LR 37 – Exhibit 1
(SEE Auditor) 9-7-11

LR 37 – Exhibit 2
9-7-11

items from
the auditor

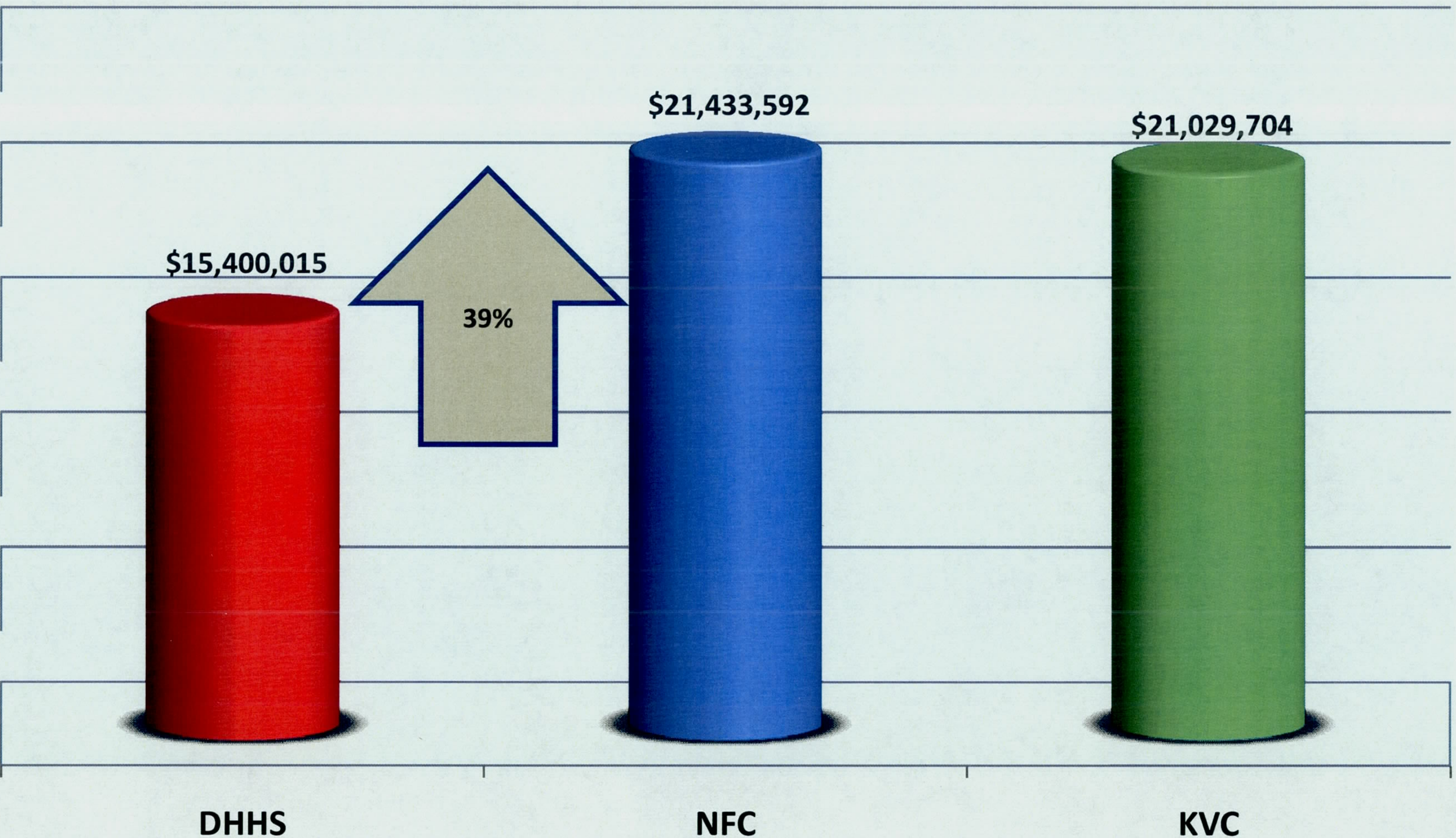
Expenditures for Reform Covered Services by Fiscal Year

	2008	2009	2010	2011
BGH Unsettled Expenditures	$-	$-	$-	$1,364,551
Reform Expenditures	$107,329,889	$107,753,602	$125,318,767	$136,558,971

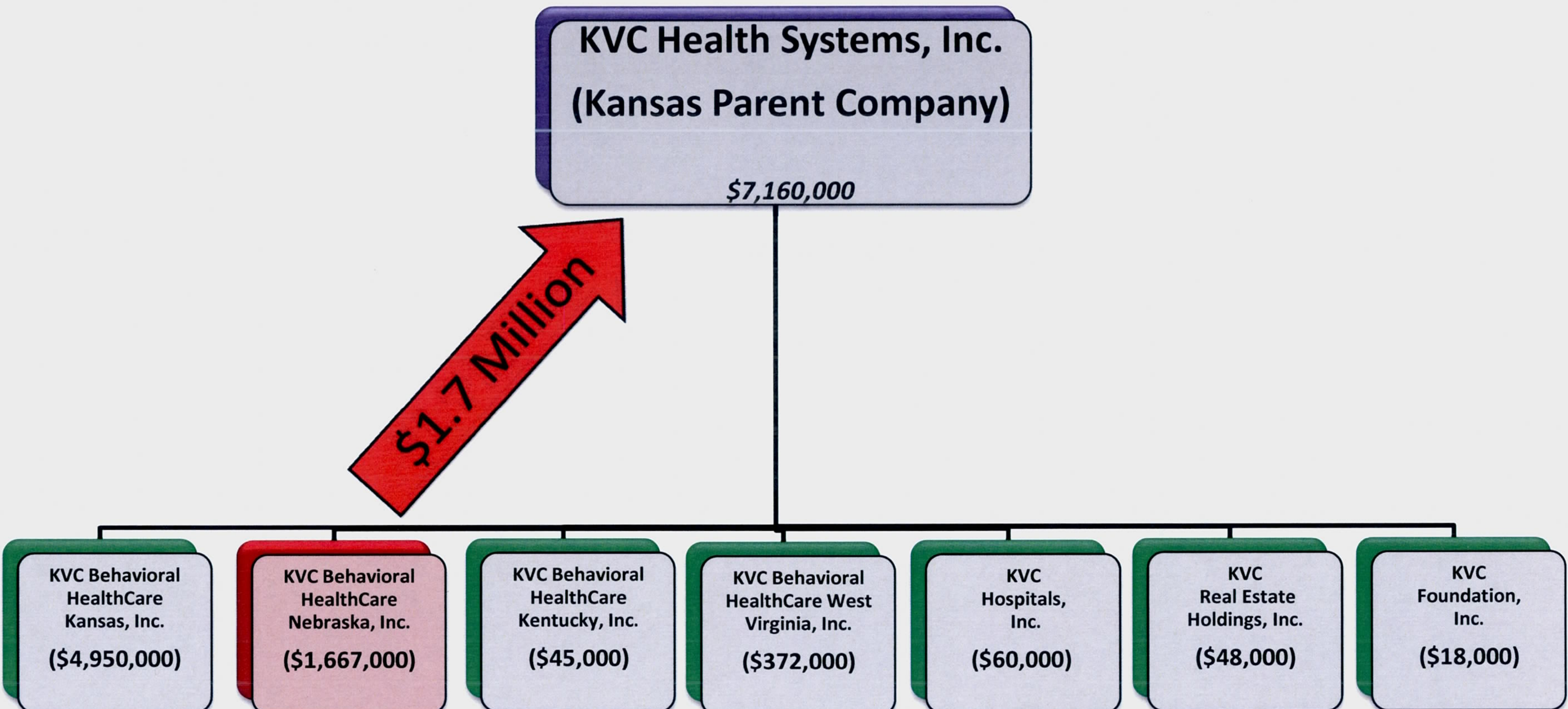
FY 2008 and FY 2009 are costs prior to Reform. FY 2010 and FY 2011 are costs for services provided by both private contractors and DHHS. BGH terminated its contracts in September 2010, for which the final settlement has not yet been made, resulting in the remaining contract costs of $1,364,551, as shown above.

Eastern Service Area FY 2011

Expenditures



KVC Management Fees from Subsidiaries to Parent Company Fiscal Year Ended June 30, 2010.



Source: KVC Health Systems, Inc. Audit for Fiscal Year Ended June 30, 2010.

Executive Summary
Attestation Report of the Nebraska Department of Health and Human Services
Child Welfare Reform (Families Matter) Contract Expenditures
July 1, 2009 through March 31, 2011

The Auditor of Public Accounts (APA) recognizes and thanks the audit staff who worked diligently on the demanding and complicated task of examining expenditures for child welfare services under the Families Matter reform implemented by the Department of Health and Human Service (DHHS) in 2009. Due to its complexity, such an examination would be difficult under even the best of circumstances; however, an already trying task was made all the more frustrating by a pronounced lack of cooperation on the part of DHHS. Thus, the audit staff deserves special appreciation for their remarkable forbearance and tenacity in the face of such consistent obstruction. This lack of cooperation by DHHS, which is among the worst ever encountered by my office, will be addressed again at the conclusion of this summary.

From the outset, DHHS touted the Families Matter reform as a way of enhancing the efficiency and accountability of child welfare services – and doing so "within existing resources." The audit report concludes, however, that DHHS failed to realize its stated goal of containing expenditures. Instead, the costs of child welfare services have skyrocketed during the past two years. More disturbing yet, the audit report points to a critical lack of accountability, primarily in the form of missing documentation, regarding how these public funds have been spent.

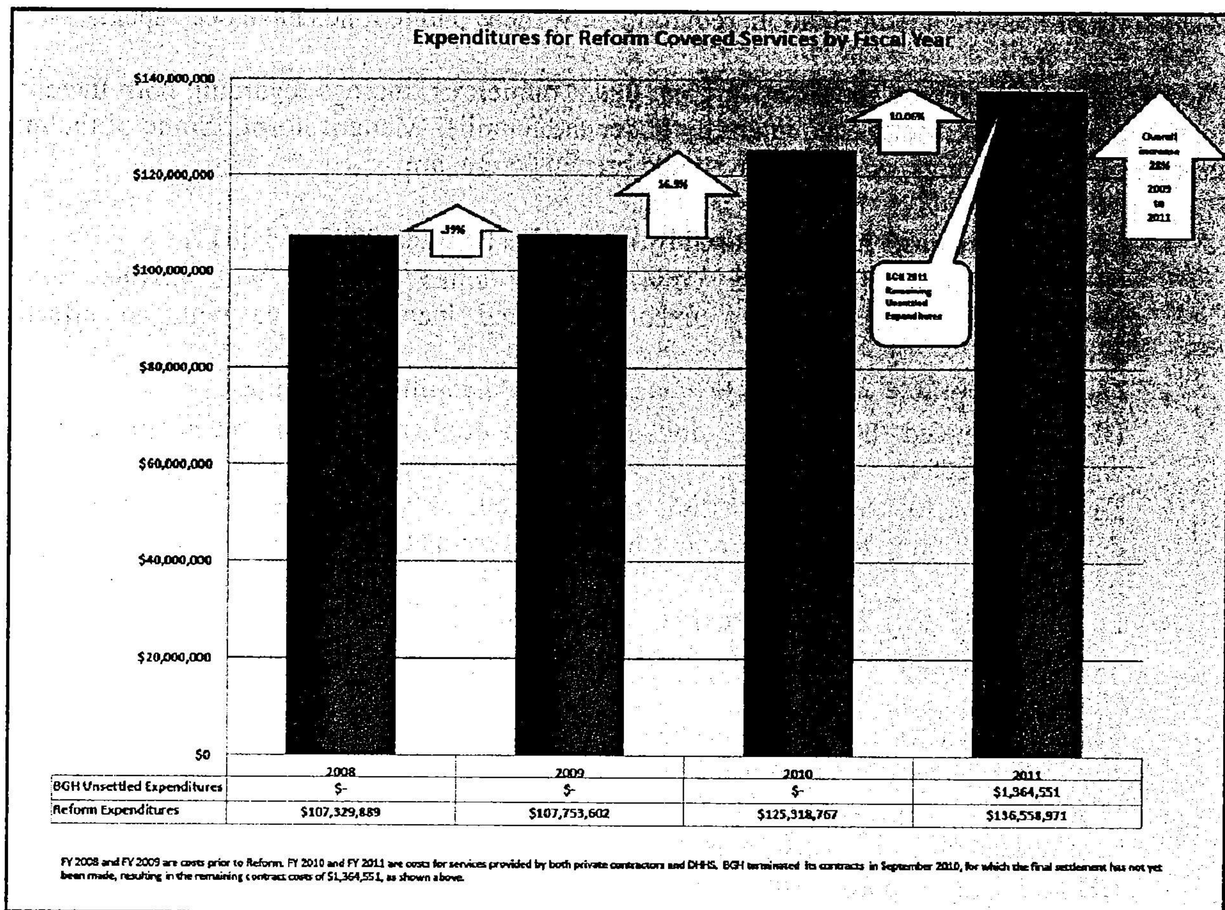
The 152-page audit report addresses in great detail numerous findings regarding both increased costs and a lack of financial accountability under the Families Matter reform. Some of the most striking of those findings, which are presented briefly herein, are:

- Child welfare costs have increased by some 27% between 2009 and 2011.
- DHHS failed to bid publicly multi-million dollar contracts with private service providers, resulting in many amendments and increased costs with no effective oversight.
- One service provider, Visinet, Inc., was overpaid by millions of dollars.
- DHHS expended thousands of dollars on both duplicate claims and payments to the wrong contractors.
- DHHS failed to secure possession of important, as well as potentially confidential, documents relating to client services following termination of its contract with a service provider.
- DHHS failed to reconcile provider billings in NFOCUS, which prevented effective agency oversight of both service expenditures and the welfare of children in State custody.
- Service providers failed to meet client service coordination and delivery benchmarks required by the service contracts with DHHS.
- DHHS failed to prevent former employees of service providers from gaining access to confidential client information in NFOCUS.
- DHHS failed to approve subcontractors utilized by service providers, as well as to ensure that such subcontractors were appropriately compensated for their services.
- DHHS failed to cooperate with the audit examination.

On June 15, 2009, DHHS initiated the Families Matter reform by entering into implementation contracts totaling $7 million with six providers. The purpose of these agreements was to lay the groundwork, through hiring and training staff and purchasing needed equipment, for the planned privatization of child welfare services in Nebraska.

Subsequently, effective November 1, 2009, DHHS entered into service contracts with five of the six contractors that had carried out the implementation stage of the Families Matter reform. Those service contracts, which initially totaled $149,515,887, have since been amended eight times. Out of the five original service providers, moreover, only two remain. As a result, DHSS employees have resumed responsibility for child welfare services left otherwise unavailable by the departure of the private contractors.

Child Welfare Costs Have Increased Significantly: Contrary to DHHS' stated goal of operating "within existing resources," child welfare costs have increased significantly under the Families Matter reform. From 2009 to 2011, DHHS expenditures for child welfare services grew from $107,753,602 to $136,558,871 – a cost hike of some 27%. Additionally, almost a year after having provided services, Boys and Girls Home (BGH), a former contractor, awaits service contract payments of some $1,364,551. Including that unpaid amount, the total increase for child welfare services would be $30,169,920 or 28%.



	2008	2009	2010	2011
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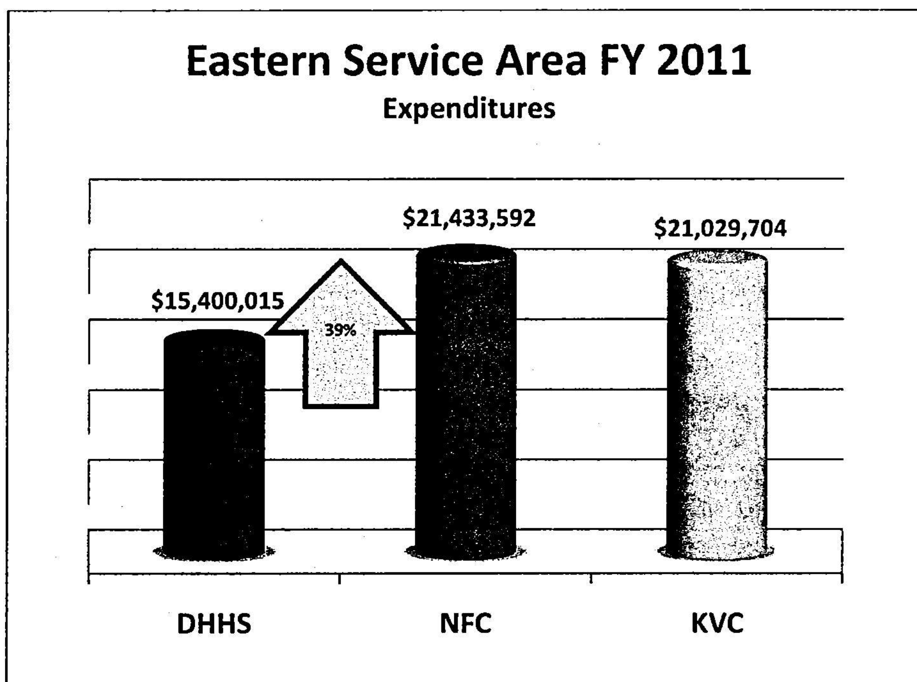
FY 2008 and FY 2009 are costs prior to Reform. FY 2010 and FY 2011 are costs for services provided by both private contractors and DHHS. BGH terminated its contracts in September 2010, for which the final settlement has not yet been made, resulting in the remaining contract costs of $1,364,551, as shown above.

The developments in one particular service area illustrate the disturbing implications of these increased costs. In the Eastern service area, child welfare cases were initially divided between three different private contractors: Visinet, Inc. (Visinet); Nebraska Families Collaborative (NFC); and KVC Behavioral Healthcare Nebraska, Inc. (KVC). Compensation for services rendered was shared among those providers. During fiscal year 2011, after the departure of Visinet, DHHS assumed that former lead contractor's case load. However, actual expenditures did not continue to correspond to the initial allotment of dollars between the private providers. As revealed in the chart below, NFC required as much as $6 million, or 39%, more than did DHHS to provide essentially the same type and number of client services.



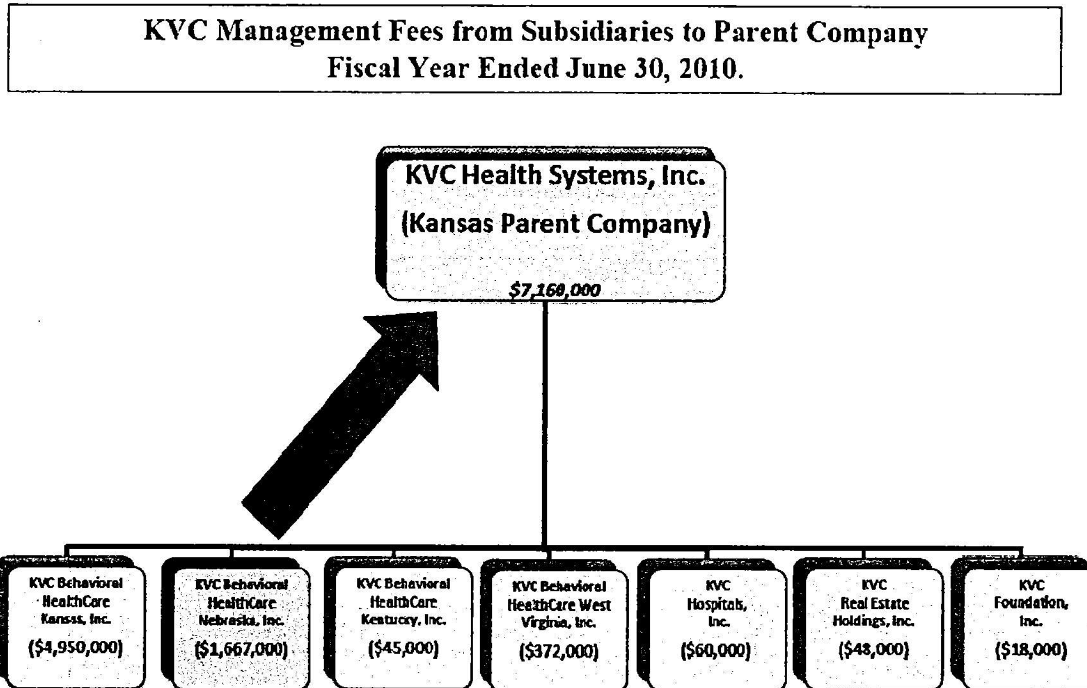
Though startling in and of themselves, the increased costs of privatization under the Families Matter reform are made more disturbing yet by the fact that DHHS lacks adequate support for them. For instance, along with the initial $7 million for the implementation contracts, there appears to be no documentation supporting the various contract amendments that have given rise to ballooning service costs – such as the total $6 million contractual increase for NFC and KVC, per Amendment 5, and a further $19 million in overall service contract increases for those same two providers, per Amendment 7.

According to DHHS, the inflated amounts paid to the service providers were the result of contract negotiations. However, DHHS could offer no documentation to show that any study was given to determining either the necessity of the dramatic growth in expenditures or a reasonable basis for the amounts paid to the private contractors for providing client services.

An additional consideration important to any discussion of the increased costs of providing child welfare services under the Families Matter reform is the fact that a significant portion of those expenditures do not necessarily further the interests of the clients whom the reform was supposed to benefit. In some cases, a not-inconsequential portion of the money received by the contractors

goes, rather than to supporting enhanced client services, directly into the pockets of corporate officers. In one instance, a significant sum of money paid to the private contractors under the Families Matter reform ends up leaving this State. The chart below illustrates this point, revealing how payments received by KVC flow directly to its parent corporation, KVC Health Systems, Inc. – the corporate headquarters of which is located in Olathe, KS.

KVC Management Fees from Subsidiaries to Parent Company
Fiscal Year Ended June 30, 2010.



Source: KVC Health Systems, Inc. Audit for Fiscal Year Ended June 30, 2010.

DHHS Failed to Bid Publicly Service Contracts: DHHS chose not to place the service contracts up for public bid, contending that the agreements were exempt from statutory bidding requirements as contracts with "direct providers" of "child welfare services to an individual" under Neb. Rev. Stat. § 73-507(2)(e) (Reissue 2009). The APA believes the statutory analysis applied by DHHS to be subject to some debate. Nevertheless, by using its own staff to oversee the contract selection process, DHHS failed to take advantage of the experience of the Department of Administrative Services-Materiel Division (DAS).

Due to both the large amount of public funds and the intricacies involved, the APA believes that it would have been prudent, not to mention more responsible to the Nebraska taxpayers, for DHHS to have placed the service contracts up for public bid. Additionally, though DAS could have proven an extremely valuable resource throughout the contract selection process, DHHS pursued a unilateral strategy that resulted ultimately in numerous amendments to the service agreements and the expenditure of millions of public dollars without any effective oversight.

