Health and Human Services Committee October 25, 2019

HOWARD: [RECORDER MALFUNCTION] --Senator Sara Howard and I represent the 9th Legislative District in Omaha, and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Hello, I'm Senator Dave Murman from District 38. Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

ARCH: John Arch, District 14, it's in Sarpy, Papillion-La Vista.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

B. HANSEN: Senator Ben Hansen, District 16: Washington, Burt and Cuming Counties.

HOWARD: Also assisting the committee is our legal counsel, Jennifer Carter. And our committee clerk, Sherry Shaffer, is actually out today. And so we're very grateful that Natalie from the Banking Committee is going to be joining us. And we do have a committee page with us, Brigita. And Senator Walz has joined us. Do you want to introduce yourself?

WALZ: I'm Lynne Walz and I represent District 15, which is all of Dodge County.

HOWARD: A few notes about our policies and procedures. Please turn off or silence your cell phones. This morning we'll be hearing an interim study and then we'll be receiving a briefing, and we'll be taking them in the order listed outside, listed on the agenda outside the room. On each of the tables near the doors to the hearing room you will find blue testifier sheets. If you're planning on testifying today, please fill one out and hand it to Sherry when you come up to testify. This will help us. Sherry--

NATALIE SCHUNK: Natalie.

HOWARD: --Natalie, when you come up to testify. This will help us keep an accurate record of the hearing. Any handout submitted by testifiers will also be included as part of the record as exhibits. We would ask if you do have any handouts that you please bring 10 copies and give them to the page. We use a light system for testifying. Each testifier will have five minutes to testify. When you begin, the light will be green; when the light turns yellow, that means you have one minute left; and when the light turns red, it's time to end your testimony and we'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone. Then please spell both your first and last name. Each

interim study hearing will begin with the introducers opening statement. After the opening, we'll take testimony. And just a reminder that interim studies are a little bit different than a regular hearing. We won't hear from proponents or opponents or neutral testimony, we'll just take testimony in turn. Unless we have invited testimony, which we'll start with. I'll note this at the start of each hearing. If the legislative resolution is a committee resolution, as the one that we're hearing today, I as Chair will introduce it and then return to my seat to to proceed with the rest of the hearing. We do have a strict no prop policy in this committee. And with that, we'll begin today's hearing with LR239, and I'll pass it off to Senator Arch.

ARCH: Morning, Senator Howard.

HOWARD: Good morning, Senator Arch.

ARCH: If you would begin by spelling your name and letting us know who you are.

HOWARD: Thank you, I might have forgotten.

ARCH: We appreciate that.

HOWARD: That's wonderful. All right. My name is Senator Sara Howard, H-o-w-a-r-d, I represent District 9 in midtown Omaha. And today I present you LR239, an interim study to examine non court-involved

cases, including voluntary and alternative response cases in the child welfare system. We talked about this a little bit during session this year, but just as a refresher, non court-involved cases arose as part of the continuing evolution of the child welfare system. Decades ago, the system was centered around orphanages, followed by a system centered around group homes, then foster care for a home-like setting for children. And now the focus is on keeping the children in the home and out of the system as much as possible. Reducing the trauma of removing a child from the home is good. The question of this interim study is whether Nebraska's method for keeping children out of the system and safe in their homes works. Because whatever our approach and however well-intentioned we are, the state remains responsible for a child's welfare. So we need to know the system in place is working. Many concerns surround our current structure, including a challenge in oversight. There is no one outside the agency, including the Legislature, to monitor and assess whether this system works. This is part of what we hope to examine today. Others that follow will provide a better explanation of what a non court-involved case is. But essentially, after a report of alleged child abuse or neglect is made, the call is screened by DHHS. The department can then decide the allegation is unfounded or, if they believe an issue exists, DHHS must either decide to file a petition with the court or ask the family if they would like to voluntarily receive services in order to avoid court involvement. As you'll hear, the noncourt cases are handled on

two different tracks, either through what are called voluntary cases, where DHHS does an initial assessment and a safety plan is established, or through what's called alternative response. Later in the year in December, we'll be talking about Family First and how that will modify some of this work. But for right now, we're just going to talk about voluntary and alternative response. Again, keeping a family intact with services they need is a good goal, but many questions remain regarding oversight, transparency and accountability for these cases. This interim study we're hoping to examine and better understand the standards used to determine which cases are handled as noncourt-involves cases. The risk assessment level for children placed in a noncourt case, so we understand the safety risk to the children involved remaining in their home. The types of services provided to families in noncourt voluntary cases, the types of placements used in non court-involved cases when the children are not kept in their homes, including whether any background checks are performed for those placements and what, if any, oversight the department has over these places. This is essentially where we say to the parents: This isn't a great situation, we're going to ask you to place your child with a neighbor or a relative. But then the department itself doesn't have any oversight. There are no background checks performed because there's no court involvement. Data on non court-involved cases such as the average length of time for non court-involved cases, and how many non court-involved cases later become court-involved. Following me are

many experts who have worked tirelessly on these issues for many years. But first I've asked Kim Hawekotte from our Foster Care Review Office to sort of provide us with a tutorial on the basics of what noncourt cases are and how they're determined. She will not have a time limit, but she will be brief. As the department continues to move further in the direction of less court involvement in child welfare cases, it's increasingly important that we understand how to provide appropriate oversight and work together for the common goals of stronger families and safe and healthy children in our state. I appreciate your time and attention to this issue. I'm happy to try to answer any questions you may have.

ARCH: Are there any questions? I don't see any, thank you.

HOWARD: Thank you. All right, and we'll invite Kim Hawekotte first.

ARCH: Thanks.

KIM HAWEKOTTE: Good morning, everybody. I love when they ask an attorney to be brief. I just think that's kind of an oxymoron, but that's OK. I'm Kim Hawekotte, I'm the director of the Foster Care Review Office. My name is spelled K-i-m H-a-w-e-k-o-t-t-e. And as you know, the Foster Care Review Office is an independent state agency that was created over 30 years ago to provide independent oversight over all children in out-of-home care within the state. We do that at a two-level process. First, we do over 4,200 individual case file

reviews every year of children in out-of-home care. When we do those case file reviews, we file our recommendations with the court and relevant stakeholders and then we also collect data. Coming around is our annual report that was just submitted that has all of the data with regards to the past year. The other level we work at, like I said, is the systemic level and trying to provide the data that's needed. Because of my history and being a former county attorney for many years and working with the up-front of this system, I think this part of this system is very confusing. And the best way that I can first start to explain it is, is if you go to the handouts that I gave, there are two charts that we use when we train our 325 local board members across the state to try to explain how the system operates. The system, child welfare system really operates on two levels. You have noncourt cases and then you have court-filed cases. The first page of this is pre-court filing. So cases come into the juvenile court system one of two ways, either through a call to the hotline that is ran by HHS or through law enforcement, through a 911 call through law enforcement. So you'll notice on this chart the law enforcement contact. When law enforcement goes to a house, they determine that children are unsafe. They have under our statutes the legal ability to remove those children from the house, they then send an affidavit to the county attorney and the county attorney has 48 hours to either file a petition requesting that those children remain out of home or the children are returned home if they don't file

within 48 hours. If law enforcement goes to a house and determines, no, we don't need to remove the children, but they need further services, they then will make a referral to the Health and Human Services in order for further investigation. For those calls that come in through the hotline, those calls are either accepted or not accepted. And I'm sure when you look at the data, you will see that they talk about accepted and not accepted calls. They have a structured decision making tool that they use for each and every one of those calls to determine the safety and the risk involved. If they decide to accept a call, when they accept a call then they have one of three options. They can either unfound it and say, we're not going to do anything. They can file with the court because they feel there is such a safety risk that something has to go forward. Or they can decide to do a voluntary case. Now, when they decide to do a voluntary case, like Senator Howard mentioned, they have one of two options. They can decide immediately go, to go to an alternative response situation, which is a community-based response. Those are for, allegedly, your lower risk, that the children don't have any risk or very minimal risk involved. Usually there is an assessment done on these families in case management that last anywhere from 30 to 60 days and they provide services based upon that. Or they can decide the family is maybe higher or very high risk and they need to be voluntary. Those are the cases where the parents voluntarily agree to provide services so they don't need to go to court. What we have seen

with regards to those voluntary cases is a huge increase in the state over the last year or two in the use of voluntary services. Now, hopefully that kind of answers how that front end of the system works. And if you have any questions, please feel free to stop.

HOWARD: Senator Arch.

ARCH: Thank you. I got lost.

KIM HAWEKOTTE: OK.

ARCH: The voluntary, so if they report to the hotline, they're accepted, and then voluntary-- you said there were two: alternative response--

KIM HAWEKOTTE: Correct

ARCH: --or voluntary?

KIM HAWEKOTTE: Correct.

ARCH: And the alternative response, what--

KIM HAWEKOTTE: What happens, the major difference in a systemic view is that if they decide this is a case for alternative response, there is no initial assessment completed on that case within the three- to five-day priority time period. Instead, it's all handled within the alternative response system. If they determine the risk is higher,

that they need that initial assessment, then it goes into the initial assessment unit to do the voluntary case.

ARCH: But the, but the alternative response is still voluntary?

KIM HAWEKOTTE: Still voluntary.

ARCH: OK. That's where I got confused.

KIM HAWEKOTTE: Right. No, it's still volut-- that's why we use terms-- we have different types of cases, but we still use terms interchangeably, which gets confusing. But yes, they're both voluntary. And a different level of services and different types of services based upon the needs of the family is probably the best way to think about it, Senator.

ARCH: Thank you.

HOWARD: Senator Williams,

WILLIAMS: Thank you. And just quickly, you just mentioned there has been a significant increase in the voluntary--

KIM HAWEKOTTE: Correct.

WILLIAMS: Can you explain why you think that's happening?

KIM HAWEKOTTE: Part of the-- no. I mean, we do know there has been-- part of that? No. I'm not really sure. I think because we have no

oversight over the voluntary cases, we do not for sure know how many voluntary cases-- the Foster Care Review Office cannot say how many voluntary cases are actually being done within the system. I, I feel that if a family is willing to voluntarily enter into services and services could be put into there, why would you involve the court system? I mean, so I think they're really trying hard to do that, Senator. To get those services in faster, keep those kids at home, which we know is better for everybody than to have them placed out of home.

WILLIAMS: Right. Thank you.

HOWARD: Senator Walz.

WALZ: Thank you, Senator Howard. How many, do you have any idea how many calls you get a year?

KIM HAWEKOTTE: The Foster Care Review Office? No. But I'm sure Health and Human Services does keep track of all the hotline calls. And there's probably some people testifying after me from like the child advocacy centers that do monitor and can tell you how many hotline calls.

WALZ: OK. And I then just have one more question because I, I don't know. Are the decisions made-- when a call comes in, those decisions are made strictly over the phone, drew out phone conversations. Are

there ever any, like, follow-up visits before you make a decision on, you know, if it's unfounded or not?

KIM HAWEKOTTE: Usually the hotline call makes based upon the hotline, the call itself, makes a decision whether to accept the call or not. And they have a tool that they use. If they decide to accept the call then, yes, they could do some further looking into it and determine what's going to happen from that stage.

WALZ: OK, thank you,

KIM HAWEKOTTE: So, so I think you bring up a good question, Senator, that it is a system we have to know how many calls are not accepted and what are the reasons as to why those calls are not accepted. And what is done if they're not accepted,

WALZ: Right.

KIM HAWEKOTTE: Or if you receive 10 calls on the same family, does that trigger something that it needs to be further investigated than just one call on a family?

WALZ: And that's, that's something that you're already tracking? I mean, if there were 10 calls on a family--

KIM HAWEKOTTE: I believe the child advocacy centers do track a lot of that, Senator, and that, that would be a good place to go for some of

that information. And I know the Department of Health and Human Services has data on that also.

WALZ: All right, thank you.

HOWARD: Any other questions at this juncture? Seeing none, do you want to keep going?

KIM HAWEKOTTE: Sure. So under our statute, under Nebraska statutes, the Foster Care Review Office has authority to review all children in out-of-home care. We are very liberal in-- [RECORDER MALFUNCTION] --for a while when they leave their children here. That's what it was designed for, and it is used a lot. But it is now being used in the child welfare system. Once it came to our attention that they were starting to use this ILAs, informal living arrangements, we contacted the department and said we should be getting a list of all the children that you're doing this with. Under our statute, we have to be reviewing those cases. Originally, in the summer of 2018, the department said, no, that this is a voluntary case. This is voluntarily done by the parents and you don't have any legal right by which to do it. We then worked with HHS legal in the fall and HHS legal agreed with us that under our current statute we do have the right to be reviewing those cases, so that we can at least try to give you guys some idea of what's happening in these informal living arrangements. So starting in-- it took many months, but starting in

January and February of this year we started receiving spreadsheets and lists from the department as to how many children are in these informal living arrangements. So in February of this year and then August of this year we reviewed and looked at all of these children that were in an informal living arrangement. We wanted to know what the situation was, what, what brought them to that. So in total, since this has started, we found that there were 156 children from 99 families in the state that are in-- placed in an informal living arrangement. We know out of those 159 that 43 have exited this informal living arrangement. We also know that 22, so 50 percent of these that exited, did do because there ended up being a court filing that safety could not be guaranteed for these children. We know that about four of these children, the parents quit cooperating and they just closed the case. We know that 10 of them were returned to the parents and never came back into the system, or as of today's date they did not. But as we started looking at, at these cases, and what's included in my testimony is we really became concerned about some of the situations we were seeing in these informal living arrangements that we felt we needed to bring forward. And so I had these listed on here. The first, I think we need to consider as a system the voluntariness of using an informal living arrangement. In other words, you have to envision yourself as a parent in your home tonight and you get a knock on the door and somebody comes and says, we think your children are unsafe and we need to remove them. But if you sign this

piece of paper, then your children can go live with whoever you say, or we're going to have to remove your children. So I think you have to really question as a system how voluntary that is. Of the 30-- of the 30 mothers that we reviewed, 18 percent of them, so 60 percent were not engaged in services. OK? So even after removal of the children, the voluntariness of it, they still are not engaging in services, so you have to question the safety of these children. Second thing, of course, are safety concerns. Safety concerns are, of course, the most serious issues. Part of the concern that we had is that, of the cases we reviewed, 30-- 56 percent of the families were high risk and another 35 percent were very high risk. So you're not dealing with the lower-risk families, the poverty situations that need help. You're dealing the majority, 75, 80 percent of them have high or very high risks in that house based upon an evidence-based structure decision-making tool. The other concerning thing that we saw in, in these cases with regards to safety concerns is that in these informal living arrangements, 84 percent of the children that were in an informal living arrangement were there because of drug use. In other words, the parental drug use, they were placed out of the home. The majority of the cases dealt with methamphetamines. So instead of those cases becoming court-involved cases, they are on a voluntary basis and the children are placed wherever the parent chooses to have them placed. On page 4 of my testimony, I listed out the reasons for the informal living arrangement placement. You'll notice, and you can have

more than one reason, but 91 percent were there because of neglect. But you'll notice, like I said, 84 percent were there because of the parental drug use. Third issue with regards to informal living arrangements from a systemic view is the legal rights of parents. You are-- there's really, in our opinion, a lack of due process, legal support, advice to the parents. You're, you're having parents sign documents they don't even know what it is they're signing or what it is they're doing, they have not been told. I think that for case managers has to be difficult for them because you're giving legal advice as to sign this document and then your kid, child can go live over here. There are no attorneys involved in any voluntary case. It is strictly the department and the, and the family. We have seen some of these cases where then they go to the parent and say, why don't you voluntarily relinquish your parental rights? Why don't you agree to a guardianship of your children with somebody else, because you're not working a plan? Again, there's been no legal advice for any of these parents as to what the long-term ramifications are by dealing with, with signing some of these legal documents. The fourth major area that we have concerns about are the safety of the placements, being that's the major oversight of our agency. With regards to informal living arrangements, the individual that the child goes to live with is selected by the parent. Which sounds great in theory, but what we have found is that in 20 of the 56 children that we reviewed, there was no background check done on the people that they went to live with. The

check was incomplete or there was no documentation of anything about the family. We don't know who these people are or what it is they do or who's living in that household and what else these children are exposed to. It's our opinion that if you're going to be using these, you have to have the same stringent requirements that we do for other children to ensure that they're safe. The fifth thing that we found was a really lack of service-- [RECORDER MALFUNCTION] --we determine that everything is going the way it should be. And we have not seen that model. Of course we need available services statewide. It sounds fine to be able to to keep kids at home, but then you need the appropriate services available statewide, especially in our rural areas, to meet the needs of the children and family. And if you don't have those services available, then we're in a different, different situation. And lastly, one of the things that we believe strongly is, is we need some type of independent third party oversight of this part of the process to ensure that everything is going the way that whatever model is created is, is actually operating. Currently, none of these requirements, in our opinion, are being met. And that's why we're here today to advocate for it. And I'm more than willing to answer any other questions, and I appreciate the more than five minutes. And hopefully I did not go too far over.

HOWARD: Great, thank you. Are there questions? Senator Arch.

ARCH: Thank you. In your presentation, you didn't mention the word kinship. Is this, is this, is this a kinship model?

KIM HAWEKOTTE: With an informal living arrangement, yes, it would be either be a relative or a kinship, hopefully. In other words, a kinship is somebody who has a significant relationship with that child. Most of the informal living arrangements were either placed with a relative or with some type of kinship placement.

ARCH: OK. You may not be the one to answer this question, maybe later on somebody could, and that is, with the implementation of the Family First Act, will there not be additional requirements on the kinship program similar to what you're talking about here?

KIM HAWEKOTTE: Yes, there will be.

ARCH: OK, thank you.

KIM HAWEKOTTE: But you have to remember, Senator, with these informal living arrangements, being it's a voluntary situation, none of those would apply to this. So we have to, as we go forward with Family First, we have to make some decisions on do we want to ensure that some of those requirements for kinship placements also apply in this part of the system?

ARCH: Thank you.

HOWARD: Senator Walz.

WALZ: Thank you, Chairwoman Howard. I have a couple of questions about the LB1184 team. First of all, can you tell me what that is and who makes up that team?

KIM HAWEKOTTE: Sure. I, I will give my best, and I'm sure there's people behind me that can be more. Many years ago there was a statute passed, and it was LB1184. And so for the last 20 years, that's what we call those teams. But each county is to have an LB1184 team. Those teams are run by the county attorney in that county. There is supposed to be under statute an investigative team that looks at calls to the hotline and accepted calls and and those type of situations. Then you also have LB1184 treatment teams that look at ongoing cases, voluntary cases to ensure that services are being met. Now, how each county implements and does their LB1184 teams vary across the state. And I do believe there is somebody coming behind me from the child advocacy centers that will testify with regards to that, because those LB1184 teams are overseen by the child advocacy centers, the CICs statewide.

WALZ: All right, thank you.

HOWARD: Other questions, Senator Williams.

WILLIAMS: Thank you, Senator Howard. And thank you, Ms. Hawekotte, for being here. You've talked about a policy change that took place back in February of '18, roughly.

KIM HAWEKOTTE: Yep.

WILLIAMS: Can you, with your experience, explain to me why you believe that policy change was implemented?

KIM HAWEKOTTE: Under the former policy, like I said, there was not the ability to do these informal living arrangements. Because if the children were determined to be or need to be in out-of-home care, then it was to go a different route that we just talked about on the chart. Under policy number 2-2018, it changed that and added a situa-- added within the policy for these informal living arrangements and the process that was supposed to be done with them. Now, as to why that was changed, I do not know, Senator, and that would have to be a question for HHS. I just know the policy change.

WILLIAMS: Would you consider that to be a major policy change?

KIM HAWEKOTTE: Yes.

WILLIAMS: Were you or your organization or other stakeholders engaged in a conversation in advance of that kind of a policy change?

KIM HAWEKOTTE: No, we were not. That's why I said we found about it accidentally about four or five months later when we were getting

calls to our office going-- regarding certain situations. And that's when we dug into it.

WILLIAMS: And in your experience, having someone sign a legal document that deals with the custody of their most precious asset, their children, is that something that should be done without the representation of the person's rights?

KIM HAWEKOTTE: You're talking to an attorney, Senator, so of course.

WILLIAMS: I know. That's why I asked that questions of you.

KIM HAWEKOTTE: So of course I am going to say of course. No, I think with something that serious it does require some type of explanation, so you know legally what it is you're signing and the effect of it. Even though this, this is a temporary delegation, so it only lasts for a certain time period, you are still delegating your parental powers to someone else.

WILLIAMS: Thank you.

HOWARD: Senator Cavanaugh.

CAVANAUGH: Thank you for being here today. This is very helpful. Following up on Senator Williams' question. So it's from my understanding from what you were saying that the individuals that are talking to the parents are also not lawyers, they're caseworkers.

KIM HAWEKOTTE: Yeah, usually they're case managers. I mean, they're the ones going to the family and going into the family. So the attorneys are not involved.

CAVANAUGH: And so there's no one with a legal expertise that is able to walk the parents through any questions they might have about their rights?

KIM HAWEKOTTE: That would be our position. Maybe I should say, Senator, that would appropriately or be able to legally explain.

CAVANAUGH: Right.

KIM HAWEKOTTE: Right.

CAVANAUGH: Yeah. So looking at this chart on page 4, I see that there are some out-of-home placements where there's no vetting of the individuals that they're being placed with. And some of these children are being placed out of home because of sexual abuse, physical abuse, and domestic violence.

KIM HAWEKOTTE: Correct.

CAVANAUGH: And they're being placed with somebody who has no-- doesn't necessarily have a background check?

KIM HAWEKOTTE: Correct.

CAVANAUGH: OK.

KIM HAWEKOTTE: That is what we found when we looked at them, Senator.

CAVANAUGH: So prior to this policy change, they would have had a background check?

KIM HAWEKOTTE: if it was serious enough that they had to be removed, Senator, then it would have gone into the normal court process with then, yes, they would have had the background check and the walk-throughs and things like that.

CAVANAUGH: Is it your understanding, and I-- obviously you're not the department, but is it your understanding that this is a more cost-effective way of removing children from the home?

KIM HAWEKOTTE: Well, I think logically-- that is a great question for the department. All, all I can really say, Senator, is that the informal living arrangement placements are not getting paid to be the placement. That if you put a child into foster care, then you would be getting the $20 a day as a foster care placement.

CAVANAUGH: Thank you.

HOWARD: Any other questions? Seeing none, thank you for your testimony today. I'd like to invite Judge Heideman up next, because he has the time, time constraint.

ROGER HEIDEMAN: Thank you, Senator Howard. And my time constraint is not as great as it was yesterday. I got until about 10:30 or so, so I can take plenty of questions. And again, my name's Roger Heideman, that's R-o-g-e-r, Heideman is H-e-i-d-e-m-a-n. I'm one of the juvenile court judges in Lancaster County, I've been on the bench now starting my 14th year. Before that, I was in private practice and provided parent representation and guardian ad litem representation in juvenile court. So my entire time as an attorney, 27 years, I've been involved in the juvenile court system. But the last 13 and a half as a juvenile court judge in Lancaster County. I can speak to, I believe what Kim Hawekotte described as the normal court process. But then also how this change or this move towards voluntary cases, and more concerning, what appears to be a change to a lot of these cases now going to alternative response and potentially going to alternative response, the current concerns I have with that. As far as the normal court process is concerned the, the juvenile courts are dictated by, by your words in 43-246. What our charge is, so to speak, and that we're to ensure the rights of all juveniles to the care, protection, and safe and stable living environment to development of their capacities for a healthy personality, physical well-being, and useful citizenship, and to protect the public interest. And to achieve that purpose, then it goes on to say that we're to maintain the juveniles in their own home whenever possible, but to separate them when it's necessary for their health, safety, and welfare or the paramount concern for that. But if

we do that, that then we have to achieve or make reasonable efforts to reunify them back into that home. That's our charge. I think a lot of times we get caught up in all this and we lose sight of common sense. Common sense would tell me, if that's the charge to the courts when these children come into the court system, that should be the equal charge the department has if they're working on a voluntary case or an alternative response case, to ensure that health and well-being and ensure that reasonable efforts are being provided. I think I maybe needs to provide a little bit of oversight. We've been operating under the-- through the eyes of a child initiative since my appointment to the bench. That initiative began just a couple of months after I was on the bench. So since 2006 we've been operating under that initiative from the Supreme Court where we have a multidisciplinary cross-section of of people who are involved in the system, who are to work in local teams to provide a collaborative effort to identify systemic issues within the system, to improve the system, to achieve that goal of not getting as many kids placed out of home and keeping their time in the system to as minimal a time as possible. For years I think we had a pretty good collaborative system, but it seems that within the last couple of years that collaborative system maybe has taken on a different definition with the Department of Health and Human Services. I know Senator Howard and Senator Williams received a letter from the juvenile court judges yesterday on a YRTC issue that brought to light that collaborative issue in regard to that issue. But in regard to

these matters, you know, it kind of goes back to in our local team. And even now at state level, I don't believe there was ever any discussion of, hey, we're looking at going in this direction where we're going to do more voluntary cases. And the first we see it, it's just a dramatic decrease in the court filings. That began, I think, in the late summer of 2017, but really kind of reached its pinnacle the first part of the year 2018, where in the second county with the second-highest population we went for, for several months with just a handful of court filings. Where in the past, you know, we would have multiple court filings and abuse and neglect cases. Then to further highlight maybe that lack of collaborative effort, the-- which I'll testify this afternoon, that's Senator Slama's hearing on the drug testing policy, we begin to hear caseworkers testifying about change in policy as far as drug testing in cases and what they're allowed to do and what they're not allowed to do. Yet, their published policy seemed to dictate that wasn't the case. And we asked for meeting with the HHS administration at that time. They came over and we met with them and they said we're looking at changing the policy. We haven't changed it yet, but this is what we're looking at doing. And we voiced their concerns about how we did not believe that to be in the best interests of the kids that we were charged with serving. And then the next thing we hear is, oh, here is our policy and it's what we said it was going to be, or what we thought it was going to be, and didn't appear to take into consideration any of those issues. When it, when

it gets to the alternative response issue, I became aware that there was a proposal to modify or basically I think eliminate the majority of the regulations in regard to child welfare. And in particular, in regard to alternative response, gut, in my terminology, what was a well-thought-out collaborative effort in determining what cases were appropriate for, for alternative response. Setting up a very precise set of exclusionary criteria. [RECORDER MALFUNCTION]

HOWARD: I received the letter at 5:00, I think, about the YRTCs from the judges. And then that got forwarded to you around 7:00 p.m.. So if you haven't had a chance to read it, that's OK. But we'll be discussing it later. Seeing no further questions, is there anything you'd like to add in closing?

ROGER HEIDEMAN: Yeah, and just very quickly, kind of anecdotally, what we've seen now that this push towards voluntary cases had been going on. What we've seen and I have, I am also the presiding judge of our family drug team in Lancaster County. So a great deal of my cases are drug-involved cases. And so what I have seen since this push towards voluntary cases are kids that are coming in as emergency removals that we're under a voluntary plan, but we're ultimately removed by law enforcement because of calls to law enforcement about ongoing drug use or arrested and found in possession of drugs with children in cars. One instance where a neighbor reported physical abuse of a child going on in front of the home where it was actually police removals on

ongoing cases that were being handled on voluntary basis, which to me is troubling.

