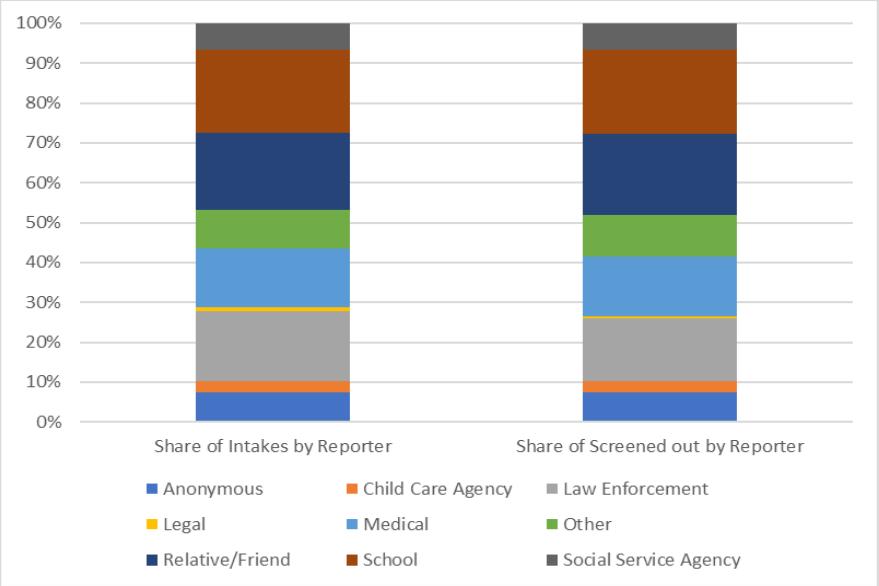
When looking at intakes screened out, by reporter type, important trends emerge. The top four reporter types include: school, relative/friend, law enforcement, and medical (see Figure 11). Each reporter type is responsible for a share of the screen outs that is close to their share of total intakes (Figure 12). There is no one group that stands out more responsible for a greater share of screen-outs than the number of their reports would suggest. Most intakes are screened out (65.7% overall), however, some reporter types had a greater percent of their intakes screened out than others (i.e., child care agencies who had three-fourths of their intakes screened out), which suggests they would also benefit from an understanding of the requirements (see Figure 13).

Figure 11. Child Abuse/Neglect Intakes and Screen Outs, by Reporter Types, 2017.

	Intakes	Share of Intakes by Reporter	Screened Out	Share of Screened out by Reporter	Rate of Screen Out/Intake
Anonymous	2,668	7.4%	1,717	7.3%	64.4%
Child Care Agency	957	2.7%	715	3.0%	74.7%
Law Enforcement	6,333	17.6%	3,738	15.8%	59.0%
Legal	351	1.0%	112	0.5%	31.9%
Medical	5,371	14.9%	3,519	14.9%	65.5%
Other	3,457	9.6%	2,482	10.5%	71.8%
Relative/Friend	6,957	19.3%	4,774	20.2%	68.6%
School	7,491	20.8%	5,015	21.2%	66.9%
Social Service Agency	2,397	6.7%	1,556	6.6%	64.9%
	35,982		**23,628**		**65.7%**

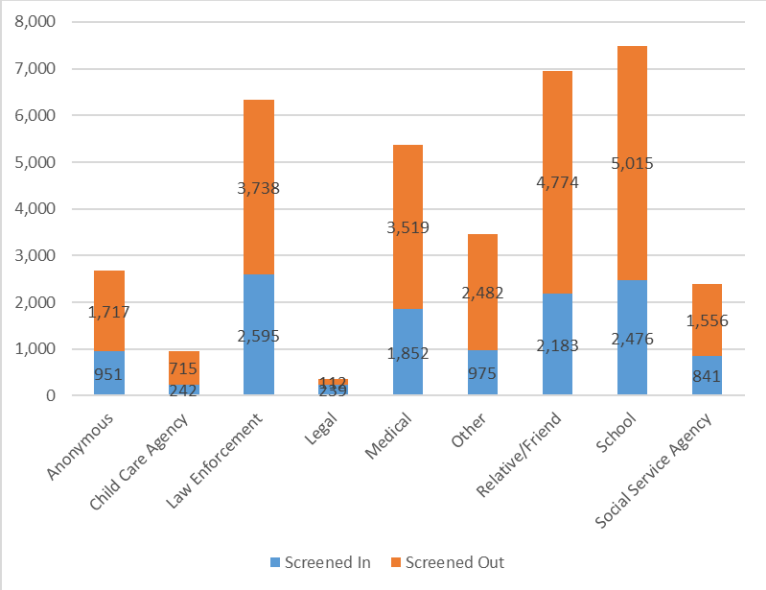
Source: DCFS, October 2018.

Figure 12. Share of Reports and Share of Screened Out, by Reporter.



Source: DCFS, October 2018.

Figure 13. Number Screened In/Screened Out by Reporter Type.



Source: DCFS, October 2018.

Figure 14. Use of Overrides for Screen Outs (Where Decision to Screen Out Requires an Override).

	2016	2017	2018	2016	2017	2018
Screened Out Reason	**Number Screened Out**			**Percent of the Number Screened Out due to either Policy or Discretionary Override**		
Does Not Meet Definition	17,788	19,464	13,665	6.7%	6.5%	4.1%
Law Enforcement	1,127	1,330	1,129	93.7%	93.7%	93.0%
Multiple Reporter	1,948	1,968	1,140	10.9%	7.8%	8.9%
Placement Concerns	533	761	540	1.5%	3.3%	3.0%
Referred for Service	0	1	0	0.0%	0.0%	0.0%
Unable to Identify	89	101	74	10.1%	13.9%	6.8%
Open Intake	3	3	21	100.0%	100.0%	47.6%
Total	**21,488**	**23,628**	**16,569**			

Source: DCFS, October 2018.