In light of the eventual default of more than half of the providers selected, it is apparent that DHHS either lacked the expertise to examine the qualifications of those private contractors or was simply indifferent to the financial implications of contracting with entities whose business backgrounds contained glaring indicators of unsuitability. In addition to being able to help overcome either of these shortcomings, it is possible that DAS could have assisted in finding more and better qualified applicants.

The Health and Human Service Committee is currently seeking the input of DAS in an attempt to address problems occasioned by DHHS' contracting misadventures. Regardless of the applicability of statutory bidding requirements, it is likely that the committee would not be burdened with these concerns now had DHHS chosen to avail itself of the contracting resources of DAS.

Service Provider Overpaid Millions of Dollars: When Visinet, one of the five service providers with whom DHHS contracted, went out of business, some assumed that company's financial woes to have been exacerbated by a lack of payment from the State. In fact, nothing could be further from the truth. The audit examination revealed that Visinet was overpaid by more than $1.8 million under its service contracts with DHHS. Moreover, despite that overpayment, DHHS entered into a settlement agreement with Visinet that cost the State an additional $2 million. Worse yet, DHHS then added insult to the millions of dollars of injury done already to Nebraska's taxpayers by managing somehow to overpay that settlement agreement by $127,472. Between the service contract overpayment, the subsequent settlement agreement, and the overpayment on that gratuitous settlement, Visinet received nearly $4 million in unearned public funds.

The APA found that a senior attorney/administrator for DHHS had cautioned against overpaying Visinet. Even so, under the settlement agreement, DHHS accepted responsibility for paying an additional $2,008,818 to compensate subcontractors, foster parents, and employees left unpaid by Visinet – an obligation that DHHS had no duty whatsoever to assume. Additionally, due to the timing of the settlement agreement, DHHS made payments for 76 days during which Visinet provided no services at all.

With regard to public funds expended under the settlement agreement, DHHS could not provide documentation to support a payment of $627,270 to satisfy Visinet's payroll and payroll tax obligations. Likewise, DHHS lacked support for $158,639 in foster parent payments. In paying various subcontractors for Visinet, moreover, DHHS did not review service invoices to ascertain the amounts actually owed. As for the $127,472 overpayment on the settlement agreement, DHHS attempted no explanation.

Duplicate Claims Paid and Payments to the Wrong Contractors: During the period examined, DHHS made $25,276 in duplicate payments for the same services. Based upon our testing, the duplicate claim error rate was 78%, which indicates the potential duplicate dollars could be as high as $629,460.

Similarly, during that same period, DHHS paid a total of $128,422 to the incorrect contractors or subcontractors for client services provided. Our testing found that the incorrect contractor claim

error rate was 75.9%, indicating that the amount of payments to the wrong contractors could be as high as $454,444.

Financial Records Were Not Obtained After Contracts Terminated: On April 15, 2010, Visinet closed its doors, and its service contracts with DHHS were officially terminated effective April 20, 2010. In concluding its business relationship with that former contractor, DHHS failed to obtain all financial and service delivery records needed both to support the settlement amounts paid and to verify that child welfare services had been provided in accordance with the terms of the terminated service contracts.

By not taking possession of Visinet's records, DHHS neglected also to ensure that potentially confidential client information contained therein would be protected. Specifically, DHHS did not secure some 3,000 boxes of service-related documents summarily discarded when Visinet ceased business operations. Prior to their destruction, the former service provider expressly invited DHHS to take possession of those records. However, DHHS disregarded its duty to confirm that client information was properly safeguarded. Because no one was able to provide an explanation of when, where, or how thousands of boxes of Visinet files were destroyed – only that they were no longer available and were disposed of prior to this audit examination – there are also concerns regarding compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Due to the failure to obtain the records in question, DHHS could provide the APA with only very minimal documentation regarding Visinet's operations. Those documents lacked the following: 1) subcontractor invoices submitted to Visinet; 2) payments made to subcontractors and foster parents; 3) bank information; 4) accounts payable and receivable; 5) contracts between Visinet and subcontractors and foster parents; 6) client service rate schedules; 7) client placement agreements; 8) employee timesheets; 9) payroll records; 10) and other information pertaining to the service delivery and coordination contracts. Without access to those Visinet records, the APA was unable to issue an opinion as to whether the financial schedule for DHHS's expenditures under the Families Matter reform, for the period July 1, 2009, through March 31, 2011, was presented correctly, in all material respects, in this report.

DHHS Failed to Reconcile Service Provider Billings in NFOCUS: DHHS failed to ensure that service provider claim information contained in the Nebraska Family Online Client User System (NFOCUS) was both current and accurate. A comparison of service provider billings sent to DHHS with corresponding claims found in NFOCUS, between November of 2009 and March of 2011, revealed inconsistencies totaling more than $28 million dollars and dating back for almost two years. These variances are attributable to poor oversight and account keeping, as well as faulty data entry, by DHHS. At no point, it appears, has DHHS ever attempted to reconcile client service billings received from contractors to information entered into NFOCUS. As a result of this serious omission, much of the child welfare service data contained in NFOCUS is neither current nor complete.

Because NFOCUS serves as the primary repository of information pertaining to DHHS clients and services, the failure to reconcile provider billings to that database deprived DHHS of verifiable documentation upon which to base payments for services. Far more importantly, due

to the inadequacy of the NFOCUS records, DHHS lacked a functional mechanism for monitoring the well being, including the proper treatment and care, of children in State custody. Thus, in addition to showing how far the Families Matter reform has fallen short of expectations of increased financial accountability, the failure of DHHS to ensure the accuracy of billing information in NFOCUS has actually increased the vulnerability of the very children whom the reform was supposed to help.

Service Providers Failed to Meet Client Service Coordination and Delivery Benchmarks: The five private contractors selected by DHHS to provide services under the Families Matter reform agreed to take control of client cases from DHHS according to percentages found in a transition schedule referenced in the service contracts. With the passing of each month, between November 2009 and March of 2010, the service providers were expected to assume an increasingly large percentage of DHHS' client case load, as specifically outlined in the transition schedule, for a particular service area. Ultimately, this gradual transition process was to bring about the complete privatization of child welfare services.

The audit examination revealed that the contractors failed to meet the required contractual percentages for transitioning client service coordination and delivery – accumulating shortfalls that ranged from 1% to 18%. Surprisingly, the service contracts contained no penalties for failure to meet these periodic benchmarks. Thus, the service providers continued to receive full compensation despite having failed to meet their contractual obligations. Because fiscal year 2010 contract amounts were based on the transition percentages specified, moreover, DHHS incurred additional costs by continuing to provide client services for which the contractors were already being paid.

Former Employees of Service Providers Continued to Access NFOCUS Data: DHHS did not revoke in a timely manner the NFOCUS access for 24 former employees of service providers. As a result, those unauthorized individuals were able to continue accessing – and, at least, one person was found to have done so – client service data contained in NFOCUS days after their employment had been terminated.

The ability to restrict NFOCUS access depends, to a large degree, upon the cooperation of the contractors, who are responsible for informing DHHS immediately when workers have ceased employment. However, even when notified within a day of a terminated employment, DHHS delayed by as much as three weeks revoking the NFOCUS access of the former employee.

DHHS Failed to Approve Subcontractors or Ensure Their Proper Compensation: Under the service contracts, all of the five providers were expressly required to obtain the approval of DHHS prior to utilizing subcontractors for client services. However, DHHS appears to have granted that approval in a perfunctory fashion. As a result, neither the qualifications nor the suitability of the subcontractors were properly verified.

Two subcontractors, BSM, Inc., and Family Skill Building Services, LLC, (FSBS) were found to be using workers who lacked appropriate credentials to provide client services. Those six employees had neither a Bachelor's degree nor a staff equivalency petition approved by the DHHS service area Contract Liaison, as required by the service contracts. The immediate prior

employment of two workers had been at Taco Bell and Walmart – neither of which is an establishment known to offer extensive training in the field of child welfare services.

It should be noted that the uncredentialed employees were paid between $10.50 and $13.00 per hour. At the same time, however, DHHS was reimbursing the direct contractor for the work of those same employees at a rate of $47.00 per hour – doing so under the mistaken assumption that such compensation was paying for the labor of qualified workers. Thus, the contractors profited enormously from paying unqualified staff wages much lower than what would have been required to retain qualified workers. Aside from creating a situation that could have proven potentially detrimental to the welfare of the clients served, the failure of DHHS to scrutinize subcontractors more closely permitted some of them to enjoy a windfall in public funds at taxpayer expense.

The audit examination revealed yet another apparent consequence of the lackadaisical approach taken by DHHS toward approval of subcontractors. BGH subcontracted with McConaughy Discovery Center, which is a trade name for BSM, Inc. That entity was incorporated by Jeannine J. Lane, who was the subject of a previous report by the APA. The report found that, as the incorporator of Alternative Learning Lane, Inc., a company paid $1.4 million to provide a computer-delivered "alternative education" program for at-risk students in the Ogallala Public School District (OPSD), both Jeanine J. Lane and her employees lacked the teaching certification required by the Nebraska Department of Education to perform such a service. Upon learning of that lack of certification, OPSD terminated its contract with Alternative Learning Lane, Inc.

Finally, DHHS failed to seek, much less to obtain, assurances that the subcontractors maintain proper insurance coverage, as required by the service contracts. Furthermore, DHHS made no effort to ensure that any of the five lead contractors compensated, both timely and adequately, subcontractors and foster parents alike for their services.

Lack of Cooperation by DHHS: Despite the fact that the APA is vested with statutory authority to access all records of any public entity, DHHS failed to provide the APA with complete and timely access to requested documentation. This lack of cooperation necessarily limited the scope of the examination and, to some degree, its overall effectiveness – not to mention generated no small amount of speculation regarding other findings that might have been developed had full agency cooperation been forthcoming.

The audit report describes numerous examples of DHHS's failure to respond either timely or completely, or both, to requests for information. Incidents involving three or four separate requests, made over a period of almost a month or more, for the same records were not uncommon. For instance, on June 20, July 5, and July 8, 2011, the APA asked DHHS for specific details regarding Amendments 6 and 7 to the service contracts. Finally, on July 19, 2011, DHHS provided a response that carefully avoided the requested details.

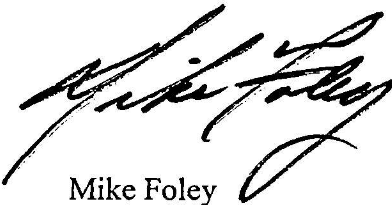
Following a July 22, 2011, exit conference that included some of the agency's senior administrators, DHHS was given 28 days to respond to findings discussed in the draft audit report, as well as to make available any additional relevant documentation, previously requested or otherwise. On August 19, 2011, moreover, DHHS signed a representation letter asserting that

all "financial and related data" had been made available to the APA. However, ten days later, it was discovered that all such information had not, in fact, been provided.

More details regarding requested information not provided by DHHS can be found in the full audit report. Suffice it to say, this failure to acquiesce both promptly and completely to records requests, made pursuant to express statutory authority, leads to the inescapable conclusion that either DHHS hoped to hinder the examination by intentionally circumventing the law requiring cooperation with the APA, or supporting documentation for the expenditure of millions of taxpayer dollars simply does not exist.

Conclusion: As a whole, the findings noted above – along with others addressed in the full audit report – indicate that DHHS has exercised poor fiscal management and control over the Families Matter reform. The consequence to the Nebraska taxpayers has been dramatic, including tens of millions of dollars in increased costs for child welfare services and a conspicuous lack of financial accountability that effectively frustrates any hope of transparency with regard to the expenditure of related public funds. Given these shortcomings, the Families Matter reform has little hope of realizing DHHS' goal of enhancing the efficiency and accountability of child welfare services, much less of doing so "within existing resources."

The full audit report is available on the APA website at http://www.auditors.state.ne.us/.



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September 7, 2011

Department of Health & Human Services
DHHS
NEBRASKA

Division of Children and Family Services

State of Nebraska
Dave Heineman, Governor

Testimony
Vicki Maca
For Sept. 7th, 2011

Good Morning, Senator Campbell and members of the Health and Human Services Committee. My name is Vicki Maca, V-I-C-K-I M-A-C-A. I am the DHHS Administrator responsible for Families Matter in the Eastern and Southeastern Service Areas (Attachment A). I have been in this position since June 17th and while I am relatively new to this position, I have over 25 years of professional experience in child welfare and behavioral health. My primary responsibility as the Families Matter Administrator is to ensure that the children and families served by Child Welfare and Juvenile Services, in the nineteen counties comprising the Eastern and Southeastern Service Areas, receive the best possible outcomes. Those overarching, statewide outcomes involve safety, permanency and well-being for Nebraska's children. There are several different strategies currently being utilized by the Eastern and Southeast Services Areas which have been implemented specifically to improve the safety, permanency and well being of children. I would like to highlight a few of the strategies identified as high priorities for the Eastern and Southeastern Service Areas.

As you know, in January of this year, DHHS contracted with KVC and NFC for case management responsibilities. KVC provides all case management services in the Southeast Service Area and for approximately one-third of the families in the Eastern Service Area. NFC provides case management for one-third of the families in the Eastern Service Area and, by October 15th, will assume case management responsibilities for an additional 600 families. Our number one priority with this transition is that it be as seamless as possible for the children and families involved. We have worked closely with staff to ensure that they had immediate information and opportunities to pursue positions with NFC and/or DHHS internal vacant positions available in the Initial Assessment Unit and the Outcome Monitoring Unit. Having all case management responsibilities provided

by the lead contractors will provide clarity to those who receive services, those who coordinate and provide services as well as to our community partners. Transitioning case management responsibilities to the lead contractors will also allow DHHS to enhance our focus on the statewide Child Abuse and Neglect Hotline, Initial Assessments and Outcome Monitoring.

Once a report has been accepted by the Hotline, it is assigned to a DHHS worker to begin an investigation. In some cases, DHHS collaborates with Law Enforcement to complete investigations, in other cases, only DHHS conducts the investigation. As you know, Law Enforcement is the only agency with the authority to remove a child. In order to ensure that we are making the best possible decisions about whether or not children are safe, we will soon begin utilizing a different assessment tool developed by the Children's Research Center. Later this fall, we will implement the Structured Decision Making Model, which is a series of evidence based tools that aid investigators and case managers with making objective and reliable decisions about safety. This fall, training on the Structured Decision Making Model tools will begin. Although DHHS staff is required by law to conduct the investigation, NFC and KVC staff will also attend this training and be expected to implement Structured Decision Making Model upon completion of their training, as it is critical that those completing investigations and those who have the on-going case management responsibilities utilize the same tools and speak the same language when it comes to child safety.

This past July in the Southeast Service Area, we implemented a new strategy designed to improve our ability to effectively connect children and families with community based resources. Many times the families we investigate do not have immediate or high child safety threats present. Often these same families have complex and urgent needs for things such as housing, food, daycare, transportation and/or parenting assistance. The DHHS investigator now has the ability to have specially trained NFC or KVC staff in a team effort, accompany them to the family's home to immediately connect the family to the resources or services they need. From July 4th to August 26, this team, referred to as the Initial

Response Unit or IRU in the Southeast Service Area, served 59 families, with 39% of those families connecting to the community resources they needed without formal court involvement. In the Eastern Service Area, the IRU teams were initiated in February of this year and have served 261 families, with 48% of these families safely being served without formal court system involvement. Strategies such as the Initial Response Unit are the types of interventions that provide families with the resources they need while keeping children safe. There is no formal system involvement or unnecessary child trauma due to being removed from their family home. We will continue to develop these types of "differential responses" that provide us with flexible, individualized and urgent approaches to responding to families and reducing child risk factors.

The majority of children entering the court system in the Southeast and Eastern Service Areas are not children who have been abused or neglected. On average, the highest volume of children being made state wards or receiving court supervision are status offenders and youth who have committed a delinquent or criminal act and have been committed to the Office of Juvenile Services. In August, this represented 79% of the youth in the Southeast Service Area and 71% in the Eastern Service Area. We have much work to do in collaboration with community partners, to develop and implement the type of services that intervene much earlier-before the onset of status or delinquent behavior and target prevention efforts for youth at risk of truancy or engaging in delinquent and criminal behaviors. Nebraska is one of only 4 states that manage youth delinquency within their Child Welfare System.

Our efforts to effectively communicate have included a variety of recent meetings with the Juvenile Judges, representatives from the County Attorney's office, the Foster Care Review Board and the system partners involved in the Through the Eyes of the Child Initiative, the statewide Partner's Advisory Council and the Center for Children Family and the Law. We will continue to share information as well as plan and coordinate with all those who impact outcomes related to Nebraska's Child Welfare and Juvenile Services System.

Over the past eight months, DHHS has transitioned the majority of our staff from providing case management to staff who are now monitoring case management. We have moved from entering data to largely analyzing and monitoring data. Over the last eight months we have been challenged to do our work differently, train our staff differently, supervise our staff differently and evaluate our work differently. Unfortunately there is no science or evidence based practice to guide how we manage these types of complicated system transitions. We are, however, learning and making rapid system adjustments as we identify more effective and efficient practices and management strategies. We are strengthening our continuous quality improvement activities and using data to guide our decisions and evaluate system outcomes. We have revised tools to more frequently and effectively monitor progress made with outcomes. We are working diligently with national experts and other states that have had experiences similar to ours in order to expedite our learning and maximize our resources. We have shifted resources to focus solely on the business of Families Matter and are much more effectively mastering the balance of holding contractors accountable for specific deliverables while at the same time, collaborate with them to ensure that Nebraska's children are safe.

We look forward to the future; there is much to do, and much to learn as we focus on continually improving the Child Welfare and Juvenile Services System in Nebraska.

Thank you for the opportunity to provide you with these updates. I would be happy to answer any questions you may have.

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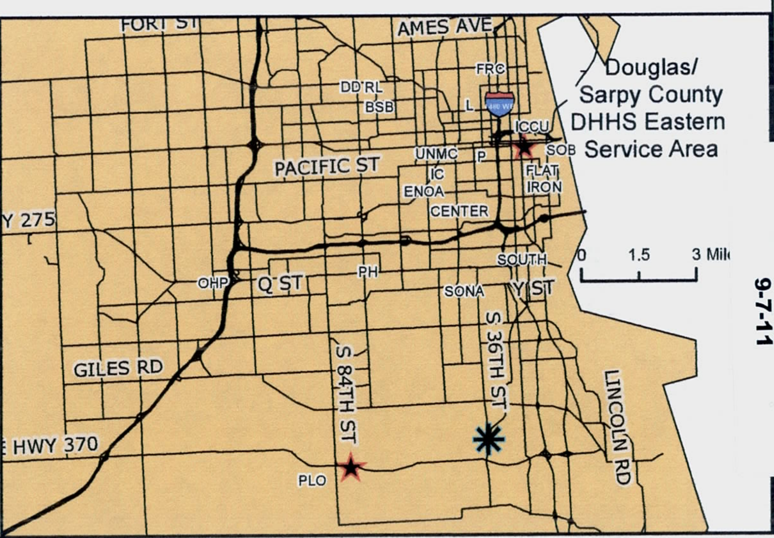

Legend

- DHHS Offices
- DHHS 24-hour Facilities
- Interstates
- Major roads
- Central
- Eastern
- Northern
- Southeast
- Western
- County outline

Department of Health & Human Services
DHHS
NEBRASKA
Geographic Information Systems

Map created by:
DHHS GIS
Revised 9-11

Source: Division of Public Health

TESTIMONY OF JEFF SCHMIDT

My introduction and role with Families Matter and Department:

Good morning. My name is Jeff Schmidt (spell name). From February, 2007 to May, 2011, I was the Service Area Administrator for the Southeast Service Area of the Nebraska Department of Health and Human Services, Division of Children and Family Services. In 2007 when I was named Service Area Administrator, that role included responsibilities in the areas of child abuse and neglect, juvenile justice, economic assistance, developmental disabilities, and adult protective services. Sometime in late 2009, the service area's responsibility for developmental disabilities cases was transferred to the Division of Developmental Disabilities.

In addition to my duties as service area administrator, I was the co-leader of the Department's child welfare reform effort from early 2008 until sometime in the Summer or Fall of 2010. In early 2008, Director Todd Landry asked myself and Chris Hanus, a central office child welfare administrator, to co-lead a confidential child welfare reform planning effort. In that role, we facilitated the reform process from its early conception and planning stage, through the contractor selection process, contract negotiations, and contract implementation, completed in April, 2010. However, during the spring and summer of 2010, these functions were increasingly held by Mr. Reckling, Mr. Winterer, Ms. Hanus, and DHHS legal counsel. By late summer, 2010, when DHHS had apparently made the decision to privatize case management in SESA and ESA, my involvement in the reform effort was focused on addressing issues within the SESA. In the fall of 2010, the Sponsors group was officially disbanded.

I understand there are three questions related to some general areas the Committee would like to address in this Hearing, but after having some time to reflect on my tenure with DHHS,

and my involvement with the child welfare system, I have some thoughts about this process and how we all came to be here that may be useful to you.

Concerns

I am concerned that this effort to reform Nebraska's child welfare system may be based as much on assumptions, incorrect information, frustration, and momentum as it is on any actual facts. As examples, I would offer two factual assumptions that seem to be gospel within DHHS, but may not be accurate. First is the assumption that Nebraska's child welfare system was "broken" or so badly flawed that a major overhaul was necessary. Nebraska's performance on the C.F.S.R. is often cited to support that assertion. In fact, the executive summary from Nebraska's 2008 C.F.S.R. review, which reviewed cases open between October 1, 2006 and July 18, 2008, does indicate some pretty low scores for Nebraska in some areas. However, it also identifies areas of strength, and identifies key factors contributing to Nebraska's poor areas of performance. Many of these key factors, such as holding family team meetings, finding non-custodial parents, and conducting caseworker visits, were certainly items that DHHS could directly influence and efforts were underway to improve in these areas. On the other hand, DHHS has very little influence over at least one key factor identified as needing improvement, that is critically importance in child welfare cases. This factor is the availability of sufficient mental health and substance abuse treatment in Nebraska and this factor reaches far beyond the Department's role in the child welfare system. The time when law enforcement and DHHS first become involved in a family, especially when kids have to be removed from the home, is the most critical time to assess mental health and substance abuse treatment needs and initiate that treatment. However, Nebraska's behavioral health system lacks resources and providers, authorization and payment systems can be cumbersome and confusing, and priorities associated

with federal funding are very restrictive. The result is that there are delays in assessing these issues within the family, and in getting the appropriate treatment in place in a timely, effective manner. It is possible that this problem, above all others, contributes more to the length of time children remain in the care of DHHS than any other single issue. However, this is not strictly speaking a failing of the child welfare system.