HOWARD: Any-- Senator Murman.

MURMAN: And their removal that-- thank you very much. The removal that you just brought up, is that from the original family or from the family that they--

ROGER HEIDEMAN: The original family.

ARCH: So they weren't actually removed from the family.

ROGER HEIDEMAN: They were not removed, yeah.

ARCH: They went that to original.

HOWARD: Any other question? Seeing none, thank you for your time today, Judge.

ROGER HEIDEMAN: All right, thank you.

HOWARD: We appreciate you moving your schedule around to visit with us. All right, our next testifier for LR239. Good morning.

SARAH FORREST: Good morning. Good morning, Chairperson Howard and members of the Health and Human Services Committee. My name is Sarah Forrest, S-a-r-a-h F-o-r-r-e-s-t, and I am the special projects coordinator at the Nebraska Alliance of Child Advocacy Centers. For

those of you who might not be familiar, the Nebraska Alliance is our, the membership organization for our state's seven child advocacy centers, more commonly referred to as CACs. CACs are community-based organizations charged with first providing high-quality trauma-informed services to assist with investigations of child abuse and neglect. And we are also charged with assisting the county attorneys with the coordination of local multidisciplinary child abuse and neglect investigation and treatment teams, also referred to as LB1184 teams, or I'm going to refer to them as MDTs, just to add on an acronym. Thank you so much for your attention to noncourt cases and the opportunity to testify today. I've distributed a copy to you of the Nebraska Alliance's most recent report on noncourt child welfare cases, which we filed with the Legislature in September of this year. In 2012, the Legislature took action to require DHHS and private case management contractors to share monthly reports listing open noncourt cases with local CACs. This would not include alternative response cases or the informal living arrangement cases that aren't receiving ongoing services that you heard about earlier. So it's a little bit of a narrower group of voluntary cases. The CACs then by law are charged with reporting on trends in these cases to the Nebraska Legislature on at least an annual basis. Also in 2012, the Legislature asked local multidisciplinary teams to come up with a protocol for reviewing noncourt cases and assessing adequacy of safety and treatment plan in noncourt cases. So the report you have before you provides information

and data that was provided to CACs by DHHS and PromiseShip, as well as the results of local MDT reviews of noncourt cases during the prior fiscal year. So among the major findings of this year's report is that actually only 797 new noncourt cases opened. So if you turn to page three of your report, you'll actually see that this is the smallest number of new noncourt cases opened in a year since CACs began reviewing and reporting on this data in 2013. So you can also see on that page there are extreme regional disparities in the number of new noncourt cases opened. Many regions in the state last year experienced a slight increase in noncourt cases. However, the statewide decline was driven by an over 60 percent decline in cases opened in Douglas and Sarpy counties, which would be marked Project Harmony on your graph. So our best information indicates that this decline was due in part to the May, 2018, policy that you all already discussed to 2018, which basically changed which cases DHHS referred for ongoing cases after an investigation. In the past, any case that was scored on a risk assessment as high or very high risk for future use or neglect, at least the department offered the family an ongoing court case. Now the policy states that DHHS will refer cases where children are safe to community services instead of opening a noncourt case. So we're not sure why only one region of the state really saw that policy impact with the ongoing cases, but that has impacted sort of the noncourt, the overall statewide picture. On the whole, data show, as in years past, that generally there's fairly high success of cases in

compliance of families with case plans for these ongoing noncourt cases where the department is involved. Graphs are found on page 5 and 6 of your report. The length of noncourt cases increased slightly this year. I am going to try to speed through this. There are still some concerns with cases not having case plans, and there are really stark regional differences. So both in terms of oversight and how noncourt cases go, it really varies region to region. So I think the most important thing is just to highlight a number of areas CACs and MDTs noted for improvement on follow up. Timely communication and data reporting about new noncourt cases opening and then current noncourt cases closing, so if you only get a monthly report sometimes there may be a case that never shows up on that monthly report just because of how it's currently structured. Teams to discuss limited service availability and accessibility, especially related to substance use, evaluation, and treatment, mental health, and dependency needs. So youth needs and behaviors that are driving familial system involvement. A lack of oversight and communication about cases that are never opened as noncourt cases, some of which you've heard about today. So these would be high-risk situations where families don't want ongoing services or have temporarily delegated parental authority. Inconsistencies about whether our cases should be staffed by teams, and then just a lack of capacity of teams in the state to thoroughly staff and review all noncourt cases. So I'm happy to answer

any questions either about this report or the work of CACs or MDTs, whatever would be helpful to the committee.

HOWARD: Thank you. Are there questions? Senator Walz.

WALZ: Thank you, Chairwoman Howard. Thanks for coming today.

SARAH FORREST: Sure.

WALZ: Can you just give me a little bit of information about what a case plan involves or the process or what it includes? What does a typical case plan look like? There probably isn't a typical case plan, but can you just provide a little bit more information on that?

SARAH FORREST: Sure. So there, I mean, there is a little bit of a typical case plan. So the Department of Health and Human Services uses a system of assessments called SDM, structured decision making. So those help identify safety threats, risk of future abuse and neglect, and then also family strengths and needs. So department policy says that case plan should be formed around family strengths and needs assessment. You're supposed to have one both by Nebraska's statute and department policy within 60 days. And so the idea would be these are services that we think will address the needs of the family based on an assessment by a case manager. In addition to a safety plan, would be more immediate, so that it's kind of like part of the case handling

case plan is looking at more of the holistic picture of the family, ideally.

WALZ: Do you have any idea why there would not be a case plan in place for somebody?

SARAH FORREST: My guess is it would vary. So this is a piece of data where it centers, again because centers have sort of tracked things differently. So some looked at whether new cases had case plans and some looked at case closure, whether there was an updated closed case plan. So in a voluntary case, one situation might be maybe the family decided they didn't want the voluntary case after all, before a case plan was even finalized. You know, that could be one situation. It could be a documentation issue. I don't know specifics breakdown, but those would be a couple of examples I think could be common in this particular.

WALZ: All right, thank you.

HOWARD: Any other questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you. So we're kind of ping-ponging in language here. So noncourt, noncourt voluntary are two different things, correct?

SARAH FORREST: It all depends on what lingo you use.

CAVANAUGH: So the data we see here, these two spreadsheets here, are the FY '18, FY '19. It's when they were the-- they're now being not tracked necessarily or--

SARAH FORREST: So the way I would explain it, or the way that I think we view it, and I, I can't speak for the department is so this is about cases that are continuing to receive ongoing services from the department or a department worker is still checking in with the family, looking at the kids, assessing the family on an ongoing basis. Some of what you've heard earlier in terms specifically about the temporary delegation of parental authority or the referral to community services, there my understanding is the department does not have ongoing contact with the families. So it's not actually an open noncourt case for the purposes of this report. Or that's how I would explain it, basically. So the family may be engaging with community service providers, but there is no formal role for the Department of Health and Human Services.

CAVANAUGH: And what we heard from Judge Heideman with that sometimes these children are returning to the home and we don't know until police are called. Would that be your understanding, because there's no tracking?

SARAH FORREST: So we don't have long-term, we don't track long-term outcomes for these cases. That's not something that we're currently

set up to do. So even for-- so I guess that's true of those and that's also true of these. I can't tell you how many cases reentered the child welfare system or maybe in a year of a noncourt case closing was there another report of child abuse or neglect. This is just sort of a snapshot of while the cases were open.

HOWARD: Any other questions? Seeing none, thank you for your testimony

SARAH FORREST: Thank you so much.

HOWARD: Good morning.

SARAH HELVEY: Good morning. My name is Sarah Helvey, S-a-r-a-h, last name H-e-l-v-e-y, and I'm the staff attorney and director of the child welfare program at Nebraska Appleseed. And I want to start by saying that Nebraska Appleseed is generally supportive of the approach of providing assistance to families without unnecessarily bringing them into the formal child welfare system. And we strongly support the investment of strong prevention programs to eliminate the removal of children from their parents in the first place. But we want to outline a few significant concerns we have with the current practice, which some have called "hidden foster care", which is interesting because you may hear that foster care is being reduced, but in some ways it's not. It's just not-- it's more hidden. And I also want to mention some ways the Legislature can act to address these existing problems. So a few concerns. Informal caregivers are not licensed or trained and

background checks may be inconsistent. Informal caregivers do not receive a monthly foster care stipend, particularly some of the relatives and kinship caregivers may be in high-poverty situations as well and they don't receive the same monthly stipend that a foster parent would receive in court-involved case. HHS is not required to provide services to help rehabilitate or reunify the family or see to it that the child achieves permanency. There's no, no court oversight, which provides an important check on unnecessary removals and oversight that case plans are appropriate. There's no right to counsel, as you have heard, so parents are left to determine whether the state's actions are appropriate without any legal assistance to do so. Parents may be denied due process when they're separated from their children without a finding of unfitness, particularly if informal agreements are not truly voluntary. And in a recent report by Child Trends, national report found racial disparities in kinship diversion practices. That's another term that's used nationally, with white children diverted to kin at a significantly higher rate than black children. Moreover, and I think this is a point that I think my testimony could emphasize and others have not mentioned, specifically there is no statutory authorization or guidance for how non court-involved cases proceed. There's no statute on noncourt really at all. Let me be clear, there is statutory authority for alternative response, but there's no statutory authority, nor is there any regulatory guidance, to guide decision making in these cases that

involve thousands of children who previously had the protection oversight of juvenile court. As you heard, I think from Judge Heideman, last month the department proposed new regulations that removed nearly 200 pages of child welfare regulations, including some related to alternative response and some pretty significant changes with regard to that. We believe that those proposed regulations make a confusing situation even worse by leaving families with very little information about how HHS makes decisions that can significantly impact their rights and interests. And we testified at the administrative hearing on those proposed regulations that we believe that the proposed regulations violate the Administrative Procedures Act and that the enforcement of them may be invalid and subject to legal challenge. So this is where we think that you can play a role. We think legislation is critically needed in this area and that now is a really good time, an important time to do that. Nebraska's 4-E waiver that is around alternative response expired a few weeks ago on September 30th. And Nebraska's, your legislative authorization at AR in Nebraska sunsets at the end of 2020. In addition, I know the committee is well aware of the Family First Act and the opportunities under that for states to draw down federal funding for children who are at imminent risk of entering foster care. I just want to mention LB328 was introduced last session by Senator Bolz, and it sought to do two things, primarily to put some statutory framework for when the department has discretion to provide services without court

involvement, and then also to implement the Family First Act into state statute. To sort of reconcile that new federal law with our state statutes. And LB328 is still pending before this committee and could be reexamined in the upcoming session. We also would recommend that the state examine opportunity under the Family First Act to draw down federal funding to provide some legal representation to children and families, that's a new opportunity under the federal law. So families who come to the attention of our welfare system deserve to be supported and to have their rights protected, but we have concerns that temporary solutions may be making the situation worse and would ask the committee to look at ways that we may be able to clarify that in the future. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, you did such a good job. Thank you.

SARAH HELVEY: Thank you.

HOWARD: Our next testifier.

LANA TEMPLE-PLOTZ: Good morning.

HOWARD: Good morning.

LANA TEMPLE-PLOTZ: Senator Howard and members of the committee, my name is Lana Temple-Plotz, and I'm the CEO of Nebraska Children's Home Society, L-a-n-a T-e-m-p-l-e-P-l-o-t-z. We at Nebraska Children's Home

Society use our over 125 years of experience to put children's needs first through an array of statewide services designed to build strong, supportive families and nurture children. I'm testifying today on behalf of the Children and Family Coalition of Nebraska, also known as CAFCON, whose members work together to shape policies and services for children, youth, and families that improve lives and communities. We appreciate the opportunity to share our thoughts on this very pressing issue. I don't come today with an easy answer on what the court and noncourt system should look like, and I've appreciated the previous testimony that describes it in more detail data that surrounds that. What I do have are some thoughts to help guide the process and a willingness to be at the table as we delineate the most effective solutions. First, we need to focus decisions related to the level of court involvement for families on data and outcomes. And so hearing data today was very helpful. We need more than stories in order to make changes that are best for children and families. Every agency involved in prevention and child welfare services can think of stories where children were removed from the home when it wasn't absolutely necessary for their safety and cases where children should have been removed and were not. Evidence overwhelmingly shows that children have the best outcomes when they are with their family. We owe it to children and their long-term well-being to make decisions rooted in this data. If we do not have enough data on the impact of the current shift to noncourt involvement and alternative response, then we must

prioritize a plan of action to get that data. Second, we need to ensure frontline staff making decisions about removing children from their homes have the training and support to make the best decisions possible. I know the department has implemented a number of training initiatives to help address the-- address this. As you know, DHHS has dedicated, hardworking staff, many of whom are new to the workforce and may not have the long-term experience that's incredibly valuable when deciding the fate of children. Making sure these team members are well supported with ample opportunity to consult with supervisors is a critical component. Third, we must ensure families who are non court-involved have access to resources, the right service at the right time, and are encouraged, nurtured, and respected as they access those services. CFS data shows that 46 percent of the children who enter care ages 0 to 5 had at least one parent who was also involved with CFS as a child. These parents were children in the system who experienced trauma, grief, and loss, and I've seen firsthand the impact that relationships, respect, and family-driven goals have on parents success. We need to use this opportunity given to us by Families First to reinvest dollars into making sure families have the access they need to the level of care that will keep them out of the system. And fourth, we need to invest in the kinship and relative families that are keeping youth from needlessly being brought into the system in the first place. Family First helps with that by creating a kinship navigator program, but barriers still exist for many families,

including access to supports like Title 20. If we want to safely prevent court involvement, families must have the support they need to be successful. For example, some kinship families can't have access to financial support until a child's made a state ward. And finally, let's not lose sight of what helps families be successful: Parenting supports from the moment the children are born, like evidence-based home visiting; access to proven addiction and mental health programing that's family friendly; fatherhood engagement; welcoming, nonjudgmental, family-friendly places they can go to help when they realize they're struggling and have the courage to reach out. Right now, families struggle to get help because they fear their children will be taken from them. And a few questions I have for the group. How do we create and provide services that lift families up to be the best that they can be? How do we provide follow up and oversight without involving the courts? And how can we destigmatize help-seeking behavior? I'm happy to take any questions that you have.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

LANA TEMPLE-PLOTZ: Thank you.

HOWARD: Good morning.

JULIET SUMMERS: Good morning, Chairman Howard and members of the committee. My name is Juliet Summers, J-u-l-i-e-t S-u-m-m-e-r-s. I'm

here on behalf of Voices for Children in Nebraska, and I thank you for the opportunity to speak to today. I'm going to-- I'm handing you hard copies of my testimony, and to save you a little time, I'm not going to read directly from it. But I'll try to highlight a little bit of data that I think may or may not have been shared yet, as well as answer a couple of questions that I heard along the way. So I do want to start off by echoing everyone who's come before me has said it, I'll say it again. Nebraska is going in the right direction in terms of prioritizing, working voluntarily with families, trying to keep children safe together, reducing the trauma of removal. Several years ago, we were one of the highest rates of removal into foster care across the country. And I think it's really important that we do keep that as a baseline, as has been said, where we can, where we can do it safely. It saves the child the trauma that comes of being entered into foster care. So I do want to start by saying that we applaud that direction. We just think that we need to get some of the details right, especially as our system moves more and more in this direction. So I've shared with you a longitudinal graph of entries into child welfare from 2011 to 2018 so you can see how this trend has gone. It's not a perfect match, as you've heard. It's not just if you go to court, you're out of home, and if you are noncourt, you stay in the home. So this chart really just reflects whether or not there's court involvement and the things that come with a court entry, such as legal representation for the parents, guardian ad litem representation for

the child, court oversight, and all the requirements that we haven't statute. And as you can see from the chart, we've actually almost perfectly flipped from 2011 to 2018. In 2011, 63 percent of child welfare cases started with an entry in a court process. And last year those numbers were reversed, 64 percent of children entered our child welfare system through a noncourt case. I think there was a question from Senator Walz about calls to the hotline. So I can tell you that last year, actually this may be 2017 data, there were 35,923 calls to the hotline, 13,718 of those were assessed. So that means the other ones were screened out. Of the ones that were assessed, 2,169 were substantiated and 9,523 were found to be unfounded. And then separate from the assess-- the ones that were assessed, 599 were sent to alternative response for the alternative response process. And I will say that those sound crazy huge, but we do see that year after year. Nebraska is a mandatory reporting state where every individual is a mandatory reporter, and that can result in a high volume of calls to the hotline. So states that-- other states that are mandatory reporting states see similar trends where there's a high volume of calls because we, we prefer a better-safe-than-sorry call approach and a lot of them get screened out. So I'll skip a little further into my testimony and say that I think there was a question about wards entering care if they had been previously involved in noncourt. Some of this data, as you've heard, is a little bit fuzzy. But we do know that in calendar year 2018 there were a total of eight-- 1,871

children who entered foster care who had been previously involved. And of those, 767 had been involved in the past less than a year. So we do know that while the department has reported some data which is really positive about a lower rate of recurrence, we also know that there are still a significant number of kids entering foster care who've had prior involvement and even recent prior involvement. You've heard a lot about the, about the placements and the alternative living arrangements, the informal living arrangements. So I'll skip that piece and just say that, you know, we echo a lot of the recommendations you've heard today. Specifically, we think a really key piece could be exploring the opportunity with Family First to draw down federal funding for legal representation for both children and parents in noncourt cases. So one piece of Family First that I think hasn't been raised yet today is we are, if we can structure it right, able to get 50 percent for reimbursement for legal representation, even on the noncourt side, which could go a long way to ameliorating some of our concerns. We also agree we need to reauthorize alternative response. But with that, set some baseline parameters in statute or working with the department in updated regulation about how cases are going to be determined appropriate for alternative response or noncourt involvement versus court involvement, how assessments and investigations work, and what families rights are. And finally, just ensure that our statute is going to align with Family First to maximize federal drawdown so we can actually get services to families

and not just an empty case plan. So thank you again for your time. I'm sorry I went over, but I'd be happy to answer any questions if I can.

HOWARD: Thank you. Are there questions? All right, seeing none, thank you for your testimony today. Is anyone else wishing to testify for LR239? Good morning.

JULIE ROGERS: Good morning, Chairperson Howard, members of the Health and Human Services Committee. My name is Julie Rogers, J-u-l-i-e R-o-g-e-r-s, and I serve as your Inspector General of Nebraska Child Welfare. There are two items I'd like to review regarding noncourt cases, a survey of county attorneys about noncourt cases and an investigation our office conducted into a serious injury of a child after the family was involved in a noncourt case. An elected county attorney reached out to our office regarding concerns about how noncourt cases were being handled by the Department of Health and Human Services. We initiated a survey of county attorneys with the assistance of the Legislative Research Office and the Nebraska County Attorneys Association. At the same time, we were contemplating improvements to the child welfare system regarding noncourt cases. The purpose of the resulting survey was to ascertain whether county attorneys shared concerns about noncourt cases and, if so, to gain a better understanding of the specific concerns, just solicit ideas on how improvements to the system could be made. The survey consisted of questions related to communication between the county attorney and

DHHS regarding noncourt cases and three areas related to noncourt: initial assessment, ongoing case management, and multidisciplinary team processes. Based on the survey, there is a great opportunity for improving communication and collaboration between DHHS and county attorneys practicing in juvenile court about noncourt cases. A majority of the county attorneys responded would like to receive more information about noncourt cases, including when noncourt cases are declined, being made aware of the criteria a family must meet in order to be offered the opportunity to work noncourt case, being notified when a family is not making progress in a noncourt case, and receiving more information provided by DHHS and multidisciplinary team meetings about noncourt cases. Now to our investigation. We looked into the serious injury of a 7-year-old boy, Ben, due to abuse and neglect by his parents, Mitchell and Stephanie. The family was DHHS involved eight months prior to the critical incident, due to the family participating in a noncourt case. At six weeks of age, Ben was removed from the custody of his biological parents when he presented at the emergency room with multiple skull fractures under suspicious circumstances. Three months after being removed from his parents, Ben was placed with Mitchell and Stephanie, who eventually adopted him. CPS history for this family started when then 4-year-old Ben wandered into a local restaurant naked and asking for food. Ben walked approximately six blocks from his home at 6:00 in the morning to a local restaurant, where he entered and asked for food, saying he was

hungry. The responding law enforcement officer was informed by Mitchell that Ben was their adopted son, that he'd suffered three skull fractures after birth, had tested positive for both methamphetamine and marijuana, had special needs, and had been tested for autism, and that he often took off his clothes after wetting the bed. The hotline did not accept the report for assessment and screened it as it does not meet definition due to the child reportedly being autistic and law enforcement not citing the parents for abuse and neglect. At the time, Mitchell was employed by a contractor DHHS provider and had previously worked for the Nebraska Department of Health and Human Services. Over the course of the next three years, the family was subject to 14 reports to the hotline, six screened out, five accepted for investigation, and three determined to be multiple reports. Following an intake which alleged Ben had been forced to stand on his head over the top of a heating vent, resulting in a knot on the top of his head, Ben was found safe. The family scored at high risk for future maltreatment and, based on this risk, risk level, the family was offered a noncourt case but declined the offer. The risk assessment narrative stated that the parents felt they were aware of and had access to community resources and did not need services. Further accepted intakes again led to assessments that found Ben safe, but with high risk of future maltreatment. Then Mitchell and Stephanie agreed to participate in a noncourt case after the initial assessment, which closed about 90 days later. Eight months after this noncourt

case case closed, an intake was accepted by the hotline alleging physical neglect and abuse of Ben by his parents. The report alleged Ben had told school personnel that his parents withheld food from him for several days and Ben was asking staff for food. The report alleged Ben appeared malnourished, underweight, and pale. He was being teased by the other students as he was coming to school smelling of urine, urine due to his parents not allowing him to bathe. A medical evaluation found Ben, who was about one month away from his eighth birthday, to weigh 31 pounds, have a distended abdomen, and nearly disintegrated teeth, along with bruising and scratches in various stages of healing on multiple areas of his body. Ben disclosed that he was often locked in his room, forced to go to the bathroom in the corner, and was denied food. After our full investigation, we found that reliable behavioral indicators of maltreatment were repeatedly dismissed as evidence, ineffective child protection practices enabled the maltreatment to continue, and that maltreatment continued due to ineffective ongoing case management of the noncourt case. In terms of our noncourt case recommendations, noncourt cases can be effective if families fully participate in them. Successfully engaging parents in the process is critical. Participation by parents must include both collaboration and compliance. When collaborating with CPS, parents participate in assessing the family's strengths and needs, contribute to the construction of case plan goals, and take part in team meetings to discuss progress and continuing needs. Along with collaborating,

parents must also be compliant in that they must display such behaviors as making appointments, keeping appointments, completing tasks, and cooperating with the process in general. Ben's case exemplified the need for clarity and structure in managing noncourt cases. During the course of a noncourt case, accurate medical and mental health information participation in services is vital to ensuring child safety, safety and assessing progress towards case plan goals. As was evidenced in this case, without a mandate from the court, parents are under no obligation to provide information or engage in recommended services, thus making an accurate assessment of the family difficult, if not impossible. Because noncourt cases are without court mandate, it can be confusing to the family and/or more easily manipulated than court cases. Noncourt cases need clear protocols, policies, and expectations for families who are freely and voluntarily agreeing to participate in them. We recommended to DHS to create noncourt case policy establishing that participating in noncourt case requires at least the following: That parents sign a release of information, that parents allow contact between the worker and their children without caregivers present, parents formally agree to participate in recommended services. We recommended the creation of a handout or brochure to be provided to the family at the time of the noncourt case is offered that includes a clearly-written explanation of what noncourt case is, the legal rights of the parents, the responsibilities and expectations of the parents agreeing to a

noncourt case, the role and expectations of the caseworker, an outline of when information is shared with the county attorney and/or the multidisciplinary teams, an outline of when a referral to the county attorney can be or is made, and contact for an explanation of our office and the Office of Public Counsel. We recommended that DHHS policy is changed to include, include a mandatory consultation with the county attorney to evaluate the progress of noncourt cases no less than 60 days after opening and that DHHS develops specific noncourt evaluation criteria to help caseworkers and supervisors determine when a noncourt case should be referred to a multidisciplinary team and/or the county attorney for review, and require formal training for supervisors to ensure that they can assist caseworkers in making referral decisions. Since a court with all legal parties is not involved in noncourt cases, it is imperative that the Department of Health and Human Services have clear and concise standards for how noncourt cases are handled. I'm sorry for going over time. I'm happy to answer any questions.

HOWARD: Thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairman Howard. Thank you, Inspector General, for being here today and for sharing Ben's story with us. How is Ben today?

JULIE ROGERS: He's adopted, and I believe-- the last information we had is he's doing fine and he's not system-involved at all.

CAVANAUGH: Thank you. And in following along with Ben's story, there was a point where his parents were offered noncourt.

JULIE ROGERS: Yes.

CAVANAUGH: And they declined because they said they had community services?

JULIE ROGERS: That's right.

CAVANAUGH: So they were given the option to just do whatever they wanted?

JULIE ROGERS: Right. Because the way the policy was at the time, and others before me have talked about a May change in policy. If-- there are two assessments, a safety assessment and a risk assessment. And if the child is found safe, which it was, and then the family is found at high risk or very high risk for future maltreatment, then they can-- the family is offered a noncourt case. But they don't have to, they can decline those services. So they were, they were able to decline.

CAVANAUGH: So how is that different from the process now? Is that still the process, that they can decline?

JULIE ROGERS: Well, yes, they can decline. But my understanding is when there is-- if there's not an active safety concern then families can be referred to community resources instead of being engaged in a noncourt case.

CAVANAUGH: And based on Ben's story, it sounds like the threshold for safety concern is extraordinarily high.

JULIE ROGERS: Right. And it depends on how those assessments were filled out. Other, other parts of this investigation that I did not have time to go over have to do with S-- SDM assessment, structured decision making, and the validating of those instruments to see if they are, if they are measuring what we think they're measuring: fidelity to those instruments and the way caseworkers fill them out so.

CAVANAUGH: And that's probably in this report?

JULIE ROGERS: Yes.

CAVANAUGH: Thank you very much.

JULIE ROGERS: Yes.

HOWARD: Other questions? You've shared your recommendations with the department?

JULIE ROGERS: Yes.

HOWARD: What was their response?

JULIE ROGERS: Yes. So the department asked-- they have accepted recommendation about creating handout broch-- brochure, which is recommendation number three, and they're already in the process of creating that. They have also accepted recommendation number five, developing the noncourt evaluation criteria. And then the others, the others under the noncourt, they have asked for modification. And we did not modify those recommendations, so they have-- they asked for a modification to include-- to only include. [RECORDER MALFUNCTION] Discussions about this topic.

HOWARD: When-- for the modifications, I just want to clarify.

JULIE ROGERS: Yes.

HOWARD: They had recommended that there be an active safety threat. What does that mean?