Generally, over-rides are used in a small percent of cases and for predominantly the "Screened Out" reason of law enforcement.

Recommendations:

- DCFS should consider auditing these cases (or doing live case reviews of these cases since this is an example of where the determination differs from the tool) (see Finding 9).
- Refined public education on appropriate reporting, with a focus on schools, medical, and the general public, as well as childcare facilities.
- DCFS may want to adopt a strategy to standardize the separation of calls based on specific assessment criteria for routing purposes. This is an approach being explored by several states, including Mississippi. Mississippi is considering separating intake calls, routing processes, and responsiveness based on Hotline calls where high risks have not been identified. [6] The criteria under considered for routing calls includes:
  - Does the report indicate allegations of abuse/neglect/human trafficking?
  - Is the report alleging a policy violation in a resource home (licensed) facility?
  - Does the report meet criteria for Resource Linkage/I&R?
  - Does the report meet criteria for case management?
  - Does the report meet criteria for CHINS/Voluntary Placement/Safe Baby/Prevention services?
  - Does the report meet criteria as a resource inquiry?

[6] MDCPS: Internal Document; 5/2018 (MS is considering integrating the TN SDM Hot Line tool into the proposed model).

6. Nebraska performs well compared to neighboring states in terms of screening out Hotline intakes and unsubstantiated investigations; opportunities to increase referrals to Alternative Response exist, which will decrease the number of investigations.

Nebraska's "Screen-Out" rate is almost 20 percentage points higher than the U.S. average, which may be due to several factors: the use of decision-making tools by Hotline staff, the collateral calls performed by staff, and the overall tenure/skill of Hotline staff in obtaining information from callers. Figure 15 includes data on Nebraska's neighboring states, two large states (provided for illustrative purposes only, not to suggest comparison), and the U.S. total. According to the Administration for Children and Families, the "Screened-in" rate includes those that receive an investigation or alternate response. The "screened-out" rate includes those that do not meet criteria for a referral. As shown in Figure 15, the only neighboring state with a higher "Screened-Out" rate is South Dakota.

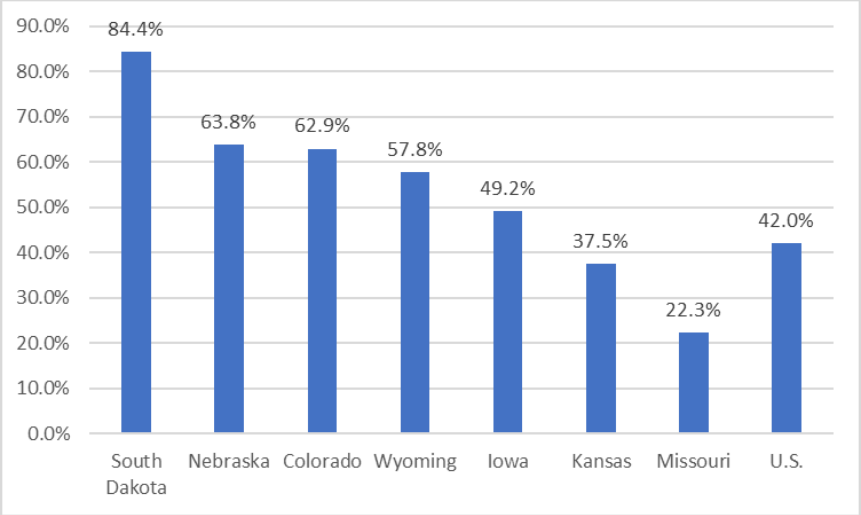
Figure 15. Data on Intakes, by State, 2016.

	Number Screened-In	Number Screened-Out	Total Calls	Percent Screened-In	Percent Screened-Out
Colorado	33,306	56,539	89,845	37.1%	62.9%
Iowa	24,923	24,143	49,066	50.8%	49.2%
Kansas	23,760	14,234	37,994	62.5%	37.5%
Missouri	69,293	19,838	89,131	77.7%	22.3%
South Dakota	2,504	13,521	16,025	15.6%	84.4%
Wyoming	2,916	3,998	6,914	42.2%	57.8%
Nebraska	**11,806**	**20,799**	**32,605**	**36.2%**	**63.8%**
Florida	166,465	58,708	225,173	73.9%	26.1%
Texas	186,024	51,509	237,533	78.3%	21.7%
U.S.	1,897,196	1,374,053	3,271,249	58.0%	42.0%

Note: U.S. total for 45 states who provided complete data.

Source: Administration for Children and Families, "Child Maltreatment," 2016, https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf

Figure 16. Rate of Intakes Screened-Out by Hotline in Nebraska and Neighboring States, 2016.



Source: Administration for Children and Families, "Child Maltreatment," 2016, https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf.

A second issue is where Nebraska falls in comparison with neighboring states on the percent of investigations that are unsubstantiated. States want to minimize this percentage so that resources are not expended on investigations that prove to be unfounded, especially if the intake tool could be refined to exclude a portion of them.

Nebraska has an Alternative Response (AR) program, but it is in its infancy and due to regulatory exclusions, many families who could potentially benefit from this intervention as opposed to traditional response are not able to be served. In FY2016, there were only 435 children served through this model. DCFS is aware of this issue and is in the process of amending its rules to allow for more individuals to be served using this model.

For comparative purposes, TSG also considered Nebraska's rate of unsubstantiated investigations and compared Nebraska to neighboring states. Figure 17 shows the percent of number of children who received an investigation or Alternative Response (AR). Note that the chart is based on children (not charts which are based on intakes that could involve multiple children).

Figure 17. Other State Comparison – Children who Received an Investigation/AR by Disposition, 2016.