The second assumption that must be questioned is the apparent belief that private contractors can improve Nebraska's child welfare system more effectively than government employees. My experience with the staff of DHHS in the SESA and the rest of the state, and my experience with private contractors, has convinced me that no contractor can outperform these public servants on an even playing field. That isn't a criticism of the contractors or their staff, many of whom used to work for DHHS. It is a recognition of the passion, commitment, and talents in the people I was privileged to work with every day. The job of a Service Area Administrator was the most challenging I've ever had, but it was also the most rewarding job I've ever had, in large part because of the people I worked with. There is a body of knowledge and experience held by state employees that is being lost right now. They know how a particularly thorny issue was resolved the last time it came up, who to call to get what the family needs, and how to get around the roadblocks put in their way by DHHS administration and other agencies. The performance, experience, and knowledge of contractors and their staff will improve over time, but the cost to Nebraska's taxpayers and children in the meantime must be considered.

In addition, claims that private contractors will be more "flexible" and able to react to changed circumstances more quickly than government workers are not supported by the short history of this arrangement. Contractors are still subject to, and must abide by, state law, agency

policy, and court orders. The result has been, and will continue to be, that they are subject to the same internal and external factors that delay and inhibit proactive, creative thinking, and will not be able to make changes any more quickly than government staff.

Red Flags

During the planning and negotiating process leading up to Nebraska's reform effort, there have been some instances of faulty information being identified, but not adequately addressed in a timely manner. For example, early in the process of selecting and negotiating with potential lead contractors, DHHS provided an estimate of the total amount of money that would be available for the anticipated contracts. However, shortly before contracts were to be signed, that estimate was replaced with an actual number that was millions of dollars less than the estimate. However, instead of stepping back to assess the impact of this change, DHHS insisted on moving forward, without contractors having an adequate opportunity to re-evaluate how to absorb the reduced funding.

In retrospect, another flaw in the design of the initial service coordination contracts was the financial arrangement. Each contractor was guaranteed a set amount of compensation, without regard to the number of children served or the types of interventions necessary. Under such circumstances it was only natural, and should have been expected, that the contractors would view privatization of case management as a necessity so they could better control costs. However, the arrangement was for DHHS case managers to have the final decision about any recommendations that were to be made to the court, or any non-court interventions that would be utilized. The result was, not surprisingly, conflict and ongoing disagreements about the proper role of the contractor and DHHS.

Priority

Finally, while the current reviews of DHHS actions and decisions surrounding child welfare reform are necessary and appropriate, I am concerned that this process will unduly distract from the vital work with children and families that is the mission of DHHS. Unfortunately, the culture of DHHS seems to lend itself to a bunker mentality in response to criticism or questioning and there has been substantial criticism recently. The combination of increased scrutiny, defensive reactions, and political pressure has the potential to result in decisions based on factors unrelated to the best interests of children and families.

Thank you.

FCRB Testimony On Child Welfare Reform

Health and Human Services Committee
LR 37 Special Hearing
September 7, 2011
Room 1510

Booklet Contents

- Red Tab – Testimony
- White Tab – FCRB Tracking and Reviewing
- Blue Tab – Managed Care Concerns
  Orange Tab – Diminished Services
- Yellow Tab – Lack of Documentation

Red Tab Divider

Testimony to the LR 37 Committee
September 7, 2011

I. I am Carol Stitt. Executive Director of the Foster Care Review Board.

II. Thank you for this opportunity

III. Children enter the foster care already wounded with increased vulnerability for further injury because of their family's pervasive alcohol and drug issues. a lack of adequate food and shelter (extreme poverty). domestic violence. serious untreated mental health issues. parental cognition issues. and/or their own serious physical or mental conditions.[1]

IV. Successful child welfare reform in Nebraska began in June 2006 and ended in 2008.

   a. Governor Heineman's leadership there was a focus on decision making to ensure children obtained permanency and moved out of the foster care system appropriately and in a timely manner.

   b. By the end of 2007 that number had been reduced to 5,043, a 19 percent reduction.

   c. In 2008, Governor Heineman, Chief Justice Heavican, and the FCRB Chair announced a joint study of children, many children's cases resolved, adoptions at all time high.

   d. That was reform, and it was working.

V. The process that is currently under way has had different definitions, and different focuses, but basic DHHS contracted with private agencies to take on case management and deliver services.

VI. The question needs to be asked, what exactly are we "reforming" and is this model the best tool for positive changes to the child welfare system.

VII. Faulty assumptions.

   As the Center for Public Policy said in a March 2005 release:
   "*In states that have privatized, private agencies struggle with the same issues that public agencies do such as obtaining adequate services, reducing caseloads, and reducing turnover. More money would increase the availability of services whether spent through the public or private sector, but merely hiring a middle man to manage services does neither.*"

   "*Even with privatization, the state must both 1) maintain oversight of each case and 2) monitor contract performance and outcomes. Across the country, in those states that have privatized, public sector administrative costs continue to grow for this very reason.*"[2]

VIII. What would have happened if resource put into 2008 system

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[1] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 6.
[2] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 19.

IX. Current "Reform" issues.

a. No focused approach

b. Communication issues.

c. Insufficient attention to infrastructure, capacity, and knowledge of the Nebraska legal system under which the agencies would be working.

d. DHHS had not corrected the lack of vigorous oversight of its contractors that existed prior to the Reform. Oversight lacking.[3]

e. Cases were transferred extremely quickly, without a pilot, and a number of issues were identified with the transfer process.[4]

f. Momentum gained in the period of 2006-2008 has been lost.[5]

X. Issues for Workers

a. Worker retention.[6] Changed positions numerous times – lead agencies changed, roles within DHHS/lead agencies changed.

b. Workloads high. Providing both case management and some services, such as transport, tutor.

c. Current placement for the child is not always available on the state's required SACWIS computer system. Critical lapses.

d. Lack of critical documentation about parental compliance[7] and health/safety in the placement.[8]

e. Delays getting authorization paperwork.

f. Delays to decisions.

g. Workers have to make crisis decisions without the benefit of fully knowing the case or having background in the legal system.[9]

h. Practices that would have been unacceptable two years ago, such as not documenting visitation or cutting foster parent pay, are now being tolerated.[10]

i. Working 70-80 hours per week.

j. Worker burnout.

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[3] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 17ff.
[4] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 7.
[5] Foster Care Review Board December 2010 Report on Child Welfare Reform, timeline page 21.
[6] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 9.
[7] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 13.
[8] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 11.
[9] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 9.
[10] Compare to Foster Care Review Board 2008 Annual Report.

2011	2008 (pre-lead agencies)
37% (871 of 2,383) of the children reviewed Jan-June 2011 lacked critical documentation on the children's placement needed to determine the safety and appropriateness of the placement.	19% of the cases reviewed (831 of 4,457) lacked critical documentation on the children's placement needed to determine the safety and appropriateness of the placement.
43% (1,028 of 2,383) of the children's cases reviewed during the first six months of this year did not have a complete plan.	26% of the children (1,162 of 4,457) reviewed did not have a complete plan.
50% of the children in out-of-home care (2,186 of 4,349) on June 30, 2011, had 4 or more DHHS workers assigned to their case while in out-of-home care. 1,215 children in the Lincoln-Southeast area were assigned to a lead agency. • 674 (55%) had 4 or more DHHS workers assigned to their case while in out-of-home care.	35% of the children (1,659 of 4,620) in out-of-home care on Dec. 31, 2008, had 4 or more DHHS workers assigned to their case while in out-of-home care.
2,606 children in out-of-home care were assigned to a lead agency on June 30, 2011. • At least 937 (37%) have had 3 or more lead agency staff (service coordinators or family preservation specialists), assigned to their case and • At least 538 (21%) of these children had 4 or more lead agency staff assigned to their case. *We know through reviews that the number of lead agency staff changes has been under-reported.* 1,215 children in the Lincoln-Southeast area were assigned to a lead agency. • 577 (47%) had 3 or more lead agency staff assigned their case while in out-of-home care, and • 357 (29%) had 4 or more lead agency staff assigned their case.	n/a
During the first six months of this year the FCRB reviewed 1,375 cases that were assigned to a lead agency. • 16% (216) had documentation that there was no lead agency staff person (FPS) contact with the child in the 30 days prior to review as should be happening, and • 7% (96) had no documentation so may not have had such contact.	n/a

XI. Issues for Foster Parent

a. Foster parent pay cuts.[11]

2008 Pre-Reform Foster Parent Reimbursement	2011 Post Reform Foster Parent Reimbursement
$725 average payment to foster families that were non-relative.	$600 average payment to foster families that were non-relative.
Foster parents receive a one-time clothing allowance.	No clothing allowance.
Foster parents reimbursed for some respite time (time away from children, such as to attend a class).	No paid respite.

b. Relative caregivers pay cut substantially.[12]

c. Lost respite.

d. Some asked to supervise visitation.

e. Trouble getting in touch with worker re crisis situations, visitation schedules, etc.

f. Visitation arrangements.[13]

XII. Issues regarding Placements

a. No information regarding placements.

b. Instability[14]

2011	2008 (pre-lead agencies)
49% of the children in out-of-home care (2,144 of 4,349) on June 30, 2011, had 4 or more placements while in out-of-home care. This is one area of minor improvement.	55% of the children (2,551 of 4,620) in out-of-home care on Dec. 31, 2008, had 4 or more placements while in out-of-home care

XIII. Issues regarding Services

a. Service providers were lost as a result of the way reform was implemented.[15]

[11] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 5.
[12] Ibid.
[13] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 10.
[14] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 11.
[15] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 14ff.

XIV. **Effect on the Children**

a. Front-line workers lack case knowledge.

b. Confusion for children and families as roles changed in rapid succession.[16]

c. More court continuances.

d. Decisions made without clear documentation. understanding of cases

e. Money being spent on the current system, including the recent additional funds, is not translating into better services for children and their families

2011	2008 (pre-lead agencies)
14% (342 of 2,383) of the children reviewed during the first six months of this year were found to have no continued need for out-of-home care.	11% of the children (471 of 4,457) reviewed were found to no longer need out-of-home care.
155 adoptions were completed during the first six months of 2011.	218 adoptions were completed during the first six months of 2008.

XV. **Agencies trying to respond to chaos.** Example, planned on 1/3, got all Lincoln area cases.

XVI. **Issues beyond lead agency control.**

a. Rigid means used to determine if managed care will pay for behavioral services needed by about 37% of the children in out-of-home care,[17]

b. Increasingly becoming apparent that the lack of Medicaid funding for transportation is becoming more of an issue in children's cases.

XVII. Reform not resolved problems present before reform, created new issues.

XVIII. Costly in terms of resources allocated and in terms of deteriorating outcomes for children

XIX. Children can't wait years for positive changes in the system.

XX. In 2010 reform report, like others we:

a. Called for audit.

b. Asked for moratorium.

c. Asked for Legislative Oversight.

[16] Foster Care Review Board December 2010 Report on Child Welfare Reform, page 10.
[17] See Foster Care Review Board 2008 Annual Report.

XXI. **System needs to go back to the basics**

a. Preventing child abuse by utilizing a proven visiting nurse format.

b. Treating front-line workers better, including looking at their workloads and supports.

c. Rebuilding the lost service capacity of services and placements and supporting quality foster placements.

d. Assuring children receive services professionals have recommended.

e. Assessing which cases can come in under "voluntary" cases.

f. Ensuring clear communication.

g. Providing oversight of workers, placements, and services.

XXII. **Any improvements.**

a. Appreciates responsiveness of lead agencies.

b. Compared to where we were in 2008, the system as a whole has experienced a decline

XXIII. **Collaboration with DHHS & lead agencies**

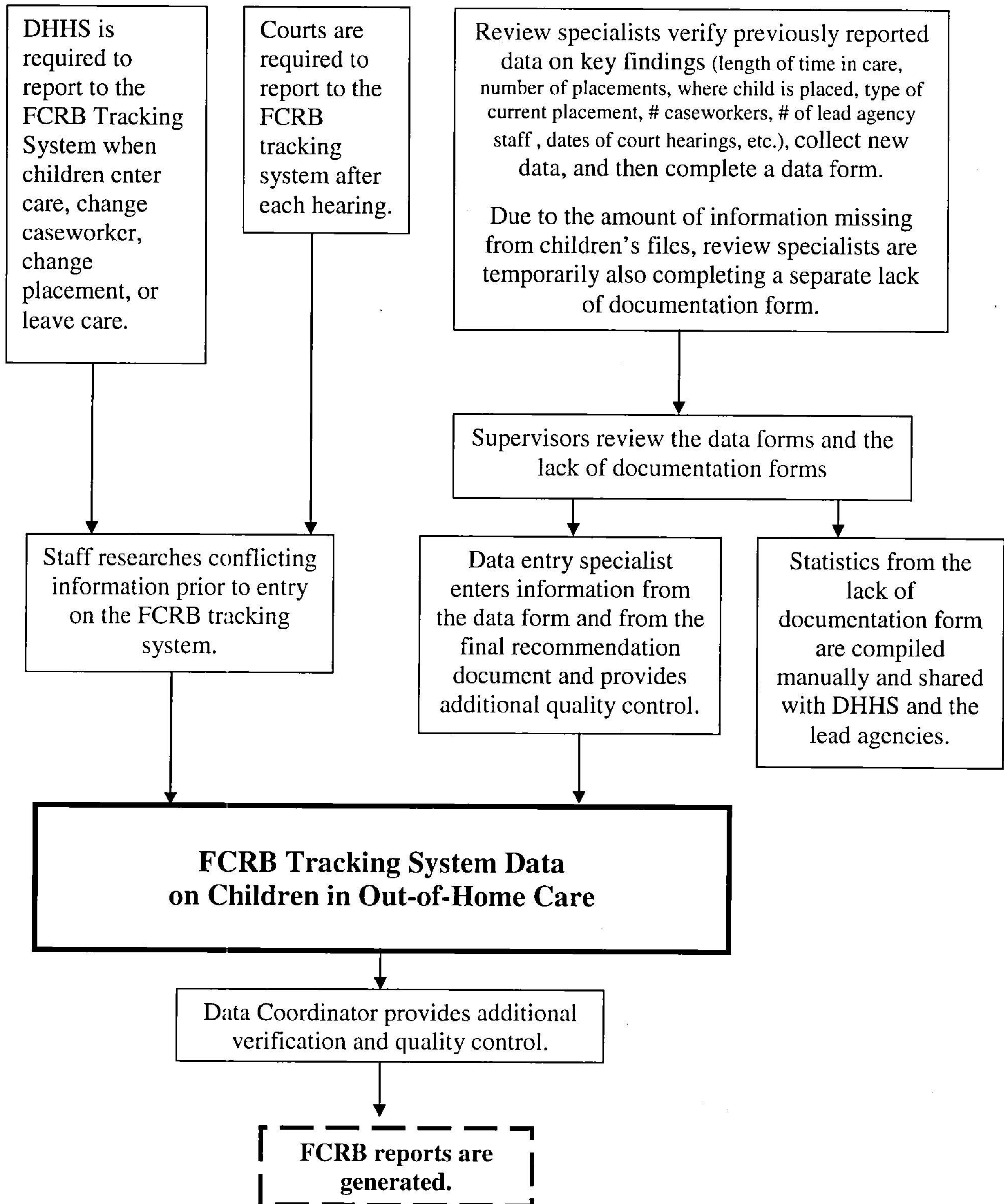
a. LOD

b. IV-E

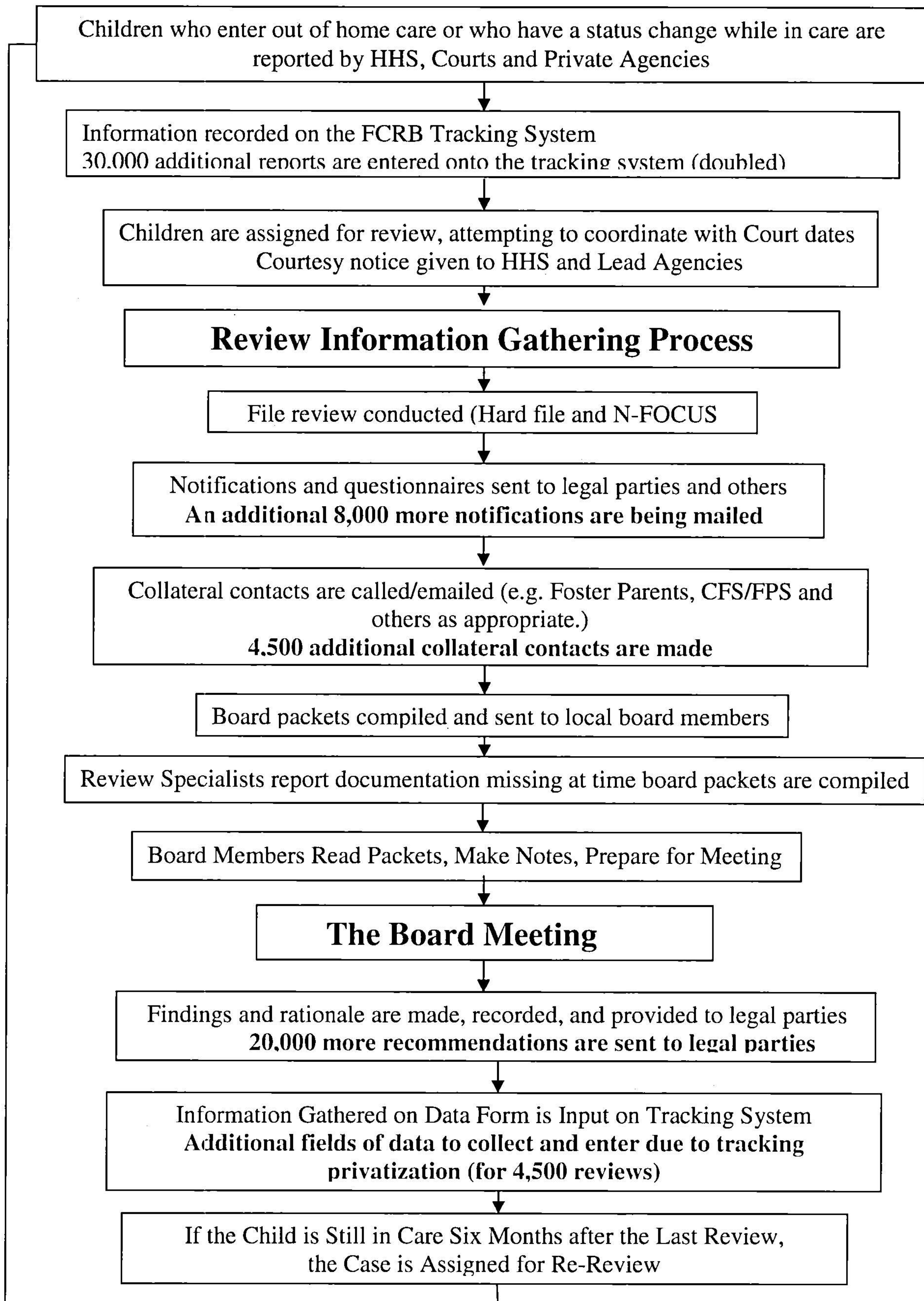
XXIV. **Thank you. Questions.**

White Tab Divider

The FCRB Tracking Process



The FCRB Review Process



There Has Been a Significant Impact on Review Process and Workload Due to Child Welfare Reform

Nebraska Foster Care Review Board
Local Review Board Findings and Recommendations

Neb. Revised Statutes 43-285 (6). Any written findings or recommendations of the State Foster Care Review Board or a designated local Foster Care Review Board with regard to a juvenile in foster care placement submitted to the Court having jurisdiction over such juvenile shall be admissible in any Court proceedings concerning the juvenile if such findings or recommendations have been provided to all other parties of record.

Board No./Location	XXX/Kearney	**Docket/Case Number**	XXX
Board Meeting Date	7/6/11	**Date Next Court Hearing**	7/14/11 Rvw&Perm
Review Number	2	**Date of Next FCRB Review**	1/2012
Agency/Area	DHHS/Kearney	**County of Court**	Buffalo

Confidential - Unauthorized disclosure of this report or any of its contents is a Class III misdemeanor under Nebraska Law.

In the Matter of:

Child's Name	Birthdate	Age	Number of Times in Care	Number of Placements	Time in Current Placement	Total Time in Foster Care	% Of Life In Care
Smith, Jill	1/8/10	1y6m	1	1	12m	12m	67%

Placement	Relative placement with 2 teenage children
Permanency Objective	Reunification (Case Plan 2/25/11)
Target Date	9/30/11 (Case Plan 2/25/11)
Number CFS Specialists	2 (N-Focus 6/29/11)
DHHS Last Visit	6/14/11 /DHHS (CFSS Email 6/29/11)
Number Service Coordinators	N/A
Service Coordinator Last Visit	N/A
GAL Last Visit	5/10/11 / Placement (GAL Questionnaire 6/27/11)

Name	Relationship To the Case	Questionnaire Sent	Questionnaire Returned	Review Invited	Review Attended	Findings Submitted
Hon.	Judge	N/A	N/A	N/A	N/A	Yes
Lana Daniel	County Attorney	N/A	N/A	N/A	N/A	Yes
Gloria Borak	Guardian ad litem	Yes	Yes	Yes	Yes	Yes
Susan Gamble	CFS Specialist	Yes	Yes	Yes	Yes	Yes
Callie Valle	CFS Supervisor	N/A	N/A	N/A	N/A	Yes
Bill Alders	CFS Administrator	N/A	N/A	N/A	N/A	Yes
David Zimmer	Mother's Atty.	Yes	No	Yes	No	Yes
Glen Carter	Father's Attorney	Yes	No	Yes	No	Yes
*Pamela Hayden	Mother	No	N/A	No	Yes	No
*Tom Smith	Father	No	N/A	No	N/A	No
Relative	Placement	Yes	No	Yes	Yes	No

*Returned from Post Office.

***Please note – All names have been changed**

Smith, Jill	Board #XXX	Date: 7/6/11

BOARD'S RECOMMENDATIONS AND FINDINGS

- **The permanency objective of reunification is not endorsed by the Board and a plan of adoption is recommended.**

Current Barriers to Achieving Reunification:

- Ms. Hayden has not made progress in her services to achieve reunification:
  - Lacks housing
  - Lacks employment
  - Is not providing proof of AA/NA meetings
  - Was not participating in family support services
- Mr. William's whereabouts are unknown to DHHS and he does not visit Jill.
- Jill has been in out-of-home care for 12 months and needs permanency.

Recommendations for Alleviating Barriers:

- The Board respectfully requests that the county attorney and/or GAL file a motion to terminate parental rights be filed with the court.