JULIE ROGERS: So when you're assessed and there has to be a safety plan put in place for the child to remain in the home and have a noncourt case. So in our view, if there is an active safety threat and there continues to be an active safety threat throughout a noncourt case then that, under current policy, it already has to go to a court case. It should be referred to the county attorney under how things go under current policy. So our, again, under our view, by adding "only

when there's an active safety threat", it negates our recommendation. Because we believe that you can already do that under current policy.

HOWARD: Thank you. Are there any other questions?

JULIE ROGERS: Thank you.

HOWARD: Seeing none, thank you for your testimony today. Is there anyone else wishing to testify for LR239? OK, seeing none, I'm going to waive closing. And then the committee will take about a 10 minute break, we'll reconvene at 10:45.

[BREAK]

HOWARD: Now we'll be beginning a briefing around the transition for the contracts in the Eastern Service area around child welfare. This will be invited testimony only. And so the order that we're going to go in is we'll first hear from St. Francis and then we'll hear from PromiseShip and then we'll hear from the department. St. Francis has two individuals who would like to testify on their behalf, so we'll start with Father Robert Smith, the CEO and president of St. Francis. Good morning, Father.

ROBERT N. SMITH: Good morning. Chair Howard and members of the committee, good morning. I am Robert N. Smith, R-o-b-e-r-t N. S-m-i-t-h, and I have the honor to serve as dean, president and CEO of St. Francis Ministries. Thank you for the invitation to be with you

today and to share the progress we're making as we work with DHHS to offer important life-affirming services in the Omaha area. I'm grateful for the opportunity. I'm going to begin our presentation by talking briefly about St. Francis Ministries and the work that we do to bring healing and hope to children and families. Then Jodie Austin, our Nebraska Regional Vice President, will offer details about the transition that's occurring in Douglas and Sarpy Counties. St. Francis was founded in 1945 by a young Episcopal priest, Father Robert Mize. Father Bob saw a need in his community to serve young boys who, as he said, had been abandoned by their families and communities. And so he opened a boy's home to provide them with support and hope for their future. In those simple beginnings much of the foundational basis of St. Francis' mission and values was set. Today, we serve more than 30,000 children and families through our work in six states and the District of Columbia and internationally. In all of our work we remain resolutely focused on meeting community needs, partnering with stakeholders to take care of vulnerable children and to preserve and strengthen families. We also are dedicated to bringing about system changes that create a stronger future for those we serve. We are proud of the work done every day by our more than 1,300 employees and we are thrilled to expand our experience and expertise in Nebraska, where we have served since 2012. Building positive partnerships with DHHS and relationships with numer-- numerous stakeholders over these past months make us confident in the powerful and strong future of the

families we serve. For St. Francis Ministries it's always about community, building partnerships and working together to make complex systems stronger. We have been pleased to work with PromiseShip as a partner in the transition process and appreciate their commitment to making sure the families they have served are well taken care of and that we have the information we need to continue that service. Transitioning state contracts is something that we at St. Francis have considerable experience with from both sides of the table. It can be difficult to acknowledge the loss of a contract and to continue to move forward in a positive way. We appreciate the way PromiseShip has supported this process, even while experiencing the pain of change. With the transition that began this week, we are seeing early signs of success. As in all adaptive challenges, this week we have also recognized opportunities for improvements. We will work to continue with our partners, including DHHS, the judiciary, and partner organizations to ensure high-quality outcomes for those we serve. As I turn the presentation over to Jodie Austin, who bring you up to date on the transition, I'd like to note that we are excited to talk, talk with you about the process and what we are currently doing to transition case management in the Omaha area. As members of the committee may be aware, St. Francis is a defendant in two lawsuits filed and pending against us: One by the current vendor and one by the Appleseed center arising from the selection of St. Francis to render services under the recent RFP. Unfortunately, because of these

lawsuits, we are unable to address or discuss certain topics. Some of those questions we can't answer maybe re-- may relate to the financial or case management aspects of our RFP and subsequent contract. I can say to you that we are confident we will meet our proposal because of decades of experience working in similar markets. With an efficient administrative and operational infrastructure, we are able to provide high-quality, value-added services for those with whom we partner. Nonetheless, there is a great deal that we can share with you, and all of it is positive. I am most pleased to be here to spread the good news of our work in Nebraska, and I thank you for your time and your service.

HOWARD: Thank you. Are there questions. Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, Father Smith, for being here today.

ROBERT N. SMITH: Thank you, Senator.

CAVANAUGH: I just wanted to go to the last page of your testimony here. And you said that there, because of the lawsuit, there's questions that you may not be able to answer about the financial and case management aspects of your RFP. I'm particularly interested in both of those pieces, I think they're kind of critical to understanding how this transition is going to work. So I guess if you

can or maybe somebody after you can explain why those pieces would not be able to be discussed here today.

ROBERT N. SMITH: I think as we, as we transition to some of Jodie's testimony, where there will be a deeper level of detail, that may illuminate some underlying questions.

CAVANAUGH: OK.

ROBERT N. SMITH: And I do look forward for the opportunity where we're able to engage in that conversation. But I am advised that with these lawsuits that's something I just need to be very particular about in speaking to.

CAVANAUGH: Thank you.

ROBERT N. SMITH: Thank you.

HOWARD: Seeing none, thank you for visiting with us today.

ROBERT N. SMITH: Thank you. Thank you.

HOWARD: Now we'll invite up Jodie Austin, the Nebraska Regional Vice President for St. Francis. Good morning.

JODIE AUSTIN: Good morning. Thank you, Chairperson Howard and members of the HHS Committee for inviting me to talk to you about our progress in transitioning services in Omaha. My name is Jodie Austin, J-o-d-i-e A-u-s-t-i-n, and as stated, I am the Nebraska Regional Vice President.

I am honored to be part of the St. Francis team. I'm a lifelong Nebraskan and I've worked in child welfare for more than 20 years. I look forward to bringing our organization's expertise and experience in the ESA. I bring a unique perspective to this position in that I work through and experience the changes and privatization in the Eastern Service Area and across the state. I know the importance and impact of these transitions both personally and professionally. St. Francis received the contract to provide case management services in Douglas and Sarpy Counties, and we've been laying the groundwork for a success-- successful transition with a very sharp focus on safety of children and families we serve and preserving the child welfare workforce. It has taken months of preparation to get to this point. We have diligently worked in partnership with DHHS and providers to meet contract requirements and continue to build a system of care that will support children and families. We often serve in the darkest times of their lives. Today, I will share with you our progress in transitioning cases, supporting the dedicated workforce that cares for children and families in Nebraska and engaging the community. We have worked with the state on what is called a readiness review process, and we are meeting those expectations and goals. Designed by the Stevens Group, the readiness review assesses our ability to accomplish adequate planning without incurring unacceptable risks that could breach thresh-- thresholds of schedule, performance, cost, other criteria. Some of that criteria include demonstrating appropriate

contracting procedures for subcontractors, demonstrating the ability to properly train staff, demonstrating the capability to deliver a continuum of safety services for the entire area, demonstrating the ability to understand the foster care rate structure, being on track for hiring all positions, and many, many other criteria. On Monday of this week, we began taking cases and have safely transitioned 326 cases, more than half of which are labeled as out-of-home case types, meaning the child or children are living somewhere other than their biological homes at this time. About three weeks ago and now ongoing, we began and still attend daily meetings where PromiseShip, St. Francis, and DHHS staff prepare in reviewing each case to prepare for the case to transition from PromiseShip to St. Francis. As of today, we have hired about 140 staff and that grows every day. That breaks out to 96 case managers, 8 directors, 22 supervisors, and a handful of support staff so far. Many of the staff who have started with us are already doing the work for PromiseShip, which really has helped to smooth the transition process. We have scheduled trainings in November and December for staff who have not previously worked with PromiseShip. And by January, staff will be trained in the St. Francis Ministries' model as well. We know that a well-trained workforce is essential for children and families. We are engaging an ongoing standard training, working closely with DHHS to maximize Title IV-E training dollars, and look forward to adding additional layers of learning that will emphasize critical thinking, a disciplined approach

to decision making, and group supervision. Childs-- Nebraska's child welfare system is only as effective as its workforce. Working locally in child welfare for the 20 years, I have a history of doing the work right alongside my colleagues and friends who share my passion to create a better system and desire for constant improvement. These relationships have helped smooth some of the rough patches, and for that I am eternally grateful. Now, as some of you know, startups are not without their hiccups. We do take each experience as an opportunity to learn, pivot, and continue to move the good work forward. For example, we experienced a communication issue related to when a court hearing was scheduled which raised concerns, one of our judicial partners. We took an in-depth look at what the process was, what happened to make sure it was addressed. And I met with that judge at-- this week to explain how it was resolved. Some other updates I'd like to include in my testimony are we are working closely with DHHS to align our computer systems and to make sure that we're collecting data that meets our contractual requirements and provides the information we need to improve outcomes for children and families. We have been meeting with providers and have applications from 36 unique service providers to date and that continues to grow. We are in the process of scheduling a community information session for mid-November to talk about the Family First Prevention Services Act to Omaha area providers, stakeholders, and anyone in the community who would like to learn more. FFPSA is the most significant child welfare legislation to

pass in decades and we are extremely excited that Nebraska leaders decided to be the early implementers. We have leased an office located at 3311 North 93rd Street in Omaha. We are currently working out of that location, we are also doing some modifications to the space to better fit our needs. You will be invited to a ribbon cutting when that work is completed. Additionally, we are working on solidifying a final lease agreement for a space in Sarpy County, which is located around the 48th and Highway 370 loca-- area. Finally, we have been practically meeting with community stakeholders to hear input on child welfare system and to share with them how we are approaching the transition and provision of services. We've met with judges, attorneys, providers, and any others who are important supporters and partners of the work we do. Transition of services from one provider to another is a complex process and we're pleased with the progress we have made as we transition cases, support the child welfare workforce and build community engagement. I do appreciate your time and dedication to Nebraska's children and families, and I'm happy to answer any questions at this time.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you. Thanks for coming and briefing us on this. Couple of questions. Provider, provider contracts, we're in a two-phase process here, right? And, and to the end of December and then January on how,

how, how is that affecting your provider contracts? Are you assuming contracts now that are in place? How are you doing that?

JODIE AUSTIN: Sure. We are not assuming the contracts as they are. We are issuing what we're calling a provider service agreement for all services currently in place. And then we're matching, honoring that rate, that service, the units, etcetera through the end of the year. December 31 is not a hard-and-fast date, but we hope to then transition to more robust contracts beginning in January.

ARCH: Robust contracts, what does that mean?

JODIE AUSTIN: So each, we would call it a provider service agreement, so there's one agreement for every service type. So there's several that are in place. And so the larger contract that we'll execute with St. Francis will include all of the services. So there's only one contract and it's ongoing.

ARCH: With different individual entities.

JODIE AUSTIN: Correct. Correct, yes.

ARCH: And so rates may be in place now to the end of December, but come January that will be a negotiated element between you and the providers. Is that--

JODIE AUSTIN: Yes, that is correct. And we have started our first conversations actually yesterday with three of the local providers. We

offered up the contract, the proposed rates, the proposed language in the contracts, and not a single one of them had any concerns about those rates.

ARCH: The un-- the unknown has been a concern from what we've received from providers, you know, what are those rates going to look like? Is it going to be totally different and so.

JODIE AUSTIN: Sure. So, and I heard that as well. We did submit and send those rates to providers so they should have them now. And so far there, there are a few special contracts out there that we're working with. Those are special, only certain entities have those. But overall, the jet-- all of the services that are currently in the service array are included and we have not had any complaints about the rates.

ARCH: OK. A second question.

JODIE AUSTIN: Sure.

ARCH: Ability to hire. We know that it's very competitive right now for all employers trying to find the necessary employees. Critical to your operation, the ability to transfer those cases. You have to have the right ratio and the right number of employees, all of that. Give us a little bit of an idea as to, I mean, I see some numbers here, but

I don't know out of a total of what you've hired, 140, 140 staff. What, what, what do you have to have in place by the end of the year?

JODIE AUSTIN: What I will tell you is that we projected that only about 45 trained caseworkers would transfer from PromiseShip to St. Francis, just given information that people have said, yes, they'll apply, but they don't plan on transitioning. To be at 96, the overwhelming majority of those being from PromiseShip, is a huge success for us. We will continue to hire. We're not going to stop at a certain number because we do know through transition turnover might be an issue for a bit longer, as PromiseShip has experienced that as well. So we will have a continual hiring process until the system has stabilized and turnover is figured out.

ARCH: So I don't want to put words in your mouth, but what I think I just heard was you're not, you're not concerned about your ability to hire and to adequately staff.

JODIE AUSTIN: Correct. No, I am not.

ARCH: OK, thank you.

HOWARD: Other questions? Senator Walz.

WALZ: Thank you, Chairman Howard. Thanks for coming today. I have more of a statement and then maybe a question at the end. About a couple weeks ago, I visited with a few kids who are either in the foster care

program currently or have aged out, and I was really shocked to hear some of the stories that they were telling me. Stories about caseworkers dropping them off and not seeing their caseworker again for three to four months, stories about not understanding their rights, stories about abuse and neglect and no ability to tell somebody about the situation that they're in. And so I just want to remind everybody that this is taxpayer money first of all-- not first of all, but this is taxpayer money. It's not the government's money, it's not DHHS's money. It is taxpayer money. And I think that taxpayers would be appalled and shocked to know that their tax dollars are not protecting kids who are supposed to be placed in homes where they can thrive. And I know that this is not on you right now, but even more important than the tax money is that not one child should have to be abused or neglected. Not Ben, who we heard about before. Not one child. So taking over this system or this process, or whatever you want to call it, how can we ensure? How are you guys going to be instruc-- because we can't-- kids can't wait for hiccups to get better. How are we going to make sure that kids are not, not one, going to be abused and neglected from now on?

JODIE AUSTIN: It is my career aspiration to figure that out. In my role at St. Francis, what I can tell you, and in my role in the Nebraska child welfare system for my entire career, we have not done as good of a job as we could have done for youth aging out. Quite

frankly, youth shouldn't age out of a system, that's not permanency. We want them to reach permanency. I also want to bring back true social work to child welfare. Case management is one aspect of social work. And so while all of those regulations and policies introduced must absolutely be done, we also need to bring back critical thinking, a disciplined approach to decision making, not one-offs in the hallway, down the line without having the discipline to sit down and really understand what is happening. What are the options? What are the impacts of those options? And really make a decision as a group so that situations like Ben or the youth that you talked to who were abused or neglected can really be thought-- a thoughtful approach to deciding as a system how we're going to respond to that.

WALZ: Can you tell me a little bit about the, the case management load?

JODIE AUSTIN: I can speak to it surely in, in general, in that the state has mandates on what caseloads are. I believe there's up to 17 children on a caseload if they're all out of home. If-- or in-home. If there's a mix of that load, it's one to 16.

WALZ: OK. And do you think that that is workable enough that somebody could be making visits to those kids at least on a monthly basis?

JODIE AUSTIN: Absolutely.

WALZ: OK. That's all I have.

HOWARD: Thank you. Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you for being here and for your career in, in social service. That's really a testament to the value of children in Nebraska. I know that this is not an easy transition and that there are a lot of really important things to be considering. One of the things that you mentioned was the IV-E funding and that you will be working with DHHS to maximize the IV-E funding. Could you tell us a little bit more about what that means?

JODIE AUSTIN: Yes. So I am not, A, a IV-E expert. So I apologize in advance if I get the lingo wrong, but I will do my best. Essentially, the-- specifically to FFPSA, there is an opportunity to draw down more federal dollars using prevention services and not having to rely on foster care only to draw down those services, so that we can in fact serve families without a separation if it's safe to do so, chil-- separating children from their families. And so that opens up an opportunity to bring what I call, some others disagree, but I call "new money" or different ways to use money to prevention, to getting involved with families a little bit sooner to try to prevent abuse and neglect from happening to begin with. We are working with the department on, well, they've written their five-year plan and I have some ideas I'd love to share with them. And we're excited that they

are on the frontiers of this FFPSA in Nebraska. They are an early leader in this. And so with that comes questions. There's lots of information, we're still waiting from the feds on what exactly services we can use. How do you draw down those dollars? So we're also working not only with the department, but with any providers to let them know and teach them and work with them on what services they could provide prior to being child welfare-involved and draw down those IV-E dollars. We're doing things like that. Because there's somewhat of limited information right now from the feds on how to, there's only a limited number of services at this time that are approved to draw down those dollars. But I'm hoping that over time there will be many more.

CAVANAUGH: And if you are not able to draw down those dollars are you still going to be able to deliver the level of services to children--

JODIE AUSTIN: Oh, absolutely. And yes,

CAVANAUGH: --within the budget that the RFP indicated?

JODIE AUSTIN: Yep. Yes, I mean,

CAVANAUGH: Additionally, prior to this briefing we had a hearing to look at our noncourt voluntary process. And as a result of the changes that were made a year and a half ago, we are now seeing fewer children in our, in this process. If those changes were to be removed and those

children were to go back into this process, would you be able to handle that increase, that influx in children?

JODIE AUSTIN: Yes, it would just recategorize, recategorizes really some of the work. There could be an increase in the number and we'll just-- we manage to the caseload. That's what we are obligated to do and that is what we will do.

CAVANAUGH: And the cost of doing that is, I think, a pretty significant concern because the contract is significantly lower than what we have previously been paying for these services. So can you speak to how that is going to work?

JODIE AUSTIN: I can speak in general. Again, thanks to Father Bobby for pointing out that there's limited what we-- what we can, what I can share with you is that our infrastructure is much, much different than PromiseShip's, it's more of a shared services model. So we don't have to rebuild that infrastructure, we really can start at, at the work. So that is very helpful. The additional of these IV-E dollars through FFPSA is also going to be a help in maintaining that budget.

CAVANAUGH: So those IV-E dollars are assumed as an addition to the contract?

JODIE AUSTIN: You know, I didn't write the RFP, so I can't speculate or guess on what they assumed.

CAVANAUGH: Who could we get that information from?

JODIE AUSTIN: We can follow up and get back to you.

CAVANAUGH: OK. So I'm sorry, if somebody else has questions, please.

HOWARD: Are there other questions? Do you want to take a break? Are there other questions? I actually have a few, just to sort of jump in. How are you telling families about the transition?

JODIE AUSTIN: In our experiencing-- in our experience of transitions throughout the country, letting families know with a letter in advance causes confusion. So what we are doing is as the case is transitioned we are, A, having all of this, the caseworkers get in touch with their families, letting them know that the transition has occurred. This first round, many of the workers continue to be the same workers where we're moving people over in teams. And then we follow up at the end of the week with a letter letting them know that this transition has occurred.

HOWARD: So they're not getting a letter in advance?

JODIE AUSTIN: They're not getting a letter in advance.

HOWARD: --have a different service provider. You transition them and then they find out that they--

JODIE AUSTIN: No, they find-- they, they've been updated through their current caseworkers through PromiseShip, I'm certain. I haven't specifically asked that, but I know the good work that PromiseShip does and I'm certain that they would have had their, their employees communicate that. They just became the first, a few, the first 20 became our employees on Monday. And so then we are able to communicate and let them know and we follow up with a letter. So they're-- so let's say, for example, Sarah is a caseworker from PromiseShip on Friday of last week and she transitions. She would have certainly communicated with the families that she's assigned to. And then as she moves over as a St. Francis employee, maintaining those same families, she can let them know here-- I-- here's my phone number, here's my email address, here's my contact. Service pro-- so really, it's the company that changes, not the actual worker for most of this cases and the majority of the ones that are coming over this week.

HOWARD: I just want to make sure I understand.

JODIE AUSTIN: Sure.

HOWARD: So you said 20 workers came over from PromiseShip this week. And so they started on Monday and they brought their cases with them, is that--

JODIE AUSTIN: Correct.

HOWARD: --the idea. And so 20 workers brought the 326 cases over?

JODIE AUSTIN: It's about that. There are some cases-- the reason I struggle giving you an exact number, because that number is the number I came up with last Thursday based on account. So with noncourt cases, some of those close. I do know a handful have closed, so I can't give you an examp-- exact number today, but that's how many were scheduled to transition on Monday.

HOWARD: So 20 workers. I just want to make sure I understand.

JODIE AUSTIN: Sure.

HOWARD: So 20 workers came over from from PromiseShip, they started on Monday, and then they brought the 326 cases. So then the caseworkers didn't change from those 326 cases?

JODIE AUSTIN: Whenever possible. So we tried to maximize bringing over cases with their teams. Because PromiseShip has by their report lost a number of employees, there have been reassignments. And so they're-- based on their assignment at PromiseShip, yes, they're coming over with those same cases to St. Francis.

HOWARD: So a couple of things that I know that you won't have on hand, but that would be really helpful just as we're looking at this issue, I'd love to know of your 96 how many have come from PromiseShip.

JODIE AUSTIN: Sure.

HOWARD: I'd love to know how many noncourt cases have been closed--

JODIE AUSTIN: Sure.

HOWARD: --in this transition. And so even if it's a point in time, so you mentioned that some have been closed. Yeah.

JODIE AUSTIN: Can I explain that?

HOWARD: Yes.

JODIE AUSTIN: So in order to-- we had to start staffing cases two weeks prior to the 21st of this month. And so between that time of that case being scheduled to transition and actually transition, cases closed. So, yes, I can get you a list of those.

HOWARD: Was it predominantly noncourt voluntary cases that were closed?

JODIE AUSTIN: I don't have that information, but I get-- I could get it to you.

HOWARD: That would be great. Do you want to walk us through just very sort of grassroots how that handoff works? I think maybe that would clarify.

JODIE AUSTIN: Sure. So approximately one to two weeks prior to, well, we work with PromiseShip and DHHS to look at all of the cases that need to be assigned and transitioned. We match workers with their cases and then we set dates for what we call case staffings, and that is the point at which it's Monday through Thursday and then we hold Friday for anything that might have changed. Where someone from DHHS, someone from St. Francis, and someone from PromiseShip go together to review each individual case to make sure everything's there, what's, what are the main issues going on with this family? Any major concerns, list of services, due-- due date tracking, all of those things. And then so it's throughout that week they're staffed and then the following Monday is when they transition. This first go around we did two weeks of staffing before the first transition. Normally it's the week before and then it transitions, so we can get employees onboarded, going for new orientation that first week before they then come over with a caseload.

HOWARD: Other questions? Senator Cavanaugh.

CAVANAUGH: Thank you. So Senator Arch had asked about the provider rates and, and you said that they-- you have not had any negative feedback about, about those contracts. Are those comparable to what they currently are?

JODIE AUSTIN: They are pretty close. In our contract it states that we need to match or be lower than the state rates. And so we did that and we did spend many hours with many accountants looking through all of the rates that DHHS has, that PromiseShip has, the different levels, tried to match up to the best of our ability. And I was very pleased to find there isn't a significant difference in the standard services. There were some rates that we didn't have until after that fact, that we weren't aware of because they're what I refer to as special contracts. And so these are very specialized services that PromiseShip has created or they were created contracts over time that only one, maybe two entities have those contracts, so they weren't in the rate sheet. So as we learn about those three providers or through PromiseShip just letting us know, I don't think it was intentional that that happened. You know, you're just running reports and it wasn't thought of. So we're working with those individual providers one-on-one to say, OK, what's, what's this service? What's the rate? What, what are the outcomes you're looking for? And then working through those individually,

CAVANAUGH: What type of service are these providers providing?

JODIE AUSTIN: So one is a service for Nebraska Family Support Network, where there's family support through that network that match up with families going through the system. It's kind of like a peer mentoring program. So we're working with them and met with them. Two of them are

specialized adoption contracts above and beyond general adoption. It's file mining, Heart Gallery putting those things on, so we're working with them. And then there's one more, it's called integrated family care, and it's just a specialized program where the family resides with a foster family to prevent a separation. And it has components of teaching, safe living environment, etcetera. So those are the three.

CAVANAUGH: And as far as the caseworkers that are being transitioned over, are their salary and benefits remaining the same?

JODIE AUSTIN: Their salary and benefits are not remaining the same. The PromiseShip benefits, which I believe mirror Boys Town benefits, are just something I don't know that any company can match, unfortunately. I was very pleased to see that there's no caseworkers that I am aware of that took any pay cut. It was either comparable pay or actually a little bit higher. And not-- we're not talking a lot of dollars, maybe $500 to $1,500. And so I was very pleased with those, those salaries.

CAVANAUGH: I guess I'm not familiar with Boys Town's benefits. What is so robust about them?

JODIE AUSTIN: If you use a Boys Town provider, you don't pay co-pays, medications are free. It's a low rate for your insurance, things like that.

HOWARD: Are there any other-- Senator Arch.

ARCH: Thank you. I want to follow up on, since this morning's hearing was the noncourt cases. Were you, were you able to see hear any of that or--

JODIE AUSTIN: I was, I heard the last bit of it and it's something I'm very, very interested in.

ARCH: OK, well, that's good. We are, too. So, so you, you will have noncourt cases under your, under your case management, is that correct?

JODIE AUSTIN: That is correct.

ARCH: OK. And I, I would assume that kinship will be one of the, one of the available services that you would be providing.

JODIE AUSTIN: Correct.

ARCH: So how would you oversee a kinship case compared to a traditional foster care case? What, what type of oversight or supervision, quality monitoring, those those kinds of things?

JODIE AUSTIN: Sure. So how we will do kinship is there's kinship case management, which will be provided by trained caseworkers. We don't separate case, kinship caseworkers from nonkinship caseworkers. They're all trained the same way. They're all have the same

requirements in terms of contracts, documentation, etcetera. All of those standards stay the same. In addition, we will have a kinship unit that specializes in the support and help licensing of those kin homes. And so there is additional oversight in there to make sure that the homes are safe, people are getting what they need. We're not just as a system placing and forgetting them because they're with family. So it operates very much like a standard foster type service would look like.

ARCH: OK. One next-- one other question follow up here. What-- where is the responsibility for the decision as to, well, that child is going to foster care, that child is going to kinship. Does that rest with St. Francis? Does that rest with the department? Where, where is that decision?

JODIE AUSTIN: We do make those decisions. We're also bound to follow all of the policies, laws, and regulations that DHHS has set forth. How you make the decision is should be based all on a battery of assessments, including is there available family? Are we searching for those family? Because if a separation has to occur, we want that separation to be the one and only until whatever has happening is resolved, whether that then that child is experiences permanency with their family or adopted, etcetera. So that we make that recommendation. Now, sometimes it is a little bit more difficult to find individual family members. We do background checks, etcetera, so

we do have family finding specific positions that will go and seek out those families, because we've heard from in the system a lot of families that say: I didn't know my niece or nephew was in care for six months to a year, and I would have been that, that person. So we know that's very important. Sometimes they're not readily available and we need to make sure that the children, if deemed that they have to be separated from their families, have a safe place to go. So that generally determines if there is an availability it has to meet minimum criteria, just like foster, foster placements do. So it's safe, background checks, walkthrough, etcetera.