State	Use of SDM Tools or Similar	Substantiated	AR	Unsubstantiated	Other	Total	% AR	% Unsubstantiated/ Total Children Who Received INV or AR	% Investigations Unsubstantiated
Colorado	SOP	11,943	10,511	28,313	4	50,771	20.7%	55.8%	70.3%
Iowa		9,560	12,956	16,870	9	39,395	32.9%	42.8%	63.8%
Kansas	SDM Go Live January 2019	2,492	-	31,736	309	34,537		91.9%	91.9%
Missouri	SDM Tools	5,741	56,162	35,756	3,617	101,276	55.5%	35.3%	79.3%
South Dakota		1,297	-	3,087	200	4,584		67.3%	67.3%
Wyoming		1,004	4,778	291	0	6,073	78.7%	4.8%	22.5%
Nebraska	SDM Tools	**2,899**	**435**	**16,948**	**7,965**	**28,247**	**1.5%**	**60.0%**	**60.9%**
Florida	SDM Risk Assessment only	44,155	-	227,304	80,391	351,850		64.6%	64.6%
Texas	SDM Tools	59,308	19,014	200,958	23,995	303,275	6.3%	66.3%	70.7%
U.S.		692,235	582,621	2,346,273	570,613	4,191,742	13.9%	56.0%	65.0%

Source: Administration for Children and Families, "Child Maltreatment," 2016, https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf.

When looking at just children whose intakes result in an investigation, Nebraska's rate of unsubstantiated accepted cases is 61% (a lower score is desirable). This rate is below the U.S. average and all but one of its neighbors. A greater share of intakes that make it through the Hotline screening and result in an investigation are substantiated in Nebraska compared to other states.

When looking at all children whose intakes result in an investigation or AR, Nebraska's rate of unfounded is 60%. This rate is above the U.S. average and Nebraska falls in the middle of its neighbors. This is because Nebraska's utilization of AR is low relative to its neighbors (1.5% of children who receive an investigation/AR compared to the U.S. average of 13.9%).

Recommendation:

- DCFS should continue with the plan to amend the exclusion criteria for AR referral so more eligible families may participate. Because Nebraska's intake assessment tool already significantly reduces the number of accepted intakes, this may be the most effective way to reduce the number of new investigations that prove to be unfounded, while meeting the needs of these families through a different program.

7. Expand the FAST program to additional counties which could also decrease the number of investigations, while meeting family needs.

The Families and Schools Together (FAST) program operates in four Nebraska counties. It is an early-intervention program linked to improved family functioning, school performance, and the prevention of substance abuse.[7] The FAST model connects families to economic assistance programs and community resources to address any social determinant needs (i.e., housing, food insecurity) and strengthen the family.

[7] Nebraska Children, "Families and Schools Together," https://www.nebraskachildren.org/our-approach/evidence-based-strategies/fast.html.

When the Hotline staff identify families where the underlying issue is poverty, as opposed to child maltreatment, and ultimately "Screens-Out" the intakes, the Hotline staff refers the families to the program. The reach of the program is limited to four counties currently.

Recommendation:

- DCFS should prioritize the expansion of this model to additional counties as a strategy of helping connect families to stabilizing resources, while also reducing potential investigations that would later be "unfounded." This may involve the need to identify public-private partnerships and explore private funding support.

8. There are opportunities to improve the Intake and Safety Assessments by adding additional fields, which will sharpen the identification of safety factors and improve the quality of casework.

DCFS self-identified the need to improve the Intake and Safety Assessment tools to identify additional safety factors. There are no options for staff to identify certain safety factors such as substance abuse and domestic violence (which affect an increasing share of cases), aside from selection of "other." The lack of specificity affects both the Intake and the Safety Assessment tools. The Intake Screening tool has an "other" category, and the Safety Assessment tool has an "other" category at Question 12.

Because "Other" is broad and not descriptive, it can be difficult for staff to craft a service plan and refer to services to address the parents' needs if they are not clearly identified. In the case where children are removed, it may be difficult to identify what needs to change in the family to reunify, given the lack of specific safety factors identified.

TSG requested the following point-in-time data to assess the frequency of the use of "other" and the impact it has on the resolution of in and out-of-home cases:

- Of children who have not achieved permanency, what number/percent have "Safety Threat #12" checked (as the only reason)?
- Of families with open in-home cases, what number/percent have "Safety Threat #12" checked (as the only reason)?

Although it is used infrequently, in 10.1% of out-of-home cases where children have not yet received permanency, "Other" is the only safety factor identified. For families receiving in-home services, 5.9% had only "Other" identified as a safety threat, in the absence of any other safety factors identified.

Figure 18. Data on Use of Other, October 2018.

Children Who Have Not Receive Permanency	
Safety Threats Selected	
Count	2,259
Percent	71.8%
Only 'Other' Selected (Safety Threat 12)	
Count	319
Percent	10.1%
No Safety Threats Selected	
Count	568
Percent	18.1%
Total Count	**3,146**

Families with In Home Services	
Safety Threats Selected	
Count	588
Percent	34.5%
Only 'Other' Selected (Safety Threat 12)	
Count	100
Percent	5.9%
No Safety Threats Selected	
Count	1,017
Percent	59.6%
Total Count	**1,705**

Source: DCFS, October 2018.

Recommendation:

- DCFS should engage NCCD/CRC to modify the Intake and Safety Assessments. Other states have modified their tools to add this specificity. For example, the Texas and Delaware versions of the Safety Assessment include these questions and maintain "Other" for unforeseen circumstances.[89] It should not be a problem achieving the specificity in the SDM Safety Assessment tool DCFS seeks; however, it is important that the tool be revalidated after the changes are planned and before they are implemented in the field. It is likely NCCD/CRC will reconsider their certification of the tool only with revalidation.

9. There are situations where case actions are taken contrary to the expected actions based on findings documented using the SDM tools, which could result in poorer outcomes for children and families and expose DCFS to risk.