Reasons Entered Care: On 6/24/10 an intake was investigated but it was determined that the parents were using their resources, there was no evidence of marijuana usage in the home, and Jill's basic needs were being met. The home was cluttered and the parents were advised of the consequences of future concerns regarding the child's well-being. On 7/16/10 an intake was received regarding concerns of domestic violence between Mr. Smith and Ms. Hayden, Mr. Smith had self-inflicted cuts, Mr. Smith' alcohol abuse, and allowing numerous adults in the residence who used marijuana in the presence of Jill. On 7/20/10, law enforcement contacted Mr. Smith and Ms. Hayden at their residences and found marijuana paraphernalia on living room and kitchen floors and in plain view. All of the floors of the residence were cluttered with trash, including kitchen knives on the floor, old stale food, small pieces of trash, and beer bottles and cans. Most of the items were determined to present a health and safety hazard for Jill. In Jill's crib there was a bottle of perfume, a large amount of dog hair, and bunched up blankets that could pose a suffocation hazard. Three people were passed out or asleep in various locations of the residence. Due to the conditions of the home, Jill was placed in the custody of DHHS. Jill received a medical exam on the same date and she had a bad case of diaper rash, Hand, Foot, and Mouth Syndrome, numerous mosquito bites, cradle cap, and bruise above the left eye. Hair follicle testing of Jill was positive for exposure to marijuana. (Affidavit 7/20/10 and Safety Assessment 6/10-8/10)

Court Information:

- Adjudication §43-247 (3a) on 7/28/10 (Justice 1/5/11)
- Court hearings are occurring every six months. (Court Doc 3/3/11)
- The court has adopted the most recent case plan. (Court Doc 3/3/11)
- Paternity has been established by birth certificate, Affidavit, Statement of Necessity to Identify Father, and Statement of Father. (Birth Certificate and Affidavit & Statements 7/23/10)
- Child support has not been ordered. (Court Report 2/28/11)

- ICWA: Ms. Hayden was adopted and advised that her biological parents are Native American. DHHS sent tribal notification letters and all of the tribes responded and stated that Jill is not enrolled or eligible for enrollment. (Letter 8/3/10 and Court Report 12/7/10)

Child's Placement:

- The child was placed in a relative home of her maternal adoptive grandfather and his wife on 7/20/10. (N-Focus 1/14/11 and Letter 8/3/10)
- A current home study was found in case file. It was recommended that the CFS specialist follow-up with the family to ensure that the ammunition has been moved and stored separately, and locked. The CFS specialist advised that the ammunition is now stored separately. (Home Study 12/16/10 and CFSS Email 2/4/11)
- There have not been any intakes or investigations on the placement regarding this child. (N-Focus 6/29/11)
- There is 2 other child in placement. The relatives' children are 17 and 18 years old. (N-Focus 6/29/11 and Home Study 12/16/10)
- The child's placement was not given health information at the time child was placed. (FP Participant 2/7/11)
- The child has not been physically or chemically restrained or secluded in their current placement. (FP Participant 2/7/11)
- The GAL believes Jill's placement is appropriate. (GAL Questionnaire 6/27/11)
- The CFS specialist visited the foster home on 5/10/11. (Narrative 5/10/11)
- Should it become necessary, this is an adoptive home for Jill. (FP Participant 7/6/11)

- The GAL does not support Jill to be moved to the mother's area until Ms. Hayden demonstrates progress. (GAL Questionnaire 6/27/11)

- Other Relatives: Karen Hayden is the maternal adoptive grandmother and is on the road with her husband who is a truck driver. (Safety Assessment 6/10-8/10) The paternal grandmother, Betty Smith, resides out of State. (Safety Assessment 6/10-8/10) The paternal grandfather, Keith Smith, is in prison. (Safety Assessment 6/10-8/10) Mr. Smith' closest relative is his uncle Lenny Ward, who lives outside of Kearney. (Safety Assessment 6/10-8/10)

Child's Services:

- The DHHS case file included updated health information.

Jill's Information:

Health/Medical:

- Date of physical exam: 6/10/11 (FP Participant 7/6/11)
- Health concerns: Skin condition, but no recent outbreaks. (Court Report 2/28/11)
- Medications prescribed: None recorded.

Development:

- Does the child have an IFSP? Not applicable. On 9/1/10, Jill was assessed by Early Development Network (EDN) and there were no identified concerns. EDN contacted the foster/step grandmother and there were no developmental concerns. EDN will re-contact in 4/2011. (MDT 9/1/10, CFSS Email 2/4/11, and Court Report 12/7/10)

Parent Information:

Mother: Pamela Hayden (DOB 6/9/88) recently moved to another area in an attempt to find housing and employment. (N-Focus & CFSS Email 6/2011 and Narrative 5/17/11)

- Ms. Hayden completed a chemical dependency evaluation on 8/26/10. She did not meet the criteria for abuse or dependence and recommendations were: 3 AA meetings per week for a minimum of 3 months and abstain from alcohol and drugs. (CD Eval 8/26/10)
- Ms. Hayden is pregnant and her due date is 8/10/11. (N-Focus 6/29/11)

Father: Tom Smith's (DOB 6/3/91) current address is not available. (CFSS Email 6/29/11)

Services: Date of Most Recent Review Hearing: 3/3/11. (Court Doc) The GAL reported that a lack of parental compliance is keeping this plan from succeeding and is recommending a concurrent plan of adoption at the 7/14/11 hearing. (GAL Questionnaire 6/27/11)

Ms. Hayden:

Services	Offered by DHHS	Court Ordered	Compliant	Verified
CD Evaluation Recommendations	Yes	Yes	Not doc	(see brief narrative)
Family Support	Yes	Yes	No	(see brief narrative)
Random UA's	Yes	Yes	Not doc	(see brief narrative)

Brief Narrative Regarding Services:

- Documentation of Ms. Hayden's attendance at 3 AA/NA meetings was in the case file. (AA/NA Card) The CFS specialist noted that Ms. Hayden has not provided AA cards as requested. (Narrative 4/22/11 and CFSS Contacts 6/11-7/11)
- 10 hours of family support services (FSS) were authorized per week to address clean and safe house, child developmental milestones, age appropriate meals for Jill, develop and follow a schedule and routine, demonstrate how and when to access appropriate medical care for Jill and herself, and develop and follow a budget to live within her means. (Referral & Provider Authorization 420/11)
    - FSS ended on 5/12/11 due to Ms. Hayden's sporadic visits with Jill and not notifying DHHS to make arrangements. (CFSS Email 6/26/11)
    - The CFS specialist noted that Ms. Hayden has not completed the required information to be on Medicaid. (Narrative 4/20/11)
    - Ms. Hayden resides with her mother and stepfather and her parents are over-the-road truck drivers. Ms. Hayden reports she is on a list for housing. (Participants 7/6/11)
- 2 UA's per week are authorized. (Provide Authorization Update 4/28/11) There were no documented UA's in the case file since the Board's last review. The CFS specialist reported that no UA's have been performed since 5/18/11 due to Ms. Hayden's move to

her area and there has not been any positive UA's since the beginning of the case. (CFSS Email 6/26/11)

Mr. Smith:

Services	Offered by DHHS	Court Ordered	Compliant	Verified
CD Evaluation Recommendations	Yes	Yes	No	(GAL Questionnaire 6/27/11)
Family Support	Yes	Yes	No	(GAL Questionnaire 6/27/11)
Random UA's	Yes	Yes	No	(GAL Questionnaire 6/27/11)

Brief Narrative Regarding Services:

- Mr. Smith was unable to work on the Case Plan until 2/8/11, due to being incarcerated. (CP/CR 2/2011) The CFS specialist reported that Mr. Smith attended the last review hearing and services were discussed. He has not made any further contact with DHHS. Ms. Hayden reports he is residing in another State. (CFSS Email 6/29/11 and Parent Participant 7/6/11)

Visitation Plans:

Parental:

- Ms. Hayden cancelled 3 formally supervised visits due to court and her brother being in town. Ms. Hayden supervised Jill well and provided a clean safe home, there was no evidence of drugs or drug use in the home, and she was engaged in the visits. (Visitation Report 3/2011) Visits are now supervised by the foster/grandparents in their home when Ms. Hayden is in the area, which is approximately 2 times per week. Ms. Hayden has been informed that she will need to start coordinating visits with the family support provider. (CFSS Email 6/29/11 and Participants 7/11/11)
- No visits occurred during Mr. Smith' incarceration. He was released from jail on 2/8/11 and contacted DHHS and has declined visits. (Court Report 2/28/11)

Siblings: None

*FCRB Identified Barriers and Recommendations continue on following page.

Barriers to Permanency

FCRB Code	
241	Lack of parental ability
245	Length of time in foster care
215	Housing issues
216	Employment issues
223	Substance abuse issues-does not provide proof of AA/NA attendance
225	Father's whereabouts unknown
240	Lack of visitation by the father

Board's Findings and Rationale

FCRB Code

A2 Reasonable efforts could not have been made to prevent the child's removal due to the conditions of the home.

B1 The child's current placement appears appropriate and safe.

C_1 1 The Board finds that all services regarding the mother are included in the plan as required by Neb. Rev. Stat. 43-285.

D_1 1 The Board finds that all services regarding the father are included in the plan as required by Neb. Rev. Stat. 43-285.

E_1 1 The Board finds that all services regarding the child are included in the plan as required by Neb. Rev. Stat. 43-285.

C_2 3 The Board finds services are being offered but not utilized by the mother.

D_2 3 The Board finds services are being offered but not utilized by the father.

E_2 1 The Board finds that all needed services are in place for the child.

F1 There is a written permanency plan with services, timeframes, and tasks specified.

G2 No progress is being made towards the permanency objective of reunification. (see main Recommendations and Findings)

H2 The Board does not agree with the child's permanency objective. (see main Recommendations and Findings)

I1 The Department has evaluated the safety of the child and has taken the necessary measures in the plan to protect the child.

J1 Reasonable efforts by the Department are being made towards the plan of reunification.

K1 Parental visitation is occurring with the Mother as ordered.

L2 Parental visitation is not occurring with the Father as ordered. Mr. Smith is not requesting visits.

M3 Sibling visitation is not applicable due to child has no siblings.

N1 There is a continued need for out of home placement.

O2 The return of the child to the parents is not likely and recommends referral for termination of parental rights and/or adoption.

P1 Grounds for termination of parental rights *appears* to exist under the following subsections of §43-292 and termination of parental rights is in the child's best interest.

43-292 (1) abandonment prior to filing petition
43-292 (2) substantially and ...repeatedly neglected and refused to give the juvenile or a sibling... parental care and protection
43-292 (4) parents unfit...debauchery...liquor...drugs...lewd and lascivious behavior...
43-292 (6) is a 3a case...reasonable efforts...under section 43-283.01 ...failed to correct...
43-292 (7) ... in an out-of-home placement for 15 or more months of the most recent 22 months
43-292 (8) parent has inflicted upon the juvenile, by other than accidental means, serious bodily injury
43-292 (9)... aggravated circumstances of juvenile or other child, ...abandonment, torture, chronic abuse, or sexual abuse

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Nebraska Foster Care Review Board
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Prepared by
Review Specialist Dawn Paulsen
Date: 7/11/11

Protections of Citizen Review for Foster Children

The Foster Care Review Board provides protections for children in foster care, and continues to review children's cases and advocate for their best interests. Through our process of reviewing and tracking children, we ensure that:

- Children's **placements are safe and appropriate** (i.e., number of children in the placement; children in the placement are appropriately matched in terms of ages and behavioral issues);
- Children's **case plans** are current and appropriate;
- **Services** are appropriate and provided for the child and their family in a timely manner as laid out in the case plan and/or court ordered;
- **Transportation** services are provided on a consistent basis to support the child and family's plan for visitation and services;
- Children are **not returning home prematurely**, yet ensuring that children are **not lingering in the foster system** beyond the time necessary;
- **Paternity is established** and family connections are made in a timely manner;
- **Relative placements are appropriate**, provided the same level of support and meeting the goals and expectations;
- Children's **cases are being reviewed in court** no less frequently than six month intervals;
- Children and family's **services are not disrupted** by transitions, and
- **Termination of parental rights is advocated where appropriate**. In 2008, the Board and DHHS studied children in foster care two years or longer and DHHS changed permanency goals for 430 children from reunification to adoption or guardianship.

The Review Board accomplishes these important protections by:

- Thoroughly **reviewing children's agency records** whether at DHHS or at the contract provider's offices.
- **Making personal contacts** with the child's placement, DHHS case managers and/or supervisors, contract service coordinators/FPS, legal staff, adoption workers, or administration, as well as guardians ad litem, investigators, prosecutors and/or interested parties on behalf of an individual child's case, to address issues of concern, to gain updates, to further research issues, and to assure medical and educational records have been shared.
- **Issuing comprehensive recommendation reports** to all legal parties to the child's case with an immediate action plan to improve the child's life, care, permanency, and to resolve concerns. (FCRB recommendation reports are made part of the child's court record per statute.)

- **Advocating for foster children** and working to assure each child's safety, that each child's basic needs are met, and that the child or youth is moving towards permanency by:
  - **Bringing case concerns** to the court.
  - **Pro-actively working with the Courts and the legal parties** to the case to address the FCRB's case concerns,
  - **Communicating additional recommendations** and findings after each review to judges and the legal partieis (including the county attorney, DHHS staff, child's attorney, parole/probation officers, and or the judge),
  - **Introducing the Board's recommendations, findings, and concerns,** and be available for legal parties for cross-examination and testimony.
- **Arranging case status meetings** between the legal parties to the case on behalf of a child or children to address case issues.
- **Following up on cases where children appear to be at risk** by either their foster care placement or biological parent.
- **Forwarding cases to the Attorney General's office for prosecution** of crimes against children.
- **Bring cases to LB 1184 meetings** to facilitate meeting the child's needs through discussion of the case with the legal parties.
- **Working to monitor, assure safety and appropriateness, and address issues regarding children's placements** through citizen review, tours of child caring facilities, and/or child specific facility visits.

The State Foster Care Review Board and staff would like to thank you for your continued support of our work for Nebraska's children in foster care.

Statistics from 2010:

- We tracked 8,500+ children in out-of-home care
- We conducted 4,730 reviews
- 300+ volunteers donated over 33,000 hours of time to review children's plans and make findings and recommendations
- Approximately 33,110 reports were provided to legal parties
- We attended court on 533 cases involving 962 children where serious issues had been identified
- We staffed 503 children's cases with DHHS
- 43 facilities/foster home visits were conducted
- We received special requests involving 146 children
- We issued an Annual Report, a report on Reform, and a report to the Legal System

Blue Tab Divider

Issues Identified with Managed Care – Excerpt from the FCRB 2008 Annual Report

Issues identified with managed care

Much of the treatment for these issues is to be paid for under the managed care contract, which DHHS entered into in order to control the costs of inpatient treatment, psychiatric placements, and other expensive services. The FCRB has identified the following issues with the current managed care system:

1. Children's behavioral disorders do not routinely receive treatment because they are not deemed by the managed care contractor to meet the Medicaid criteria for "medically necessary" services that it requires before it will pay for services. (11.5% of children who entered care due to their behaviors did not have services in place) Additionally, there appears to be no alternative source of payment for these much-needed services.
   a. While child welfare funds could be used for such services, it is not the routine practice. Consequently, many children are denied the appropriate services to meet their behavioral problems based on financial grounds
2. Reviewers report that many children go through a process involving unnecessary repeated failure in lower levels of care (placement changes) before the managed care contractor will approve the higher-level treatment placement that was originally recommended by a professional after assessing the child's needs.
3. Some children are prematurely moved from treatment placements based on whether the managed care contractor will continue to approve payments, rather than based on the children's needs.
4. There are reports of numerous communication breakdowns. For example, the managed care contractor is responsible for arranging with and paying subcontractors to provide children's transportation to and from therapy sessions. It has been reported that there are frequent communication breakdowns in this system, and therapy sessions are missed as a result.

The cases below illustrate how denials can impact children.

- A judge ordered a child to a treatment placement based on a professional recommendation. The child was there a few days, and then moved because the managed care contractor did not authorize payment for the placement. This reportedly occurred because the judge's order did not explicitly specify that the treatment had to be completed, even though that was clearly the order's intent. It is unclear why other funding was not used for this court ordered treatment when the managed care contractor denied the payment.
- One child entered a facility for a managed care approved eight-week treatment placement. The child was progressing on schedule, but had not completed the course of treatment. During the third week, a managed care review happened that denied continued payment. The reason for the denial was not found in the file. The child was

abruptly moved, disrupting treatment. The child's education was also negatively affected, as the child was in three different school systems in a one-month period.

- Children have been moved from a treatment placement when they were within a few days (sometimes less than a week) of completing a semester's work rather than allowing them to complete the semester at the treatment center's school. The reason cited for the move was managed care refusing to authorize the additional week.
    - It is not clear why child welfare funds were not used to keep these placements intact. According to DHHS policy (390 NAC 7-000) reasonable efforts are to be made to provide continuity for a child in his or her school placement. Paying for a week or less in order for the child to finish a semester would seem reasonable and clearly in the child's best interest.

Too many children in foster care are not receiving recommended behavioral disorder or mental health treatment. This situation will, predictably, result in troubled adults later in life. The following case illustrates some of the above points:

> "Nancy," now age 14, entered care due to sexual abuse at age 12. A psychological evaluation recommended treatment group home level of care. She was placed at that level, and the provider recommended that she be transitioned to the next lower level of care. Managed care approval would be needed for this level of care. This was discussed with the managed care company, and not challenged. Upon preparing for Nancy's discharge, the placement provider was notified that managed care denied the previously discussed level of care, and recommended that Nancy be returned home without transition. The provider strongly felt that Nancy was not ready for this as sibling issues had not been resolved.
>
> Nancy was discharged against medical advice into a foster home. When Nancy's boyfriend broke up with her, Nancy threatened suicide and attacked a teacher and the police officer that responded to the school's call. Nancy required both handcuffs and shackles to get under control. She was transported to another town for a suicide evaluation. From there she was placed at a shelter in yet another town. Nancy ran from that shelter and was found in a town a hundred miles away. Nancy was then brought back to the shelter.
>
> The plan for Nancy remains reunification with the father, who recently lost his job and house, so he now resides with a relative. One of the brothers that sexually abused Nancy resides in the home. There is no record of the brother receiving treatment. There is also no documentation regarding the appropriateness of the relative with whom the father is living.

While managed care denials are not the only issues in "Nancy's" case, she was discharged against medical advice to a level of care unable to meet her individual needs. Her future remains uncertain.

Multiple needs

Some children have additional issues that make finding treatment for behavioral/mental health needs even more complicated, even if funding were not a factor. For instance,

- Some treatment models will not work for children with sight or hearing impairments, and many facilities are not equipped to accommodate these specific needs.
- Many facilities are not able to serve children with certain physical issues.
- Treatment facilities for children who do not have skills can be limited, as can family therapy for the non-English speaking, particularly if their native language is not common, such as some Asian or African dialects.

Often the only treatment facility available to meet a particular child's needs is out-of-state, which makes maintaining the family bonds during treatment very difficult. Waiting lists can also be problematic.

The FCRB suggests that economic development funding sources be considered to see if there could be incentives to create such facilities within Nebraska. [1] Oversight of the children's care, and ability of parents to maintain contact or participate in family therapy would be enhanced if children remained in Nebraska at a facility that could meet their needs.

The FCRB recommends a more humane approach to mental health, including statewide development and support of community mental health centers, and better support following adoption of children from out-of-home care.

Statistical findings:

- 17.1% of the children reviewed in 2008 (554 of 3,236 children) entered care due to their own behaviors.
- 61.0% of the children reviewed (1,973 of 3,236 children) entered care due to neglect – the failure to provide critical care, basic and necessary medical care and hygiene, or minimal supervision.
- 8.4% of the children reviewed (274 of 3,236) had been abandoned.
- 50.5% of the reviewed children ages 9-12 (259 of 513) entered care due to parental substance abuse.
- 37.1% of the children in care on December 31, 2007, (1,718 of 4,620 children) had been in six or more placements (foster homes or group homes) over their lifetimes.

[1] And, in 2009-2010, possible ARRA (stimulus) dollars.

Orange Tab Divider

Diminished Service Capacity 2009-2011

A number of foster parents in areas with lead agencies report that they will not be taking in new children and will be "done" as foster parents when the children currently in their home reach permanency. Others will not renew their licenses when their current license (3-year) expires.

The following statistics on foster home/placement capacity are from the Department of Health and Human Services:

Douglas County

- Licensed homes (homes that have completed training)
  - 11/2009 there were 793 licensed foster homes in Douglas County
  - 1/2011 there were 628 licensed foster homes in Douglas County – a decrease of 165 homes.
- Approved foster homes (homes that can only accept children from a family they know. Being in these types of homes disqualifies children who meet other criteria from being eligible for federal reimbursement for foster care).
  - 11/2009 there were 746 approved foster homes in Douglas County
  - 1/2011 there were 812 approved foster homes in Douglas County – an increase of 66 homes.
- Child caring bed (treatment and non-treatment)
  - 11/2009 there were 1015 beds.
  - 1/2011 there were 989 beds.

The following is a partial list of closures of other types of facilities with reasons, where known:

Eastern Area (Douglas and Sarpy Counties)

Cooper Village - Omaha[1]
Closed an Enhanced Treatment Group Homes for boys in May 2010.

Douglas Co. CMHC - Omaha[2]
Due to Douglas County budget reductions, Douglas Co. CMHC eliminated 2 therapists (of their total of 4) from their staff in June. They also eliminated 12 inpatient beds (they now have a total of 18) in July partly because of Douglas County budget reductions and partly because their average census for the past 2 years has been 14.

Uta Halee – Omaha[1]
Closed an Enhanced Treatment Group Home in early September due to lack of referrals. They had 24 beds and now have 12 beds for ETGH.

Youth Emergency Services – Omaha[1]
Shelter stopped accepting state wards in 2010.

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[1] Learned through reviews conducted by the Foster Care Review Board.
[2] Learned through print and/or broadcast media.

Southeast Area

Cedars TLC home for pregnant & post-partum girls – Lincoln[1]
Closed.

Cedars Youth Services – Lincoln[3]
Cedars ended its contract as a lead agency with the State of Nebraska and Nebraska Department of Health and Human services on June 30, 2010.

CenterPointe, Inc. – Lincoln[2]
A 31-year old residential treatment program for youth with substance abuse and mental health issues closed in 2010 due to funding issues.

Lancaster Co. CMHC – Lincoln[2]
This budget cycle the County of Lancaster cut $400,000 from CHMC's budget, they lost 2 Community Support positions, 1 Jail Diversion Case Manager, 1 clerical support position plus other cuts in staff development & training, equipment, food and supplies.

St. Monica's – Lincoln[2]
Due to a continued reduction in referrals to their adolescent treatment group home, St. Monica's closed their 8 bed TGH for girls. They will provide IOP and Day TX services for adolescent girls. They also moved as many staff as possible to open positions within the agency, but still reduced their staff by 4.

Samaritan Counseling Center – Lincoln[2]
Samaritan Counseling Center closed on September 30, 2010. This brought to an end the Center's 23 years of service to Lincoln and surrounding communities.