ARCH: The background check that you reference, that could be problematic. Just number of days, turnaround, making sure that that's completed before the child is placed. Training of kinship, I mean, this isn't like everybody gets in line and maybe someday I might have a child from a relative. It's, it's immediate. And so training and background checks that's, that can be a challenge, I would assume.

JODIE AUSTIN: Initial background checks aren't actually a challenge because DHHS can run them for us very quickly in the moment. Training, yes, nobody I think-- I don't think people wake up in the morning and assume that they're going to be a foster parent or a kinship parent to one of their family members. So that training is specialized. That's where the support comes in and the training really comes along as they're doing this. So the initial is-- luckily, they know the child,

so the bond is there. So it's things like walking them through what this process looks like. What are the rights, what might they expect with behaviors of someone who's been removed or separated from their family, etcetera. So that is the process that we move right along with them at the pace that they're able to take in the information.

ARCH: Are they paid for that?

JODIE AUSTIN: It's not a black and white answer. I believe our intent, well, we will be reimbursing kin just like foster parents are for sure. There are some that don't want it or deny it. But yes, there are funds for that.

ARCH: OK, thank you.

JODIE AUSTIN: Sure.

HOWARD: Senator Walz.

WALZ: I just have one more follow up. Thank you, Chairwoman Howard. Thank you so much. Direct care, the case manager, the case manage-- man, I can't talk. The case managers are probably the most important people, in my opinion, working with the families. Can you talk a little bit about the training? Like what's involved in the training? How long does it take?

JODIE AUSTIN: Sure. I have never personally been through that training because I've always been on the provider side of things in my career

and/or advising on case management. So I haven't gone through it. But in general, with the state-- and where, we will be using the state CCFL training so that we can additionally maximize the IV-E dollars, so they will be doing that. It's 12 to 14 weeks, I am told. I haven't seen the curriculum yet, our training people have. So they will be going through that. And then in addition to that, we'll provide additional training from St. Francis, such as critical thinking, group decision making, overseeing our supervisors for group supervision, have forums for learning, etcetera.

WALZ: OK, thank you.

JODIE AUSTIN: Sure.

HOWARD: Just for me, how many total case managers are you planning on having?

JODIE AUSTIN: I shot high and have a goal of hiring 130. That's more than we'll probably need, but it's always better to have more than not enough.

HOWARD: And then remind me, how many cases total are you going to be taking from PromiseShip?

JODIE AUSTIN: You know, that number changes. The, it's anywhere from, fluctuates between 1,600 and 1,800 or so.

HOWARD: Any other questions? Oh, Senator Murman.

MURMAN: I've got one, thanks. It seems like to me and with kinship placement that there would be a high risk that the family says the judge mentioned earlier would, the kids would go back with their original family. How was that monitored? Because typically with younger kids, I would think they would probably want to go back to their family. Older kids might want to stay away, but it seems like I'd be a high risk that they would be back there, as the judge mentioned. You know, especially, for instance, from the family-- the parents were picked up with drugs and had the kids with them and so forth.

JODIE AUSTIN: Sure. Well, as Senator Walz talked about, that's why knowing your families are very important. While there is a standard that you interact with families once a month, that is the bare minimum standard. And so in addition to case managers visiting and working with their families, if they are an out-of-home situation, they'll meet with them and they will also have the support-- we call them a kinship support specialist, who will also be in that home to support. Also oversee what's going on in the family. They have monthly reports, they have visits one-on-one with the child without those kinship folks around so that they can ask about it. They're trained to observe what's going on to see if there's any indication or evidence that other people are moving in, asking the children. You know, there's not

full on surveillance, but I would say we do hear-- probably the 1 percent of stories where things go wrong, I would say more often than not, kinship families actually provide really great care and are grateful that there is some separation so that they have the authority to keep some boundaries from those biological parents as we move those cases forward.

MURMAN: Thank you.

JODIE AUSTIN: Sure.

HOWARD: Seeing no other questions, thank you for your testimony.

JODIE AUSTIN: Thank you.

HOWARD: We'll next hear from Ron Zychowski from PromiseShip. Good morning.

RON ZYCHOWSKI: Good morning, Madam Chair. Good morning, members of the committee. My name is Ron Zychowski, that's R-o-n Z-y-c-h-o-w-s-k-i, and I'm the CEO PromiseShip. And I appreciate the opportunity to be able to come and talk a little bit about the transition. Let me give you a little bit of my background so that you can perhaps put some of my comments in perspective. After 25 years in the Army, I retired. Last duty station was actually here in Omaha, Nebraska. Moved to Florida, where I started a career of nearly 22 years in human services. I spent eight years with the Department of Children and

Families in Florida, and the remainder of my time in the private private sector, either as CEO of a company very much like PromiseShip or as the chief operating officer of a much larger, multi-state human services company, much like St. Francis. I've been involved in privatization at its inception in Florida, beginning in 1998 when the legislature required the department to privatize child welfare in Florida and have been engaged in transitioning both from the government side and the public sector side. So this is not new work to me, although it is new work to me in Nebraska. We returned to Nebraska to be close to family. The previous CEO of PromiseShip talked me into taking a job with the, with the company in September of last year then walked into my office in January and said, hey, how would you like to be CEO because I'm going to Washington? So on May the 25th, I became the CEO of PromiseShip. And then on June the 3rd, it was announced that the department intended to award the contract to St. Francis. So it has been an interesting year. With that said, as, as Jodie Austin bried you all, we have commenced transition. It started this week. We did transfer 326 cases. I think the number-- the interesting thing is the number is never exactly correct. And the reason is cases close, cases come in, cases go out. So at the time that Jodie looked at the number, it was 326; when I looked at it at about 7:00 last night, it was about 304 because some cases had closed. And we did transfer 20 case managers, 3 case management directors, 6 case management supervisors, and 6 support staff, many of whom had started-- or

previous earlier with St. Francis so that they could be on board, oriented to St. Francis by the time the case manager showed up with their cases on and on Monday the 21st. As Jodie indicated, cases are staffed every two, two weeks in advance of transfer. And present at those case staffing are the PromiseShip supervisor, case manager, a leader from St. Francis, and a representative from the department. All cases being transferred in October and November are moving with their current PromiseShip case manager. That means there will be no disruption and no case change for those cases that move in October and November. And that's a, that's a significant positive in any transition in child welfare. And, you know, Madam Chair, I know you, you asked a question about how do you notify families. The best person to notify a family of what's going on is the case manager who was with them before the transition and who will be with them the day after the transition. All of the other nice to-do letters from the CEO and all of that other sort of thing are great. But the real relationships in child welfare relationships between case managers and families and kids, they are the best transmitters of the message. Case transfer packets, as Jodie indicated, provide a wealth of information to, to, to the case manager and supervisor and puts it all in their fingertips. In those case transfer packets are family demographic information, genograms, permanency goal, next court date. All of the current information around what are the services being provided to the families? Who is providing them? What is the cost of those services?

The due date tracking form out of N-FOCUS, the DHHS child welfare system that lays out the next critical events in the case; and supervisor's last consultation point, which lays out what are the next steps that need to happen in this case in order to move it to permanency. St. Francis and DHHS has been provided all of our services information, all of our contracts, all of our letters of agreement, all of the rates that we pay so that they can then work together to tie St. Francis' systems into N-FOCUS system, which is the system they're going to be using, I believe, for referrals. So all of that is out there and in place. As with any transition of this size, as Jodie indicated, issues are going to arise. But I will tell you that PromiseShip, St. Francis, and the department will work collectively to make sure that those issues are properly resolved. Now, according to the-- I want to talk a little, according to the staffing schedule that we have and our own projections on known case managers who have been hired by St. Francis and will be transferring, we'll be transferring 208 cases next week and 930 cases across the four weeks in, in November. All of these cases are scheduled to transfer with, as I said before, with their current case manager. Directors, supervisors, and support staff have been hired by St. Francis and will move to St. Francis as cases and case managers move to St. Francis. That will leave about 150 cases to be transferred in December. One of the things I failed to mention was that the department's transition plan had cases commencing-- case transfers commencing in October and to be

completed not later than the week of 9, December, would be the last case transferred from PromiseShip to St. Francis. Got a bit of cold. So in December we'll have about 150 cases out of nearly 1,300, actually nearly 1,600 cases that will be transferred, that will be going to a to a new case manager. And as I said, PromiseShip and St. Francis and the department is working on how we're going to make that happen. And as you've also heard, St. Francis is hiring and training case managers in November and December who are not PromiseShip staff. So I was asked to say a few words concerning PromiseShip's current staffing. So since June the 3rd, when the intent to award the contract to St. Francis was announced, 111 staff have departed the company. Of this 111, 40 are direct service case management folks, 28 case managers, 7 supervisors, and 3 trainees. Thirty-seven staff worked in kinship support, family finding, prevention, independent living, and on-call. Twenty came out of essentially administrative services, HR, finance, training, and quality; and 14 came-- departed the company out of our network and service coordination units. So looking closer at the 113 remaining case management staff, what we see is that 76 will transfer to St. Francis and 37 will be departing the company by December 31. So we right now, all of the case managers that St. Francis has hired, right now it's looking like about 76 of them will be PromiseShip case managers. All of our K-13 of our case manager trainees have been hired by St. Francis and will transfer to St. Francis, and their training will be completed not later than the 19th

of December. And 18 of our 22 current case management supervisors will be moving to St. Francis. And I'm actually pleased to say that two of those have been promoted to directors at St. Francis. So there is a significant amount of seasoned talent that is moving from PromiseShip to St. Francis in the way of seasoned supervisors, seasoned directors, and seasoned case managers. One other issue I'd like to raise before I open it up for questions is that I've been told that there is a concern that's been raised that cases are being closed prematurely. I want to make sure that you know that that is absolutely, unequivocally not the case. And as a matter of fact, what you see in terms of case closures during this transition is what you would absolutely expect to see. And that is that case closures have slowed because of all of the noise and dust and construction that is, that is created when you have a transition of this magnitude. And so, for example, over the course of the past four weeks, we had 48 youth exit foster care. You would have expected during the same four-week period under normal circumstances that that number would have been closer to 80. So, so we are exiting children from care, we are closing cases when it is appropriate to do so. And when cases transfer to St. Francis, they will close cases when it's appropriate to do so and not any sooner. So, Madam Chair, that concludes my briefing. Subject to your questions.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, and thank you for being here. I just wanted to be sure that I understood these numbers about the case managers coming over.

RON ZYCHOWSKI: Sure.

WILLIAMS: That the cases that are being transferred in October and November will all be with their same case manager.

RON ZYCHOWSKI: That is what is planned at this moment. Yes, Senator, that's correct.

WILLIAMS: And at the end of the day, out of approximately 1,600 cases being transferred, there will only be about 150 that will be assigned to a--

RON ZYCHOWSKI: That will not be transferring with their PromiseShip case manager. That's the way--

WILLIAMS: I just wanted to be sure that--

RON ZYCHOWSKI: That's the way it's playing out right now. That's correct, Senator.

WILLIAMS: I just wanted to be sure I--

RON ZYCHOWSKI: Yes.

WILLIAMS: --got those. Thank you.

HOWARD: Other questions? Seeing none, thank you for briefing with us-- briefing us today. I appreciate it.

RON ZYCHOWSKI: You're welcome, Madam Chair.

HOWARD: CEO Smith. Good morning.

DANNETTE R. SMITH: Good morning. Good morning, Senator Howard and members of the Health and Human Services Committee. My name is Dannette R. Smith, D-a-n-e-t-t-e, middle initial R., last name Smith, S-m-i-t-h. I'm the Chief Executive Officer for the Department of Health and Human Services. I'm here to provide an update on the progress and process of the transition of child welfare contractors in the Eastern Service Area made up of Douglas and Sarpy Counties. I think to best understand where we are going, we should take a deeper look at the history of this transition. Last year we hired Stevens Group, a national child welfare consulting firm, to measure the effective-- effectiveness of Nebraska's outsourcing model and whether it was meeting the department's goals of economic efficiency and improving outcomes for the children and families of all-- of the Omaha area. While the report identified both successes and shortcomings, it provided guidance for improving the privatization and the model going forward. The department used the recommendations to create a request for proposals to attract a vendor that could deliver high-quality case management and child protective services that strengthen families and

build protective family capacity. There were two proposals submitted and determined to be qualified under the RFP. One proposal from long-time ESA contractor PromiseShip and the other from St. Francis Ministries, a department provider partner for several years. The Department of Administrative Services reviewed the proposals and oversaw a scoring panel that included representatives from Foster Care Review Office, the Nebraska Indian Child Welfare Coalition and Nebraska Children and Families Foundation. St. Francis Ministries scored higher than PromiseShip and intent to award was issued in June, 2019, making the beginning of the transition. The Stevens Group reported also-- report also informed the department's efforts to develop a contract that provides a clear vision that defines success, demands accountability, and encourages collaboration between the department and the contractor. Negotiating a final contract with St. Francis included clarifying their ability to achieve the department's goals and to meet statutory requirements like caseload numbers. With that case-- with that conversation settled, a five-year contract was finalized in July of 2019. Continuity has been our top priority, and a seamless transition with minimal impact on children and families is our ultimate goal. To achieve both, the department created a team to work with both PromiseShip and St. Francis to execute the handoff. Together with the two vendors, we have created a tripod approach to handling this transition. Again, this tripod approach is a solid ground for three agencies to work together. Those agencies again are

PromiseShip, St. Francis Ministry, and the department. The DHHS transition team is made up of a dozen of the department teammates guiding and directing elements of the transition related to planning and coordination. Financial management, human resources, information technology, logistics, contract management, quality management, operations and services, coordinated communications, mobile rapid response, and readiness review. And if I can, I'd like to take just a moment to thank my staff for an awesome job. They've worked extremely hard with PromiseShip and with St. Francis to make sure that as we do this transition that we're being comprehensive. These teams have been working individually and collectively, driving a robust transition process that includes skilled and experienced staff monitoring and measuring transition milestones to maximize St. Francis' ability to succeed. In preparation for case transfer, the department developed a readiness, a readiness review tool to determine overall readiness, as well as reviewing financial, functional and structural preparedness. To ensure we are ready for the transfer this week, I set the following milestones exceptions which were met by St. Francis. One was to successfully onboard the necessary staff to meet our case management transfer schedule and to meet our caseload racial standards. That was one worker for every 17 cases. And, Senator Cavanaugh, wanted to clarify some information that I gave you, was that our initial assessment cases are 1 to 12. And I was not clear about that and I do apologize for that. Number two, provide contract in process or in

place. And that's with their network, that needed to be in process or completely done. And that's, they're working on that as we speak. And number three, completion of a comprehensive review of all potential case ready-- cases ready for transfer October 21st. That was done early, I was given a report by my staff that cases were being pended and ready to be transferred during this upcoming week. We have developed an intentional, comprehensive process for case transfer. This involves a phased-in approach to this transition so that we have time to work collaboratively with St. Francis and PromiseShip, as well as others in the child welfare system, including providers, judges, and CASA. This phased approach will help the entire system with us to continue to provide children and families with comprehensive child welfare services. This change in vendor is not solely dependent on the state or St. Francis or PromiseShip, it is indeed a systems change, a system shift. St. Francis began assuming case management responsibilities for existing cases this week. And you've heard from both St. Francis and PromiseShip about the number of cases that thus far have been transferred, and it's approximately between 326. And Ron said his last count was 304. We are anticipating another, and these are approximate numbers, and you did get this from PromiseShip and St. Francis, during the week of October 28, 200 cases are slated to be transferred. And then during the week of November 4, approximately 200 cases will be transferred, and I totaled that to approximately 726. By mid-December we think that we'll be between 1,550 cases to six-- 1,600

cases to be transferred to St. Francis. My staff, along with St. Francis and PromiseShip will use, will use the remainder of December to reconcile cases to ensure no case, no family, no child is missing. And when I've spoken with each of you, I have talked about from December 13th until December 31st is our two weeks of reconciliation of cases to ensure that all cases from PromiseShip have indeed been transferred over to St. Francis and that we've left no child behind. An additional aspect of this phased approach involves my DHH staff maintaining responsibility for new noncourt cases through the end of December 2019. The case transfers involves managing dozens of details and ensuring that St. Francis and PromiseShip receive comprehensive and timely information from the department. So to ensure that, and you heard Ron kind of talk about the transfer process, I know that my staff are also collecting data and documents to make sure that we have a manual transfer file for each child that's being transferred, and that includes a face sheet, case transfer sheet from the N-FOCUS management system, a signature page for accountability because we want to make sure that that case has been staffed and the supervisors from PromiseShip and from St. Francis have signed off. Case managers due date tracking form, printouts again from N-FOCUS that documents the most recent supervision on the case, a family genogram, and service printout of FAMCare. Across the board, our efforts and our transparency have been received positively. Throughout this transition, PromiseShip has graciously and professionally accommodated

both our teams and St. Francis' team by providing additional information as requested by sharing their workspace for meetings, job fairs, and new employee orientation, and by maintaining open lines of communication. I personally have talked with Ron almost on a weekly basis about this transition and Ron has graciously submitted to me daily reports in terms of the transition from PromiseShip. And I want to acknowledge how much I appreciate Ron's leadership during this process. As you know, PromiseShip has been our partner in the Eastern Service Area for more than 10 years. We are grateful to their commitment to remain focused on the well-being of children and families when the when the results of the RFP were announced. St. Francis has been an eager and available partner in this transition, and I would expect nothing less as we move forward. I expect this level of engagement and responsiveness to continue after the transfer is completed. We know there are concerns about St. Francis' ability to meet the terms of their contract. Remember, though, St. Francis is not new to us, just new to the Eastern Service Area. They have proven to be a strong, compassionate, and professional team in the efforts to strengthen Nebraska's families. Further, they have experience doing this in other states in markets similar to the Eastern Service area. They are well-positioned to provide efficient and effective case management services to the families we serve. As this transition continues, I look forward to personally providing updates to each of you, to the public and to the key stakeholders who partner with us to

keep children safe and to strengthen Nebraska's families. I thank you for the opportunity today to testify before you, and I'm happy to answer any questions you may have.

HOWARD: Thank you. Before we get started with questions, just one that I think is pretty basic. Are there any cases that are being picked up by the department? So we're talking about the transition of cases from PromiseShip to St. Francis, but what's happening to new cases in the meantime?

DANNETTE R. SMITH: Yes. So for new cases, the noncourt cases, the department is picking up those cases in the Eastern Service Area.

HOWARD: Just new noncourt?

DANNETTE R. SMITH: Just new noncourt.

HOWARD: And then who's taking new court cases?

DANNETTE R. SMITH: I think that St. Francis is. I'm not sure. I may have to get clarity on that.

HOWARD: OK.

DANNETTE R. SMITH: Let me get clarity on that.

HOWARD: Thank you. OK, are there questions from the committee? Senator Cavanaugh.

CAVANAUGH: Thank you, Chairwoman Howard. Thank you, CEO Smith, for being here today. You and I have spoken about this that there's a difference in the contract amount between PromiseShip and St. Francis. And I was hoping that we could talk a little bit more about how that works, because I know no one here wants to provide lower quality services to our children, especially hearing what Senator Walz was saying about a child not receiving adequate services. This is our most precious resource and we want to make sure that those dollars are being utilized and whatever amount is needed. So in June the contract was awarded to St. Francis at 60 percent less than what our previous contract with-- was with, with PromiseShip. Could you maybe illuminate for us how that cost savings is working with not cutting provider rates and not cutting salaries for workers? How are we actually realizing a 60 percent savings?

DANNETTE R. SMITH: So because of the lawsuit, I'm going to have a difficult time answering that. I'm not going to be able to answer that for you at this point. Once the lawsuit is resolved, I'm sure I'll be able to discuss that information with you in detail.

CAVANAUGH: OK. So once the lawsuit is resolved, you will be able to provide an answer to that 60 percent cost savings?

DANNETTE R. SMITH: Yeah.

CAVANAUGH: OK. What is the cost that DHHS and the state of Nebraska is incurring for the transfer from PromiseShip to St. Francis? But this, this transition period that we're going through?

DANNETTE R. SMITH: Because we started early?

CAVANAUGH: No, just generally speaking. If we-- I'm assuming there is a cost related to transferring services from one contract to another and those costs are in some way coming to Nebraska.

DANNETTE R. SMITH: Right. And so I would need to get that figure for you. I don't have that with me.

CAVANAUGH: OK.

DANNETTE R. SMITH: And I can get that for you.

CAVANAUGH: Thank you. I think that would be helpful for all of us.

DANNETTE R. SMITH: Yes.

CAVANAUGH: Was there ever a discussion with PromiseShip about if they had the ability during the RFP process to provide services at a lower rate so that we could avoid the transition? It's my understanding that when the decision was made that they both scored equally and that St. Francis had a lower bid, and that's why St. Francis was chosen over PromiseShip. Was PromiseShip given the opportunity to say whether or not they could provide the services at a lower rate?

DANNETTE R. SMITH: And again, Senator Cavanaugh, I'm sorry that I'm not able to answer that for you. It is part of the lawsuit and so I'm not able to answer those questions. I do apologize.

CAVANAUGH: Thank you. One last question is are, are providers being notified of the transition by the caseworkers or-- and I apologize, this occurred to me while you were speaking. Probably should ask somebody else, but I'll put it out there in case you can't answer it. Are providers being notified of the transition through the caseworker? So if a provider is attached to a certain case, how are they getting notification?

DANNETTE R. SMITH: So my understanding is that St. Francis is handling that communication with all new families, and I'm sure that they are allowing their case managers to have those conversations about the new provider being St. Francis.

CAVANAUGH: OK. Thank you.

HOWARD: Other questions? Senator Walz.

WALZ: Thank you, Chairman Howard. Good morning, thanks for coming today.

DANNETTE R. SMITH: Good morning.

WALZ: I am just interested again about the training that's going to be provided to caseworkers prior to them going on the job. Jodie talked a

little bit about the fact that it takes about 12 to 14 weeks to train somebody. Will-- do you foresee every caseworker getting that complete training prior to going on the job? So you foresee that, first of all, I guess?

DANNETTE R. SMITH: Yes, I do. And it's my understanding that that's a requirement that everybody has that training in order to take a caseload. So we'll be following that process.

WALZ: OK.

DANNETTE R. SMITH: So, you know, in terms of if you're asking me will the department be taking or allowing St. Francis to take a shortcut around the training, that won't be allowed.

WALZ: How many new employees are you going to have to hire?

DANNETTE R. SMITH: I know that she indicated, and I'm speaking about Jodie, she indicated that she's hiring up to 130 new staff, direct line staff or case managers. I know that based on the data that we have, she needs approximately 112.

WALZ: OK. And everybody will be in place by December?

DANNETTE R. SMITH: Our goal is to have everybody in place by January 1.

WALZ: By January 1.

DANNETTE R. SMITH: Our goal would be to have as many cases, many staff and cases in place by December 13.

WALZ: OK. I'm just wanting to make sure that you have enough time. Twelve to 14 weeks, I don't know where that takes us, but--

DANNETTE R. SMITH: It takes us right up there.

WALZ: OK.

DANNETTE R. SMITH: Yeah, it does. It takes us right up there.

WALZ: OK. All right, thank you.

DANNETTE R. SMITH: Thank you.

HOWARD: Other questions? Senator Williams.

WILLIAMS: Thank you. I just want to be sure with, with Senator Walz's question that I'm understanding. Staff members that are fully trained from PromiseShip that are coming over and going to work for St. Francis, do they have to have an additional 12 to 14 weeks of training or is their training taken care of?

DANNETTE R. SMITH: Their training is taken care of.

WILLIAMS: Thank you.

DANNETTE R. SMITH: But my understanding is that St. Francis will be doing some additional training on their model.

WILLIAMS: Yeah. Thank you.

HOWARD: And I'd like to follow up on the-- a friend from our colleagues on the Appropriations Committee. What's the budget impact of starting St. Francis early? So our anticipation was that they would start January 1, that's when the contract starts. But so, so how are we sort of fiscally managing paying two contractors at the same time?

DANNETTE R. SMITH: So what we've done is we've put together an amendment, and I don't have all the details. I can get all of that for you. But we have put together an amendment to St. Francis to assist with this transition period. But we know that once we get into January, they have their network in place, that we'll have to do a balancing act of that finance. And I don't have the specific number with me now.

HOWARD: OK, so, so but right now we're paying both of the contractors?

DANNETTE R. SMITH: Yes.

HOWARD: OK.

DANNETTE R. SMITH: Yes, we are.

HOWARD: OK. Do you want to tell us a little bit about the readiness assessment? I know you've had some conversations with our colleague, Senator Bolz, about the readiness assessment. Do you want to just give us an overview of--

DANNETTE R. SMITH: Sure.

HOWARD: --where we're at on it?

DANNETTE R. SMITH: Sure. The readiness assessment is a huge document that spells out the accountabilities that St. Francis must achieve as part of getting ready to be our partner and to do some of the case transfer, transfer activities. It looks at financing, it looks at staffing, it looks at IT requirements. It looks at oversight and leadership, workforce development, workforce training. And in the readiness tool, it talks about what the contract says, the questions that we're asking St. Francis to do, and by when they're getting it done. It is spelled out and it's a very detailed document. The readiness tool also marries up against the actual contract. So if the contract says A9, we have something on the readiness tool to say, was that accountability done and by when and by who? So it's a very comprehensive document. And St. Francis has done a fairly good job in making sure that they're accountable.

HOWARD: OK. Any other questions? Seeing none, thank you for visiting with us today.

DANNETTE R. SMITH: Thank you for having me.

HOWARD: This will close the briefing on the transition from PromiseShip to St. Francis in the Eastern Service Area. We will take a break until 1:30.

[BREAK]

HOWARD: My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha. And I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves, starting on my right with Senator Murman.

MURMAN: Hello. I'm Senator Dave Murman, District 38: Clay, Webster, Nuckolls, Franklin, Kearney, Phelps, and southwest Buffalo County.

WALZ: Lynne Walz, District 15, which is all of Dodge County.

ARCH: John Arch, District 14, which is Sarpy County, Papillion, La Vista.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36: Dawson, Custer, and the north portion of Buffalo Counties.

HOWARD: Also assisting the committee is our legal counsel, Jennifer Carter, and our committee clerk, Sherry-- our committee clerk, Sherry Shaffer is actually out right now so Katie Quintero from the Retirement Committee is helping us out today, which we're very

grateful for. A few notes about our policies and procedures. Please turn off or silence your cell phones. This afternoon we'll be hearing two interim studies, and we'll be taking them in the order listed on the agenda outside of the room. On each of the tables near the doors to the hearing room, you'll find a blue testifier sheet. If you're planning on testifying today, please fill one out and hand it to Katie when you come up to testify. That-- this will help us keep an accurate record of the hearing. Any handout submitted by testifiers will also be included as part of the record as exhibits. We would ask that if you do have any handouts, please bring ten copies and give them to a page or pass them off to Katie. We use a light system for testifying. Each testifier will have five minutes to testify. You'll get four minutes with a green light, one minute at a yellow, and then when it's red, we'll ask you to wrap up your final thoughts. When you come up to testify, please begin by stating your name clearly into the microphone, and then please spell both your first and last name. Each interim study hearing will begin with the introducer's opening statement, and they will have an opportunity to make a closing. After the opening, we'll take testimony. And just a reminder that interim studies are a little bit different than regular hearings. At regular hearings, we hear proponents and opponents and neutral testifiers. But here today, testimony will not be grouped in that manner. We'll just be taking testimony for anyone who would like to talk to us today. We do have a strict no-prop policy in this committee. And with that,

we'll begin today's hearing with LR131-- LR134. Welcome, Senator Slama. This is your first time in HHS, isn't it?