DCFS policy and procedures manuals provide staff with instruction on the case actions to take depending on the outcomes of each assessment. In conversations with DCFS management and executive staff, concerns were raised about situations in which case actions are taken contrary to the expected actions and/or DCFS staff recommendations.

NCCD/CRC expects some degree of deviation, and certain policy over-rides are included in each tool to allow for staff to document the reason for over-riding the tool. In other instances, discretionary over-rides occur, for a variety of reasons. These over-rides can result in inconsistent decision-making, potentially poorer outcomes for children and families, and can expose DCFS to risk (such as in reuniting a family too quickly or delaying reunification too long which can be unnecessary and costly).

[8] Texas Procedures and Policy Manual, Safety and Risk Assessment, Version 1.4; p. 10, May 2018.
[9] Delaware Structured Decision Making Procedures and Policy Manual, July, 2016; p. 41.

According to DCFS, there are some oversight procedures in place to prevent these situations from occurring. At the individual case level, supervisors are required to review the following:

- Any SDM Assessment in which an override is utilized.
- Every SDM Assessment for a CFS Trainee during their first 6 months or until the Trainee is promoted to a CFS Specialist;
- Random sample of SDM Assessments. One SDM Assessment each month for each CFS Specialist.

Quality Assurance Reviews may also identify issues with the use of SDM tools. However, at the individual case level, there are no system level analyses completed to regularly assess where over-rides occur and analyze the underlying reasons behind those over-rides.

TSG reviewed data from DCFS on instances in which case actions are taken contrary to the recommendations in policy, noting that there are opportunities to over-ride all of the tools using logic built into the tools.

Risk Assessment

There are in-home cases with a Safety Assessment finding of "Safe," but who are identified through the Risk Assessment as having "High/Very High Risk" and are ultimately closed with no services because the family declines to participate. This is a group of cases with an elevated level of risk and DCFS would prefer to continue serving the family if not for the family's refusal to participate. Figure 19 demonstrates the frequency of these cases (464 in FY2016 and 345 in FY2017). Of note, these cases where the family does not receive any services or interventions are at a higher rate of recidivism (12.8% and 9.6% in FY2016 and 2017, respectively) compared to the general population of cases that are closed (between 6.1-6.3% over June – August 2018).

Figure 19. Intakes with Safe and High or Very/High Risk that are Closed with No Services.

	Central	Eastern	Northern	Southeast	Western	Total
2016						
Intakes	498	1,236	493	961	445	3,633
Subsequent Substantiated Maltreatment	60	135	58	166	45	464
Rate of Subsequent Substantiated Maltreatment within 12 months	12.0%	10.9%	11.8%	17.3%	10.1%	12.8%
2017						
Intakes	497	1,155	515	938	491	3,596
Subsequent Substantiated Maltreatment	46	70	50	127	52	345
Rate of Subsequent Substantiated Maltreatment within 12 months	9.3%	6.1%	9.7%	13.5%	10.6%	9.6%
2018						
Intakes	308	594	293	515	208	1,918
Subsequent Substantiated Maltreatment	17	24	19	31	13	104
Rate of Subsequent Substantiated Maltreatment within 12 months	5.5%	4.0%	6.5%	6.0%	6.3%	5.4%

Source: DCFS, October 2018.

Figure 20. Recurrence of Maltreatment within 12 months.

Jun-18	Jul-18	Aug-18	Target	Region
4.5%	4.4%	4.0%	7.9%	Eastern
9.8%	9.3%	9.8%	7.9%	Southeast
3.6%	4.3%	4.5%	7.9%	Central
5.0%	4.4%	5.0%	7.9%	Northern
4.7%	4.3%	3.8%	7.9%	Western
6.3%	5.8%	6.1%	7.9%	State

Source: DCFS, October 2018.

TSG also examined data on Risk Assessments for children in in-home cases with low or moderate risk (which implies that a caseworker could begin to close the case). TSG found an average of 13.6% of cases meet this definition. TSG did not have data to assess how long the cases had been open after a Risk Assessment reflected low or moderate risk. If most caseworkers take steps to begin closing these cases upon completion of a Risk Assessment with these findings, then there may not be an issue. If caseworkers are risk adverse and do not want to close cases despite changes occurring in the family, there may be a need to do additional staff coaching.

Figure 21. In-Home Risk Assessments with Low or Moderate Risk (point in time October 2018).

Region	Number	Total In-Home	Percent
Central	21	196	10.7%
Eastern	45	409	11.0%
Northern	31	185	16.8%
Southeast	82	472	17.4%
Western	18	188	9.6%
Total	197	1450	13.6%

Source: DCFS, October 2018.

Assessment of Placement Safety and Suitability

Deviation from the recommended actions related to this tool is rare. Point-in-time data for October 1, 2018 were provided by DHHS to TSG showing that only 3 out of 3,013 children are currently in an unsafe placement (rate of 0.1%).

Reunification Assessment

NCCD/CRC expects between a 5-10% override count in the Reunification Assessment tool. TSG requested data on children in care on 10/1/18 whose most recent Reunification Assessment had a safety determination of 'Safe' or 'Conditionally Safe', a risk level of 'Low' or 'Moderate' and a primary caregiver parenting time result of acceptable (implying could go begin to reunify)

Figure 22. Children in Care on 10/1/18 with a Reunification Assessment indicating reunification can begin.

Region	Number	Total Out-of-Home	Rate
Central	7	292	2.4%
Eastern	46	1,444	3.2%
Northern	17	409	4.2%
Southeast	14	527	2.7%
Western	12	341	3.5%
Total	96	3,013	3.2%

Source: DCFS, October 2018.

This finding is within NCCD/CRC's expected range. It is not possible to discern from this data how long ago the Reunification Assessment occurred. If completed recently, there may be no delay in reunifying families (either due to DCFS or external parties in the judicial system).