Visinet, Inc. – Lincoln[3]
Visinet declared bankruptcy, therefore ending its contract with the state and closing its doors in April 2010. This included foster homes and its emergency shelter.

Central Area

Cedars Youth Services – Broken Bow[1]
Cedars closed their Shelter/Staff Secure program in Broken Bow earlier 2010.

I Believe in Me Ranch – Kearney[1]
I Believe in Me Ranch closed in October 2009.

Richard Young – Kearney[1]
RY closed a 19 bed RTC on June 30, 2009.

[3] *Stated in an April 23, 2010, op-ed by NE Appleseed, an estimated 500 people lost their jobs when Cedars ended their contract and Visinet filed for bankruptcy.*

South Central BH Services - Kearney[1]
SCBS closed a men's halfway house for substance abuse in October 2008 due to the rate not matching the service definition and inability to recruit staff to meet the service definition.

Northeast Area

Behavioral Health Specialists – Norfolk[1]
Sunrise Place Treatment Group Home closed in December 2009: authorizations/referrals to that program came to an abrupt stop in June 2009.

Boys and Girls Home – Sioux City, IA[1]
Boys and Girls Home ended its contract as a lead agency with the State of Nebraska and Nebraska Department of Health and Human services on October 15, 2010.

Shelter in Columbus[1]
The shelter in Columbus ceased operations in early 2011.

Western Area

Reach-Out Foster Care[1]
Reach Out, the last provider of foster homes and foster home support in the Panhandle, has ceased providing its services and working with regional mental health agencies in June 2011. This was a provider that had a good reputation amongst professionals in the area for providing quality services, including parenting classes, respite care, independent living skills training, foster parent support, supervised visitation, and agency-based foster care. It has been reported that payment issues from the time that Boys and Girls was a lead agency was a major factor in their decision to cease operations.

Nebraska Boy's Ranch – Alliance[2]
NBR temporarily suspended services in July 2009 due to lack of referrals and lack of control between HHS and BGH which left NBR in a position of not knowing which services it would be able to provide for families. The NBR website states that is NOT closing, but is taking time to restructure.

Wilcox House – North Platte[1]
Wilcox House a Salvation Army Group Home closed earlier in 2010.

Yellow Tab Divider

Lack of Documentation:

The Director of DHHS Division of Children and Families Todd Reckling met with the FCRB Director, Carol Stitt in April 2010 to discuss issues regarding missing case documentation. The FCRB staff shared that when cases were assigned to Lead Agencies for service coordination significantly less documentation was available for review in the DHHS case file at the time of the Board's review.

The Lead Agencies at this time were required to forward all documentation received on a parent (family support notes, visitation, therapy, psychological, psychiatric, chemical dependency treatment, etc.) and/or child (educational, medical, therapy, and placement) to the DHHS case manager. The documentation should have been placed in the families 'case file' and provided to the court and legal parties as necessary.

Documentation was missing on many children's cases both in the hard file and on N-FOCUS even though the Department and Lead Agencies were given prior notification of the case files that were to be reviewed 4-6 weeks in advance of our review.

HHS Director Todd Reckling asked to be notified immediately when there is missing documentation, so that he can work with his staff and the Lead Agencies to improve this situation.

1. The FCRB proposed a plan for how FCRB could track what specific documentation was not available in the DHHS case file nor on N-FOCUS at the time of the Board's file review and report it back to DHHS.

2. A 'Lack of Documentation' form was subsequently developed to track information missing from the DHHS file. The form was provided to DHHS and Lead Agency Administrators for review.

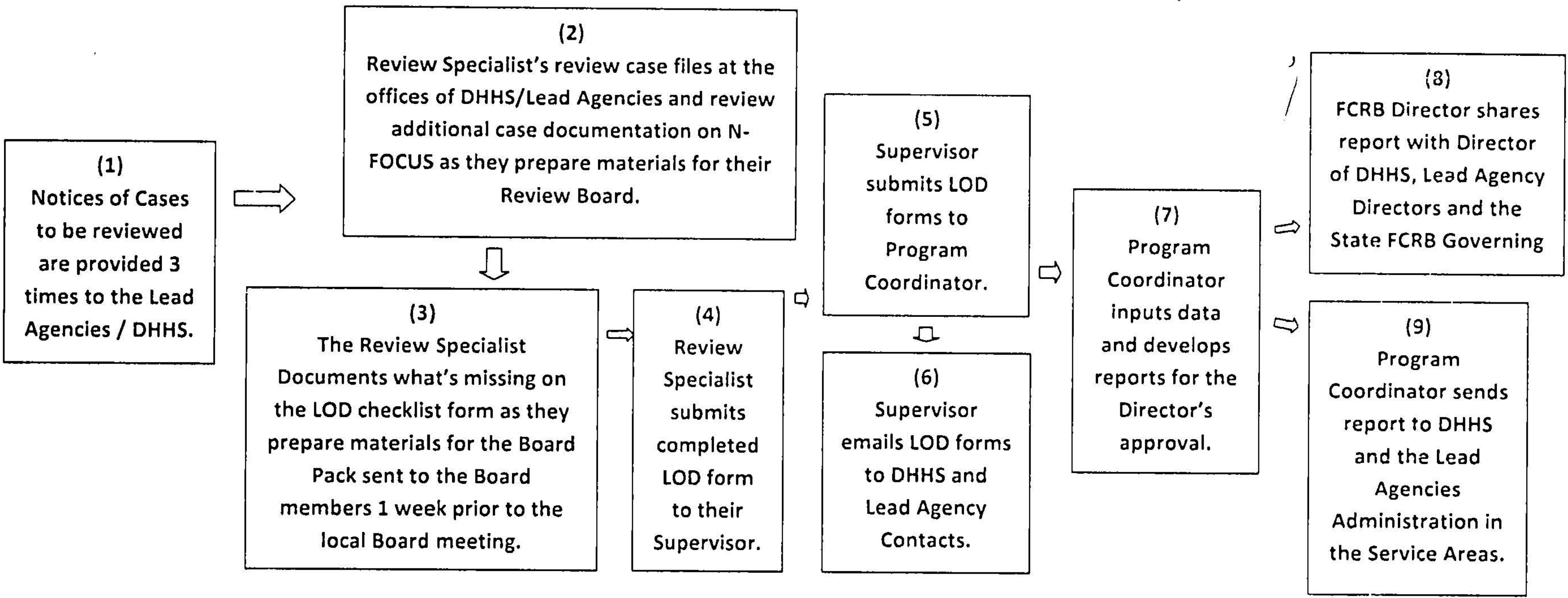
3. The FCRB provided training to Lead Agency staff in all service areas on what documentation is required to be in the file and reasons for why this documentation is critical to our review and to the child's case.

4. The Lack of Documentation form is completed by the Review Specialist at the time of their case review and then emailed by the Review Specialist Supervisor to the DHHS CFSS Supervisor, the DHHS Service Area Administrator and the Lead Agency designated staff and lead contact.

5. Data from the forms is compiled and a monthly summary report is emailed to the DHHS Director, Service Area Administrators and the Lead Agency Administration.

Lead agencies are responsible for assuring service coordinators are adequately trained to perform expected duties. Service Coordinators are expected to abide by the contracts and perform at the same level of expertise as case managers. Service Coordinators are to obtain services, create and forward ongoing documentation to DHHS, comply with court orders, recruit, oversee and support placements, and provide stability to case management, whether provided directly by the Lead Agency or one of the Lead Agency's subcontracted. Documentation is a critical aspect of the Service Coordinator's duties. Service Coordinators also assure children's safety in the placements and services that are provided.

FCRB Process for Reporting "Lack of Documentation" During Case Reviews



FOSTER CARE REVIEW BOARD
REPORT ON LACK OF DOCUMENTATION
Reviews Conducted Statewide for Boards in June 2011

conjunction with DHHS and Lead Agencies, FCRB Review Specialists are completing a case review checklist for each case reviewed during the review process indicating what items were missing from the DHHS file and N-FOCUS. These checklists are then shared with DHHS officials and Lead Agencies in an effort to improve file documentation.

This report covers June case reviews in preparation for 37 separate local review board meetings representing 359 children statewide.

Of the 359 children's cases reviewed, 192 cases were assigned to lead agencies and 167 cases were managed by DHHS and not assigned to a lead agency at the time of the case review. KVC was the lead agency for 142 cases, and NFC the lead agency for 50 cases.

Of the 359 children's cases reviewed, 183 cases were in the Eastern Service Area, 72 in the Southeast, 34 in the Central, 48 in the Western, and 22 in the Northeast.

Review Specialists were not able to locate the following information during their reviews prior to their Board meetings that were held **statewide** in June 2011.

Description	All 359	%	DHHS All 167 (State)	%	DHHS Eastern 63	%	DHHS NE 22	%	DHHS Western 48	%	DHHS Central 34	%	KVC ALL 142 (Southeast and Eastern)	KVC All %	KVC Eastern 70 (Omaha and Papillion)	KVC Eastern %	KVC SE 72 (Lincoln and Rural)	KVC SE %	NFC Eastern 50 (Omaha and Papillion)	NFC %
Court Report and Case Plan	15	4%	11	7%	7	11%	4	18%	0	0%	0	0%	4	3%	3	4%	1	1%	0	0%
Affidavit, Petition, Current Dispositional Review Order	7	2%	5	3%	1	2%	2	9%	0	0%	2	6%	0	0%	0	0%	0	0%	2	4%
Most Recent Court order	50	14%	21	13%	12	20%	0	0%	0	0%	9	26%	11	8%	10	14%	1	1%	18	36%
Paternity Information	72	20%	27	16%	12	20%	1	5%	8	17%	6	18%	27	19%	18	26%	9	13%	18	36%
Therapy Reports	153	43%	58	35%	26	41%	9	41%	9	19%	14	41%	61	43%	33	47%	28	39%	34	68%
Educational Records	144	40%	49	29%	28	44%	7	32%	10	21%	4	12%	70	49%	42	60%	28	39%	25	50%
Immunization Records	87	24%	33	20%	32	51%	0	0%	0	0%	1	3%	26	18%	20	29%	6	8%	28	56%
Assessments / Evaluations	67	19%	34	20%	21	33%	2	9%	5	10%	6	18%	15	11%	13	19%	2	3%	18	36%
alth Records/Medical eports	109	30%	39	23%	34	54%	0	0%	0	0%	5	15%	45	32%	35	50%	10	14%	25	50%
PTA/BPS/MH/ Sub Abuse Evals	45	13%	8	5%	3	5%	0	0%	4	8%	1	3%	19	13%	15	21%	4	6%	18	36%
ILP Plan and Specific Services	28	--	13	--	7	--	3	--	0	--	3	--	8	--	2	--	6	--	7	--
Placement Reports	104	29%	41	25%	31	49%	1	5%	1	2%	8	24%	39	27%	33	47%	6	8%	24	48%
Visitation	96	27%	51	31%	28	44%	8	36%	15	31%	0	0%	33	23%	13	19%	20	28%	12	24%
Monthly Contact Narratives	74	21%	17	10%	16	25%	0	0%	0	0%	1	3%	41	29%	13	19%	28	39%	16	32%
Home Study or Licensing Update	128	36%	60	36%	30	48%	8	36%	10	21%	12	35%	32	23%	27	39%	5	7%	36	72%
Intake/Investigative Reports	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Other Case Specific Documentation	18	5%	11	7%	4	6%	3	14%	4	8%	0	0%	6	4%	6	9%	0	0%	1	2%

LR 37 - Exhibit 7
9-7-11

Nebraska Foster Care Review Board

Report on Child Welfare Reform

Issued December 2010

From the FCRB Executive Director...

The Foster Care Review Board's (FCRB) role under Neb. Rev. Stat. §43-1303 is to independently track children in out-of-home care, review their cases, collect and evaluate data, and report and make recommendations on conditions and outcomes for Nebraska's children in out-of-home care. Reports are to be distributed to the judiciary, public and private agencies, the Department of Health and Human Services (DHHS), and the public.

In 2009, the FCRB augmented the scope of data collected in anticipation of reported changes by DHHS in the supervision and management of child welfare cases. This included, but was not limited to collecting data on service coordinator changes, continuity of care, the continuity of services during the transition, and whether visitation, transportation, placement, and therapeutic services were being provided in a safe and timely manner. The additional data collected was collated with historically collected data to determine the effect of the Reform on children and their families. Resulting statistics are here utilized to clarify if the contracting of services resulted in a stabilization of placements, services being provided in a timelier manner, increased safety of the children, and achieving permanency sooner.

As an increased number of cases transitioned to service coordination and Lead Agencies were assigned, it became apparent to FCRB staff that a significant decrease in documentation was located in the DHHS case file at the time of the Board's review. The FCRB met with Director of DHHS Division of Children and Families Todd Reckling in April 2010 to discuss the development of a mechanism to track documentation that was <u>not</u> available in the DHHS case file nor on N-FOCUS (the DHHS computer system) at the time of the Board's file review. The Lead Agency is required to forward all documentation received on a parent (family support, visitation, therapy, psychological, psychiatric, chemical dependency treatment, etc.) and/or child (educational, medical, therapy, and placement) to the DHHS case manager. The information should then be placed in the families 'case file' and provided to the court and legal parties as necessary. This was not occurring on many children's cases. A 'Lack of Documentation' form was subsequently developed to track information required by Federal law and the Juvenile Court.

This report focuses on the Reform implemented by DHHS, and how those changes have affected the safety of children, decreased service capacity, and oversight. Specifically, the FCRB is focusing on children's safety in placements, whether placements are appropriate to meet the child's needs, whether court ordered visitation with the parents was occurring with supervision, and whether there is documentation. The documentation is important to know how and whether a case should progress towards reunification or if alternate goals should be sought.

As this Report will show, a little over a year into the reform, the FCRB is finding that there are safety issues, accountability issues, implementation issues, and evidence that there has not been a correction of issues that existed prior to the reform.

Definition of the Reform

On June 15, 2009, the Nebraska Department of Health and Human Services, Division of Children and Family services (referred to in the contracts as the "Department") entered into agreement with various agencies (referred to in the contracts as the "Contractor", also known as Lead Agencies) to develop the infrastructure, staffing and programs necessary to implement the proposed Service Delivery and Service Coordination Contract beginning October 1, 2009 with full implementation by April 1, 2010.

The goal of the Reform was to increase in-home care and services while decreasing out-of-home services, and to improve outcomes for child and community safety, permanency and well-being for children and families. Per DHHS, the contracting of service would rectify deficits in Nebraska's child welfare system that were identified in the 2002 and 2008 Child and Family Services Review (CFSR) by the Federal Department of Health and Human Services. Nebraska was not in conformity with any of the seven measures of child safety, permanency, and well-being. There also existed problems with data collection and licensing procedures.

The premise for Reform is that many of the 2008 issues would be resolved by having private agencies take over service delivery. Five contractors, also known as Lead Agencies, were originally chosen. These included: Boys and Girls of Nebraska, Inc. (Boys and Girls); CEDARS Youth Services (CEDARS); KVC Behavioral Healthcare Nebraska, Inc. (KVC); Nebraska Families Collaborative (NFC) and Visinet, Inc. (Visinet). The Lead Agencies would "provide an individualized system of care for families and their children and youth who are wards of the State of Nebraska." (Service Delivery and Service Coordination Contract 10/28/09)

The Master Operations Manual, as updated July 2010, described the Department's responsibilities as primarily case management oversight, with the Lead Agencies being responsible for the provision of services, acquisition of documentation, and reporting to the Department. The Lead Agencies are responsible for arranging services, locating and monitoring out-of-home placements (identification of foster families), arranging transportation, facilitating home studies, scheduling family team meetings, and providing aftercare services to the biological families. They are responsible for payment of all services, including subcontracted foster parents.

CEDARS withdrew from their contract on April 2, 2010, Visinet declared bankruptcy and subsequently ceased operations on April 16, 2010, and Boys and Girls contract terminated effective October 15, 2010. In spite of those unresolved issues, and without seeking input from any of the major stakeholders, DHHS issued a news release on October 15, 2010 stating DHHS' intent to layoff DHHS caseworkers and obtain case management through contracts. Caseworkers report they have begun seeking new employment.

Pre and Post Reform Data Comparison

The following are issues prioritized in the pre-reform 2008 FCRB Annual Report and are compared to what the 2010 data is showing through October 10, 2010.

The data below is collected by the FCRB from information provided by the Courts, DHHS, the professional FCRB staff who complete data forms at the point of review, and from the findings made by the local FCRB board members.

	For Children in care as of December 31, 2008	For Children in care from January – October 2010
Children in out-of-home care	**4,620** children were in out-of-home care Dec. 31, 2008	**4,426** children were in out-of-home care on Oct. 10, 2010
Changes in Decision Makers[1]	**35%** DHHS wards in out-of-home care on Dec. 31, 2008, had 4 or more caseworkers	**34%** DHHS had 4 or more caseworkers **51%** had 2 or more service coordinators **9%** had 4 or more service coordinators
No Documentation of Placement Safety or Appropriateness	**19%** of the 2008 reviews found a lack of documentation	**30%** of reviews Jan-Sept 2010 found a lack of documentation
Lack of a Complete Case Plan	**26%** of the 2008 reviews found a lack of a complete case plan	**47%** of reviews Jan-Sept 2010 found a lack of a complete case plan
Lack of Progress Towards Permanency	**32%** of the 2008 reviews found a lack of progress towards permanency	**32%** of reviews Jan-Sept 2010 the cases found a lack of progress towards permanency
Placement Instability in Foster Care	**55%** of children in care experienced 4 or more placement moves	**48%** of children in care experienced 4 or more placement moves
Rate of Children Returning to Foster Care	**41%** of the children in out-of-home care Dec. 31, 2008, had been in care before	**39%** of the children in care on Oct 10, 2010, had been in care before
Adoptions Completed	**572 adoptions** were completed in 2008.	**366 adoptions** were completed Jan.-Nov. 22, 2010, including those completed at the November Adoption Days across the state.

*Note: The FCRB 2009 data is not included here as implementation of the DHHS Reform began implementation mid-2009 which would not allow for a clear comparison.

[1] Research shows that there is an increased probability that a child will be successfully reunified with the parents or otherwise achieve permanency when there are fewer caseworker changes. [*Placement Instability in Child Welfare...* Seattle, WA: Casey Family Programs found children who had only one worker achieved permanency in 74.5% of the cases. As the number of case managers increased the percentage of children achieving permanency substantially dropped, ranging from 17.5% for children who had two case managers to a low of 0.1% for those children who had six or seven case managers.] Case worker continuity can affect placement stability. Placement stability is beneficial for children's overall well-being and sense of safety [e.g., American Academy of Pediatrics statement], and research finds it is more cost-effective. Thus, caseworker stability increases children's well-being and decreases costs.

New Issues Identified Since Implementing Reform

Since January 2010, the following issues have been identified through the FCRB's reviews of children's cases and tracking indicators:

Deterioration of the infrastructure, including therapists, placements, and other service providers reporting they are or soon will be no longer providing their services due to payment, communication, and coordination issues.

- Per DHHS there has been a decrease in the number of licensed foster homes, from 2,094 in October 2009 to 1,815 in October 2010.
- DHHS eliminated their Resource Development units, which formerly provided some oversight of placements.
- 50 foster parents have directly reported to the FCRB professional staff in the past few months their intention to cease foster parenting.
- Therapists and other service providers have directly reported to FCRB staff that they are no longer doing foster care cases or going out of business entirely due to payment issues, or issues with Lead Agencies not using service providers outside their organization.
- Foster parents have directly reported that multiple agencies are seeking to place children with them, often without knowing or asking about the other children already in the placement.

Service Coordinator Changes self reported to the FCRB on the 3,929 children in care on Nov. 8, 2010:

- 1920 children had 1 service coordinator.
- 1049 children had 2 service coordinators.
- 617 children had 3 service coordinators.
- 206 children had 4 service coordinators.
- 99 children had 5 service coordinators.
- 29 children had 6 service coordinators.
- 7 children had 7 service coordinators.
- 2 children had 8 service coordinators.

FCRB staff report that during the review process, many Service Coordinators reported to be assigned to the case are no longer on the case and are not current.

Inadequate foster parent reimbursement

Average non-relative reimbursement was $725 per month, which the 2008 statewide assessment for the federal audit found was too low.

- Non-relative foster parents directly report that they are receiving $600 per month in 2010, and this is often substantially less than they were receiving previously.
- Relative foster parents directly report that they are receiving $300 per month in 2010, which makes it difficult for them to feed, clothe, and provide for the children.

Description of the Children and Families Affected by Reform

The goal of the reform is to better serve families. Thus it is important to understand some fundamental facts about the children and families involved. On December 31, 2009, there were 4,448 children in out-of home care, all of whom had experienced a significant level of trauma and abuse prior to their removal from the parental home.

Through reviews of the children's cases we know that the reasons for children being removed from the home are varied, with many children having multiple reasons. The following are the top ten reasons children enter care:

1. Neglect (58.3%), defined as the failure to provide for a child's basic physical, medical, educational, and/or emotional needs.
2. Children's behavioral issues, which are often a symptom of the child's mental health issues (22.9%).
3. Parental drug abuse (35.2%).
4. Substandard housing (23.2%).
5. Physical abuse (12.4%).
6. Parental alcohol abuse (11.7%).
7. Parental incarceration (10.1%).
8. Parental illness/disability (9.5%).
9. Sexual abuse (8.1%).
10. Abandonment by the parent (8.0%).

What the above statistics do not adequately communicate is that children enter the system already wounded with increased vulnerability for further injury because of their family's pervasive alcohol and drug issues, a lack of adequate food and shelter (extreme poverty), domestic violence, serious, untreated mental health issues, parental cognition issues, and/or their own serious physical or mental conditions.

In cases where ongoing safety issues exist and/or the parents are unwilling/unable to voluntarily participate in services to prevent removal, the children are placed in a foster home, group home, or specialized facility as a temporary measure to ensure the children's health and safety.

It is the statutory charge and duty of the DHHS and the other key players of the child welfare system to reduce the impact of abuse whenever possible and minimize the trauma of the child's removal. This is accomplished by providing appropriate services to the family in a timely manner, obtaining written documentation of their participation and progress in those services, and then providing those reports to the court and legal parties. Thus the time in out-of-home care is minimized.

Reform's Impact on Safety, Service Capacity, Oversight, and Accountability on Children and Families

The FCRB has monitored lead agencies assuming service coordinator roles since November 2009. The interjection of another layer of out-of-home service providers requires increased attention to specificity and accountability. Further complicating this situation was the speed with which the Reform was implemented. It has been a year of trying to understand what "Reform" is, clarifying roles and responsibilities, deciphering language, learning the different criteria that are being used to determine what is safe by the individual agencies, and communicating concern to the appropriate individual.