SLAMA: Yes.

HOWARD: Well, welcome.

SLAMA: Thank you. Good afternoon, Senator Howard and members of the Health and Human Services Committee. My name is Julie Slama, J-u-l-i-e S-l-a-m-a, and I represent District 1 in southeast Nebraska. And I almost forgot that I do have exhibits. I come before you today to introduce LR134 with the hope of having a productive conversation regarding the drug-testing protocols in place at the Department of Health and Human Services. The drug-testing protocol issue came to my attention from some of my constituents who are foster parents this March. It was also in March that KETV ran a story on this protocol change. There was widespread concern from foster families in my district regarding the safety of children as it relates to current drug-testing protocols which were changed, to them seemingly, without notice in October of 2018. After hearing this outcry, I knew I had to look into this drug-testing issue further, which is how LR134 came about. My concerns with this policy are fourfold. First, given the outcry following the media attention to this policy change, it seems that stakeholders, from judges to foster parents to providers, were not kept in the loop. Second, it largely limits drug testing to being

within court orders. Third, parents now have a few days to clean up ahead of a visit and drug test, creating a facade of a safe living environment. And even then, a positive drug test does not automatically lead to the removal of the child from the household. Let me repeat, a false-- a pos-- sorry, a positive drug test of a parent now does not lead to the automatic removal of a child from a household. Drug usage by a parent and the aftermath of that usage, which is the hindsight-- and subsequent withdrawal, is very traumatic for kids. It goes without saying. My concern with the new drug-testing protocol lies in the fact that studies show that children suffer physically, mentally and behaviorally in homes where drug use is prevalent. I know many of these parents who abuse drugs want to make sure their children are-- are making it to school, are going to dance lessons or football practice, or seeing a dentist for a loose tooth. However, their addiction is so powerful, it is their first priority. I have heard stories about parents who lost their children because of drug use in the home, and they say that if it were not for testing, they would not have gotten clean. Their rock bottle-- bottom was removal of their children. No one here will disagree with me when I say that the best place for a child is usually in their own home. But when drug use and abuse is happening, many times the best place for the child is out of that home while the parent gets help. If we are no longer testing our parents who are suspected of neglect or abuse, how do we know that the parents-- or the children are safe when the visit

ends? It is not inconceivable to think that a parent who uses drugs in a home can clean up for a couple of days and pass an inspection by a caseworker stopping by the home. The appearance of the parent being clean with the children fed and bathed and the home looking presentable is attainable. But is that really the whole story? It seems that the department went about changing its drug-testing protocol in somewhat secret fashion. If judges and providers were unaware of the change until told by caseworkers months after the fact, there is a serious problem here. To make the system work effectively and keep our children safe, we all have to work together. When we are not all on the same page, it only hurts our most vulnerable, our kids. I have handed out to you written testimony from Wahoo Police Chief Bruce "Fennell." Chief "Fennell's" testimony, which I encourage you to read, gives you a look at the concerns law enforcement have regarding-- regarding the new policy. One of the testifiers you will hear from today is Wahoo police officer, Stacia Nelson. Officer Nelson will be able to reiterate Chief "Fennell's" comments in his written testimony while also expanding on her experiences with the new policy. We have other stakeholders here to testify today on how the new drug-testing pol-- policy has generated negative outcomes. It is my hope that the conversation we have today with these stakeholders will shed some light on the and effect change on this policy. Ultimately I hope that after this hearing, the Department of Health and Human Services will sit down with judges, law enforcement, providers, foster

parents, and other interested stakeholders to try to find a compromise policy that lies somewhere between what is in place now and what was in place prior to October 2018. We owe it to the children of Nebraska to have this conversation. Thank you, and I will happily answer any questions you may have.

HOWARD: Thank you. Are there questions? Seeing none, will you be staying to close?

SLAMA: I will be. Thank you.

HOWARD: Wonderful. Thank you. Our first testifier for LR134?

ROGER HEIDEMAN: Good afternoon. Roger Heideman, that's R-o-g-e-r, Heideman, H-e-i-d-e-m-a-n, I'm juvenile court judge in Lancaster County. I'm also the presiding judge of our family drug court in Lancaster County and have been so for now six or seven years. I provided a couple of exhibits. I will confess, they're kind of the lazy man's way of not breaking the county's budget by printing thousands of pages. Let me give you a little background in our acquiring information in regard to this new drug-testing policy by the Department of Health and Human Services. I think I mentioned this morning in early testimony this morning in the earlier LR, that in the spring of 2018, we were on a routine basis having caseworkers coming to testify at court about what they could and could not do in regard to drug testing as a result of the new policy at the Department of

Health and Human Services. This was in flat contrast to what was still their published policy on their Web site. We then asked for a meeting with the Department of Health and Human Services administration, met with Director Wallen, Deputy Director Harder, our southeast service administrator, and also legal counsel for the department who indicated at that time they were in the process of looking at modifying their drug-testing policy and would welcome any feedback on what they were suggesting. And we gave them feedback, and it was we don't believe this to be best for the children, and we don't believe it to be in line with what we know to be best practices in these cases. That was all we heard. That was in, I think, May of 2018. Still after that, we're having a case where it's coming on a routine basis, talking or testifying about this new drug-testing policy, to a point that I had one hearing in around September of 2018, where legal counsel for the department was there. And after the hearing I said, I think you have a problem because your workers are still continuing to testify of a policy that is contrary to what you have published on your Web site. It was shortly after that then, that we received the letter from Director Wallen with the new policy that would be placed into effect on October 1 of 2018, which was what they had initially relayed to us that was going to be their policy, which I think sets up a two-pronged approach which is noncourt cases and court cases. Court cases I don't have a concern about because those are cases where I as the judge will dictate whether or not drug testing is an important component of a

rehabilitative plan that would be designed to correct or ameliorate the condition which brought the children under my jurisdiction, which would have-- would have to have some nexus to a parent's substance use disorder. The more concerning policy or provision of the policy is in those noncourt-involved cases, those voluntary cases. And again, as I testified this morning, potentially now these cases go into alternative response, which would have little if any oversight. What if any drug testing will be done to ensure a parent's compliance with a treatment plan? The two exhibits I've handed out, one is the link to the-- where you can find on the Web site what the department has quoted on their drug-testing policy, which is this drug testing and child welfare practice and policy considerations. What-- what I suggest to you is that the department has conveniently pulled out excerpts of an introductory statement to that. And if you read that policy in its entirety, I think what you will come to the same conclusion is-- is that that policy actually says, this is why it is important to drug test in a child welfare case because we are not strictly dealing with a parent's recovery. We are also involved with a child's safety as well. And the second handout is a Web link to a newly released family and treatment court's best practice standards. I had the honor and privilege of serving on the advisory council for the preparation of those best practice standards. That was a 2.5 year project conducted by the National Association of Drug Court Professionals and Children and Family Futures that have now come out

with best practice standards for family drug court cases. These will soon be adopted, as I'm also the chair of the state committee to adopt these standards. I am confident these very national standards will soon be the state standards as well so that we can measure adherence to standards with our family drug courts. You may ask, well, we're not just talking strictly about family drug court cases? I would suggest to you, if you look at this-- or those standards in detail, I think they provide a good baseline for what would be best case practice standards for case management whether it's in drug court or if it's just a substance use disorder case that's outside of a drug court. They are manageable standards even in that regard. And what you will find is the policy that I mentioned earlier is cited as why it's important to drug test in these cases. And it's not that we are trying to catch people, a gotcha service as I think one time somebody within the department said this-- this is what it is an attempt to do it. It serves a different purpose. It serves to ensure a parent's compliance with the treatment plan. At the last national conference, I think the best analogy I had was from the gentleman, who's the editor for the Association of Addiction and Medicine [SIC], who said common sense would tell you. If you are trying to measure adherence to a hypertension treatment plan, what do you do? You test your blood pressure. If you're trying to determine adherence to a diabetes treatment plan, what do you do? You measure your blood sugar. Same with drug testing. How do you ensure it's adherence to a treatment

plan? You drug test. And then it allows us to not remove children if that's safe and appropriate to do so because of sobriety. It allows us to get children back in the homes sooner and quicker if we can measure that sobriety. But it also allows us to intervene, to modify treatment protocols, and provide additional services for those parents who continue to struggle with substance use disorder. And that's what's at the heart of this, is how do we help these parents with what's going to be a lifelong issue for them, a lifelong recovery and treatment of that substance use disorder? I would welcome any questions.

HOWARD: Thank you, Judge. Are there questions? Senator Arch.

ARCH: Thank you. Thanks for coming. I-- I-- the question is if-- if an individual does not pass a drug test-- now let's say-- let's say that it is given. And walk in and there's-- there's-- you see-- perhaps you see some drug paraphernalia in the home, whatever. And the parent does not pass a drug test. Is that an automatic removal of the child?

ROGER HEIDEMAN: Wouldn't have to be. Would not have to be. I think we are at a point in time, with what we know to be best practice in the research, that, you know, we can put safety plans in place, appropriate safety plans. But that safety plan at a minimum should include regular and consistent testing so we can detect what we know to be drugs of choice. And quite frankly, we're not talking about marijuana anymore. Our-- our biggest concern still remains

methamphetamine. We are seeing opioid cases. We continue to see a few cocaine cases. We see alcohol as well. We're not talking about marijuana. We're talking about those more serious drugs of addiction.

ARCH: Thank you.

HOWARD: Further questions? Senator Williams.

WILLIAMS: Thank you, Chairwoman Howard. And thank you, again, for being here this afternoon. When HHS implements a policy like this, it would seem to me that the judicial system would recognize there's a reason for this. What do you think the reason for this change in policy would have been?

ROGER HEIDEMAN: Well, it's no mystery. A-- a proper protocol for drug testing is expensive because you're talking about an on-site test that then would have to be sent in for lab confirmation. It's an expensive proposition. I don't know if that was the genesis for it. I can only surmise that had some "impart" into their decision.

WILLIAMS: So we're-- we could potentially be trading off a little costs for the safety of kids.

ROGER HEIDEMAN: In my view, yes.

WILLIAMS: Thank you.

HOWARD: Other questions? Senator Walz.

WALZ: Thank you, Chairman Howard. Thank you for everything that you're doing. I just attended my first joint court graduation a couple of days ago, and it was amazing. And I just found out before this hearing what you're doing with the family treatment. So first of all, thank you for what you're doing. It's-- it's a very, very good program from what I saw.

ROGER HEIDEMAN: Well, I never envisioned I would be doing this at this stage of my life. But I can say I am glad I am because the rewards are-- and-- and I-- I have to, at least at this point, say, I get more credit than I deserve for this. You know, we are still talking about the lowest-paid individuals in our system, the caseworkers at the department level who are doing the brunt of the work, taking the brunt of the flack, so to speak, from parents who are in the throes of addiction, who don't get nearly the credit they deserve because they are the ones who are pushing these cases and making sure they continue to progress through the system to get these kids back in homes and cases closed successfully.

WALZ: So I was just curious, how many-- how many families or how many cases do you feel you could take on? Or are you already to the max of--

ROGER HEIDEMAN: Well, again, with-- when these new standards will be adopted by the state, we will have to sit down with our team and make

sure what we have set up as a protocol will comply with these standards and resubmit that program to the Supreme Court for their approval because they will then be the ones that ultimately will weigh in on whether we're adhering to the standards. Right now, our program is-- is not a voluntary program. We identify the cases when they come in, and if there's one with substance use disorder, they're-- for the most part, most of those are coming over to my docket. And then we're handling them on this track. It's, you know, what the national experts would-- would call an infusion model. We are infusing-- infusing these standards into the case management. So we're using what we know to be best practice, based upon the research, to manage these cases. Now, I will tell you, one of the ramifications of that has been, and rightfully so, attorneys are saying why aren't we doing this in all of these cases? Why are-- why are we not using a similar approach in all of these cases? And I can't answer that other than-- than resources at this point.

WALZ: All right. Thank you. Did you have something extra?

ROGER HEIDEMAN: Nope.

WALZ: OK. Thank you. Thank you for your work.

HOWARD: Any other questions? Seeing none,--

ROGER HEIDEMAN: Thank you.

HOWARD: --thank you for taking time with us today. Our next testifier for LR134?

STEVE GREENE: Hi.

WALZ: Good afternoon.

STEVE GREENE: Good afternoon. Relatively new for me, this is first time being before the committee, so I apologize for any going ahead before I should have. I was just this eager to testify. Let me get to my place.

WALZ: We almost never hear that. Whenever you're ready.

STEVE GREENE: Good afternoon, Chairperson Howard and members of the Health and Human Services Committee. My name is Steve Greene, it's S-t-e-v-e G-r-e-e-n-e. And I serve as a deputy director for the Division of Children and Families at the Nebraska Department of Health and Human Services. I'm here to provide information regarding the division's recent decision to change our drug-testing protocols. Before I get into the body of this testimony, I just want to say one thing that at the department, one of our missions is helping people live better lives. That's important to say because I want to note that the shift in our policy was, in part, wanting to help the children and the families that our team serves every day live better lives. We do this by ensuring children are safe while giving families the appropriate services they need and helping them remain together

whenever possible. As you're aware, on October 1-- October 1, 2018, CFS altered the division's drug-testing protocol for children and families involved in the state's child welfare system. After a review of our existing policy, it was determined that CFS needed to revise its drug-testing protocols in order to enhance parents' protective capacities, provide opportunities to strengthen the parents' protective factors, and safely raise their children in their family home. We sought to develop a policy that aligns with national best practices. Drug testing can be time-consuming. It can be costly and appear punitive, and sometimes it can miss the point when the point is child safety and family well-being. However, we continue to use it as one part of working with families as a system when it's recommended by a treatment provider or ordered by a judge. And our policy currently allows for that. The department believes that the new policy is trauma-informed and data-driven while retaining CFS's focus on child safety and better understanding the needs of parents. A primary goal was to ensure that this policy was executed with fidelity. Prior to implementing these changes, we did have conversations with some of those representing the courts, as Judge Heidemann had-- had mentioned, as well as members of the child welfare community. We also did this in consultation with the national organization named Casey Family Programs and then also the Substance Abuse and Mental Health- Health Services Administration, SAMHSA, prior to implementing in this change in protocol. Effective October 1, if substance-- 2018, if substance

use is suspected by a parent, the CFS specialist immediately assesses for the safety of a child living with the parent. In cases where there is evidence in the home of substance use, the CFS Protection and Safety Team assesses the impact of substance use on the well-being of a child and if appropriate, makes a referral for substance use evaluation. A family's risk level and the decision to refer for substance use evaluation is guided, in part, by the evidence-based, structured decision making tool used by staff. If there is a safety threat present that cannot be mitigated, the child is removed. CFS specialists will assist with helping the parent obtain the substance use evaluation and help to ensure the recommendations of the evaluation are followed. Overall this new policy means several things for the state of Nebraska's child welfare system. First, through family engagement, CFS hopes to work with the entire family to better understand causes that lead to the investigation while providing appropriate services to that family so that a parent and a child can remain together. However, CFS continues to assess for safety related to substance abuse. Virtually every day in the state of Nebraska, children are removed-- removed from their home due to drug use considered to be a threat to their safety and well-being. Drug testing remains an available tool for identi-- identifying threats to children's safety and is used when determined to be appropriate by a treatment provider. A drug test alone does not indicate if abuse or maltreatment has occurred, nor, importantly, does it indicate the

level of substance abuse or addiction or the degree of family function. The department believes that the update to our drug-testing protocols is not only good policy, but reflects national best practices. In 2010 the Substance Abuse and Mental Health Service Administration, which was alluded to in-- in a previous testimony, had-- had a paper, Drug Testing in Child Welfare: Practice and Policy Considerations, and for the sake of time, feel-- I'll let you all read that. But in short, it says this in one part: in addition, drug tests do not provide sufficient information for substantiating allegations on child abuse or neglect or for making decisions about the disposition of the case. We're not the only state that has revised their drug-testing protocols. Similar states such as Kentucky, Iowa, Arizona, and Massachusetts have or are in the process of modifying their drug-testing policies to reflect the current body of research and best practices. I do just want to take a moment to thank not only you all, but also Senator Slama for introducing this resolution. This is an important conversation. We all want what's-- what's best for kids and families. And so I just want to say thank you for-- for letting us have this conversation. The-- the department acknowledges, and I think it's clear, there's more work to do to enhance our communication with all stakeholders and with child-- with our child welfare part-- partners regarding such an important policy like this. I want the committee to know that the department is open to discussion and looks forward working with all community members to ensure

Nebraska remains a great place to raise a family. Thank you for the opportunity to testify before you today, and I'm happy to answer any questions you might have.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you, Chairman Howard. And thank you, Deputy Director Greene, for being here. I'm sure you heard-- I know you were sitting here when-- when Judge Heideman was talking, and you have indicated in your testimony that your new protocol was discussed with many stakeholders, including representatives from the court.

STEVE GREENE: Um-hum. Right.

WILLIAMS: And I think his testimony was that all of a sudden they were seeing some things different. Caseworkers were coming in and telling them that a policy had changed.

STEVE GREENE: Um-hum.

WILLIAMS: In fact, he did some checking then, and the policy that was being implemented did not match the policy that was on the Web site.

STEVE GREENE: Right.

WILLIAMS: Can you explain the department's position on that?

STEVE GREENE: Sure. And thank you, Senator, for the question. And I want you all to know that I'm relatively new to the job. I've been

here since Septem-- December of 2018. So part of this policy-- I was a part of the actual communication, but as we have-- as we have discussed this internally, we recognize the fact that we could have done a better job in enhancing the communication with stakeholders like-- like judges and with others. So I just want to acknowledge that and that that's something moving forward. We want to-- we want to make sure we have buy-in from all-- all-- all across the system, and that everybody feels a part of the process, not victims of the process.

WILLIAMS: OK. And this follow-up to that is Judge Heideman also presented us with some information that we have not had a chance to look at yet--

STEVE GREENE: Sure.

WILLIAMS: --that would tend to tell us where, from their perspective, the uniform standards would be in having drug tests like this.

STEVE GREENE: Uh-huh.

WILLIAMS: And I think you're telling us that there are some national best practices--

STEVE GREENE: Sure.

WILLIAMS: --that are different from that. Can you square those two things for me?

STEVE GREENE: Yeah, I think what we-- so it's important to understand that we're not saying don't drug test and we're not saying that there's not a value to drug testing. What we are saying is that our specialists-- or I think what our policy reflects is that our specialists that go into those homes are assessing for the risk of the child and the safety of a child in that home and that the drug-- the substance use assessment that's provided is for the-- for the benefit and is being referred to clinicians who have expertise in substance use disorders and do-- and see it as a-- as a treatment. And we are helping following-- follow that treatment plan for those families. So it's not that we're saying that we're not recommending it being used. It's saying that we want it to be a part of systemically something that clinicians are offering as part of their-- their treatment for those families and those parents.

WILLIAMS: As the deputy director of this division,--

STEVE GREENE: Um-hum.

WILLIAMS: --how would you see your role in facilitating an adequate solution to this problem we're faced with today?

STEVE GREENE: I appreciate the question, Senator. Just to indulge you a little bit, so my background is actually in theological studies, of all things, and-- and ministry for a season. So I think part of that is taking a bit of my prior-- previous experience is that you have--

you just want to get by, right? And you want to, again, make sure that you're having discussions with all players and reiterating some of the changes so that people feel like they're part of the conversation, again, and a part of that change and not sort of victims of that. So I think that's an important thing that we would want to-- want to see.

WILLIAMS: I appreciate that. We've had some discussions as-- as recently as this morning in a hearing about the definition of collaboration--

STEVE GREENE: Yeah.

WILLIAMS: --and what that means between department-- department and stakeholders. And I would suggest that we need to be sure that there is a--

STEVE GREENE: Um-hum.

WILLIAMS: --definition and an understanding of what collaboration is.

STEVE GREENE: And I would say that CEO Smith and the division, especially CEO Smith shares that-- that-- that desire for robust collaboration and wants to move further-- moving forward is committed to collaboration with all stakeholders.

WILLIAMS: Thank you.

STEVE GREENE: Um-hum.

HOWARD: Other questions? Senator Arch.

ARCH: Thank you. And-- and I'm sure you haven't had a chance to see this, but the Chief Ferrell from the Wahoo Police Department submitted a letter to us. And he prompted something in that letter that-- that I guess I hadn't thought through before. Pregnant women would not be included in this, is that correct?

STEVE GREENE: Um-hum. Correct.

ARCH: Because it's-- it's a born child that you're-- that-- that's-- that's your authority, right?

STEVE GREENE: Correct. Um-hum.

ARCH: And so the issue of the ability to test in the case of drug use or suspected drug use, that would not-- you would not have a policy regarding that within the department.

STEVE GREENE: Um-hum. Correct. Prior to the birth of the child, we would-- we do not have a policy, however, that can come to our attention. And I think this has been asked before, but a doctor can order a drug testing for that baby. And, of course, that's going to be a safety threat--

ARCH: Right.

STEVE GREENE: --that is going to cause serious concern for us.

ARCH: OK. Thank you.

STEVE GREENE: Um-hum.

HOWARD: Senator Murman.

MURMAN: Yeah. We did talk a little bit earlier about the expense or how much the cost would be for drug testing. I'm sure it varies according to what drug you're testing for. It would involve, of course, a caseworker and possibly a health professional and maybe even a clinic. I'm not sure.

STEVE GREENE: Um-hum. Um-hum.

MURMAN: But just, I'd like your ideas on the cost or how much of a factor that is.

STEVE GREENE: Yeah. Yeah, I appreciate the question. I don't have specific-- specific costs. There's different types of drug tests that can be administered, and I'll be happy to provide that for you. What I can say is that this policy was driven by keeping-- by wanting to do both keep kids safe and help strengthen families. And sometimes good policy can result in a fiscal-- a savings. That was not what direct-- that guided this policy decision, right? It's a sweet moment when we can actually have good policy in there in some sense because-- and also be a fiscal savings. But this was driven by serving families, protecting kids, and wanting to get parents the help that they needed.

MURMAN: Thank you.

STEVE GREENE: Um-hum.

HOWARD: Other questions? So I want to make sure I really understand this policy. So prior to October 1, a caseworker could order a drug test of a parent or a child?

STEVE GREENE: Correct.

HOWARD: And then after October 1, they weren't able to?

STEVE GREENE: It's not something-- they are going to either comply with a court order for drug testing or if they were referred for substance use assessment and the clinician is asking-- or as part of their treatment plan requiring drug testing, then they'll help comply with that-- that assessment or that treatment plan for-- in accordance with the clinician's directives.

HOWARD: So I actually-- I really appreciate sort of the idea that we would have a physician be directing when we're doing drug testing and ensuring that you're following a treatment plan. I think my main concern for this is that we're not testing children to make sure that they're not being exposed--

STEVE GREENE: Right.

HOWARD: --and that if a CFS worker comes in and sees the paraphernalia that Senator Arch was speaking about, there's no way to know if that child has been exposed to it. So what-- what tools do you have in place for your workers to make sure that the kids aren't being exposed? Because I'm more concerned about them.

STEVE GREENE: Yeah, and I am as well. As a-- as a dad of four kids, I totally understand that. And so that's-- the safety of children, it really is our primary concern. I think we are-- we are wanting to look at the whole-- the whole environment in which the child is-- is involved in. And so oftentimes drug testing alone is kind of a point in time. So a kid may have-- their child may have been exposed to drugs, but that doesn't show necessarily where or how frequent, and so we-- that-- that exposure has been. So while that's an important-- the drug-- the use of drugs of a parent is important to sort of look at and evaluate, there are other factors in the home that are going to tell sort of what's going on in that family. Was the-- is the child have adequate access to clothing and shelter? Is the home a safe place? Is it a clean place? There's all these other symptoms that-- that can tell-- in that environment that a specialist can use to kind of assess what's going on. And drug testing was something that was typically used prior to this policy in those types of situations. And that's changed.

HOWARD: What other tools would a CFS worker have if they suspected drug exposure for a child?

STEVE GREENE: Sure. So there's a-- and I would actually be happy to share this. There is an assessment tool that we use called-- with-- structured decision making, and it's an evaluation that a specialist would-- would have to complete. And again, it's surveying the whole-- the whole entire environment in which the kid is being-- in which the child is in. And so it's not just the drug testing. It's-- it's, whether it's interviews or whether it's looking at the home and assessing for safety, it's sort of multipronged.

HOWARD: So if they suspected, could they send the child to a physician, or what do you recommend if they suspect drug exposure?

STEVE GREENE: If they-- I'm not sure if I understand the question. I'm sorry.

HOWARD: So I'm concerned that you've removed a tool for ensuring that if a child's been exposed to meth or something along those lines,--

STEVE GREENE: Um-hum. Um-hum. Sure.

HOWARD: --for the-- for the CFS worker to be able to-- to prove that.

STEVE GREENE: Right. So in part, I think it's important to understand that, again, it goes back to the structured decision-making tool that we use that is assessing the entire risk of the family. Abuse by-- or

excuse me, drug-- drug abuse by itself is not going to tell the extent of what neglect or abuse is happening. And so it's not saying that because this-- this drug test is-- that we're taking that away, that those things can't be mitigated or they can't be evaluated by using other-- other assessments that are included in that. And that-- that really goes to the safety plan assessment and just the risk assessment that we would do and that the specialists would fill out and observe for holistically what's going on in the home.

HOWARD: So if there's a safety plan that-- that considers drug exposure,--

STEVE GREENE: It does.

HOWARD: --would they be able to drug test for that if it was in the safety plan?

STEVE GREENE: Can I-- I'm sorry, I just don't know the answer to that question.

HOWARD: No. That's OK.

STEVE GREENE: Can I get back to you on that one?

HOWARD: Absolutely.

STEVE GREENE: Sorry. I don't want to give you incorrect information, and I'd rather check with my experts.

HOWARD: Sure. Of course. All right. Senator Walz.

WALZ: Thank you, Chairwoman Howard. Thanks for coming today. I-- can you-- can you give me some examples of evidence of drug use in the home that-- where you would not--

STEVE GREENE: Uh-huh.

WALZ: --recommend a drug test? What-- like I just need some examples. What do you see when you go into a home that you would say, we really don't need to do a drug test on this person?

STEVE GREENE: Yeah. So let's say, for instance, it's the close-- it's disclosed that a parent went to Colorado and planned a weekend away from the kids and went and somehow tested positive for-- for marijuana. We would say that those are examples, or for instance, alcohol or prescription medicines, that those are-- that's a spectrum that could be-- a wide spect-- spectrum in which it doesn't give a sense of what's going on with the family and to the extent that substance-- or excuse me, abuse and neglect is occurring. It just-- it just lets us know that a substance has been used. And so there are-- there are-- I think that's the difficult part and part of the reason why we need to have this conversation is that it's-- that substance use disorder is-- is a large spectrum. And when we have the conversation of what substances are involved, it gets harder to

delineate that to that point-- to the point that you're making of what, in that case, would you test? Does that make sense?