Recommendation:

- DCFS should establish reports for regular executive and management review of all of the instances in which case action is taken contrary to the tools and on the types of over-rides used, which would allow trends to be identified at a system level and interventions to be designed as appropriate (i.e., staff coaching or re-training).

10. There are opportunities to improve engagement of stakeholders on safety, risk, and the SDM tools.

DHHS and DCFS leadership, management, supervisory, and caseworker staff identified opportunities to improve stakeholder (i.e., judges, CASA, guardian's ad litem, county attorneys, law enforcement, public) knowledge of how DCFS defines safety and risk, and the underlying evidentiary basis, methodology, and use of the SDM tools. Gaps in stakeholder knowledge about the approach to safety/risk and the SDM tools create challenges for DCFS including:

- Reports to the Hotline that cannot be accepted as intakes because they do not meet definitions to be "Screened in." These intakes require staff resources to be vetted and ultimately screened out.
- Instances in which DCFS staff and stakeholders disagree over case decision-making (i.e., the decision to close an in-home case, change a placement, or reunify a family).
- Instances in which case actions are taken contrary to the logic and recommendations of the SDM tools (i.e., children remaining in a placement identified as unsafe, a case remaining open past the point at which safety has been achieved and the risk level has been reduced).

When the SDM tools were initially implemented, DCFS conducted outreach to stakeholders and offered training on the tools. TSG identified recent efforts by DCFS leadership to engage legal stakeholders about the tools, and instances in which training has been offered but may not have been well attended.

Recommendations:

- Implement a comprehensive stakeholder engagement plan on the SDM tools, to coincide with implementation of any revisions coming out of work with NCCD. This should include training, facilitated discussions with judges, county attorneys, CASA, guardian ad litems, community advocates, and any other relevant stakeholder.
- DCFS should consider use of a tool to engage community stakeholders about reporting of child abuse and neglect, consistent with the state's definitions, such as the Child Protection Reporting Guide developed by NCCD. The goals of this tool are to help the community understand its responsibilities for reporting, provide reporters with guidance, and help the state child welfare agency to concentrate its resources on the most appropriate cases, according to NCCD.
- DCFS staff should receive training on how to explain the tools and the underlying decision processes used when interacting with stakeholders and in court.

11. DCFS should build an SDM management dashboard as part of its quality assurance process

It is important for DCFS management to monitor caseworker and supervisor performance and use of the SDM suite of tools in order to maintain fidelity and also to enhance safety and well-being going forward. We found a robust amount of data related to the use of the SDM tools available during our research, but management is not using the data systemically to identify real time issues related to possible inappropriate decision making, misuse, inappropriate supervision, or delays in timeliness of completion. Using existing data and making the data available to regional management, by way of useful performance management dashboards which can be incorporated into the DCFS quality assurance process, would enhance the future fidelity, as well as child safety and well-being.

Recommendation:

- DCFS should also build an SDM Regional Management Dashboard and incorporate it into its existing quality assurance process using existing data, to include some of the following suggested key performance indicators:
    - Hotline intakes:
        - Number and percent of cases screened in and out by region
        - Over-rides by region (noting type as policy or discretionary)
    - Timeliness of completion by region for:
        - Safety Assessment
        - Risk Assessment
        - FSNA
        - Risk Re-Assessment
    - Number of overrides, per tool, broken out by type (policy or discretionary)
    - Number and % of Risk Assessment with Safe with High or Very High Risk that are closed without service and recidivism of this population relative to recidivism of all closed cases

- Number and percent of open in-home cases where Risk Assessment shows Low or Moderate risk
- Number and percent of children in out-of-home cases where Risk Re-Assessment indicates reunification can begin
- Number and percent of cases where Assessment of Placement and Stability indicates a child is placed in an unsafe placement

VII. Related DCFS Priorities

Behavioral Health, Medicaid, and the Child Welfare Population

The American Academy of Pediatrics has found that access to behavioral health services represents "the greatest unmet need for children and teens in foster care."[10] A 2016 *Medicine* article found that "Mental disorders affect a substantially greater proportion of children and adolescents in the child welfare system than in the general population. The 49% pooled prevalence for any mental disorder is nearly 4-fold greater than the prevalence among the general population."[11] The National Conference of State Legislators writes that "Up to 80% of children in foster care have significant mental health issues, compared to approximately 19-22% of the general population."[12] These facts, along with the ground breaking "Adverse Childhood Experiences (ACEs) study on the effects of trauma on children and youth,[13] are well known by child welfare professionals and advocates.

Throughout the DCFS staff focus groups, TSG found a high degree of caseworker commitment in accessing behavioral health services for the children/youth in care. There was a great deal of consistency around the challenges that DCFS faces in accessing behavioral health services through the Medicaid managed care organizations (MCOs) including the lack of:

- evidence-based practices (MST, trauma informed cognitive behavioral health, fidelity wrap around);
- access to needed services falling back on DCFS;
- adequate provider network;
- mutual understanding of how each system works ("lack of knowledge on each side"); and,
- access to MCO data in the Medicaid data warehouse to track case progress.

TSG identified several positive, action-oriented strategies occurring among DCFS, Division of Medicaid and Long-Term Care (MLTC), and the MCOs that include:

- Weekly call-in meeting between DCFS offices and the MCOs to discuss individual cases.

[10] American Academy of Pediatrics: Healthy Foster Care America.
[11] Medicine: The Prevalence of Mental Disorders Among Children and Adolescents in the Child Welfare System: A Systemic Review and Meta-Analysis"; G. Bronsand, MD, Ph.D., Marine Allessandrini, MD; Volume 95, Number 7, 2/2016; p. 1.
[12] National Conference of State Legislators: Mental Health and Foster Care; 5/9/2016
[13] Adverse Childhood Experiences Study: Kaiser Permanente/CDC, 1998; American Journal of Preventive Medicine: "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults"; 1998; Volume 14; pp. 245-258.