As a result of the FCRB tracking and reviewing over 2,000 cases, we are highlighting the following issues for Nebraska foster children in out-of-home care.

SERVICE COORDINATORS AND SAFETY:

The FCRB recognizes the dedication and efforts of service coordinators who have and are serving across the state. The following observations in no way minimize their efforts.

Lead agencies are responsible for assuring service coordinators are adequately trained to perform expected duties. Service Coordinators are expected to abide by the contracts and perform at the same level of expertise as case managers. Service Coordinators are to obtain services, create and forward ongoing documentation to DHHS, comply with court orders, recruit, oversee and support placements, and provide stability to case management, whether provided directly by the Lead Agency or one of the Lead Agency's subcontracted. Documentation is a critical aspect of the Service Coordinator's duties. Service Coordinators also assure children's safety in the placements and services that are provided.

The following describes how deficits in any of the duty areas can impact safety:

CONCERN:

1. **Service Coordinator Case History Knowledge**
   FCRB professional staff were invited to participate in the transfer of the over 3,400 children's cases from DHHS to Lead Agencies (cases the FCRB had reviewed). Through presence at these transfers, the following issues were identified:
   a. Although there were meetings between DHHS staff and Lead Agency staff about the cases as they transitioned to the Lead Agencies, the ongoing DHHS case manager who had the most intimate knowledge of the case often was not present.
   b. Supervisors who substituted for caseworkers often lacked knowledge of critical details.
   c. Transfers were done in 15 minute increments or less, limiting the scope of information sharing.
   d. Many critical issues were not discussed.

As a result of the speed at which the implementation occurred, the service coordinator often lacked:

- Experience in case coordination.
- Necessary history of a case to determine service provision.
- Knowledge of the current status/progress of a case to make recommendations.
- Information on the quality and availability of services.

In addition, when conducting reviews FCRB professional staff ask service coordinators about the most serious issues in children's cases. In doing so, staff have found that the many of the service coordinators and/or the subcontractors used for direct services have been uninformed of the chief issues in the children's cases. Information transfer gaps have been identified at the initial case transfer, in transfers between coordinators, and as information needed to be shared between lead agencies and subcontractors.

2. **Service Coordinators Contact with Children and Youth:**
   The safety of children is ensured through ongoing in-person contact with the child and placement. The best practice is to visit the child in his/her placement as well as outside the placement, where the child may feel free to speak about the caregivers. However, the following are contact requirements according to the July 20, 2010, DHHS Operations Manual:

DHHS CFSS **Contact and visit with child, youth, family and caretaker**	**CONTRACTOR / LEAD AGENCY** **Contact and visit with child, youth, family and caretaker**
Face to face contact and visit with each child or youth per policy [monthly].	Contact with the child or youth **as necessary** to effectively evaluate the needs of the child, monitor the quality of the services and determine if progress is being made.
Face to face contact and visit with all parents of children or youth per policy (1 time per month).	Contact with the parents of children or youth **as necessary** to effectively evaluate the needs of the parent, monitor the quality of services and determine if progress is being made.
[No comparable requirement]	Contact and **visit caregivers** of each child [does not mandate the child must be present] at least monthly in the home when the child is being cared for in an out of home setting. If Contractor is unable to visit a caregiver, Contractor may contact CFSS to request their assistance with required contact. If agreement by CFSS, Contractor will document the agreement on N-FOCUS.
If CFSS is unable to visit a child, youth or parent, CFSS may contact the service coordinator to request their assistance with required contact. If agreement by contractor, CFSS will document the agreement on N-FOCUS.	As agreed upon, service coordinator makes required contact with child, youth or parent per policy. Document contact on N-FOCUS.

Taken from Chapter 3: Contractor and Department Roles and Responsibilities
DHHS / Contractor's Operations Manual - Revised 07/20/2010

A review of 2,973 cases assigned to a Lead Agency (January - September 2010) showed that:

- 371 (12.5%) had documentation that there was no service coordinator contact with the child.
- 604 (20.3%) unknown/undocumented if service coordinator contact with the child occurred.

3. **Service Coordinator Training:**
Through the FCRB's contact with service coordinators during their initial training and at reviews, while some have had experience or knowledge, many service coordinators had not previously been involved with the child welfare system and were ill-prepared to deal with the responsibilities of case coordination. A review of 2,973 cases assigned to a Lead Agency (January - September 2010) showed that:

   - New service coordinators initially received 5 weeks of training until 10/09 when training decreased to 10 days of UNL Center for Children Families and the Law (CCFL) training and 2 weeks new employee training.
   - In comparison, DHHS case managers received 27 days (core training), 6 days (in-service), 27 days (specialty training), and a minimum of 14 additional days for ongoing, adoption and Juvenile services.

4. **Service Coordinator Retention:**
Through the review process the FCRB has identified that a consistent theme of service coordinators who have left or who have indicated a desire for different employment is that the caseloads are unmanageable, there is little support or mentoring available, and they are frustrated that decisions regarding services and placements appear to be based on financial considerations rather than the child's best interests.

   Documenting service coordinator changes (leaving employment or being reassigned) is a challenge. Through reviews the FCRB is aware that many service coordinator changes have not been reported. Through tracking the FCRB is aware of cases of children where the service coordinator was never reported. From the changes that have been reported, the FCRB knows that 51% of the children in care on October 10, 2010 had two or more service coordinators while in out-of-home care with some cases having six service coordinators in six months), and 9% had 4 or more service coordinators.

IMPACT:

Based on the reviews of 2,973 cases assigned to a Lead Agency (January – September 2010) and upon the numerous reports from guardians ad litem, foster parents and other case participants the FCRB has seen:

- Service coordinators do not have sufficient training or background to keep children safe and obtain needed documentation/evidence.
- Service coordinators report their workloads preclude their ability to be proactive for children and families.

- Confusion by parents as to who is in charge, the case manager or service provider. Although the case manger is legally 'in charge', he/she does not provide services. This further confuses the parent.
- Lack of support to foster parents for day-to-day and crisis intervention resulting in fewer foster homes.
- A delay in services provided to children and parents.
- Creation of evidentiary issues when documentation is missing.
- Difficulty in completing some termination of parental rights trials.
  - County attorneys report increased difficulty when trying a termination of parental rights case due to the personnel changes in some children's cases and the difficulty involved in finding, subpoenaing, and paying travel and witness costs.
  - For example, in one case less than a year into the reform, the county needed to find and subpoena the 4 DHHS caseworkers and 8 service coordinators that had been on the child's case.
- Delays in achieving permanency.

Case examples:

Example 1. DHHS had kept mother's visits at fully supervised because she has a pattern of doing well then "falling off the wagon." She cannot do well consistently to make DHHS comfortable with moving to monitored visits. The Lead Agency did not agree with DHHS. The Lead Agency decided they would not reauthorize supervised visits and refused to provide supervised visits. Mother missed two days of visits before the case manager convinced the Lead Agency that visits were court ordered and they had to provide them.

Example 2. A parent was having unsupervised visitation with her toddler. The child was running a high fever and becoming dehydrated. When mother tried to get an appointment with the doctor she was told there was an issue with payment authorization. The mother made numerous unsuccessful attempts to contact the service coordinator, service coordinator supervisor, HHS caseworker, and HHS supervisor. Mother then called the FCRB for help. FCRB staff made several calls before reaching a DHHS administrator who was able to immediately facilitate the child getting needed treatment.

RECOMMENDATIONS:

- In January and February 2011 make a concerted effort to focus on documentation and train service coordinators and their supervisors on what needs to be documented, when it needs to be documented, and how it needs to be documented.
- Provide training to Lead Agency staff on how to enter data and case information into N-FOCUS and the importance of getting the information onto the system within 48 hours.
- Clarify the service coordinator's role and assure this is communicated effectively to service coordinators and their supervisors.
- Assure service coordinators or their supervisors can be reached in emergency situations.
- Assure service coordinators receive training the equivalent to that of a CFSS worker. Provide Legal training for all Service Coordinators.
- Examine caseloads for service coordinators and establish reasonable limits.

PLACEMENT SAFETY AND APPROPRIATENESS:

CONCERN:

Most children enter care due to abuse/neglect. The system has a statutory obligation to ensure they are not further victimized while in care. Pursuant to Nebraska statute, the FCRB is required to make a finding on the safety and appropriateness of children's placements during each review regardless of how long the child has been in the placement.

The FCRB cannot assume safety in the absence of documentation. The safety of children is ensured, in part, via home studies, which contain critical information about the foster family's history, parenting practices, social issues (drug/alcohol use), and condition of the physical plant (house). The mixture of children in the placement, the individual needs of the children, placement progress reports, and whether or not a safety plan is in place also are considered. Regarding appropriateness, consideration is given as to whether this is the least restrictive placement possible for the child, and whether there is documentation that the placement is able to meet this particular children's needs.

After carefully considering the above information, the FCRB found for 3,569 children reviewed Jan.-Sept. 2010:

- 1,086 children's files (30%) did not contain the documentation needed to make a determination of the safety and appropriateness of the placement.
- 10 children were in unsafe placements (in need of immediate removal) at the time of the review as designated by the FCRB. In making this finding the FCRB considers the type of placement, the mixture of children in the placement, the individual needs of the children, and whether or not a safety plan is in place.
- 124 children were in inappropriate placements as designated the time of the review by the FCRB. The placement was found to be safe, but not able to meet the individual child's needs. Some common examples: child free for adoption but placement not willing to adopt, placement had high number of other children with special needs, too restrictive a setting, a teen placed in a placement best suited for young children, or placed too far away to be conducive to visitation.

The FCRB has diligently worked with DHHS and the Lead Agencies to address documentation missing in the official record since spring 2010. However, for 340 reviews conducted in September 2010:

- 34.7% of the cases did not have home study documentation.
- 30.6% did not have immunization records, which need to be shared with the placements.
- 29.4% did not have placement reports, indicating children's day-to-day progress.

DHHS is required to report placement changes to the FCRB within three days according the Nebraska statute. Lead agencies are to forward documentation to DHHS as it is

received. This information has consistently been missing from the case files. Consequently, the FCRB cannot determine if many children are safe in their placements and if appropriate services are being provided. A review of 2,973 cases assigned to a Lead Agency (January - September 2010) showed that74 (15.3%) lacked documentation as to why the most recent placement change occurred.

In early October 2010, placement information was still not current on the N-FOCUS system for a number of children whose lack of placement information had been previously identified and forwarded for correction. This is non-compliant with FCRB statutory and contractual requirements: "The contractor agrees they are subject to and will comply with state law regarding the FCRB."

IMPACT:

- The safety of a significant number of children cannot be ascertained due to a lack of information.
- Evidentiary/Reasonable efforts issues when documentation regarding parental compliance and progress is missing or not available.
- Permanency may be delayed when documentation regarding parental compliance and progress is missing or not available or possible cost prohibition of counties subpoenaing all DHHS and Service Coordinators on a case at a termination trial.

RECOMMENDATIONS:

- All placement information be inputted and corrected as needed by January 30, 2011, and a concerted effort made to train service coordinators and their supervisors on what needs to be documented, when it needs to be documented, and how it needs to be documented.
- DHHS be required to have monthly contact with the foster parent and/or other caregiver in order to determine its appropriateness and if safety issues exist.
- DHHS create an internal unit with authority to respond in a timely manner to

Case examples:

Example 1. *5-month-old twins were transported from Omaha to Lincoln every weekend for day visits with potential adoptive parents. The driver from subcontracted agency to provide transportation was in a car accident with the babies due to faulty brakes on his vehicle. The driver knew his brakes were going out and chose to transport the babies anyway.*

Example 2. *A subcontracted visitation worker who is contracted with a lead agency contacted the daycare center to report when the visits are instead of calling the foster mother. Neither the visitation worker nor the Service Coordinator returns phone calls. The visitation worker is not aware of the child's feeding schedule. It was reported that the visitation worker leaves the three year old in the car by his/her self. Visits are scheduled the day they are to occur, often at the same time something else, such as a therapy session, had already been scheduled. Communication to create a cohesive plan for services is not occurring.*

Example 3. *The FCRB reviewed a case and recommended placement oversight as the foster parent noted concerns regarding financial instability. A few months later the FCRB found that foster mother and foster child are homeless and have been so for a couple of months. The youth will turn 19 in soon. Independent Living arrangements have not been made.*

identified placement issues and a duty to provide general oversight over foster placements.

- Lead agencies should continue to be required to have monthly contact with placements.
- Home studies and relicensing documentation be completed within the mandated timeframes (within 30 days of placement for licensing, prior to expiration for relicensing)
- Placement progress reports be obtained by the Lead Agency monthly and provided to DHHS for placement in the case file.
- Educational/medical/therapy reports for the children be obtained by the case manager and forwarded to DHHS for placement in the case file.

SAFETY and SUPERVISION OF PARENTAL VISITATION:

CONCERN:

A review of 2,973 cases assigned to a Lead Agency (January - September 2010) showed that 38% of the cases lack visitation documentation. When considering 340 reviews conducted in September 2010, 28% lacked visitation documentation.

Courts order supervision of parental visitation when there is evidence that the child could be at significant risk if the parents were allowed unsupervised contact. The purpose of supervising parent/child contact is to:

- Meet the child's developmental and attachment needs;
- Assess and improve the parent's ability to safely parent their child;
- Assist in determining permanency.

Without visitation reports, it is not possible to determine the appropriateness of contact, if parent/child contact should increase, and if progress is occurring. Visitation reports also allow an assessment of consistency of the personnel providing supervision, and assist in determining if there are scheduling barriers (i.e., visitation scheduled when the parent is at work, or the child is in school, or no visit occurring because there was no visitation supervisor or transportation driver available.)

IMPACT:

- The safety of children is unable to be determined, as is parental compliance and progress.
- Evidentiary/Reasonable efforts issues when documentation regarding parental compliance and progress is missing or not available.
- Permanency may be delayed.

RECOMMENDATIONS:

- Contact the DHHS caseworker immediately regarding any safety concerns.

> Case examples:
>
> *Example 1.* *A father was scheduled to have supervised visitation with his child. The service coordinator made arrangements for one staff to transport the child to the visit, a second staff to supervise the visit, and a third staff to return the child to the foster home. Staff #1 waited 15 minutes and left the child unsupervised with the father. Staff #2 never showed up.*

- Deficits in visitation documentation be corrected by January 30, 2011.
- Reduce the number of workers the children interface with during transport and visitation.
- Assure workers transporting the children to visitation have continual training on the proper use of car seats.
- Information should be provided to the foster parents regarding the visit (emotional state before, during, after visitation, naps, what was fed to the child, when medications were taken, etc.)
- All parties should be informed of the visitation schedule to reduce children's disappointment and/or anger if visits do not occur as planned.
- Basic training standards be created and implemented for all contracted visitation supervision and transportation providers.

Case examples (cont.):

<u>Example 2</u>. The Court ordered supervised visitation with the father who was incarcerated. Service Coordinator never submitted authorizations for visitation. County Attorney filed termination based on abandonment. Filings were withdrawn as visitation arrangements were never made.

<u>Example 3</u>: A DHHS Supervisor reported that at a recent visit Mr. W struck the children with a "switch" as punishment. The Supervisor reported that the children had red marks, and that the children reported what had happened. The Supervisor stated that a Visitation Aide was present at the visit, but did not intervene. The Supervisor reported that the Aide was immediately removed from the case, and that this person is no longer employed by the visitation provider. The Supervisor reported that this incident was reported to the Child Abuse Hotline, and that the children were interviewed following the event.

DECREASED SERVICE CAPACITY

<u>CONCERN:</u>

There is notable documentation of the lack of a statewide service system for vulnerable children and families. Prior to reform the FCRB had for several years reported in its annual reports that there was a need to develop a more complete service array.

At the onset of reform the Lead Agencies acknowledged that none had sufficient capacity of foster homes and group placements, nor did they have in place trained staff. The same concerns applied to finding other services providers including visitation workers, dentists, doctors, and others. DHHS awarded significant funding to those agencies to defray start-up expenditures.

Services are now being done in-house by the lead agencies. Existing service providers have been lost as a result of the way reform has been implemented.

Foster Parents

- In the past few months over 50 foster parents have directly reported to the FCRB staff their intention to cease foster parenting. Foster parents' pay has generally decreased while their roles and responsibilities have increased. They are now

expected to provide supervision for parental visitation, and supervise sibling contact without adequate support or training. The supervision of parent/child contact could create a potential conflict of interest if the foster parents are potential adoptive parents.

- Between April 1 and May 20, 2010, foster parents made at least 80 contacts to the FCRB seeking assistance with getting past-due payments, or getting previous reimbursement rates restored.
- Foster parents directly report they are receiving less reimbursement than prior to the reform.[2] They also report they are no longer receiving respite care or clothing reimbursement.
- Several relative placements have contacted the FCRB to describe the difficulty caring for children when receiving only $10 per day reimbursement[3], as particularly grandparents who are on a fixed income.

2008 Pre-Reform Foster Parent Reimbursement	2010 Post Reform Foster Parent Reimbursement
$725 average payment to foster families that were non-relative.	$600 average payment to foster families that were non-relative.
Foster parents receive a one-time clothing allowance.	No clothing allowance.
Foster parents reimbursed for some respite time (time away from children, such as to attend a class).	No paid respite.

Service Providers

- Therapists and other service providers report leaving the foster care system due to payment issues, or issues in which certain Lead Agencies will only utilize particular therapists with whom they presumably have an economic relationship.
- Some bio-parents have reported they are not being provided assistance with transportation to visitation with their children or to services.
- Visitation sessions have been cancelled due to a lack of transportation drivers and visitation monitors.

IMPACT:

- Children placed in inappropriate or unsafe placements (as discussed previously).
- Longer waiting lists for remaining service providers, such as therapists, substance abuse treatment, or anger management.

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[2] The 2008 statewide assessment for the federal audit found the 2008 rates were problematically low.

[3] Lower foster parent and relative caregiver pay scales have been adopted by KVC and the Nebraska Families Collaborative. See Appendix B – Foster Parent Payments by State.

- Parental visitation cancelled due to a lack of staff needed to transport or supervise visitation.
- Lack of support to foster parents for day-to-day and crisis intervention resulting in fewer foster homes.
- Children and youth's lives are disrupted by avoidable placement changes.
- Creation of evidentiary issues when foster parents supervise parent/child interaction.
- Possible delay in ordering services creating delays in achieving permanency.
- Parents lack clarity of what needs to be accomplished to achieve reunification.
- Current DHHS caseworkers have reported to FCRB staff that they are actively seeking alternative employment before potentially losing their jobs and benefits. This will leave substantial gaps for children's cases during this new transition.
- Early on there were payment issues that were not adequately addressed. Professionals and others are still owed money by agencies that are no longer Lead Agencies, and there have been payment issues reported with the remaining agencies. As a result of the payment issues, some professionals and providers have either gone out of business entirely or are no longer willing to provide child welfare services and the capacity of resources in the State has diminished.

> Case example:
>
> *A foster parent reported that there are too many people involved in the children's case. When she is at work she has many people calling her, for example, rescheduling visits between the child and the parents, and DHHS and the Service Coordinator are each scheduling visits with the child at separate times. The foster parent reports that it is chaotic. The number of worker and procedure changes has been too much for her family and they will not continue providing foster care.*

RECOMMENDATIONS:

- DHHS and the Lead Agencies address the services and placements that have been lost and recruit and support additional services and placements. This includes DHHS requiring that the Lead Agencies reimburse foster parents no less than certain minimum rates, including relative caregivers.
- Payments to foster home and service providers should be made in a timely manner.
- Cases should be assigned to Lead Agencies based on their strengths.
- Work to address the ongoing concern that older youth are not given adequate services or training to prepare them for living independently.

OVERSIGHT

CONCERN:

In addition to Judicial and FCRB oversight, there are two types of oversight that needs to be developed and strengthened: 1) DHHS must provide vigorous oversight of its own performance and that of its contractors, and 2) the Lead Agencies need to provide oversight of their own and their subcontractors' services and placements.

On October 15, 2010, DHHS announced it intended to transfer more case management responsibilities to the lead agencies. Until such time as DHHS demonstrates consistent, effective monitoring and oversight of its existing contracts for child welfare services and placements, the FCRB cannot agree with the DHHS decision to extend additional contracts. Therefore, the FCRB requests that DHHS immediately reassess this decision. The FCRB also requests that DHHS immediately put in place a system of consistent, effective monitoring and oversight of its existing contracts.

It could be expected that as Lead Agencies were building a basic infrastructure some oversight issues would be identified. However, as discussed in the capacity section, agency capacity is still an issue, as is self-assessment of how well services and placements are being provided.

It has become difficult to measure the progress in children's cases due to the lack of complete plans and the lack of current documentation. A review of 2,973 cases assigned to a Lead Agency (January - September 2010) showed that:

- In 38.4% of the cases the plan was incomplete.
- In 8.6% of the cases, the plan was either outdated or there was no plan.
- In 38% of the cases, updated visitation reports were not available.
- In 1,143 (32%) of the cases there was no progress being made towards permanency.
- In 731 (20.4 %) of the cases it was unclear what progress was being made toward permanency.

Self oversight is needed to improve these outcome measures.

IMPACT:

- Receiving a set amount of funding per case regardless of services provided and completed may lead to financial incentives to close cases by returning children home, even if unsafe or not in the child's best interests.
- Judges may not be provided sufficient documentation/evidence on which to base permanency, placement, and visitation decisions.
- Children and families may suffer if lead agencies do not have the quality and capacity of services to fit their needs.
- DHHS and Lead Agencies should have sufficient oversight of staff and subcontractors.

RECOMMENDATION:

For DHHS

- Put in place a mechanism to determine if children are being sent home prematurely due to possible financial incentives.
- Put in place a mechanism to determine if family issues are being addressed.
- Lead agencies should ensure that written documentation of parental compliance and progress in court ordered services is obtained from the services provided and forwarded to DHHS for placement in the case file.
- Ensure that Case Plans are complete, detailing specific services with realistic timeframes for the family.
- Delineate how they will evaluate service provision to avoid negative outcomes for children and families.
- Lead Agencies evaluate all sub-contracts, and DHHS evaluate all lead Agency contracts for precise, clearly stated expectations, including consequences for non-compliance.
- Specify basic qualifications required, including mandatory and thorough background checks to be conducted at regularly defined intervals.
- Provide a clear reporting mechanism for each contractor, as well as a clear method by which DHHS can verify that services have been performed satisfactorily prior to issuing payments for such services.
- Assure that DHHS has specific qualified and trained individuals in position to monitor contractor compliance on a regular basis in order to fulfill the child welfare responsibilities.
- Contractor performance issues must be considered and resolved prior to issuing any new contracts with that provider.

For the Judiciary

The following are some of the ways the judiciary, guardians ad litem, and/or county attorneys can better provide case oversight:

- Insist on an appropriate case plan
- Hold DHHS and the Lead Agencies accountable
- Specify in court orders that services are to be successfully completed

The Foster Care Review Board Response to the Reform

Since the beginning of the Reform effort, the FCRB has been understanding and patient as the Reform was implemented, Lead Agency's personnel were trained and some consistency in operations was achieved and communication issues addressed.