WALZ: A little bit.

STEVE GREENE: OK. Sorry.

WALZ: So you said something about there-- it was "founded"-- or it was "founded" that there was drug usage.

STEVE GREENE: Um-hum. Yeah. So if if the child is at risk and the child's in danger and that safety-- and that threat cannot be mitigated, then we're going to-- we're going to remove the child. But at the same time, what we want to do, and it goes back to just overall in the policy, we want to-- we want to get the treatment the parents need. So if a chair-- if a parent, for instance, and I'm sorry, and this might be-- tie in to what you were asking about earlier, Senator Howard. If-- if a-- if a parent or a child is "aclosing" yeah, mom and dad are using A, B, or C, well, we're going to refer them to substance use assessment. And part of that substance-- sorry, I blanked out. The substance use assessment is-- it could order drug testing as part of the clinician's diagnosis and would be a proper sort of tool in-- in sort of-- in-- in the road to recovery for those parents in getting the services that we need. And that's the important part that we want to delineate here in this discussion is that the-- the parent-- or the to child see-- or the CFS specialist is looking for the safety and

risks factors that resulted in that call coming to the hotline-- or report coming to the hotline. And if there is a need for a substance use assessment, we want to put that in the hands of the clinicians who are trained in substance use disorders and be a part of that process to getting the parents the help they need. Does that make sense?

WALZ: It makes a little bit more sense.

STEVE GREENE: OK.

HOWARD: May I ask a follow-up?

STEVE GREENE: Sure.

HOWARD: So when they go to the substance use sort of specialist or assessment, does that person-- that-- that person is just assessing the parent around their substance use disorder.

STEVE GREENE: Um-hum. Um-hum. Right.

HOWARD: Are they assessing exposure of the child to drugs?

STEVE GREENE: I don't know the answer to that question.

HOWARD: OK.

STEVE GREENE: And I'll-- I'll get that for you. I'm sorry.

HOWARD: No, that's all right. All right. Any other questions? Seeing none, thank you for your testimony, Mr. Greene.

STEVE GREENE: OK. Thank you very much.

HOWARD: Our next testifier for LR134? Good afternoon.

AMBER PELAN: Hi. Thank you for having me. I'm Amber Pelan, A-m-b-e-r P-e-l-a-n. I am here to testify on-- for-- regarding LR134. Previously, I worked with Health and Human Services Children and Family Services as a Children and Family Services specialist for approximately five years. And then I went over to the Center on Children, Families, and the Law, which does the training for CFS. So then I was a field training specialist there. And I also trained the structured decision making assessment and worked with workers in the field on how to learn and utilize those. Currently I'm a program director for youth services out of Saunders County where I work with diversion, truancy, and I'm also a member of the 1184 treatment team. So that's kind of my background and that's kind of what led me to being here today. One of the things that I did as a worker is I really focus with substance use. I'm also the child of a meth addict, so I have personal and work experience regarding it and its impact and lasting impact it has on families. One of the things that I always heard repeatedly, over my ten-year career with HHS and CCFL when I was in the field, was that these families needed the drug testing to have

that accountability and that support. And as a member of the 1184 team, one of our biggest struggles, from our team in Saunders County, is when we have an intake for substance use which-- currently approximately 35 percent of our intakes are related to substance use, and we average between 100 and 120 intakes a year. Thirty-five percent of them are related to substance use. But that doesn't include the ones that the intakes come in for something, and then we get in the home and find out that the maltreatment is due to a substance use issue, which is often the case because substance use isn't ever just by itself. It's always got another contributing factor that's an issue because of it. And oftentimes substance use isn't just substance use. It comes with a mental health disorder. It's usually a dual diagnosis. So substance use, the exposure to the child that we're concerned about on our team, not being tested, I trained workers on how to recognize substance use in the parents. They're not experts. We're just basically telling them, do you see any symptoms of someone being actively high? So that's not necessarily saying-- especially-- one of our issues that we've had on our 1184 team, and when I was out with workers, is if we have an officer who is trained in determining if someone is high or, you know, not able to safely drive or to do whatever, when they're saying this person is actively unsafe or on a substance, we weren't able to test the kids or do anything with the parents. And I'm not against leaving kids in the home and safety planning as long as there can be a safe parent or someone in the home

ensuring that safety, which is really difficult to do with substances as methamphetamine and heroin. And-- and I've seen it personally, what they look like when they come off. So at that moment when we're going to the home, the majority of the time they're not high. We're arriving at 2:00 in the afternoon. So they've had time to sleep off their high, which is one of the things clinicians will tell you, and the therapists that we've worked with, is we're not getting the view of what's happening between 2:00 a.m. and 5:00 a.m. when they're coming down. And so that's what the schools hear about, and that's what the workers hear about. And if we're not able to test that exposure, it just makes it difficult. The long-term and short-term consequences of even youth being exposed to it, it's behaviorally, emotionally, it's linked to impulsive behavior, delinquency. The truancy kids that I work with and the diversion youth and the juvenile delinquents, once you get involved with working with them, they've been exposed to substances their whole life. So I mean not only does this just impact in the beginning, and I understand it's a money-saving thing and they're trying to be family friendly, but long-term this has systemic impact that costs us money regardless. It's costing us money for mental health and substance use for these kids, treatment for their delinquency, and then for them into adulthood because we're repeating the cycle by not showing them healthy behaviors in the home. And that leads me to prenatal substance use. Currently we're one of the only states that doesn't have any legislation or policies regarding

substance use. And I didn't know the copy rule, so I apologize. But I do have a printout that I can get to all of you. But basically we are the only state that doesn't have a policy regarding substance use during pregnancy. I'm not coming here saying like it needs to be criminal, it needs to be punitive, or anything like that. But one of the things that Chief Ferrell was talking about is we did have a pregnant mother who was using who needed help. You can't get help. And it's really hard to navigate an extremely difficult system by yourself if you don't know who to contact, you don't know how to access resources. And so one of the things that other states do is they have-- it's basically like a safe program where they begin working with the family-- the pregnant mother prior to the birth of the child. So they give them-- CFS works with them, and they give them treatment resources and case management services to help them become sober and get the help they need before the baby's born. And then once the baby is born, they continue to work with them for 30 to 60 days to make sure that sobriety and that safe home is maintained. And we don't have any policies regarding that. And so I've reached out to HHS Children and Family Services, and I've also talked to Senator Bostelman about trying to get something like that going so that we can do more of this preventative instead of coming in when they're three and they've already been exposed to methamphetamine prenatally and as infants and toddlers. So then we're not only dealing with the issues of exposure afterwards, but we're forgetting about that prenatal exposure that's

just-- the impact of that is substantial. So that's one of the things that we're working on. And we're working with EDN, Early Development Network, Head Start. And then I've been in touch with Jackie Moline with the Maternal Infant Health Program. She's the program manager at HHS for that. And so we're working on trying to get a program going where we can help them when they're pregnant, not that they're going to be in trouble. Because that's a lot of the other issues too is they're afraid to come forward to get treatment because they're afraid once their baby's born, their baby is going to be tested and taken from them. Where it's we want to help that-- more of a proactive instead of a reactive model, is kind of what we're trying to do here. And then the other thing that we're concerned about, in our county especially, is when they're referring them for a substance use evaluation, we don't often see that in our county if they go in and they're determining they have enough food, they have enough shelter. They have shelter, they have food, and they're getting to school, which-- sometimes even if they're not getting to school, even if they score high on risk, which I know they score high on risk because I trained that, we're still getting cases closed. And so we have families who are asking for services, and their cases are still getting closed. And we know that they've had issues with substances because they've recently been arrested for meth possession, or they've recently been-- I work with their child and their child's telling me that they're using drugs. So we have a lot of these issues to where

actually, in our county we're developing our own programs, and we have our own grants that now include in-home therapy and in-home support that we're doing outside of Children and Family Services just because we didn't feel like our need was being met in our county. And so we're pretty proud of that work with that. And when you're referring them for a substance use evaluation, our concern waiting for that is it takes a long time to get in for a substance use evaluation. So when you're going in at that point in time to determine if they're safe, you're seeing that moment, but you're not seeing all the times that they're coming home and they're using or when they're having their users come over into the home. But you're also leaving that child in that home without anyone ensuring their safety until they can get in for a substance use evaluation. So what is that child exposed to until that time? We have waitlists anywhere from six weeks to six months to get in for that evaluation. So the concern, too, is what is happening in that time period. And I can go into like details as far as like statistics and stuff, but I'm sure you guys are already pretty aware of the concerns we have. And let SAMHSA-- SAMHSA does report that when any youth live in the U.S. in substance use homes with at least one addict and it does go into the lasting impact that has on them. They are looking at the basic needs of the child. Are they being fed? Are they being sheltered? But they're not looking at the emotional state of the child either. So with that substance use evaluation, if they're getting the child also evaluated by a therapist and using that

recommendation, that would be something that would be helpful as well. So any questions?

HOWARD: Are there questions from the committee? Senator Hansen.

B. HANSEN: Thanks. Thanks for coming and testifying. With some of those statistics, where do you think Nebraska lines up with other states when it comes to drug testing? You said we're one of the only states that doesn't test for prenatal?

AMBER PELAN: Right, which-- it's my understanding, and I'm not sure what research Mr. Greene had, but it's my understanding if you look at the state policies on substance use during pregnancy, they're-- they're pretty severe in other states, like even in Kansas and Iowa where they're very active with women who are pregnant and using. I didn't do the research. I'm doing this for a grant because I'm working on this program to try to help our pregnant females. So I didn't do the research on who's actively drug testing. As far as-- the majority of them that I've researched, and I've talked to California, I've talked to Kansas, is they're doing more of the drug testing on the child where they're doing hair follicle testing because they're more concerned about the use around the child. But my thoughts like in my world would be if they have this strict of a policy of use during pregnancy, I can't imagine their policies after pregnancy would be

lighter. But I can do the research and get back to you. I don't know if I should.

B. HANSEN: Thank you.

HOWARD: Any other-- Senator Murman.

MURMAN: Thank you very much. Maybe this would be too personal for you, but if you would want to-- care to, I would be interested knowing what it would be like to be raised by someone that's a meth addict. I'm not that familiar with meth.

AMBER PELAN: Well, it was like-- it's like riding a roller coaster. And so one of the things that, and I've gone to therapy for it in order to become like a healthy human, obviously because it takes a lot of work, but your fight or flight is always activated. So like little things-- you're always living in a state of panic. So it kind of-- it changes your brain so you can see the children of trauma versus children who haven't experienced trauma which-- trauma is living with a drug addict because you never know what to expect from your parent. Is you parent going to come home and hug you or is your parent going to come home and scream at you and throw stuff because they're addicts? Their behavior is erratic. And so and-- he was-- he was a meth addict, and then he did quit meth because he got busted and then had drug tests and had stuff like that. But then he became an alcoholic too which-- the meth was 10,000 times worse because the

highs and the lows and when you're coming off of meth, your depression that you enter and just your erratic, angry behavior, which is all typical to what SAMHSA reports from when you're going through withdrawal from methamphetamines. And then heroin, the withdrawal from that is even worse. So I guess I'm just like it wasn't as popular around here but then because-- who knows? But I had-- I mean I had to go to therapy. I had to make conscious choices. And I feel I'm-- I have pretty good tools and I had a good support system that a lot of these kids don't have. I had a mentor and I had people in school that supported me. That isn't a common occurrence with a lot of the families we work with.

MURMAN: So you feel the drug testing was a big part of your recovery?

AMBER PELAN: Absolutely. My-- my dad has specifically said, and he actually helps me with some of the youth I work with now because he's been sober for ten years, but if-- he says if he wouldn't have been drug tested, he never would have quit. And then my sister is a recovering addict too because that's also really common, right? The children of addicts become addicts. And she quit. She's been clean 3 years and she's 31 and her-- she was drug tested. She got pulled over for driving under the influence of drugs, and she was drug tested. And she said if she wasn't drug tested, she never would have been sober. So I mean my personal experience is why I'm also really passionate

about it because I know if they weren't drug tested, who knows what, you know, my life would have been like so.

MURMAN: Well, I'm glad to see you-- great to see you here. Thanks.

HOWARD: Any other questions? Thank you for your testimony today.

AMBER PELAN: Thank you.

HOWARD: Thank you for sharing with us. Good afternoon.

IVY SVOBODA: Good afternoon. Good afternoon, Chairperson Howard and the Health and Human Services Committee. My name is Ivy Svoboda, I-v-y S-v-o-b-o-d-a. I'm the executive director of the Nebraska Alliance of Child Advocacy Centers, a membership organization for our state's seven Child Advocacy Centers or CACs. Thank you to the committee and the opportunity to appear before you today, and to Senator Slama for introducing the important study to examine drug testing in our child welfare system. As you may remember from this morning, Child Advocacy Centers are community-based organizations that assist in the investigation of and response to child abuse and neglect. Our centers do this in two main ways: by providing high-quality, trauma-informed services to children and families to assist with the investigation and promote healing; and, by assisting county attorneys in the coordination of local multidisciplinary teams or those 1184 teams, which have been required to operate in every county or group of counties in our state since 1992. The teams provide an opportunity for

different agencies and professions to set protocols and work collaboratively on cases to minimize trauma, assist in treatment, and to make sure children and families don't fall through the cracks of our system. The study today touches on both direct services and coordination aspect of the work of the Child Advocacy Centers in Nebraska. Since 2008 the CACs in Nebraska have provided hair and nail testing of children to determine prolonged and passive exposure to substance-- to substances as part of the initial investigation into child abuse and neglect through contracts with the Nebraska Department of Health and Human Services. A small number of tests have also been performed outside of these contracts when requested by law enforcement. As far as I know, the CACs are the only ones who provide the testing of children in Nebraska, and the Nebraska cost per test are $100 from the Child Advocacy Centers. And as you can see on my handout, that just covers the cost of the test. Passive and prolonged exposure includes contact with an actual drug or drug smoke, contact with the sweat of someone using the drug, and ingestion of drug whether accidental or intentional. The tests used by the CACs detect use over a three-month period and are substantially different in terms than urine drug tests, especially used with adults, that show acute and recent exposure or ingestion of drugs within past few days. Testing children for exposure can be an important part of the medical examination of a child-- child where drug endangerment is suspected in order to assess treatment needs. But test results are also an

important piece of evidence used in the court process, as we're hearing, either juvenile or criminal. Prior to DHHS's 2018 policy change, these tests across the state would often be requested in cases where there was an allegation that a child may be drug endangered, exposed to use, manufacture, or distribution of substances. And because of that environment, child abuse or neglect was suspected. These tests were primarily conducted in younger children, very rarely for youth over the age of 13. One example of a case where an exposure test might have been used, the parents of a two-year-old come to the attention of the department because of a concern about unsafe or unsanitary living environment and possible neglect of the child. When asked by the department, both parents deny any drug use, but others have reported concerns that the parents are using on a frequent basis. The child is too young for an effective forensic interview, so a hair test is conducted to determine whether the child has been exposed to those substances and confirm whether substance abuse is playing a role in the concerns that brought the family into the system's attention. In 2018, the department stopped ordering tests of children for exposure unless there was a court order requiring them to do so. The change in the department's practice occurred in the spring of 2018, and then was finalized in the new drug-testing memo that was issued in the fall. As you can see on the first page of the fact sheet I've distributed, this has resulted in a significant decline in the overall number of tests. Statewide CACs used to average nearly 70 tests of

children a month, almost 60 percent of which were positive in the first half of the year of 2018. The monthly average was only fif-- this year, the monthly average was only 15 or 55 fewer tests a month. Interestingly, while the rate of positive tests remains over 50 percent, it has slightly declined. While the change in policy has reduced the number of tests, it does not necessarily improve the accuracy or appropriateness of children tested. The Nebraska Alliance strongly believes in the coordinated, collaborative approach to child protection. Children and their families are best served when many agencies and professionals who investigate, respond, support the following child abuse allegations work together. In the case of children who may be drug endangered, best practice wrestling-- best practice recommendations from both SAMHSA and Department of Justice's Task Force on Drug Endangered Children stress the importance of agency communication across agency protocol for a consistent response, for a response that ensures safety and fairness and promotes healing for children and families. Our CAC membership is concerned that currently there is not enough collaboration around drug-endangered children and that cases are not being appropriately detected and responded to. Increasing multidisciplinary team coordination in these cases and working across professions is an important part of the solution. Children-- the CACs stand ready to assist the state in improving our response to drug endangered children and child abuse and neglect more comprehensively. Testing is only a small part of the broader work and

collaboration that needs to take place for our Nebraska children and families. Thank you, again, for the opportunity to share with you some of the most impact of the recent policy changes on Nebraska's response to drug endangered children. I'm happy to entertain your questions.

HOWARD: Thank you. Are there questions? All right. Seeing none, thank you for your testimony today. Officer Nelson. Actually, it was my-- my bad. The introducer has asked for some of-- have the invited testimony to go first. So we have two invited testifiers. Officer Nelson, you're one.

STACIA NELSON: Good afternoon. My name is Officer Stacia Nelson, S-t-a-c-i-a N-e-l-s-o-n. I'm a police officer with the Wahoo Police Department. I have been so for three years. Prior to-- prior to being a police officer, I was a children family specialist or CPS worker with the state of Nebraska and Iowa for over ten years. I've been a CASA in Nebraska. I was on the Foster Care Review Board for several years. And I have been a licensed foster parent in Nebraska and Iowa for ten years. One of my-- one of my jobs now is a police officer. I'm also the DARE officer in Wahoo. And in DARE we talk a lot about being responsible and what is-- what is our greatest responsibility? Being a law enforcement officer and CPS worker, that has a lot of responsibility. But I always tell my kids that my greatest responsibility is being a mother. I tell them that I want to do my very best that I can for my children. Even parents who are using and

abusing drugs, they also want to be good parents. Sometimes they lose sight of that in the drug use as we've already heard. If you apply for pretty much any job anymore, there's a drug test as part of that process just because the health and safety concerns associated with it. You would not have dropped your kids off at a daycare to come here today to be watched by someone who is under the influence of drugs. Even if there was another adult in the room to watch them, you just wouldn't have done that. We don't allow somebody to operate a motor vehicle under the influence of drugs because we know that it's not safe. Nobody disputes these two things, but there is still an ongoing debate about if someone can or can't parent their child under the influence of drugs. Over the past years, parents have told me that they want to stop using drugs. They want to get help, but they just haven't had that defining, crossroads moment to make it happen yet. Maybe it's because they're afraid of the legal-- legal aspects. Maybe it's because they fear judgment by those they know or losing their family. Regardless, they haven't come to that defining moment. As you heard from my chief, we-- we investigate approximately 100 intakes of child abuse/neglect a year. We come into contact daily with members of our community who are actively using, and many of them do have children. Like most areas, methamphetamine and opiates are our biggest concern right now. We do work closely with HHS, our local schools, probation, medical and mental health centers around there, and youth services as you heard earlier from Amber Pelan. We try to provide our

own services and assessments along with making sure that the children are safe in the home. In the last year, there was one resource that we lost as you've all heard. That's the drug testing. Even when we've been able to identify there is drug use in the home-- maybe we had an officer that was there, and someone was cited for drugs. Maybe a child had said something before. They were at a friend's house, and there was drugs there. When law enforcement, trained professionals, have asked for drug testing in the home, we have not been able to get it done. We have also been told that it either needs to be court-ordered, or they need to get an assessment. And if you know anything about assessments, they take months. So for us to go into a home and do a safety assessment, we're not able to know and get a drug test if a parent is using or a child's been exposed unless it goes through the court system or they get an assessment. So in Wahoo we had a five-year-old child that was living with both parents, dad and pregnant mom. They were both IV meth users. Both parents were in and out of jail. Mom failed drug testing through probation and medical appointments multiple times. And she didn't follow through with services that were put in the home for her probation. The five-year-old was eventually removed by law enforcement after a noncourt case was closed and drug paraphernalia was found in the home and dad went to jail. Mom did not go to jail because she was pregnant and there was concern for her pregnancy and being in the jail, so they said just to cite her and not bring her to jail. A couple months

later, mom did give birth to the baby. Law enforcement and probation again requested that a drug test be done on that newborn infant because we knew mom was still an IV drug user, and we were told that that would not be done. The baby was not drug tested. The baby went home with mom. And the five-year-old remained out of the home and still had supervised visits. But the infant went home, and there was nothing that we could do about it because they said that there wasn't any new or current situation to prove that she was still using. So there was nothing that we could do about that. During child abuse/neglect assessment from a law enforcement perspective, we would advocate for the drug testing for a reasonable suspicion standard. So we wouldn't go and drug test somebody just because a neighbor heard something. We take the intake. We take interviews. We take all the evidence combined and decide is it reasonable? Is there a reasonable suspicion that this person is using some drug? If there is, then-- then a drug test shall be provided. Children should also be tested to determine exposure, as we've heard before, just the exposure in the home. I've had numerous parents over the years tell me, well, I smoked when my kid was in the other room or they were outside and then they came in as if they-- the room that they were smoking in was airtight and they couldn't get out. A safety assessment is often done when drug use is-- a safety assessment is always done where we're concerned about drug use in the home, but we're not ever able to test them. It's just not anything that's happened in the recent time. As a worker for

the last ten years, we did do a lot of drug tests and they are costly. But as we've heard, those drug tests, a lot of them came back positive, more than didn't. And I would always tell the people that I would train, and even now, the number that we need to remember is number one, the one child that we're looking at right now. Can I go home tonight and know that that one child is going to be OK? Because if I can't say that, that's the one number that I'm concerned about. We all want to keep kids safe and do what is best for the family. Drug testing is a tool for accountability just as many other things are. It's often the defining crossroad in a parent's life that they've later told me that they're glad it happened. Even though it was very difficult at the time, it was what they needed to make a healthy change for themselves and more importantly their family, to become the parent that they always wanted to be. If it wasn't for drug testing parents and children, if we're not going to do that, not only are we not making sure that children are safe and comfortable in their own home, we're enabling the parents to continue doing what they're doing. If Wahoo Police Department who we see just 100 families and this is-- remains an ongoing concern, there's no doubt that it's the same way throughout Nebraska. We respectfully ask for your help to provide us with the tools to keep kids safe in Wahoo-- from Wahoo to Council Bluffs and everywhere in between. If you have any questions or you need any more information, we would absolutely provide you with that. I did make one note. Earlier someone had mentioned if you could go to

a doctor's office and get a test or go somewhere other than like through the state. I have had a case in the past where they had asked a family to go to the doctor and get a drug test on two kids, and it was $100 a kid. And even in-- I mean I think I budget my money fairly well. If you told me to take my children to the doctor right now and pay $100 each to give them a drug test to show you I was or wasn't using, I couldn't do that. So I think that's just an unrealistic expectation for anyone.

HOWARD: Thank you. Are there questions? Senator Arch.

ARCH: Thank you. I would ask the same question that I asked Judge Heideman. And that is so you failed a drug test-- this is prior to this policy. So you failed a drug test. What was your experience? What were the consequences of that? Was it an automatic removal of the child? Was it, you know, what-- what happened at that point?

STACIA NELSON: Yeah. No, it was not an automatic removal. It depend-- it depended on the type of drug. As you said, we're not real worried about marijuana anymore. Obviously, we don't want that smoked around the children either. It depended on the type of drug. It depended who else was in the home. Maybe there was only one parent that was using. You know, can that parent leave the home and the other parent safely stay in the home and take care of the kids? Can-- you know, there's all kinds of different things that could be done. Removal should

absolutely be a last case scenario. There's all kinds of different tools and things that were set up throughout my years in Iowa and Nebraska that you could have a positive drug test and still keep the kids in the home. But that way, everyone knows what's happening. And the parents know this is kind of, you know, we called, their come-to-Jesus moment. Like this is happening, OK? What-- what are you going to do about this? Help-- help me make a plan. And a lot of times, if you put it back on the parent and say, what can we do this isn't safe for them, they have good ideas of their own.

ARCH: So right-- it's according to the testimony we heard today, there is an assessment that they are referred to. Without a drug test, they're referred to an assessment. And if during that assessment if that's determined at that point they need one, then they can receive one. Prior to this policy, so the drug test was given. They-- they failed the drug test. Did that-- did that information go into an assessment or is that a stand-alone piece of information that decisions were made on?

STACIA NELSON: It all used to be together. So the-- the SDM was called the, I think it's, "standard" decision making model. It's kind of a list of questions that you go through, you know, caregivers in the home? Does the child have disabilities? Do they have food? Do they have-- just basic things. The drug test was a part of that. So now that's not there. Even if, now, they rate poorly on the safety or the

risk assessment, and they say, well, this recommends that you go get a substance abuse evaluation. OK. I'll do that. But even in smaller Wahoo, you can't go get a substance abuse evaluation today because that's a concern. I'm at your house. I heard that you've been using meth, and you've had your small children here. I need to know before I leave. We're not going to know that before we leave. We're not going know that probably in a month or two because there's such a waiting list for assessments, for treatments, for everything. So that's not a realistic expectation for that to be the baseline to which we measure safety on because by the time we get that, months have passed.

ARCH: Thank you.

STACIA NELSON: Um-hum.

HOWARD: Other questions? Seeing none, thank you for your testimony today. I'm looking for Jimmy Herman.

DEMETRIA HERMAN: That's me.

HOWARD: OK, great. Good afternoon.