- MLTS call-in meeting between MCOs and DCFS on complex cases, chaired by Dr. Lisa White, Medicaid Medical Director.
- The Division of Behavioral Health (DBH) sponsors the development of the Nebraska System of Care Community Response model that funds ten Community Response collaborations across the state. The model is a prevention initiative designed to reduce the need for higher-end systems and services. Implicitly, the model is a very positive initiative to reduce the number of children, youth and families from entering into the DCFS system yet does not directly impact the lack of access to evidence based services in the state's Medicaid MCO system.

DCFS children/youth in foster care are enrolled in the MLTS Heritage Health managed care system. DCFS Protection and Safety Procedure #15-2017 (4/21/2017) requires that the "CFS Specialist will ensure" that the child/youth will receive a medical examination within 14 days of home removal as well as dental, vision and behavioral health assessments "as soon as possible." In addition the CFS Specialist is responsible for ensuring all EPSDT well-child screenings occur (based on MCO Table of EPSDT Periodicity) throughout the life of the case. In addition, DCFS requires foster care parents to provide a month update to their DCFS Specialist on the medical status of the child/youth and their receipt or omission of EPSDT age-related screenings. Throughout this process, the need for, access to, receipt of, or lack of service access for needed behavioral health services is processed with the MCOs.

A brief review of Nebraska MCO contract #71164-04 (1/1/2017-12/31/2022) indicates that several critical services and concepts relevant to the child welfare population are missing. The terms "DCFS," "wraparound," "evidence-based practice," and "EPSDT" are not mentioned.[14] The MCO Outpatient Mental Health Services benefit requirements of the contract for individual, family, and group services do not include specific evidenced-based outpatient modalities that are often needed by families and children at risk, such as Multisystemic Therapy.[15]

The crossover point of the utility of the SDM assessment instruments and the need for behavioral health services is the identification of high-risk/high-need children and youth who are removed from their homes as a result of the findings of the assessment and the decision of the DCFS Specialist and supervisory review. The caseworker will often know a child/youth's need for behavioral health services before the case is enrolled in Medicaid, making the response time of the MCO critical to their immediate emotional and mental status.

Recommendations:

- Develop a DHHS/DCFS Leadership Team. This recommendation suggests building on the two existing scheduled meetings (DCFS-MCO weekly calls; Dr. White's DCFS-MCO meeting on complex cases) and the DBBH Systems of Care to create this team. A successful model for Nebraska's consideration is the State Executive Council leadership structure of the Virginia Children's Services Act.[16] The primary duty of the SEC model is to "establish interagency programmatic and fiscal policies" across DHHS and participating agencies through the promulgation of regulations or administrative action with the goal of the multiple state

[14] It is possible that these subjects are referenced in contract amendments.
[15] Contract, pp. 3-4.
[16] Code of Virginia: Section 2.2-2648

agencies/divisions that touch the child welfare population working in an integrated collaborative manner to the extent possible. The SEC leadership model is designed for the long-term coordination, collaboration, and adaptation necessary to assure the medical, behavioral health, and developmental needs of children in care are met, their education is successful, and transitions to adulthood prepare transitional youth for the challenges and opportunities of adulthood.

- Establish a collective round table between DCFS, MLTS, and the MCOs. This would involve establishing consistent, on-going meetings for the purposes of:
  - Developing mutual knowledge of each other's systems;
  - Developing "cross-over" staff training ("Medicaid Managed Care 101/ DCFS System 101");
  - Developing a collaborative communication plan with foster families and youth;
  - Identifying immediate and longer-term challenges and project managed-oriented solutions;
  - Identifying access issues and develop proposed solutions such as network expansion;
  - Appointing a select team that includes DBH for the purpose of identifying the behavioral health evidence and best practice services that are most needed by Nebraska's children and youth in foster care/in-home placements and a plan to develop these services and contractually implement them;
  - Developing and implementing a mid- to long-range plan on growing the supply of credentialed practitioners by working with community colleges and institutions of higher education; and,
  - Considering Alternative Payment Model contractual requirements that are designed to attract more credentialed providers.
- MLTS should consider adding a 24-Hour Behavioral Health Crisis Consultation service and a Behavioral Health Targeted Case Management Benefit for complex cases (eligibility based on clinical assessment) for the purpose of assuring continuity of care and avoiding unnecessary ER visits and psychiatric residential treatment facility admissions.
- MLTS and DCFS should share Healthcare Effectiveness Data and Information Set (HEDIS) across system partners to increase accountability and drive improvement. MCOs are required to report HEDIS measures already. The measures include a series of EPSDT-related information that would be valuable for DCFS, MLTC, and the MCOs, as well as stakeholders, to periodically discuss based on the aggregate number of DCFS enrolled children/youth and overall compliance and possibly low compliance rates.
- DCFS, MLTS, and the MCOs should consider the feasibility of an electronic Health Passport for foster children and youth. Other state models for consideration include the model used in Texas. The Health and Human Services Commission contracts with a single statewide MCO to serve foster children and requires the population of certain health and claims data into an electronic Health Passport. The Health Passport is a secure website that collects key child/youth medical information, including EPSDT wellness checkups, and is accessible by medical consenters, state child welfare caseworkers, health care providers, and authorized state Medicaid staff.

Suicide Assessment and Prevention

In June 2018, the federal Centers for Disease Control (CDC) reported that the rate of age-adjusted suicide across the country increased 30% between 2000 and 2016, rising from a rate of 10.4/100,000 population to

13.5/100,000 population.[17] The 2016 rate of suicide in Nebraska was 13.1/100,000.[18] Of the ten leading causes of death by age group in 2016, the CDC reported that the second leading cause of death among the 10-14, 15-24, and 25-34 age groups was suicide.[19]

Suicide is of particular concern for children in foster care. Research published in the *Child and Youth Services Review* reported an estimated prevalence of suicidal ideation of 24.7% among children and youth in care, compared to 11.4% among the non-care population. The authors estimated that suicide attempts were three times more likely among the in-care population than the non-care population.[20] The Nebraska Foster Care Review Office's 2017-2018 Annual Report also highlighted the importance of professional consideration and response to the occurrence of youth self-injury (cutting, suicide attempts) within the overall mental health needs of youth in state care.[21] The 2017-2018 Annual Report of the Inspector General of Nebraska Child Welfare highlighted their concern about the increasing rate of critical incident reports of suicide attempts by wards of the state.