The FCRB has communicated directly to DHHS' staff and leadership and to the Lead Agencies issues regarding missing documentation, concerns related to service coordinator staff changes, specific issues related to individual cases that merited immediate attention, and the FCRB assisted with training on plan requirements. The FCRB staff has outlined

processes and worked with DHHS and Lead Agencies' staff regarding documentation, processes and reviews, so that our findings would be as accurate as possible and to ensure that Nebraska's children were safe and that children, families and foster families received the Court ordered services in order for the children to achieve permanency.

The FCRB's Recommendations for Next Steps

The following are the FCRB's recommendations regarding the current (as of Nov. 10, 2010) situation with the reform. These are based on a review of the data and knowledge gained from reviews conducted by the FCRB between January and September 2010. These issues have been identified and shared with the Department, Lead Agencies, and the Courts.

FCRB recommendation #1: We request that the Appropriations Committee and the HHS Committee of the Legislature, along with the Performance Audit Committee review the Reform effort to date to determine if the Reform can meet cost savings expectations, and meet the State's responsibility of being custodian of these children. We request that the experience of other states be considered. For instance,

> "*In states that have privatized, private agencies struggle with the same issues that public agencies do such as obtaining adequate services, reducing caseloads, and reducing turnover. More money would increase the availability of services whether spent through the public or private sector, but merely hiring a middle man to manage services does neither.*"
>
> "*Even with privatization, the state must both 1) maintain oversight of each case and 2) monitor contract performance and outcomes. Across the country, in those states that have privatized, public sector administrative costs continue to grow for this very reason.*"

Center for Public Policy (March 2005)

FCRB recommendation #2: We request the State Auditor examine where state and federal dollars have been spent on reform to date, and examine the proposed contracts to extend reform.

FCRB recommendation #3: We request that DHHS provide the Legislature and the citizens of Nebraska with a more comprehensive explanation of the risks and rewards of their outsourcing proposal for review before such a plan is implemented, including the number of children, bio-families, and foster families affected, and whether out-of-state based contractors will be utilized.

Additionally, the report from DHHS should include costs incurred by reform to systemic partners such as the judiciary, counties, service providers, and lead agencies.

FCRB recommendation #4: We recommend, in light of the failure of three of the original Lead Agency contracts, that the current system be stabilized, that a thorough review of the Reform effort to date be conducted and that DHHS in conjunction with all

stakeholders, including the court system and the Legislature, analyze the failures related to the implementation of the Reform and prepare a phased-in approach to privatization. It is unfortunate that DHHS is accelerating the Reform effort as stated in the October 15, 2010, announcement including planned layoffs of trained and experienced case management staff.

FCRB recommendation #5: In January and February 2011 make a concerted effort to focus on documentation and train service coordinators and their supervisors on what needs to be documented, when it needs to be documented, and how it needs to be documented.

FCRB recommendation #6: We recommend that focused efforts be made to ensure that the children previously assigned to Boys and Girls have been transitioned to an assigned case manager/service coordinator. Additionally, some assurances that the children previously assigned to Visinet and CEDARS have appropriate oversight.

FCRB recommendation #7: We request that DHHS and the Lead Agencies address the issues identified in the FCRB 2009 Annual Report, as all are still relevant. The top issues were:

1. Address chronic familial issues such as substance abuse, mental health and domestic violence and make services to address the issues available statewide.
2. Stabilize children's cases by addressing case management issues.
3. Reduce the length of time children spend in care.
4. Assure children have realistic case plans that reflect current circumstances.
5. Reduce the number of children returned to parents too soon or to uncorrected situations.
6. Build a system of rigorous oversight and accountability measures within DHHS.
7. Improve access to treatment for children with mental health and behavioral issues and assure older youth are prepared for adulthood.
8. Assure all guardians ad litem provide quality representation of the children.
9. Create an adequate infrastructure of placements and treatment placements.

Conclusion:

Nebraska statute is clear, and the federal Department of Health and Human Services concurs, NDHHS retains responsibility for children's safety, well-being, and permanency regardless of whether or not it chooses to contract for placements, services, service coordination, or case management.

Therefore, it is imperative that DHHS immediately put in place measures to monitor contracted services and correct identified issues.

The Foster Care Review Board will continue to track, analyze, and report on conditions for children in out-of-home care, and as part of its statutory mission will continue to point out deficits in the child welfare system and make recommendations for improvement.

Appendix A – Reform Timeline

Governor Heineman Announces Directives

June 21, 2006: Governor Heineman announced new child welfare directives. At that time Nebraska had an all-time high number of children in out-of-home care (over 6,200). The Governor ordered DHHS to prioritize cases of children age five and younger and work to resolve cases more quickly. He asked for all professionals involved with children in out-of-home care to collaborate on resolving children's issues.

September 2006: The Supreme Court held the first Through the Eyes of a Child Summit, and regional teams formed for collaboration.

Dec. 31, 2006: The number of children in out-of-home care had been reduced from 6,204 at the beginning of the year to 5,186.

Dec. 31, 2007: The number of children in out-of-home care was reduced to 5,043.

July 10, 2008, Governor Heineman, Chief Justice Heavican, and the FCRB Chair Georgina Scurfield, held a press conference to announce that the FCRB and DHHS would be conducting a joint study of children who had been in out-of-home care 2 years or longer. As a result, both agencies instituted routine joint meetings on cases of concern.

September 2008: DHHS unveiled its plan for child welfare and juvenile services reform, including contracting for in-home services.

Dec. 31, 2008: The number of children in out-of-home care was reduced to 4,620.

Through 2008, adoptions were at an all-time high – 572 children were adopted in 2008.

Private Agencies Assume Service Coordination

In July 2009, the current Reform efforts began. A timeline of implementation includes:

July 2009: State and Federal funds were given to the Lead Agencies for recruitment of staff, locating work sites, leasing of equipment, and any other purposes reasonably necessary to prepare for full implementation.

August 2009: Training of Service Coordinators began. 25 days of initial case manager training was provided to Service Coordinators, with additional training to be provided by the Department and Lead Agency.

Summer 2009: Concerted effort made by DHHS to train case managers and Service Coordinators regarding Roles and Responsibilities; licensed foster parents contacted by DHHS regarding the impending change and the need to be licensed under a Lead Agency or sub-contractor.

October 2009: Contracts amended for service delivery to begin on November 1, 2009 with full statewide implementation by April 1, 2010.

October 2009: FCRB began planning on reform data to be collected.

November 2009: FCRB began training staff on reform data collection.

November 1, 2009: Weekly transfer of child welfare cases began in Douglas and Sarpy County. Individual case staffing occurred and <u>one year's worth</u> (not the entire file) of the families' case file documentation was copied and given to the Contractor.

December 31, 2009: There were 4,448 children in out-of-home care.

Jan. 1, 2010: FCRB began collecting reform data.

April 2010: Transfer of child welfare cases to Lead Agencies complete.

April 2, 2010: CEDARS announced its intention to withdraw from their contract by June. The cases of 300 children reverted to DHHS for case management.

April 16, 2010: Visinet declared bankruptcy. The cases of 1,000 children reverted to DHHS for case management.

April 2010: FCRB began working with DHHS on documentation deficits and how best to report them to DHHS for correction.

June 2010: The process for recording documentation deficits was in place, and the FCRB began reporting individual cases to DHHS and the Lead Agencies.

July 2010: Change of contracts.

October 15, 2010: Boys and Girls ceased operations. The cases of 1,400 reverted to DHHS for case management.

October 15, 2010: DHHS issued a press release titled *DHHS Announces Next Steps to Strengthen Child Welfare/Juvenile Services Reform*. In this announcement it stated that $9.86 million in emergency federal funding for TANF and $6 million dollars of state general funds was received. DHHS also announced a reduction of staff and transfer of more responsibilities to the remaining service agencies by January 1, 2011, further accelerating the Reform effort.

October 2010: Caseworkers reported they are seeking alternative employment in response to the announcement of reductions in staff.

November 8, 2010: There were 4,508 children in out-of-home care.

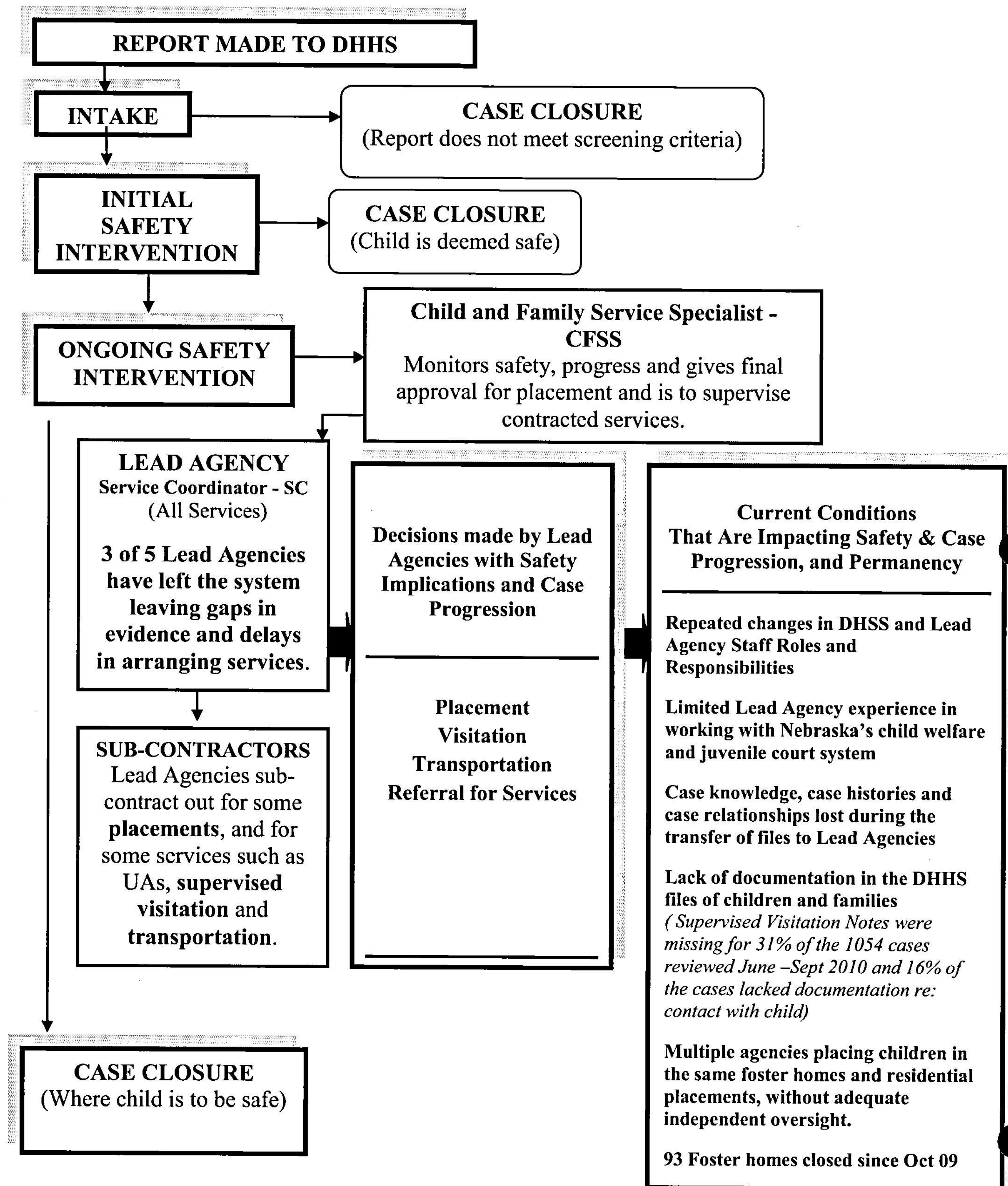
November 15, 2010: Governor Heineman weighed in on reform, noting that both state and lead providers have to do a better job in the future.

November 17, 2010: Seven Lincoln area State Senators hold a town hall meeting on child welfare reform.

As of November 8, 2009, there were 4,508 children in out-of-home care. Since that time all children in out-of-home care have been impacted by Reform and related system challenges such as more than one lead agency, different safety models, different service coordinators, interruptions in services, and services not being documented.

APPENDIX B

DHHS INTERVENTION AND SAFETY SYSTEM / REFORM



The DHHS Child and Family Service Specialists (CFSS) were responsible for case management including approval of placement, monitoring safety, contact with family, child, placement, updating N-FOCUS narratives and placement changes, and developing the case plan and court report.

The Lead Agency and Service Coordinator (SC) are now responsible for providing an appropriate placement, coordination and provision of all services (i.e., placement, support to foster families, visitation, transportation), making referrals for evaluations and treatment, visiting child in placement, updating notes on N-FOCUS, reports to DHHS.

Lead Agencies sub-contract out for some placements, and for some services such as tracking and monitoring juvenile offenders, drug use testing, visitation and transportation.

COMMUNICATION AND DOCUMENTATION AFFECTS SAFETY DECISIONS MADE BY LEAD AGENCIES

Lead Agency staff training, child welfare and juvenile court experience or expertise: Many Lead Agency staff do not have the necessary skill sets or case work knowledge necessary to understand the needs of the child and their family. The DHHS case worker (CFSS) often mentors the Service Coordinator and directs their action steps on a case, what to do in court, and what to do regarding the court ordered services.

Communication: Bio-parents, foster parents, guardians ad litem, sub-contractor agencies, therapists and other professionals consistently report a lack of communication regarding cases and regarding the roles and responsibilities DHHS, Lead Agencies and Sub-Contractors. Foster parents get mixed messages from the various service providers.

Documentation and missing evidence: Documentation in both the hard file and on N-FOCUS is chronically lacking. UAs, evaluations, assessments, visitation reports, & contact notes are all examples of documentation and evidence used to provide proof in court that progress is or is not occurring.

Delays / Lack of Progress: (e.g., slow referrals and services, delays in adoptions)

Placement issues: 38% of the cases reviewed by the FCRB did not have home study documentation. Over 50 foster parents have directly reported their intent to cease foster parenting citing payment, communication and logistical issues. Foster parents report that several agencies call them each day to place a child even though they are at their maximum number of children. Between April and May the FCRB received over 80 calls seeking assistance in getting previous reimbursement rates restored and paid for months of service.

Visitation: Out of 2,973 reviews 38% of the cases reviewed did not have supervised visitation reports. Visitation workers fail to show up to supervise the visit, or cancel visits due to the visitation worker's personal commitments.

Transportation: Children have been transported in unsafe vehicles and by providers that are not professional, e.g., 2 children were transported in a car with bad brakes and were involved in an accident, and others are being driven by providers that take the child with them on unauthorized personal errands. Still others that do not follow safety protocols including showing ID and escorting children to and from appointments.

Appendix C – Foster Parent Payments

Most states fall short of researchers' recommendations

Minimum monthly foster care payment, by state, for children ages 2, 9 and 16, and what the minimum rate should be to cover actual costs, according to a study released today (recommended rates do not include travel and child care expenses but include extra costs particular to children in foster care):

	Current rate			Recommended rate				Current rate			Recommended rate		
Age	**2**	**9**	**16**	**2**	**9**	**16**	**Age**	**2**	**9**	**16**	**2**	**9**	**16**
Ala.	$410	$434	$446	$567	$650	$712	Mont.	$515	$475	$572	$598	$685	$751
Alaska*	$652	$580	$688	$629	$721	$790	Neb.	$226	$359	$359	$636	$729	$799
Ariz.	$793	$782	$879	$606	$695	$762	Nev.	$683	$683	$773	$638	$731	$801
Ark.	$400	$425	$475	$558	$639	$701	N.H.	$403	$439	$518	$724	$830	$910
Calif.	$425	$494	$597	$685	$785	$861	N.J.	$553	$595	$667	$751	$860	$943
Colo.	$348	$392	$423	$659	$755	$828	N.M.	$483	$516	$542	$600	$688	$754
Conn.	$756	$767	$834	$756	$866	$950	N.Y.*	$504	$594	$687	$721	$826	$906
Del.	$517	$517	$517	$625	$716	$785	N.C.	$390	$440	$490	$630	$722	$792
D.C.	$869	$869	$940	$629	$721	$790	N.D.	$370	$418	$545	$584	$669	$734
Fla.	$429	$440	$515	$579	$664	$728	Ohio	$275	$275	$275	$635	$727	$797
Ga.	$416	$471	$540	$588	$674	$738	Okla.	$365	$430	$498	$557	$639	$700
Hawaii	$529	$529	$529	$629	$721	$790	Ore.	$387	$402	$497	$642	$735	$806
Idaho	$274	$300	$431	$602	$689	$756	Pa.*	$640	$640	$640	$671	$770	$844
Ill.	$380	$422	$458	$661	$757	$830	R.I.	$438	$416	$480	$723	$828	$908
Ind.	$760	$760	$760	$630	$722	$791	S.C.	$332	$359	$425	$576	$660	$723
Iowa	$454	$474	$525	$626	$717	$786	S.D.	$451	$451	$542	$633	$726	$795
Kan.	$603	$603	$603	$628	$720	$789	Tenn.	$627	$627	$737	$574	$658	$722
Ky.	$599	$599	$660	$569	$652	$715	Texas	$652	$652	$652	$557	$638	$700
La.	$380	$365	$399	$567	$649	$712	Utah	$426	$426	$487	$634	$726	$796
Maine	$548	$577	$614	$686	$786	$862	Vt.	$475	$528	$584	$705	$808	$886
Md.	$735	$735	$750	$628	$720	$789	Va.	$368	$431	$546	$605	$694	$760
Mass.	$490	$531	$616	$766	$878	$962	Wash.	$374	$451	$525	$657	$753	$826
Mich.	$433	$433	$535	$646	$740	$812	W.Va.	$600	$600	$600	$561	$643	$705
Minn.	$585	$585	$699	$661	$758	$830	Wis.	$317	$346	$411	$648	$743	$814
Miss.	$325	$355	$400	$555	$636	$697	Wyo.	$645	$664	$732	$608	$696	$763
Mo.	$271	$322	$358	$627	$719	$788	**U.S. avg.**	**$488**	**$509**	**$568**	**$629**	**$721**	**$790**

* — Alaska, New York and Pennsylvania do not have state-established minimum rates. For these states, the current rate is for each state's most populous region.

Source: Foster care study by the University of Maryland School of Social Work, National Foster Parent Association and Children's Rights

Appendix D – CFSR Result Comparison

Federal reviews of individual State's child welfare systems started in 2001 and continue on an alternating schedule. These reviews measure outcomes for children in a systematic manner. The following States compared with Nebraska's CFSR review results were chosen because Kansas, Tennessee and Florida have initiated privatization prior to Nebraska's reform efforts.

Systemic Factors and Items	Nebraska		Kansas		Tennessee		Florida	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect	**77.4ˣ**	**37.5ˣ**	**87ˣ**	**93.8ˣ**	**84.6ˣ**	**53.3ˣ**	**85.7ˣ**	**70.0ˣ**
Item 1: Timeliness of investigations	58ˣ	37 ˣ	Not Reported	97*	71ˣ	52ˣ	85.7ˣ	90*
Item 2: Repeat maltreatment	100*	92*	Not Reported	93*	97*	82ˣ	91.8ˣ	64ˣ
Safety Outcome 2: Children are safely maintained in their homes when possible and appropriate	**88.6ˣ**	**52.3ˣ**	**90***	**75.0ˣ**	**68.4ˣ**	**50.8ˣ**	**78.0ˣ**	**61.5ˣ**
Item 3: Services to prevent removal	88*	68ˣ	Not Reported	95*	78ˣ	72ˣ	90ˣ	74ˣ
Item 4: Risk of harm	91*	52ˣ	Not Reported	77ˣ	71ˣ	51ˣ	78ˣ	65ˣ

Federal findings – Area Needing Improvement ˣ
Strength*

All numbers are from CFS CFSR reports found at
http://library.childwelfare.gov/swig/ws/cwmd/docs/cb_web/SearchForm

Systemic Factors and Items	Nebraska		Kansas		Tennessee		Florida	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Permanency Outcome 1: Children have permanency and stability in their living situations	**45.7ˣ**	**25.0ˣ**	**68ˣ**	**52.5ˣ**	**31ˣ**	**27.5ˣ**	**75.9ˣ**	**34.1ˣ**
Item 5: Foster care reentry	85*	100*	Not Reported	91*	75ˣ	85ˣ	96.4*	100*
Item 6: Stability of foster care placements	77ˣ	67ˣ	Not Reported	67ˣ	66ˣ	67.5ˣ	89.7*	59ˣ
Item 7: Permanency goal for child	54ˣ	43ˣ	Not Reported	74ˣ	59ˣ	42.5ˣ	58.6ˣ	59ˣ
Item 8: Reunification, guardianship, and placement with relatives	57ˣ	41ˣ	Not Reported	82ˣ	69ˣ	43ˣ	50ˣ	70ˣ
Item 9: Adoption	0ˣ	23ˣ	Not Reported	47ˣ	10ˣ	37ˣ	70*	44ˣ
Item 10: Other planned living arrangement	50ˣ	17ˣ	Not Reported	80ˣ	44ˣ	N/A	33.3ˣ	64ˣ

Federal findings – Area Needing Improvement ˣ
Strength*

All numbers are from CFS CFSR reports found at http://library.childwelfare.gov/swig/ws/cwmd/docs/cb_web/SearchForm

Systemic Factors and Items	Nebraska		Kansas		Tennessee		Florida	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Permanency Outcome 2: The continuity of family relationships and connections is preserved	**65.7ˣ**	**67.5ˣ**	**80ˣ**	**90.0ˣ**	**37.9ˣ**	**57.5ˣ**	**89.7***	**47.5ˣ**
Item 11: Proximity of placement	97*	97*	Not Reported	93*	85*	97*	96.6*	93*
Item 12: Placement with siblings	87*	91*	Not Reported	100*	67ˣ	91*	95.5*	87ˣ
Item 13: Visiting with parents and siblings in foster care	71ˣ	73ˣ	Not Reported	97*	70ˣ	68ˣ	80ˣ	53ˣ
Item 14: Preserving connections	71ˣ	80ˣ	Not Reported	84ˣ	64ˣ	85ˣ	96.2*	77ˣ
Item 15: Relative Placement	67ˣ	64ˣ	Not Reported	91*	38ˣ	61ˣ	96.6*	61ˣ
Item 16: Relationship of child in foster care with parents	55ˣ	59ˣ	Not Reported	90*	61ˣ	43ˣ	87ˣ	28ˣ

Federal findings – Area Needing Improvement ˣ
Strength*

All numbers are from CFS CFSR reports found at
http://library.childwelfare.gov/swig/ws/cwmd/docs/cb_web/SearchForm

Systemic Factors and Items	Nebraska		Kansas		Tennessee		Florida	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Well Being Outcome 1: Families have enhanced capacity to provide for children's needs	**32.0×**	**32.3×**	**76.0×**	**65.6×**	**52×**	**35.4×**	**62×**	**24.6×**
Item 17: Needs/services of child, parents, and foster parents	56×	40×	Not Reported	69×	56×	38.5×	72×	29×
Item 18: Child/family involvement in case planning	26×	39×	Not Reported	75×	65×	39×	53.1×	35×
Item 19: Caseworker visits with child	60×	65×	Not Reported	73×	92*	63×	75.5×	80×
Item 20: Caseworker visits with parents	44×	30×	Not Reported	64×	68×	26×	69×	31×

Systemic Factors and Items	Nebraska 2002	Nebraska 2009	Kansas 2001	Kansas 2008	Tennessee 2002	Tennessee 2008	Florida 2001	Florida 2008
Well-Being Outcome 2: Children receive services to meet their educational needs	**86.1×**	**76.5×**	**93***	**91.5×**	**82.2×**	**83.3×**	**78.9×**	**82.5×**
Item 21: Educational needs of child	86×	77×	Not Reported	91×	82×	83×	78.9×	83×

Federal findings – Area Needing Improvement ×
Strength*

All numbers are from CFS CFSR reports found at http://library.childwelfare.gov/swig/ws/cwmd/docs/cb_web/SearchForm

Systemic Factors and Items	Nebraska		Kansas		Tennessee		Florida	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Well Being Outcome 3: Children receive services to meet their physical and mental health needs	**55.3ˣ**	**62.3ˣ**	**78ˣ**	**85.5ˣ**	**69.4ˣ**	**66.1ˣ**	**74ˣ**	**61.4ˣ**
Item 22: Physical health of child	73ˣ	77ˣ	Not Reported	92*	89*	91*	85.1ˣ	79ˣ
Item 23: Mental health of child	66ˣ	70ˣ	Not Reported	88ˣ	71ˣ	63ˣ	76.3ˣ	67ˣ

Estimated Annual Penalty for not meeting Federal Standards	$264,696	$366,580	$415,056.42	$134,088	$1,488,696	$1,522,580	$2,951,544	$3,365,779

Highlights of Findings	Nebraska 2002	Nebraska 2009	Kansas 2001	Kansas 2008	Tennessee 2002	Tennessee 2008	Florida 2001	Florida 2008
# of National Standards met	2 of 6 standards.	1 of 6 standards.	3 of 6 standards.	3 0f 6 standards.	1 of 6 standards.	2 of 6 standards.	2 of 6 standards.	2 of 6 standards
# of outcomes substantially achieved	0 of 7 outcomes.	0 of 7 outcomes	2 of 7 outcomes.	0 of 7 outcomes.	0 of 7 outcomes.	0 of 7 outcomes.	1 of 7 outcomes.	0 of 7 outcomes
#of Systemic factors where substantial conformity was achieved	3 0f 7 systemic factors.	5 of 7 systemic factors.	6 of 7 systemic factors.	4 0f 7 systemic factors.	4 of 7 systemic factors.	5 of 7 systemic factors.	5 of 7 systemic factors.	4 of 7 systemic factors.