DEMETRIA HERMAN: Good afternoon. Thank you. My name is Demetria Herman. I go by Demi. It's easier for everyone. That's D-e-m-e-t-r-i-a, Herman, H-e-r-m-a-n. I am a prosecutor. It's not just my job. It's who I am. I've solely practiced as a prosecutor for my entire 20-year career. And I'm going to apologize that I read my notes

because this is not a five-minute topic. And I want to try to focus on the specific issues that you're concerned with here. Currently I'm the chief deputy Saunders County attorney. I handle the felony caseload. I've also handled the juvenile caseload. I also handle mental health proceedings and pretty much anything else that comes up. But my focus and my passion is on working with victims of crime, particularly with children, with the child of victims of crime. And frankly, no one's excited to meet me ever. A felony matter usually represents the absolute worst or most traumatic event that anyone has suffered regardless of whether that person is a victim, a witness, or an offender. The vast majority of my cases stem from one of three root causes, addiction, mental health, or generational poverty. And it's rarely just one. In every case, I strive to work myself out of a job. That means address the root causes that the case came to my attention so that the offender will not be involved in the justice system again and the victims have a sense of stability and safety in their lives. A court case can be powerful motivation to get help, to follow through. It's also a wonderful funding source for those who don't have the resources. In my nearly 28 years of experience dealing with addicted offenders and in working with those impacted by the behaviors of addicted offenders, those most severely impacted are the children of the addicts because they rely on those addicts for their most basic of necessities: food, clothing, shelter, getting to school, being tucked in, knowing they're safe. I'm aware of no safe level of

methamphetamine use. Saunders County, in the 5th Judicial District, is starting a drug court program. And I recently attended the three-day training on how to conduct a successful adult drug treatment program. It was put on by the National Association of Drug Court Professionals. And the overarching message from that three-day training was that addiction creates a master manipulator. The addiction is a master manipulator. The addiction will overtake all other behaviors to survive. The addict needs consistency and support, monitoring and accountability so that as a united team we can address the addiction as if that addiction is a separate entity in the equation. Frequent testing-- frequently as testing for controlled substances is used, these controlled substances will be metabolized in the body and undetectable within 72 hours. And the 72-hour time frame is important. So the drug court training mirrored my own experiences. Addicts need regular drug testing and account-- and alcohol testing to monitor their usage, to allow for consequences, and to provide support and opportunities to recover. You can't get better if you don't address there's a problem. Addicts who are parents of minor children need twofold the efforts, twofold the testing, twofold the support for recovery because that parent addict is not our sole focus. They're not even our primary focus. We must always focus first on the child who cannot act on their own because that child has no other option but to rely on their addict parent. This year we encountered a woman in Wahoo who had elementary-age children, multiple children, as well as a

newborn at home. She was a methamphetamine addict. She admitted to her use. There were also other substances on board and frequently used in the home, and law enforcement received reports she was actively using while the children were in the home. That was confirmed through school and other sources. HHS was notified of this report. Personally and professionally, the HHS response was alarming. HH work-- HHS worker called and informed the woman that, hey, we had this report that you're using meth in the home. And then inexplicably, they set up an appointment to show up three days later. Unsurprisingly three days later, no-- no drugs were in the home. The woman indicated she wasn't using and that allegation was unfounded. So nothing happened. Several months later law enforcement got a search warrant based on separate information, located methamphetamine, other substances, and the children were tested positive. Those children were removed. And because of the court involvement, mom got help, and a year later she's on the road to sobriety. But it's not because she wanted to do it on her own. Voluntary referrals are great, but that's insufficient motivation for the addict. That's insufficient motivation for the addiction to give up control. These parents deserve our united front to help battle their addictions. They can't do it on their own. And we cannot work ourselves out of a job if we let them do it on their own because we know that's not going to happen. I truly want to see the parents get help because I want their children to not come see me. I don't want them to be charged. I don't want them to be court-involved.

I want them to learn the tools of how to raise their own children and be successful themselves. But they can't do it on their own. It just starts with accountability, and frequent random drug tests is the start. I welcome any questions.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today.

DEMETRIA HERMAN: Thank you.

HOWARD: Our next testifier?

KIM HAWEKOTTE: Good afternoon, Chairperson Howard and members of the HHS Committee. My name is Kim Hawekotte, K-i-m H-a-w-e-k-o-t-t-e, and I'm the executive director of the Foster Care Review Office. I have a packet coming around for you with some information. I'm going to try not to repeat what people have said to you previously. In the spring of 2018, it came to the attention of the FCRO that there was a change in HHS's practice with regards to drug-testing policies. So we started practice, not necessarily policy, as to what was being said kind of like what the judge talked about. So we looked up the policy, and attached to my testimony is a copy of the policy that was in effect. It's HHS policy 17-2016 with regards to drug testing. And we were unable to find any written changes as to why all of a sudden drug testing was not being done. So we began having discussions with HHS and numerous external stakeholders from providers to the inspector

general, and nobody quite knew. I agree with the judge. After meetings were held then, the policy that went into effect October 1, 2018, which also is attached to my testimony, is 3-2018. That is the new drug-testing policy that went into effect then. Another thing that occurred at the same time is the Inspector General in our office was contacted by pediatricians here in Lancaster County in the summer of 2018, that they were getting extremely frustrated because they were calling the hotline to report drug-positive newborns and concerns with parental drug use, and their calls were being not accepted. So they weren't being investigated. They wanted to know what was going on because the prior practice of Health and Human Services was any hot-- call to a hotline for any child aged zero to five by somebody within the medical profession would be accepted for an initial assessment to see if that child was safe or not. Something had changed. We didn't know why. So after numerous meetings with the pediatricians and with Health and Human Services, I've also attached to my testimony, they did do and changed their procedure. It's 5-2019, was finally released, which now at least-- which is good news. The department and hotline does accept all phone calls from any medical provider on any child zero to five. So at least we know that an initial assessment is being done on those. And within that, comes that positive-newborn type. But it goes also to the bigger picture of if it isn't a newborn and they feel the parent is using, Senator Howard has pointed out, sometimes we have to drug test the child to see what their exposure to the drugs

have been, that the parent might not test at that point. We do know and all of us know that there's been some dramatic changes with the out-of-home population within the child welfare system in the past two years. While the changes to the HHS drug-testing practice and policies might have influenced these changes, it's probably not the sheer extent of it. There's probably some other factors. On page 2 and 3 of my testimony, I felt it was important that we at least provide to you the number of children in out-of-home care, where they're located over the past two years. In 2017-18 there was about a 9 percent decrease in children in out-of-home care. In the past year there was about a 10 percent decrease. And on the top of page 3, you will see that we give a chart on the average daily population of state wards in out-of-home care. And you can see the decrease over that time period, over that two years. The main reason for the decrease, when we did more of a deep dive, is there are few-- fewer children entering the foster care system. So the chart on the middle of page 3 gives you how many children entered out-of-home care by each month-- by each quarter for those time periods. So you can see that once the drug-testing policy was-- went into effect, the dive in the out-of-home care, OK? Senator Walz, I know you asked me this morning, and one of the areas we did look into when we saw this practice start was whether there were fewer calls to the hotline because if there's fewer calls to the hotline, then there should be fewer accepted intakes and then your numbers would go down. Makes logical sense, correct? But what we found was

that there was not a decrease in any calls to the hotline. According to HHS's own data, the number of hotline calls has remained consistent or gone up. But there was a much lower percentage of intakes that were accepted for assessment, and there were a higher number of families served in your noncourt services, either your alternative response or your voluntary services. And that's by their own data. You wanted to know-- at the bottom of page 3, there is a link to that data as to where we got it from HHS so that you would know where to go for it, Senator Walz. I think the biggest concern-- and then on page 4, I do detail out for you we know about 50 percent of the children in out-of-home care through the court system are there because of drug addiction. Judge Heideman was correct that the courts adapted very quickly once that policy came out in October, and they are court ordering it. The biggest concern we have are the cases we discussed this morning, those voluntary cases, where we know 85 percent of them involve drug use, and there's no drug testing going on. That is the concern of the cases that we have. And I know I'm out of time, so I will stop.

HOWARD: Thank you. Are there questions? Senator Walz.

WALZ: I would just-- if-- if you have other things to add, we would certainly be appreciative, Ms. Howekotte.

KIM HAWEKOTTE: I think the rest of it really is in my testimony. I know Senator Williams or somebody had asked what's the solution? To me, if all of us sat down between the judicial system and HHS system and all the relevant stakeholders, we could probably arrive at a drug-testing policy that all of us would feel would meet the needs of the families, the children, and the situation. But because this wasn't discussed, it was just implemented, we're now all adapting to something else. But I do believe it is solvable if we all sit down and do it.

WALZ: OK.

HOWARD: Any other questions? Seeing none, thank you for your testimony today. Our next testifier?

SARAH HELVEY: Good afternoon. My name is Sarah Helvey, it's S-a-r-a-h, last name, H-e-l-v-e-y, and I'm a staff attorney and director of the child welfare program in Nebraska Appleseed. I don't have prepared testimony today. I think this is a first for me, just to jump up here. But I wanted to share some information with regard to the questions and some of the previous testimony with regard to pre- and post-natal drug testing and just share that I participated over the last year in an effort actually by one of Senator Howard's constituents, Dr. Ann Anderson Berry, who is a neonatologist at Nebraska Medicine. And through her perinatal-- Perinatal Quality Improvement Collaborative,

which I believe was created and funded in part by a bill Senator Howard introduced a few years ago, brought together a number of experts in the state, pediatricians, psychologists, experts in addiction medicine to try and-- and de-- HHS was at the table as well throughout that, very actively involved in that, to develop a protocol for how doctors and birthing hospitals can handle cases where children-- they have concerns about exposure-- prenatal exposure to drugs. They've developed that protocol. I believe that it's been approved. It essentially says that doctors have a man-- a mandate or a report is that they suspect child abuse they need to provide-- make a report of child abuse and neglect. If they have evidence of drug-- drug exposure but no other indicia of abuse or neglect, they provide data essentially to the department without any identifying information consistent with HIPAA as part of the requirement under the Child Abuse Prevention and Treatment Act, the federal CAPTA law. And then there's a requirement that the department and the treating provider develop a plan of safe care for that child and family. So I'd be happy to access that information. I believe it's going to be distributed through the birthing hospitals in the state with how those cases are handled. Thank you.

HOWARD: Thank you. All right. Are there any other questions? Any questions? We're cool.

SARAH HELVEY: OK. Thank you.

HOWARD: Is there anyone else wishing to testify on LR134? Seeing none, Senator Slama, you're welcome to close.

SLAMA: All righty. I'd just like to thank the committee for their consideration of LR134 and thank everybody who took the time to come out today and express their concerns with this policy change. I truly hope what comes out of this is a discussion between the Department of Health and Human Services and the relevant stakeholders to find a compromise that puts our kids back in the priority for this policy. Thank you.

HOWARD: Thank you. Are there any questions? Actually, I have a question.

SLAMA: Oh, you have one? Sorry.

HOWARD: So based on the work that you've been doing over the interim--

SLAMA: Yes.

HOWARD: --are you planning on introducing something in the next session about this issue?

SLAMA: I'd say it depends upon what the results are of the discussion between the Department of Health and Human Services and the stakeholders and if a discussion takes place. I'd rather see it be

resolved outside of the Legislature just given that the Legislature can be tough to get things through, especially in a short session.

HOWARD: Sure. All right. Any questions? Seeing none, thank you.

SLAMA: Thank you.

HOWARD: All right. We're going to take a quick break. This will close the hearing for LR134, and we'll reconvene at 3:10.

[BREAK]

HOWARD: All right. We will now open the hearing for LR233, Senator Arch's interim study on the-- on fingerprinting and childcare facilities. Welcome, Senator Arch.

ARCH: Thank you. Good afternoon, Chairwoman Howard, members of the Health and Human Services Committee. For the record, my name is John Arch, and I represent the 14th Legislative District in Sarpy County. I'm here today to introduce LR233, which is an interim study to examine fingerprint collection and national criminal history record information checks for employees of childcare facilities and child-caring agencies. In November of 2014, the federal Childcare and Development Block Grant Act was signed into law and contained a requirement for all licensed childcare providers, which would include daycares, home-based daycares, and preschools, to undergo national criminal history record checks, including submitting fingerprints. In

February of 2018, the federal "Families" First Prevention Services Act was signed into law. And it too required submitting fingerprints for background checks, but in this case, for employees of child-caring agencies which would be group homes, residential treatment centers, shelters, and other congregate care settings. You will recall this past session, at the request of the Department of Health and Human Services, this committee introduced two measures to bring the state into compliance with these federal mandates. LB459 was introduced in order to comply with the Child Care and Development Block Grant Act, and LB460 to comply with the Families First Prevention Services Act. LB459 was eventually merged into LB460. The bill passed and was signed into law. Failure to take action could have resulted in the state losing over $30 million from the Child Care and Development Block Grant and up to $39 million in federal IV-E funding. The department has sent out notices to the child-caring agencies that all current employees must have submitted fingerprints to the State Patrol by today, October 25. With respect to childcare providers, any new licensees and employees have to submit fingerprints beginning October 1 of this year, but as provided in LB460, current providers and employees have two years to comply, with a deadline of October 1, 2021. Now that the provisions of LB460 are being enacted, I thought it would be helpful to this committee as well as for our state agencies carrying out the law, DHHS and the State Patrol, to hear from providers and get feedback regarding the implementation process. It is

also a good opportunity for our providers to hear from our state agencies to address any concerns or confusion with respect to the new requirements. Initially someone from the State Patrol was to be here to testify, but it's my understanding written testimony has been submitted instead. I have been informed that DHHS has been working closely with the Patrol on this issue and should be able to handle any questions. During the legislative process, our committee and representatives from DHHS did foresee and discuss some of the issues that are causing concern today with respect to carrying out this mandate. I believe that almost everyone in this room would agree with the wisdom of conducting background checks of those caring for our children, but we do recognize there are challenges. First, the issue of having to wait for the clearance of a background check while addressing the need to hire employees. In today's employment market, it really doesn't work when an employer offers to hire someone and then says they can't start for two more-- or more weeks until their prints clear. That prospective employee most likely will move on. Or worse, the employer makes the offer, begins the background check process, but because of the delay, the applicant finds another job. The employer not only loses the applicant, but also the cost of fingerprinting. So the timing of that clearance is-- is that first issue. These positions are often entry-level positions, and the effort to hire this same employee in our present employment climate is very aggressive. In our earlier discussions, there was mention of the

ability to apply for a waiver that would permit employees to work provisionally, but it's my understanding Nebraska can no longer apply for that waiver. When the representative from DHHS comes up, I think it'd be helpful to explain that matter. Second, there is the issue of cost. The fiscal note indicates the average costs for an FBI fingerprint background check is $45.25. LB460 requires the check to be paid by the employee, but there is nothing that prohibits the employer from covering those costs if they choose. However, should the potential employee find another job during the wait time, that is a cost incurred by the employer that can't be recaptured. The bill does include permissive language for DHHS to adopt regulations concerning the costs associated with the fingerprinting. It was suggested that Title IV-E funds could be leveraged to offset some of these costs for-- for providers or employees. This would be another item that I think would be helpful for the department to discuss today. And finally, with respect to the background checks and fingerprinting, there is definite confusion regarding the inability to use information from background checks that are already required as well as the prohibition of using fingerprints that have already been submitted. I think some clarification on this issue would also be helpful. I brought LR233 at the request of the Children and Family Coalition of Nebraska. I believe there are at least a couple of their member providers here to testify as well as representatives from other organizations. How I would like to proceed with this hearing, suggest,

is to have providers and related groups testify first, and then I would like to conclude the hearing with the Department of Health and Human Services. So that concludes my opening. Senator Howard, I appreciate you scheduling this hearing at 3:00 on Friday afternoon so we can have a good discussion and a better understanding as we adjust to this new process mandated by our federal government to keep our kids safe. I'd be happy to answer any questions if I-- if you have any.

HOWARD: Thank you. Are there questions? Do you want to tell us a little bit more about the letter from the State Patrol? Is there anything that sticks out in your mind about the letter from the State Patrol?

ARCH: The State-- the-- the-- the State Patrol letter that was submitted referred to the timing issue primarily. And-- and they said that they're running about-- according to the state Patrol letter here-- let me-- let me get the exact days here. The processing time-- with regard to turnaround or processing times, we understand that the time frame required to complete such fingerprinting and background checks can directly impact the operations of employers. Currently our process for completing a state and national fingerprint-based background check is averaging seven to ten business days. Part of that is dependent, as the letter says, upon the FBI turning around their

results. But right now, they're averaging about seven to ten business days. And I think that's the primary--

HOWARD: And then-- my only question, and this may be a preview for the department, what-- but there's a sentence in here that says, it's my understanding that DHHS is alleviating much of the costs to individuals needing fingerprints for childcare work through a federal grant.

ARCH: Yeah. And that was my-- and that was one of my points here. And I believe the department's ready to respond to that.

HOWARD: OK. OK. Great. Thank you.

ARCH: OK.

HOWARD: Any other questions? Seeing none, thank you.

ARCH: Thank you.

HOWARD: Good afternoon. Hello, Senator.

THERESA THIBODEAU: Good afternoon. My name-- Hi. How are you? My name is Theresa Thibodeau. I am the owner of the Primrose School of La Vista, and I live at 12811 Izard Street, Omaha, Nebraska, 68154. I'm here today testifying on behalf of the school that I own.

HOWARD: Will you spell your name for us?

THERESA THIBODEAU: Oh, sorry. T-h-e-r-e-s-a, I'm out of practice, T-h-i-b-o-d-e-a-u, and I am here on behalf of my school, other Primrose schools in the area, and then other area schools that we talk to as well that have sent me multiple e-mails of difficulty. And a lot of what I have to say is similar to what Senator Arch had said. However, I do want to point out that most providers are paying for this for the employees. One, in this industry, it is not a high wage industry. And asking somebody to pay $45, you're not going to get employees to come in the door. However, it does put us holding a big burden on our hands. One, we go and send them for their prints. We pay for it, and they never show up day one. That's a problem. Or the state finds them unacceptable in some way to start, and so therefore, we're stuck holding that cost as well. Most of us run, obviously, your Datasource or One Source background checks before an employee even enters the door. And then it would be nice if we could have some leeway time to get those fingerprints back. In-- in the letter that the State Patrol submitted, they are exactly correct. It is taking seven to eight days minimum if not longer. In fact, I have a statement from a provider here in Lincoln who says she's had an employee sitting at home unpaid for two weeks because DHHS is telling us that the employees absolutely cannot start until they have those fingerprints back, even though she has all other background checks completed. So with that, obviously, it's hard to get qualified people in this industry, especially with the low unemployment rate. It throws up

roadblocks. And unless there's a plan for a quick turnaround time, adequate staffing is at hand here. And I have to tell you, adequate staffing is probably more of a danger to a child, as long as everybody is doing their proper background checks, than getting the fingerprints back because when you don't have adequate staffing, places will go out of ratio. And once somebody goes out of ratio, children are in danger of getting hurt, and something bad can happen. Nebraska is new to the fingerprint rule. And I understand that you guys did this in compliance with federal law. And I'm not opposed to fingerprints. I just wish that there was a better way to implement it. For instance, they did grandfather in existing employees to give us time to have all of those employees' fingerprint checked. So why such-- such the stringent rules on new employees? Could there be a 30-day time frame? Would be nice. And then the fact that-- so for instance, in my school all of my employees are already fingerprint background checked because I have a contract with Child Care Aware. And just to let you know, we send our employees to the State Patrol. They ask for an FBI fingerprint check which costs no money whatsoever. They then bring those fingerprints back to us. We send that fingerprint off to the FBI who does the same check, sending to the same place that State Patrol is sending to. And we pay $18. However, DHHS is telling us that they will not accept those as proper requirements. So now we are going to be stuck in our contract with Child Care Aware, seeing that we have to do the FBI ones plus the state ones. So we're looking at $63 per

employee for a background check when essentially they're going to the same places. And that is also-- doesn't even include the cost to run your regular One Source or Datasource background check that-- that we run anyway. So those are just a little bit of my thoughts on there. It would be nice if they could reconsider and let Child Care Aware be included and grandfathered in there. And then basically it was just the other things that we've had. I've had several people tell me that they have lost employees, and it has-- it has deterred them from being hired. And they're not employees who would have a bad background check because we've already done background checks before they come into the door. So with that, I would be happy to answer any other questions that you may have.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you. Thank you, Senator, for being here. Tell me a little more about Child Care Aware, what that is.

THERESA THIBODEAU: So Child Care Aware is-- you can participate with Child Care Aware, and that is a subsidy for military families. And so obviously most of mine are from the Air Force because of where I am located. And so what happens is the Air Force will help subsidize the care for those families, especially when one member of the family is away on duty and-- and the spouse is-- is working. They will help subsidize the care for that family.

WILLIAMS: OK. So that wouldn't be a solution for other areas that don't deal with military itself.

THERESA THIBODEAU: Correct, but one of the solutions, I think could be-- is having employers just do the FBI check and sending it into the FBI themselves.

WILLIAMS: Yeah. Thank you.

THERESA THIBODEAU: Um-hum.

HOWARD: Any other questions? Seeing none, thank you for your testimony.

THERESA THIBODEAU: Thank you.

HOWARD: Good afternoon.

JP LAUTERBACH: Good afternoon, my name is JP Lauterbach, that's J-P, L-a-u-t-e-r-b-a-c-h. I'm the COO of the YMCA here in Lincoln. I'd like to start also by thanking this committee, Senator Arch for spearheading the research you're doing into this fingerprint issue and how our state can best implement it. And also, thank you to Senator Howard and your office for being so responsive and attentive to this issue. The YMCA definitely shares your concern about keeping kids and families as safe as possible. And we have always worked very hard to keep the children in our care-- to keep their safety our top priority. Now with that said, the implementation of this federal mandate does

come with some hardships and practical issues that we have experienced firsthand at the Y as this has been rolled out. As was already mentioned, the timing of the fingerprint turnaround. We have test-drove this a little bit and gone-- done some clearing with employees. And our initial experience has been that we are receiving fingerprints back from the State Patrol in the range of 12 to 15 business days after the fingerprints are taken. While this turnaround is much better than the 30 to 45 days we had initially been told that it might take, it's still a hardship on our program, as was mentioned, to have to wait up to 3, 3.5 weeks before we allow staff to begin working. Often at times we are in urgent need of staff due to high turnover, and that delay is obviously very troublesome. Our childcare staff is primarily made up of 18- to 24-year-olds, and having them wait for 3-plus weeks is kind of a lifetime for them. And before they can start working that's a-- that's a big challenge because they can seek much more immediate employment elsewhere. The second hardship is, as was mentioned, is the cost. The $45.25 per employee is something that will be a hardship for our organization to afford. Eventually these fees will most likely need to be passed down to the families we serve, contributing to more financial hardships when we already have families that receive YMCA financial assistance as well as many families that receive childcare subsidy funding. And then the administrative costs, developing the new fingerprint procedures internally, training for our directors, implementing the new steps to

get these done, and sending staff to the State Patrol office to get prints captured, they all have money and time costs associated with them. And again, those costs will need to be passed on to families. I'd like to note that we have met both in person and on the phone with DHHS as well as the Nebraska State Patrol. And I'll say both have been very cordial and accommodating to us as we work together to train on the new procedures. And we would-- we'd definitely like to thank them for their time and their-- their positive attitude. Specifically, I'll name Lindsay Braddock at the Department of Health and Human Services and Dee Lange at the Nebraska State Patrol. They've been very gracious with their time and have updated us very often as their procedures have changed because, you know, they started with a list of what they thought was going to work. And then as the implementation started, they've had to tweak and and make minor adjustments here and there. And they've-- they've been pretty good about keeping us aware of that. So we really appreciate their help. As we move forward, any help that this committee can lend to make the turnaround times shorter would be very appreciated. Additional fingerprint locations, additional hours or staffing at the Nebraska State Patrol office, and any technology that's out there that might be able to be added that would help speed up the process would be-- would be very much appreciated. Additionally, any funding- as was mentioned, any funding that might be available to childcare providers to help offset the fingerprinting cost and administrative costs that we incur would be very helpful.

Thank you very much for your time on the matter and for your service to the children and families of the great state. So I appreciate it. And I would answer any questions that you might have of us.

HOWARD: Thank you. Are there questions? Senator Williams.

WILLIAMS: Thank you. And thank you, Mr. Lauterbach, for being here.

JP LAUTERBACH: Sure. Um-hum.

WILLIAMS: In-- in a facility like yours here in Lincoln, I'm assuming those positions are paid positions.

JP LAUTERBACH: For-- of the staff? Yes, sir.

WILLIAMS: Of the staff. OK. Do you know-- and maybe somebody else can help me with this one. I am aware of smallerwise throughout the state that this position in their facility is often filled by a volunteer that just volunteers to spend time in that room, childcare when moms and dads are working out, dropping their kids off.

JP LAUTERBACH: Yep.

WILLIAMS: Do you know if they would have to comply with the fingerprinting?

JP LAUTERBACH: Well, our interpretation of it is that any staff who count toward licensing must be staff, must be hired and paid staff at the Y. And at least that's-- in Lincoln that's how we're implementing

it. So while we might have some people working as volunteers, they would not be counted toward our ratio. They might come in to read or do some separate club activities with kids, but they would not necessarily count toward our ratio. So anybody that is a licensed staff person has to have this done.

WILLIAMS: OK. Thank you.

JP LAUTERBACH: Yep.

HOWARD: Any other questions? And then do you receive Title XX as well?

JP LAUTERBACH: We do. Yep. Yeah. We-- we-- some of the families that qualify and are in our program, we do reimbursement through childcare subsidy. Yep. Yep.

HOWARD: Great.

JP LAUTERBACH: And we'll have-- you didn't necessarily ask this, but-- but over the course of a year at just the Lincoln YMCAs, we'll have probably 350 staff that we'll hire. So while right now we're-- we're doing just new staff that we hire, which it's not a huge number right now, but over the course of time, it's about 350 new ones a year. So you multiply that out by the dollars, I mean it'll be $15,000 to $20,000 per year cost for-- for just us up at the Lincoln Y.

HOWARD: Thank you. Seeing no further questions, thank you for your testimony today.

JP LAUTERBACH: OK. Thank you.

ROBERT PATTERSON: Good afternoon.

HOWARD: Good afternoon.

ROBERT PATTERSON: I also noticed you paid the heat bill in here.

HOWARD: Yeah, I'm sure.

ROBERT PATTERSON: My name is Robert Patterson, R-o-b-e-r-t P-a-t-t-e-r-s-o-n. I live at 4821 N 126th Avenue in Omaha, and I am currently the CEO of Kids Can Community Center, a nonprofit organization in Omaha with a mission to educate, engage, and inspire children through early childhood care and out-of-school experiences, meeting before school, after school, and full-day programs. The organization's been a stable part of our community, first founded as a social settlement in 1908. So we are now in our 111th year of serving Omaha children and families. All of our programs are state-licensed, so we do receive childcare subsidies. Although it should go without saying, safety is our number one priority for all of our programs, safe environments, not only the physical space but obviously the staff, the people that are there to nurture the children. In the past we've conducted the two background checks: the first being the

criminal background check, normally we do this through One Source; and, the second through-- the child abuse and neglect background check through DHHS. These are pretty comprehensive background checks and pretty thoroughly vet our candidates prior to employment. As we have added the fingerprint collection, we've run into three different issues that have created barriers for running effective programs. The first, I was-- little bit mentioned before, is the timeliness of the turnaround for approval. With any childcare, especially after school programs, this has been-- that use very-- part-time employees, this has been difficult to get qualified-- qualified individuals in the door. Adding an extended and inconsistent turnaround has compounded that hardship in hiring staff. As a recent example, we had two employees complete their fingerprint background check on the same day. One was approved after four business days, and then we got the official letter after six business days. The second employee, I think we're on the 11th business day, so we haven't even heard back from them. So just to give you a little bit, just as my YMCA counterpart had talked about, a little test drive to show the reality that we're facing. But with that said, I also want to commend the-- especially the staff at the Omaha Sheriff's office. They've been fantastic to work with and helped us to step through the process so, even though they also had very little time to implement this. Two, the availability for employees or candidates to complete the fingerprint-- fingerprint check is very limited. It's currently Monday through

Friday-- Friday, 8:00 to 4:00. This is sometimes referred to as banker's hours, but my bank is actually, and post offices, open longer than that. So very difficult when we're either going after some college students or even our-- we use a lot of paras from schools. They can't take off in the middle of the day to be able to go do this to run our after school programs. So I would open the possibility to kind of widen that availability of time as well as locations to make it as easy as possible. Three, the financial impact will be significant. Adding that third background check to our other background checks will end up kind of ballooning-- ballooning that up to about $100 per employee now before they even walk in the door. We currently carry about 60 direct-care employees at any one time, but when you add that-- the seasonal employees and summer only, it's-- that's at least double that that we see throughout the year. So that will be a significant expense to us. As nonprofit director, I'm keenly aware of all of our expenses and try to run as lean a ship as possible. I can invest in quality programs, but this new expense will begin to take away from that as we move forward. And I put a little note, but in addition to the checks, the-- they begin to feel a little bit duplicative that each-- I know each are required for a different appropriate licensure. But there's-- there's not a whole lot that the fingerprint will be adding on top of it that we're not already kind of prevetting with the One Source and the child and abuse neglect record. As I stated in the beginning, I'm all for doing what it takes to

provide the safest environment for our children. But the supplementary check is-- doesn't appear to be providing a significant layer of protection necessarily, only adding in the cost of money and time. However, I'm happy to work with anybody on the committee to provide feedback, recommendi--recommendations, and solutions to make the highest safety-- highest level of safety in the most efficient way possible. I know this isn't an easy road, and it's a road we're going to have to take. But I think there's ways to make it a little bit more efficient for organizations. And with that, I open it up to any questions.