Figure 23 Number of Critical Incidents Related to State Ward Suicide Attempts, 2016 – 2018.

Year	Number
2016-2017	23
2017-2018	24

Source: Office of Inspector General of Nebraska Child Welfare, 2017-2018 Annual Report.

Recently DCFS added suicide prevention training in response to concerns of the Office of the Inspector General of Nebraska Child Welfare. The QPR Gatekeeper suicide prevention training program is embedded as a 1½ hour learning module during the 14-week new worker training curriculum. QPR is based on the action steps of training caseworkers to recognize the warning signs of a suicide crisis/ideation and implement the "Question, Persuade, and Refer" skills designed to refer a child/youth or parent/caregiver for help. Gatekeeper training teaches caseworkers to recognize the warning signs of suicide, how to offer hope, and how to access help and services. QPR originated in a mental health environment (Spokane, WA Mental Health), has been in existence since 1999, and is considered an emergency mental health intervention with an emphasis on early recognition. Project Harmony also provides QPR training and has scheduled 12/13/2018 as the next available training date.

Suicide recognition and prevention is a public health challenge across the country and illustrates the importance of integrating the recognition, prevention, and treatment of the underlying causes of suicidal ideation and self-harm. During an investigation, the caseworker's ability to recognize the risk of suicide for a child/youth and assess the imminence and need for immediate referral for mental health treatment will be critical components of assuring immediate safety. It will also be important for caseworkers in on-going

[17] CDC/NCHS Data Brief No. 309, June 2018.
[18] CDC: Suicide Mortality by State, https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.
[19] CDC: National Suicide Statistics, https://www.cdc.gov/violenceprevention/suicide/statistics/index.html.
[20] Child and Youth Services Review: Comparison of suicidal ideation, suicide attempts, and suicides in children and young people in care and non-care populations: Systemic Review and Meta-Analysis of Prevalence"; Rhiannon Evans, James White; Volume 82, Nov., 2017; pp. 122-129.
[21] Nebraska Foster Care Review Office 2017-2018 Annual Report; p. 67.

cases to monitor for the risk of suicide. For children and youth at risk of suicide who are in foster care, continuous assessment is a critical component of assuring that preventive and treatment needs have been met.

Recommendations:

- DCFS, DBH, and DMLTC work together in developing a comprehensive operational pathway to assure that access to psychiatric emergency crisis services and on-going mental health treatment for the underlying causes of suicidal ideation and self-harm is clearly defined for caseworkers who identify children at risk. This will require the Medicaid managed care organizations (MCOs) to be involved and raises the question of what behavioral health crisis service consultation services are provided through the MCOs.
- DCFS should consider discussing the mental health screening assessment process required of the MCOs during the child/youth 14-day medical evaluation after being taken into care. There are several best practice assessment instruments that can be used in the clinical setting (Columbia-Suicide Severity Rating Scale, PHQ-9 Depression Screening tool) and training products such as the Five Step Evaluation and Triage Tool (National Suicide Prevention Hot Line) and the Suicide Tool Kit for Schools (SAMHSA). In addition it is important for DCFS to have a reporting system of some kind documenting the findings of case workers during SDM Initial Assessments and on-going case work based on the use of the QPR Gatekeeper skill set in order to recognize trends, the need for adaptation, and, most importantly the outcomes from the use of this model.
- DCFS should consider discussing suicide assessment with NCCD/CRC by reviewing current training and casework protocols on the QPR in relationship to SDM tools and related policies and procedures.

Comprehensive Addiction and Recovery Act (CARA)

The federal Comprehensive Addiction and Recovery Act (CARA) was signed into law on July 22, 2016 and included an amendment to sections 106(b)(2)(B)(ii) and (iii) of the Title V Child Abuse Prevention and Treatment Act (CAPTA) related to plans of safe care for infants (aged 0-1) who are exposed to substances. Changes include removal of the term "illegal" as applied to substance abuse, which expands provisions to include legal substances, a requirement that safety plans address the needs of infants and their families (or caretakers), and requirements relating to data collection and monitoring.

The original CAPTA provision did not establish a federal definition of child abuse and neglect for infants affected by substance abuse. The provision requires a Safety Plan of Care focused on keeping the infant safe and address the needs of the child and caregivers. Each state was required to submit a CAPTA Plan to the Administration of for Children and Families/Children's Bureau. The states decide what entity is responsible for the Safety Plan of Care. The National Child Abuse and Neglect Reporting System was chosen by ACF/CB to collect CARA. There is Federal Participation for IT adaptations under IVE via Advanced Planning Document.

Each Safety Plan of Care must consider the immediate safety needs of the affected infant and the health and substance use disorder treatment needs of the affected family or caregiver. Considering the need for a continuum of services for any addicted/dependent parent/caregiver there is a need for collaborating

partners, agencies, MCOs, and health insurance providers to be included in the development of each Safety Plan of Care.