HOWARD: Thank you. Are there any questions? Thank you.

ROBERT PATTERSON: Oh, and I also have-- one of my counterparts at Completely KIDS had to go to her after school program, so she provided a written testimony that I'll give to you as well.

HOWARD: Sure. Thank you. Our next testifier? Good afternoon.

ANDREA WRIGHT: Hi, Chairwoman Howard. Thank you very much, Senator Arch. Thank you for having this discussion today, and for all the committee for listening. Good afternoon, my name is Andrea Wright, spelled A-n-d-r-e-a W-r-i-g-h-t. I am the director of an in-home-- of in-home services at Heartland Family Service. And I am here today in conjunction with the Child and Family Coalition of Nebraska and the Nebraska Association for Housing and Services for Children. First, I

would like to thank this committee for the work that has done this last year on LB459 and LB460. You listened to our concerns and found a way to ease what could have been a very burdensome process for the provider community. While the new requirements for background checks are full of good intent and come as a mandated change from the federal level, we have concerns that can be easily remedied. As you can see from the written copy of my testimony, I have some items bulleted and will briefly go through the concerns and some possible solutions: the exception process for our work force, clearance letters, varying requirements and coordination of checks, DHHS internal process and structure for processing fingerprint results, and communication between agencies on eligibility. I'd like to start by speaking about our work 4force. As anyone who works with children and family knows, trauma affects us all. Over the last decade, there has been a much-needed shift to addressing the needs of families and the root of trauma in our society through models of trauma-informed care. Many of us have heard the saying that hurt people hurt people. It is a powerful sentiment and used often in our field. We keep it in mind when working with clients and implementing a culture of trauma-informed care within our agencies and communities. The other side of this is that healed people heal people. I think of this as we develop a work force that is battle-worn and on the front lines serving our most vulnerable populations. We all have different experiences. The hard reality is a lot of time we cannot change that,

and we most definitely cannot go back in time. What we can do is we can change today and tomorrow, and we can heal. We can make this world a better place. This is what so many of the people that work in this field have decided to do. They have overcome their own odds and now help others. They have cell phones that ring at all hours of the night. They hear the stories of sadness and see families fall apart and get torn apart. But they do this because they are our first "offense" at healing. In my experience, those who have been through a similar experience are the best at guiding others through it. Many of these people have red flags that are raised in doing background checks which is why it is so important that exceptions are allowed to be made. We currently have a system that clears these individuals to work with children and families through an exception process. While the new statute has set up a process for fingerprinting, there has been little to no communication on what the process will be for obtaining except-- exceptions for existing or prospective employees. There is also no guidance around where the information will be housed. There has been no conversation around regulation or procedure for transportability of clearance within the field. All of these factors contribute to an environment of confusion and worry. We have concerns that the new process for fingerprinting sends all of the results to the department to decide on employment and send a determination, not to the employer who has made-- who is making the hiring decision. This will no longer give us the freedom to recruit, develop, and advocate for employees.

The process as it is now will shift all the decision making to the state. At this point it appears there will be a clearance letter that will simply be disseminated bearing results of a simple yes or no on clearance to hire. It's also been communicated that this will then be the responsibility of the provider to keep at the worksite. The shift will culminate in a process with little to no input from agencies that are recruiting staff and paying for the fingerprints. The provider community fears that from the lack of information we have received around implementation of this process, they'll create more bureaucracy and place further hardship on the system. All this also brings us to the issue of turnover as we've talked about already today. There is historically, especially in times of change, the issue regarding turnover. At our agency alone, one staff turnover is $5,500. In an industry where turnover is a way of life, our agencies suffer. There is difficulty sustaining these fluctuations as we begin to see a wait time on fingerprinting results. Turnover costs can also increase as we are days or weeks-- or as we are waiting days or weeks for our program to meet ratio. One way we can ease the burden of this would be a system to track the fingerprints and the granted exceptions for individuals working in the field. With a tracking system in place, we could implement transportability of these costs-- costly checks and clearances and exceptions to maintain our work force in a way that we've been unable to do in the past. The last point I have is-- that we would like to bring to your attention is what it takes throughout

the process. More than just the fingerprinting goes into background checks. There are hoops to jump through, Adult Protective Service, Child Protective Service, county checks, and checks from every state that the prospective employee has lived in for the last five years. These will be done by the agencies and, depending on contracts, they will have differing requirements. For example, in the eastern service area currently, it is a every-two-year requirement on these checks, and it will be every year. It will change to a yearly requirement with St. Francis. I'm out of time so.

HOWARD: Do you want to finish?

ANDREA WRIGHT: Yep. I just have a little bit left.

HOWARD: Sure.

ANDREA WRIGHT: All this creates a simple change-- all this creates what was a simple change in fingerprinting requirements to an issue of work force development and system sustainability. We ask that you grant agencies to have access to results, and the ability to apply for exceptions at their discretion and to help advocate for a process where background checks and the exceptions can be tracked and transported between providers and the states. Thank you.

HOWARD: Thank you. Are there questions? Seeing none, thank you for your testimony today. Nice to see you.

ANDREA WRIGHT: Thank you.

HOWARD: Good afternoon.

ANASTAZIA BAUER SCHEER: Good afternoon, Chair Howard and members of the Human-- Health and Human Services Committee. My name is Anastazia Bauer Scheer, A-n-a-s-t-a-z-i-a B-a-u-e-r S-c-h-e-e-r. I'm here today as a Boys Town employee and to provide an update on the status of fingerprinting as it relates to LB459 and LB460. I first off would like to thank each of you, especially for clarifying the scope concern and for your ongoing commitment to this important change as it relates to agencies required to conduct fingerprinting of staff. With the passage of the federal "Families" First Prevention Services Act, the new statutory requirements imposed by this act require that Title IV-E agencies apply procedures for fingerprint-- fingerprint-based criminal records checks and child abuse registry checks to any adult working in a child-caring institution, which includes group homes, residential treatment centers, shelters, and other congregate care settings. During this past legislative session it became quite clear, the need to update the law to ensure the safety of Nebraska's children and so that Nebraska can continue to utilize federal funds. We too, are integrate-- are in agreement. I wanted to provide you an update on the implementation of the statute. As Theresa-- Theresa mentioned, we face the same issue. Because of the new FBI and State Patrol code which has been-- required us to refingerprint all of our direct-care staff, we

have been doing this fast and furiously at a cost of approximately $11,000. The timeline was quite a change from the information originally provided. So you can imagine, with an organization our size, we are basically fingerprinting in our sleep. Keeping agencies informed as changes occur is pivotal not only for transparency, but also compliance. Right now it takes us approximately two weeks to clear a background check for a new hire. Our fear is that this new process will add up to two additional weeks to have the clearance letter for our staff members. We need a hardworking, dedicated, and compassionate work force to serve our most vulnerable children and families. With a 44 percent turnover rate, agencies struggle to have people commit to the difficult work and entry level salary. I want to be sure that we are creating the best processes possible to eliminate duplication of efforts, costs and ensure we are responding timely to applicants so we do not create a work force issue. We had also discussed last session whether or not Nebraska is able to draw down federal Title IV-E administrative funds to offset fingerprinting costs. I am hopeful that Nebraska is still exploring this as an option. To the credit of many departments, CFS and NSP have been responsive and are trying to address the many concerns that we originally voiced. I would hope that we can stabilize the cost of fingerprinting in the future because this process has added significant cost and staff resources. I also hope that there is an ongoing commitment and that it remains, that we can work through the

details and the requirements without seeing a negative impact to Boys Town and the rest of the agencies in the state. Thank you for allowing me the opportunity to speak today and for your support. I'm happy to answer any questions that may be.

HOWARD: Thank you. Any questions? Seeing none, thank you for your testimony today.

ANASTAZIA BAUER SCHEER: Thank you. Good afternoon.

TIM HRUZA: Good afternoon, Madam Chair, members of the Health and Human Services Committee. My name is Tim Hruza, T-i-m H-r-u-z-a. I am here on behalf of the Children and Families Coalition of Nebraska. You heard from a couple of our members there as they work through this process in the wake of the passage of LB460. Let me first start out by thanking very quickly, Senator Arch, for all of his work on this issue and for introducing this study at our request. We had testified on LB460, and you had all heard from me on a couple of different occasions as this new change was going to take place with concerns from a number of our members about some of the things that you've heard about today. I very much want to thank you, Chair Howard, for your work, your support working through this process last year and your staff's support as well as we've run up against this October 1 date and the changes and the fear I think that has been expressed by a number of providers heading into it. There's just a couple of things

that I want to hit really quickly and then I will get out of your hair on this Friday afternoon. First of all, you've heard about turnover of employees. And I think that that's something that we would like to keep on the front lines. Obviously, there's going to be some growing pains as we implement this process. To their credit, both the Department of Health and Human Services and the State Patrol have been sincere and have been interested in trying to help providers and work through this process so that it does become smooth in the future. But as we head into a long-term, new way of handling this issue in Nebraska and particularly with those turnover concerns in an industry that's hard to find consistent, stable workers because they're not always the most high-- high-paying jobs. It's sometimes very stressful fields in both the child-caring and the childcare facilities as well. We just want to hit on a couple of ways that we think that turnover issues might be addressed, either now or heading into the future, both by the agencies and maybe the Legislature. First of all, I know that we're working through a lot of things, and I think it will get smoother. The department-- or the State Patrol is committed to continuing to work on their turnaround times. And obviously, they've got to deal with the feds. But one thing that we've been looking at that's come up with our providers is a model that they use in Arizona where an employee can get a fingerprint. It's called a fingerprint clearance card. Arizona has a number of of different professions that require-- I think it's 52 total reasons that you could be required to

have a fingerprint card to be employed in certain areas. And some of our providers think that maybe exploring that type of idea for someone who will work in the field for a long period of time-- or a student who is going into the social work field could get that ahead of time and carry that card with them, especially so that they can transition smoothly between agencies. So that would be something that we would-- we would think would be worth exploring. The second thing I want to talk about, and you heard it from me on LB460 last year, is the overhead costs that this entire process places on providers. You heard a number of $11,000. I've heard from some other providers that this has been a lot more costly maybe than they had planned. And one of the estimates that I had-- heard from a provider was that they expect-- $45 is the cost of the actual fingerprinting. But it can get closer to $100 just for the onboarding and the fingerprinting side for a new employee or a new hire. By the time that you account for the $45 fee, you paid them the hourly wage to go down to the State Patrol office. You pay them the mileage driving there, and you do all of those things. So you can-- you can invest in an employee $85 to $100 pretty quickly in just getting this done before they ever come on board. So we would like to continue to explore whether there is a possibility to-- and I know that we're not eligible for the waiver. But some of the language in that federal-- the federal rules, at least, that are referenced by our statute seems to allow maybe an employee working earlier or during the transition period. And I think that we would

just reiterate our desire to continue to explore that possibility because when you invest $100 or so, $85 to $100 in a new employee and it takes two weeks and by the time that-- that comes back and they've been fully approved and entirely cleared, if they've found other employment, that can be very disheartening and can really set an organization back. Along with that, we would also encourage you to consider that as you-- you talk about and consider provider rates and the reimbursement rates that we provide to your child welfare providers in the state. With that, I very much appreciate all of your work in this area. Very much thank you, on behalf of our providers and our members. We all care about kids' safety. I think in the long run, this process will get smooth-- smoothed out. And I think-- I think we'll be in a place in a few years where things are working very well, but for now it's very painful for a lot of-- a lot of providers in a lot of different areas who provide services to families of all types in our state. So I'd be happy to answer any questions. I thank you for your time and thank you for holding the hearing today.

HOWARD: Thank you. Are there questions? Senator Murman.

MURMAN: Yeah, thanks a lot. Would-- would that comply with federal standards if they would work before they're cleared?

TIM HRUZA: So and that's something that we've been-- we've been talking about and discussing. Our statute simply references the rules

and regulations as they existed, and part of my reading of that, I am no expert in this area, seems to suggest that somebody might-- a prospective employee might be able to start working pending the outcome of the fingerprinting check if they do one of two things. And one of those is the federal FBI background check. But it seems to use, my reading of it as an, or a state fingerprinting background check of some sort. And I'm not-- I have not had a chance to visit with anybody. I've talked with committee counsel, and we've had this discussion, as well as some other attorneys, lobbyists, and representatives, about whether that's an option. I intend to have that conversation with the department. Maybe somebody who comes behind me will have a little bit more information. But as far as I understand, we've explored whether we could get a waiver to allow that for all types of employees. I don't know if there's not-- if there's something on the state level that we don't do or if it's an and/or issue in terms of just a language tweak or something that we're doing. But right now, my understanding is that the position from the department is that they cannot start working until they have been cleared and receive their clearance letter from the department.

MURMAN: And then if that was a possibility, would-- would-- I assume the employer would be responsible if there would be an incident or maybe the employer would have to sign off, you know.

TIM HRUZA: Under the federal regulation, it requires that the employee perspect-- or employee pending the outcome of background check be supervised by somebody who has been fully background checked and cleared, at least in the direct language. But again, implementationwise I don't know how that's working in other states. And there-- there are states that have gotten a waiver from that and that have allowed it. We're not eligible for that is my-- my understanding.

MURMAN: OK. Thank you.

HOWARD: Any other questions? Seeing none,--

TIM HRUZA: Thank you very much.

HOWARD: -- thank you for your testimony today. Our next testifier? Good afternoon.

ADRIANNE AGULLA: Hello. My name is Adrianne Agulla, A-d-r-i-a-n-n-e A-g-u-l-l-a. And Senator Howard, I am a constituent of yours. I live on 55th Street and we have exchanged some e-mails--

HOWARD: Where on 55th are you?

ADRIANNE AGULLA: --on this topic-- 109 South 55th.

HOWARD: Oh yeah, my mom's on 55th and Howard.

ADRIANNE AGULLA: Yep. Yep.

HOWARD: She's like right around the corner from you. Awesome.

ADRIANNE AGULLA: So we're neighbors.

HOWARD: Sorry. [INAUDIBLE]

ADRIANNE AGULLA: Right. So I am also the owner and executive director of Hamilton Heights Child Development Centers, which operate three childcare centers in northwest Omaha. We serve 450 children and their families every day. And so I first-- this is my first time here, and I want to thank you guys for the hard work that you do, helping advocate for our children and families in the line of work that I am in. Our very first core value at Hamilton Heights is that we put the well-being of every child in our care as our number one priority. And fingerprinting and background checks are very much in alignment with that-- with that value. Make sure-- it helps us make sure that we hire the right people that keep our children safe every day. However, fingerprint collection and additional background screening have presented challenges to our business that we've heard today. And I just want to reiterate so that the committee is fully aware of it. I think first of all, it's critical that we understand the labor shortage that affects our industry. It is unique to the labor shortage that affects other industries because of the educational requirements, the age requirements, the low pay that goes along with having a high

education and and being over 18 years of age and things like that that the-- that the state requires our employee base to have. So it's very difficult for us to find qualified workers, even without restriction. And then in this labor market, it's even more challenging. So the logistics of the implementing the fingerprint collection have compounded this challenge. I have only gone through this with one new employee so far. And she submitted her fingerprints on October 9, and we have not received any-- any notification back yet. And so as you know, we have to keep a certain teacher-student ratio in each of our classrooms. And one employee out means either 4 infants that I can't care for or 10 preschoolers or 15 school-aged kids. And that's-- that's a large number of families that I-- that I have to deny service for while I wait for-- for the State Patrol letter. In addition, the cost of the background check is a large burden on our center. This basically doubles the cost of our background screening, and that does not include the wage that we will pay for people while they go get the-- while they go get the fingerprints done. And we will do that for all of our 85 employees when it comes time for them to do that. I employ 85 people regularly with about a 40 percent turnover rate, which means that I send out 120 W-2s every year. And that's 120 scre-- you know, 40 additional screenings every year and then 80 every five years. And that's going to represent thousands of dollars that could otherwise be put into quality programing in my center. As you know, most of us in this industry struggle to achieve sustainable profit

margins. At the same time, the families that we serve struggle to pay the childcare bill. And so adding costs in this industry, we have to be really, really sensitive to how-- to why we're doing that and how it's being done. Lastly, the only other point I want to make is I want to make sure that the big hearts and the professional passion of early childhood educators are represented in this-- in this hearing and on this committee. There's so much media coverage and legislative focus on the rare and heartbreaking crimes that occasionally take place in childcare settings. What is obscured there is the thousands of hardworking, well-educated, and nurturing professionals across our state that show up every day to create moments of wonder for the kids that they take care of and that dedicate their lives to the well-being of those children. And so our industry really needs the support and advocacy of all of us to help encourage people to go into that profession and then once they've made that choice, to support them in that endeavor. So thank you for all that you do for that.

HOWARD: Thank you. Are there questions? Seeing none, nice to see you.

ADRIANNE AGULLA: Thank you.

HOWARD: Thank you. Our next testifier? Department? Good afternoon.

NICOLE VINT: Good afternoon, Chairwoman Howard and members of the Health and Human Services Committee. My name is Nicole Vint, N-i-c-o-l-e V-i-n-t, and I am childcare and development fund

administrator for the Department of Health and Human Services Division of Children and Family Services. And I appreciate this opportunity to update the committee on the implementation of the criminal history checks that are now required for all childcare providers and residential child-placing agencies due to the enactment of LB460 during the 2019 Legislative Session. As you recall, LB460 resulted from a federal mandate placed upon all states. The new federal and state laws now require criminal history background checks for two separate categories of entities who provide childcare for Nebraska. The first requirement is for all licensed childcare providers. They must have every new childcare staff member in any setting or any new residents in a family childcare home submit fingerprints if they are 18 years of age or older. The fingerprints are collected by the Nebraska State Patrol and submitted to the FBI for a national criminal history check. The criminal history check must be repeated at least once every five years so long as a staff member is employed or an individual is living in the childcare home. The second requirement is for the residential child-caring agencies. LB460 required all employees of those agencies who are 18 years of age or older are now required to submit to a national criminal background check at least once every five years. The employees are also now required to be checked against the national sex offender registry and the Nebraska criminal, sex offender, and child abuse and neglect registries. The fiscal note for L4B460 specified that the cost of each background

check is $45.25 and that the childcare staff member being screened shall pay the actual cost of the fingerprint and the national criminal history record information check. It also stated that staff members of a child-caring agency being screened shall pay the actual costs of fingerprinting and national criminal history record information check, except that the department may pay all or part of the cost if funding becomes available. The department has been working collaboratively with the Nebraska State Patrol to implement the requirements of this new law. The department notified all childcare providers and all residential childcare agencies separately prior to October 1, 2019. The background check is a multistep process with different timelines for each phase. Individuals will complete an application and have their fingerprints taken. The State Patrol then runs through the Nebraska AFIS, Automated Fingerprint Identification System database. Next, the fingerprints and identifiers such as name, date of birth, social security number are submitted to the FBI Next Generation Identification system. The FBI then returns records that consist of: state and federal fingerprint-based criminal histories; information from the National Criminal Information-- National Crime Information Center; Interstate Identification Index; National Sex Offender Registry; and, other applicable criminal databases. Once the State Patrol receives the information back from the FBI, that information is forwarded to the department to make the eligibility determination. Currently the department is processing applications the same day they

are received. The FBI is returning fingerprint data to the Nebraska State Patrol within seven to ten business days which is then provided to the department. Our licensure unit is currently making the eligibility determinations within two business days after the receipt of results from the State Patrol. An eligibility letter is then mailed or e-mailed to the individual and the employer. As volume increases, the department anticipates being able to process applications and make eligibility determinations within seven business days following the receipt of the results from the State Patrol. This process may be expedited if individuals and employers provide the department with an e-mail address. The department will continue to work with the State Patrol and the FBI to receive results in a timely manner. We know these background check standards will help keep children safe, but we do acknowledge these new requirements may be burdensome for some providers. It is our desire to make this process as smooth as possible, and we will continue to evaluate our communications, applications, and procedures to ensure they are clear and efficient. We welcome feedback from providers and stakeholders as applications ramp up and we standardize our process. The agency thanks the State Patrol for being an outstanding partner in this effort. Thank you, Senator Arch, for your interest in the subject matter, and for this subject matter impacting childcare providers and residential childcare agencies. Thank you for your time. And I will take questions.

HOWARD: Thank you. Are there questions? So I have a few, with the committee's patience.

NICOLE VINT: Um-hum.

HOWARD: One is in the State Patrol letter, they said that there was a grant that you're working on at-- to alleviate the costs. Can you tell me about that?

NICOLE VINT: Correct. I think that is miscommunicated. Currently, and we have been actively looking at funding to help support this, there are two different funding streams that come in. One is the IV-E and the other is the Child Care and Development Block Grant. So we have been exploring if there would be any funding available to further assist.

HOWARD: And for the IV-E, we know that there-- there's a draw down in the IV-E. Have you applied for that?

NICOLE VINT: I'm not familiar with the IV-E program, but we can definitely get you an answer to that.

HOWARD: OK. And then on the Child Care Block Grant, are you exploring any way of paying for some of these fingerprints?

NICOLE VINT: Correct. We are. We are looking at-- there-- there are, of course, funding requirements and rules to spending money, so we are reviewing that actively with our federal partners.

HOWARD: And-- and correct me if I'm wrong, but didn't you pay-- when we had to bring them up for CPR,--

NICOLE VINT: Correct.

HOWARD: --how did we-- how do we supplement that?

NICOLE VINT: We had quality dollars. So we are federally required to spend 9 percent of our block grant on quality and quality initiatives. And we identified at that time that the cost of first aid CPR would fall under our quality targets. We also have those targets earmarked for other initiatives across the state as well.

HOWARD: OK. We heard from some of the testifiers that they're interested in exemptions.

NICOLE VINT: Yeah.

HOWARD: Is there-- are we able to do any exemptions?

NICOLE VINT: No, unfortunately we are not eligible. At the time, you had to meet milestones within your state. And one was that you were currently fingerprinting all new and ex-- or all new providers. And

the waiver allowed you additional time to implement the existing providers.

HOWARD: So we're not eligible because we missed a timeline?

NICOLE VINT: Correct. Correct. There's two different waivers. The first year started 10-1 of '18, and so we were not into compliance then. And the second one started 10-1 of '19, and we were still not eligible to apply at that time.

HOWARD: Oh, s---. OK. Another testifier talked about this fingerprint clearance that-- card that they were using in Arizona.

NICOLE VINT: Correct.

HOWARD: Have you looked at that at all?

NICOLE VINT: You know, I have the opportunity to communicate with a lot of other states in this role. And so we all learn from each other. I do know I have not heard of Arizona as he referenced, but I also know Georgia has something similar. And so we are exploring opportunities to, of course, streamline and make this as easy as possible for our providers and the department.

HOWARD: Yeah. And then I was reviewing your testimony and looking for-- can you tell me a little bit about how the agencies were told about this change? Were they sent letters or--

NICOLE VINT: Yes, they were provided letters that were mailed out. We had two separate letters because they were going to two different populations, the childcare-- child-caring and childcare licensing. As far as other communications, I was not aware or a part. That doesn't mean it didn't happen.

HOWARD: When were those letters then?

NICOLE VINT: I can speak specific for childcare licensing, and it was in September.

HOWARD: OK.

NICOLE VINT: And I'm not sure when the child-caring agency letters were sent.

HOWARD: OK. Thank you.

NICOLE VINT: Um-hum.

HOWARD: Senator Williams.

WILLIAMS: Thank you, Senator Howard, and thank you for being here. What about a volunteer position? I asked that concerning the YMCA, if that is a position that still is required to have fingerprinting under this.

NICOLE VINT: Sir, current understanding is that if they are caring for children, supervising children, and even unsupervised access, that

they are required to have those fingerprints. I will let you know that as we are currently implementing this and hearing from providers, that we are learning unique situations and different types of volunteers. And so we do-- and I do regularly send questions through my regional office of the office of childcare, who submits them to administration of Children and Family Services. So not only Nebraska, but all states are still learning and finding some of these nuances and specific situations. So we do have some specific volunteer questions pending a response.

WILLIAMS: Going back to the waiver idea and concept that we've talked about a little bit here, and not to get hung on-- hung up on what you call it because whether it's a waiver or whatever, is there some way that could be worked, that you could think of, that could get a person working during that-- sooner during that period before everything is back from the State Patrol and the FBI and the whole thing? Right now, you take-- the position is no, right?

NICOLE VINT: We-- Correct. And-- correct. And that is the true answer from ACF. I will tell you that it is a conservative state and it has been previously. A couple of years ago, the previous director, Director Wallen sent a letter to the acting HHS secretary expressing our concerns with that. About two or three weeks ago, I was fortunate to participate in a roundtable opportunity in Kansas City where Ivanka Trump spoke, and a lot of states-- so I was with Missouri, Iowa, and

Kansas. And all providers and families and even professionals expressed that being one of the biggest barriers that every state is experiencing.

WILLIAMS: OK. Thank you.

NICOLE VINT: Um-hum.

HOWARD: Any other questions? Seeing none, thank you for your testimony today.

NICOLE VINT: Thank you.

HOWARD: Is there anyone else wishing to testify? All right. Seeing none, Senator Arch, your welcome to close.

ARCH: Thank you. Thank you for the time this afternoon for this hearing. I think you hear in the testimony and recognize that this is going to be an ongoing discussion. It's not a one time and we're done. I think that this will be evolving over time because I think that the-- some of the complications to some of the requirements from the federal government that we've implemented I think are going to necessitate ongoing. And as you just heard, there's a lot of things that are being explored right now. I don't think that there's hard conclusion, we'll-- we'll be able to do this for funding or do that. So we'll-- we'll-- we'll continue to monitor this as a committee. And I appreciate your time.

HOWARD: Thank you. Any questions for Senator Arch? Seeing none, thank you, Senator Arch. This closes the hearing for LR233, and we are done for the day. Happy Friday.