The Nebraska CARA Plan of Implementation includes several key clarifications designed to assist Nebraska's birthing hospitals in complying correctly with reporting requirements, including:[22]

- Correct definition of reportable conditions (prenatal drug exposure or Fetal Alcohol Spectrum Disorder);
- Clarifies that a CARA notification is not a Maltreatment Report to the Hotline;
- Identifies prenatal exposure conditions requiring a CARA notification: 1) Mother is stable and engaged in medicated-assisted treatment with a licensed physician; 2) Mother is being treated with opioids for chronic pain by a licensed physician; and, 3) Mother is taking medication as prescribed by her licensed physician.
- Clarifies the Safety Plan of Care "will be completed by the treating professional or health care provider and provided to the infant's primary care physician for ongoing monitoring" when there are no safety concerns.
- Clarifies that reporting birthing hospitals should call the DCFS Hot Line if there is "*any* reason to believe that there is child abuse or neglect." The current acceptance criteria for substance exposed infants is based on the Structured Decision Making™ Intake Screening Policy and Procedures Manual.
- Provides a DHHS email address and fax number for CARA notifications when there are no safety concerns. DHHS will collect and report CARA specific data. This process should avoid or at least control unnecessary CARA Hotline calls.
- New worker training on CARA has been integrated into covering Notifications, Reports Not Accepted, and Reports Accepted (expect MCO involvement in Safety Plans of Care for necessary covered services).

State child welfare programs have been significantly impacted by the opioid epidemic over the past several years. A March 2018 study by the federal Office of the DHHS Assistant Secretary for Planning and Evaluation estimated that for every 10% increase in opioid deaths there has been a 4.4% increase in child entry into foster care.[23] The Nebraska 2016 rate of drug-related deaths was 6.4 per 100,000/120 total deaths compared to national average of 19.8 deaths per 100,000.[24] Preliminary 2017 data indicates Nebraska's drug-related deaths increased to 164, a significant increase and cause of concern. The Robert Wood Johnson Foundation's County Health Rankings website reports that Buffalo, Lancaster, Lincoln, and Sarpy counties had high rates of opioid-related deaths relative to other Nebraska counties. Although Nebraska's rate of opioid-related deaths has been significantly lower than the U.S. average, the current trend is noteworthy and requires considerable monitoring and attention related to the potential growth of prenatal exposure.

[22] All information sourced from the Summary Document of Nebraska's CARA Implementation Plan as of September, 2018
[23] ASPE Research Brief: "Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study"; March 2018; p. 3.
[24] CDC Drug Overdose Death Data, https://www.cdc.gov/drugoverdose/data/statedeaths.html.

In TSG interviews with Hotline staff, staff indicated that CARA has not yet had an impact on call volume. TSG requested data on these calls but was instructed that data are too preliminary for release. Given the Nebraska CARA reporting process for birthing hospitals in prenatal exposure cases this might be expected at this time. Due to the recency of the reporting policy change and the lack of available data, it is too early to make conclusions about the potential impact of CARA reporting requirement on the Hotline.

Recommendations:

- Create a weekly report of CARA-related intakes for management review. This new report and regular analysis of CARA-related trends will allow management to remain appraised of the situation, detect whether there are any unexpected spikes in call volume, and act swiftly if state response is needed.
- Develop a CARA decision-making and process map, based on Nebraska's CARA Implementation Plan, to be shared with birthing hospitals, stakeholders, and Hotline staff.

Appendix A: TSG Reports/Data Requests

Request 1:

General Resources:

1. Copy of the PIP
2. Summary table of SDM tools – "Overview of SDM Assessments"
3. NCCD written report on hotline case review
4. Department annual data book/report

Data Request:

Please provide the last two complete fiscal years and current fiscal year to date.

1. Hotline intakes broken out by reporter type, allegation type, region.
2. Of hotline intakes, what was the disposition? (How many were screened out vs. sent for investigation.)
3. Of hotline intakes screened out, any further information about the subject or categorization.
4. Monthly Hotline QA Report
5. Of intakes that are accepted, disposition: by region
6. For cases closed at the end of the 30 days (no in home or out of home), how many were closed by region and also reason codes for closure.
7. Data on Fidelity of Safety Assessment
8. Analysis of FSNA data related to assessment of child well-being
9. Of in-home cases closed where the child is safe but with high or very high risk:
   - Provide the number by region
   - Any data on case closure (i.e., parent refuses services)
   - For this group of cases, what were the recidivism and maltreatment rates, also by region?
10. For all in-home cases where the child is safe but with high or very high risk:
    - In what number/percent of cases does the family consent to services?
    - In what number/percent of cases does the family complete services?
11. How many out-of-home cases are open past the point where a Reunification Assessment indicates the child is ready to go home
12. How many in-home cases are open past the point where a Safety Re-Assessment says can be closed?
13. Generally, do you have data on where there have been "over-rides" based on what a tool has recommended?
    - Are these over-rides due to staff or the courts?
    - We are open to how you can pull this data.
14. Of children who have not achieved permanency, what number/percent have "Safety Threat #12" checked?
15. Of families with open in-home cases, what number/percent have "Safety Threat #12" checked?

16. Any data on completion and timeliness rates of the tools by staff, by region, including:
    - Initial safety assessment - % timely within 24 hours
    - Risk assessment - % timely within 30 days
    - FSNA – timeliness based on 6 month update schedule
    - Percent of closed in-home cases where Safety Re-assessment was performed prior to closure (or conversely, how many cases are closed where the tool is not used)?
    - Percent of out-of-home cases where Reunification assessment is performed prior to closure?

Request 2:

General Resources:

5. Annual # and rate of removals (statewide average) from FY2011 – present (want to pre-date implementation of the SDM tools which we understand to be FY2012 – if that is incorrect, please adjust the timeline).
6. # / % of Hotline Intakes that are not accepted (so no full investigation occurs), where there is another Intake within 12 months.
7. Rate of closed cases that are re-opened within 12 months after one of the SDM tools (i.e., the Safety Re-Assessment, Reunification Assessment) indicated case closure was warranted, for:
   - In-home Cases
   - Out-of-home Cases (re-entry after reunification)
8. Unsubstantiated cases, where a new allegation of maltreatment occurs within 12 months