Federal findings – Area Needing Improvement ˣ
Strength*

All numbers are from CFS CFSR reports found at http://library.childwelfare.gov/swig/ws/cwmd/docs/cb_web/SearchForm

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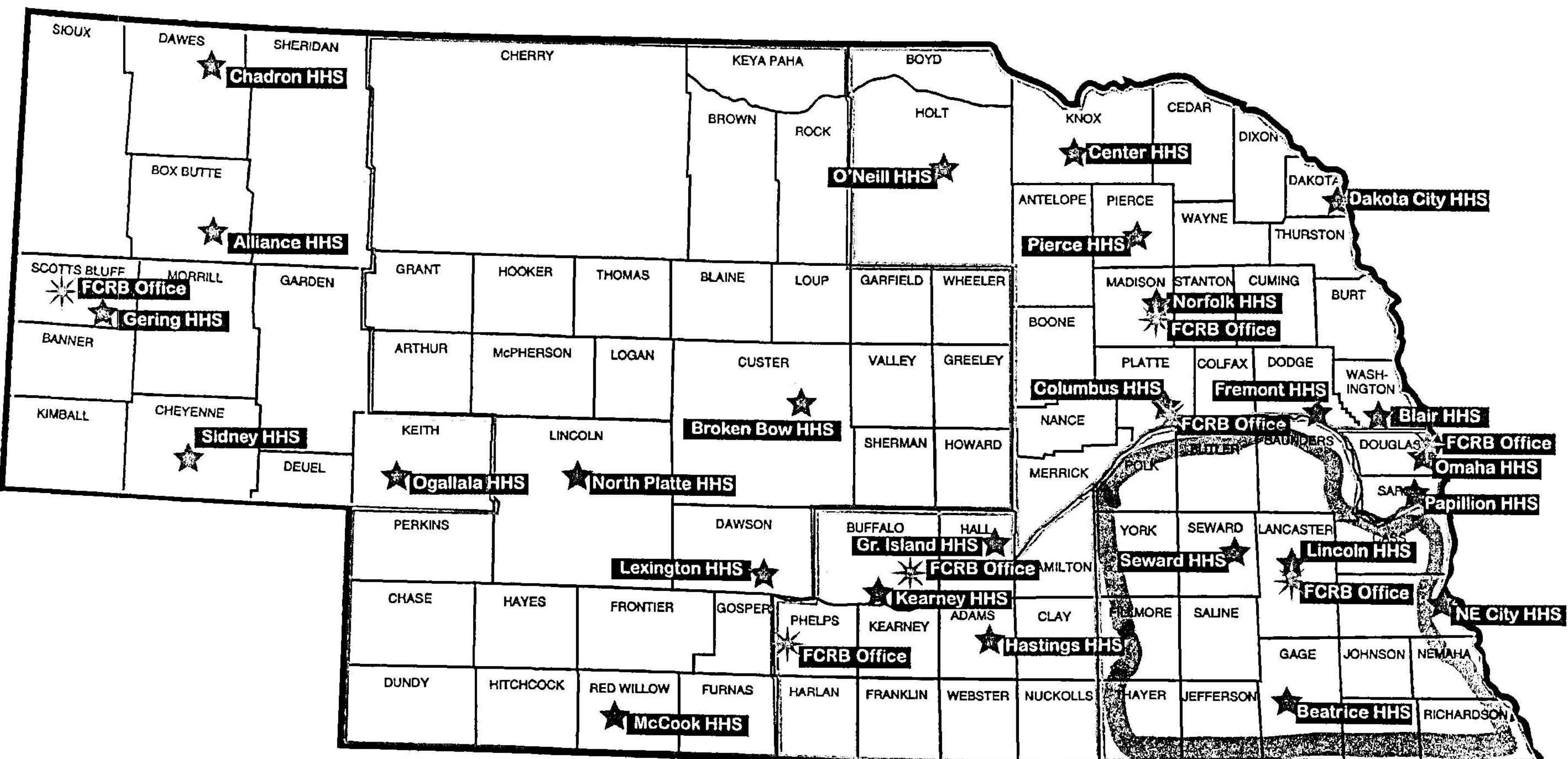
The Foster Care Review Board can be reached at: www.fcrb.nebraska.gov, or 521 S. 14th, Suite 401, Lincoln NE 68508 or 402.471.4420.

LINCOLN/SOUTHEAST: 1,211 Total Children (as of 6-30-11)

485 (40%) children in care more than once
603 (50%) children have had 4 or more placements
357 (29%) children have had 4 or more lead agency staff assigned to their case while in out-of-home care
674 (55%) children have had 4 or More DHHS Workers



Testimony – Health & Human Services Committee, Nebraska Legislature
Wednesday, September 7, 2011

Good morning Senators, my name is Dawn Rockey and I am the Executive Director of Court Appointed Special Advocates (CASA) for Lancaster County. I would like to thank Senator Campbell for the invitation to appear before you today.

I have been with CASA for Lancaster County for almost five years. In that short time, there has been a tremendous amount of change in Nebraska's child welfare system. At CASA, our volunteers and staff spend a great deal of time trying to navigate that system to ensure that children's best interests are being met. Navigating the system has been problematic at best and at worst, downright impossible.

I would like to share with you some of the obstacles that we believe delay permanency for children who are wards of the state.

- **Case loads are too high.** KVC manages all abuse and neglect, truancy, and OJS cases here in Lancaster County. Turnover in staff has been constant. Much of the time turnover is due to people leaving their position at KVC. However, all too often turnover in case management has occurred due to internal reorganization at KVC and shifting case loads from one "team" to another. We have had situations in court where neither the KVC Family Permanency Specialist (FPS), nor their supervisor or the Health and Human Services representative know much of anything about the children and the family because the case was just transferred to them. We have had a few hearings continued so that the previous FPS could appear for questioning so that relevant facts can be on the record. Some FPS's have reported to our volunteers and staff that they have as many as 25 cases and really haven't had time to follow up on numerous requests just due to their workload. At the onset of the reform effort we were told that caseloads would be 14 to 16 cases per worker. Prior to KVC taking over, large caseloads were identified as being a major roadblock to effective case management. I don't believe progress has been made in this area. I've heard it suggested in the past that more money for more workers won't necessarily make a difference but I think it would be a good start.

- **Hearings are often continued which delays permanency and keeps children in foster care longer than necessary.** During the months of June, July and August of 2011; we had approximately 81 hearings. Of those, approximately 26% were continued thereby delaying case progression. Many of the hearings were continued because needed evaluations and assessments had not been completed. While I can't lay the blame for this totally on KVC's doorstep, much of it does come from lack of follow up by KVC staff – follow up with parents who have been directed to make appointments for assessments and follow up with providers in order to get the written reports. Another large contributor to continued hearings has been late case plan/court reports. Many times hearings were continued because the parties to the case (including the judge) just received the case plan/court report immediately before the hearing or just a few hours before the hearing leaving no time to review the plan or for attorneys to go over it with their clients. I have been told that KVC and DHHS are implementing some new strategies to make sure court reports are submitted on time and that the content is correct. I hope these measures are successful because each time a hearing is continued; permanency is delayed for a child. The longer a child is in foster care, the higher their anxiety is about what can happen next and with more anxiety often comes bad behaviors resulting in further damage to a child.
- **Communication problems permeate the entire system.** Communication between KVC staff and the other professionals assigned to the case is often inadequate. Phone calls and emails are not returned in a timely manner or at all. We also see a number of court orders for services not being implemented. When this occurs, our volunteers and staff try to find out where the problem is – are authorizations or referrals for the service not being made; is it an issue with getting appointments made or a service set up? Calls and emails to the FPS assigned to the case are not returned so we end up not being able to assist in getting the service up and going because we don't have enough information. In some cases, it would even be helpful to get a response that says they are aware of an issue and are working on it. The lack of effective and regular communication has a negative impact on the team of professionals assigned to a case being able to work together to keep the case moving and to achieve an outcome that is in the children's

best interests. My recommendation on remedying this problem is for KVC to enforce a policy where workers return calls or emails within a specified time period.

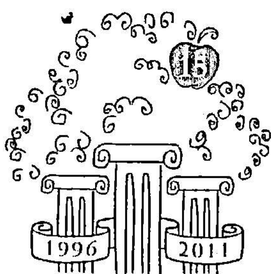
- **In some cases, CASA volunteers have been put in the position of "policing" the case plan and court orders.** In other words, our volunteers have had to continually ask if a service ordered by the court has been implemented and if not, why not, and often ask (we hope) what they can do to get things going. When things still aren't happening CASA staff intervenes and I have had days where I feel like the class tattle-tale because I am emailing administrators within KVC to see if we can get some answers or some movement because the FPS isn't responding. For example, we had a case in court a few weeks ago. The children have been placed at home with their mother but there isn't sufficient stability yet to close the case. In January, 2011 the FPS worker told the mother that the children needed to go to the dentist and to make the appointment (the children as wards of the State have Medicaid). There was no follow up by KVC staff even though the FPS was supposed to be seeing the children once a month and there was also a Family Support Worker in the home on a regular basis. The CASA volunteer and the volunteer coordinator assigned to these children visited them in late July/early August and were horrified about the condition of the children's teeth – they were literally rotting in their heads. No dental appointments had been made nor had there been any documented follow up by KVC staff. Even though these children were placed with their mother, they are still wards of the state.

  We have also had incidents where state law or HHS policy isn't being followed when it comes to placement of children. Recently six children were removed due to repeated domestic violence. As you know, placing all six kids together is almost impossible. The children were placed in two separate foster homes shortly before school started in August. There was little or no regard for making sure the children remained in their previous schools. Of the six, only one is attending the school he attended last year. The chief reason cited by KVC was transportation. Given that one of the foster homes is outside of Lincoln, the foster parents were unwilling to transport the children daily to Lincoln to school and KVC was also unwilling to transport. Removing these children from their home and then from their school further traumatizes the children. State and

federal statute (known as Fostering Connections) requires that every effort is made to keep kids in their schools – in this case I don't think much effort was made to do so.

When I think about the myriad of problems in our current system, I keep coming back to training of workers. At present, I do not think the training is adequate. New workers often do not know what decisions are theirs to make and what needs to be cleared with a supervisor or HHS. The result is a sort case purgatory where nothing is resolved and no progress is made. One suggestion I would make is to include "shadowing" of a current worker as part of the training. No two cases are alike and being able to see how someone else handles an issue or be able to discuss why and how a service is implemented can help a new worker get up to speed quickly. Likewise, being able to discuss the different nuances of a case with another worker can help new workers think on their feet when they have their own case load.

In closing, I believe we have too many children falling through the cracks. I am encouraged by some of the recent information I have received from KVC and DHHS about additional changes to the system. However, we shouldn't forget that the time it takes to implement more and more changes also is time that children are needlessly lingering in child welfare system limbo. It isn't good for the children, their families, the foster parents and ultimately it isn't good for the taxpayers of the state of Nebraska. Thank you for your interest in tackling this issue and I'd be happy to answer any questions.



NEBRASKA
Appleseed

Fifteen years sowing the seeds of justice.

September 7, 2011

Senator Kathy Campbell
Chair, Health and Human Services Committee
Room 1402, State Capitol
Lincoln, NE 68509

RE: LR 37 hearing and investigation of child welfare reform

Chairwoman Campbell and members of the Health and Human Services Committee:

On behalf of the Nebraska Appleseed Center for Law in the Public Interest, thank you for the invitation to testify today.

I want thank Sen. Campbell and the Committee for your leadership on this issue and for your commitment to prioritizing the improvement of our child welfare system. Nebraska Appleseed and others called for and advocated in support of this evaluation to look at the programmatic and fiscal components of the reform and believe this process is critical to accountability both to the families in the system and the taxpayers in the state and also to prevent a continuation of the problems experienced to date.

Since the beginning of this reform effort, more than two years ago, Nebraska Appleseed has raised questions about the viability and sustainability of this reform. While Nebraska Appleseed has long supported comprehensive reform of the child welfare system and shares some of the underlying goals of the current reform efforts, including safely reducing the number of children in out-of-home care, requiring evidence-based practices and drawing on the strengths of local providers, we are deeply concerned about the effect the reform has had on children and families in the system.

In our work in the Southeast Service Area and across the state, we have received calls from numerous attorneys who are members of our child welfare listserv, callers to our intake line (including affected parents, foster parents, relatives, and other concerned individuals), providers, and other stakeholders. Although I testify today on behalf of Nebraska Appleseed only, these contacts inform the work we do and the concerns and recommendations presented today.

Concerns

At this time, our top three concerns about the child welfare reform effort are the impact the privatization has had on children and families from: 1) Medicaid cost-shifting, 2) weakening service infrastructure and inadequate service array in the state 3) lack of oversight from the state.

Medicaid cost-shifting

One of the primary concerns we hear is from parents and caregivers of children with significant behavioral health needs for which Medicaid has denied recommended services. Many of these children are former state wards with particular diagnoses or conditions, such as developmental disabilities. In too many cases, when Medicaid denies services, parents are given the draconian option of making the child a state ward – not

because of abuse or neglect – but in order to obtain a court order – and thus payment - for treatment. Under the privatization contracts, this shifts the cost from Medicaid to private providers, or, in areas not currently privatized, the cost is paid with state child welfare funds. This is the same for children who are already in the foster care system (when Medicaid denies services required by the case plan or ordered by the judge, the cost shifts to the private providers under the existing contracts). This stopgap process exerts additional pressure on private agency contracts and limited state child welfare funds. For children not previously in foster care, it unnecessarily breaks-up families and places children in a dysfunctional system not intended for them. In addition, we believe this cost-shifting is financially unsustainable, violative of the rights of children and families, and contrary to children's best interests.

Weakened service infrastructure and limited service array

We are also concerned that the existing service array in the state is inadequate to meet the needs of children and families. In particular, we are concerned that the state does not have adequate prevention and supportive services in place currently to achieve the goal of "flipping the pyramid" to reduce the state's high number of children in out-of-home care. We are also concerned about gaps in the state's children's behavioral health system. Namely, the state lacks wrap-around or "B-level" behavioral heath services for children. That is, there is a gap in services for children who cannot safely remain in their own home (level "A") and for whom inpatient or residential treatment (level "C") is not appropriate. As a result of these gaps, far too many children end up in inappropriate, unnecessary, and unsafe placements.

Relatedly, we are concerned about the effect the privatization has had and is having on the service capacity in the state. Since the implementation of this reform, a number of providers of child welfare and related services in the state have closed their doors or limited their services. This is of particular concern in rural areas of the state, where more limited services already existed prior to the reform and where, since the termination of Boys & Girls Home's contract, a number of subcontractors have taken a hit from unpaid debts, despite the infusion of millions of dollars to private contractors in the metro areas. In addition, there are concerns about the effect of the privatization on the recruitment and retention of foster families, with reports of significant shortages in some areas. The weakened service capacity in the state creates instability, unmet needs, and delayed permanency for children.

Lack of oversight

Finally, we have expressed concerns from the beginning of this process that oversight, monitoring, and transparency are insufficient. The state is legally responsible as the custodian of children who are wards of the state and, as such, has a duty to provide for the safety, permanency, and well-being of children in their care. However, state caseworkers are providing an increasingly restricted role under privatization contracts and, in some cases, have limited knowledge of the case. It is also troubling that millions of dollars have been invested in this reform with little transparency, and that the Department failed to provide proper oversight of how these funds were being managed and failed to step in to prevent the loss of taxpayer dollars, instability for children, and cost to subcontracting agencies that resulted from the termination of the Boys and Girls Home and Visinet contracts.

Recommendations

In light of the current instability and unsustainability of the system, we believe the state should pull back from this reform until core issues are addressed, including: 1) eliminating Medicaid cost-shifting and insuring that children receive appropriate services in the appropriate system and setting, 2) creating an adequate service array that includes preventative and wrap-around services, and 3) establishing a structure that meets the state's obligation to provide proper oversight of cases.

Strengthen the "front door" so that children receive appropriate services in the appropriate system and setting

One of the primary changes we believe must occur is for the state to provide, as required by federal law, all necessary behavioral and mental health services to children under Medicaid. The federal policy behind the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of Medicaid is to prevent conditions from getting worse and to avoid more costly services that result. Instead, we are seeing in Nebraska that such services are often not provided because of blanket exclusions based on a child's condition or because a service is deemed not to be medically necessary by Magellan. As a result, children end up in inappropriate placements and systems, or without care at all.

Providing federally mandated services under Medicaid is the responsibility of the Department and this responsibility must be enforced. Moreover, the Department – and not private providers – should be responsible for payment for court-ordered services denied by Magellan. Under the current contract, this cost is shifted to private providers, putting lead agencies at significant risk as state Medicaid and Magellan policies and procedures constantly change and putting further financial pressure on an already-stressed system.

State legislation could clarify that all necessary behavioral health services under Medicaid shall be provided, with only reasonable limitations based on an individualized medical necessity assessment. In addition, the Legislature and the public should have more involvement in providing input and feedback on guidelines that dictate whether a service is covered. When a service is denied, parents and providers should be given enough information in written paperwork regarding the basis for the denial in order to effectively challenge the denial and advocate for services. Finally, legislation could make clear that the Department is responsible for court-ordered services denied by Medicaid or, in the alternative, that, in the future, private contractors are not at-risk for such services.

Rebuild and create a full service array, including preventative and wrap-around services

The state also has a responsibility to provide access to an adequate service array that meets the needs of children and families. Unfortunately, while this reform is premised on widely-shared goals to improve outcomes and serve more children in their own home, it was launched before the necessary service infrastructure was in place to support these goals, and now the system has been weakened further. Specifically, as noted

above, the state is lacking and needs to create additional prevention, in-home, and wrap-around services.

The state should pull back from the reform and the moratorium on further privatization should remain intact until a system of care is created that is stable and sufficient to support the goals we all want for children and families in the system. This could be accomplished by legislation limiting privatization or aspects of privatization at least until an adequate service array is in place and by an appropriation to establish and encourage additional prevention, in-home, and wrap-around services in the state.

Establish a structure to meet state's obligation to provide oversight of cases

Finally, the state must establish a clear oversight structure. This reform was undertaken without the guidance of the Legislature and has, since its inception, suffered from an unclear, inadequate and changing oversight role from the Department. We believe it is critical that the Legislature make clear what duties can and cannot be delegated to private agencies and what level of oversight the state should retain. It is also critical that additional and more detailed financial reporting and oversight be put into place to safeguard that taxpayer dollars appropriated for vulnerable children are best used for this vital purpose. LB 433, which was introduced last session and remains in committee, includes some concrete oversight pieces that could serve as a model for clarifying these issues. Finally, we believe an oversight body should be established to provide direction on the future of reform. This body should include a way to obtain input from all three branches of government, consumers and family representatives, and other stakeholders.

As the policy making branch of government, the Legislature has an important role to play in setting overarching policy for the provision of child welfare services in the state of Nebraska, and for insuring that the state is meeting its legal obligations to children and families in the system and is transparent and accountable for the use of taxpayer dollars. We believe these changes are necessary in order to meet these core responsibilities and finally, truly reform Nebraska's child welfare system.

Thank you for the opportunity to testify today and for your commitment to the LR 37 process and to finding solutions to address the challenges in Nebraska's child welfare system.

Sincerely,

Sarah Helvey
Program Director/Attorney
Child Welfare System Accountability Program

Executive Director
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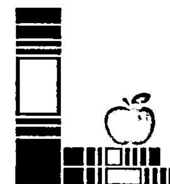
Core Values
Common Ground
Equal Justice

LR 37 Feedback from Lincoln Public Schools



Department of Student Services ~ Pam Robinson-Administrator

The mission of the Student Services Department with Lincoln Public Schools is to provide services to students in a manner that recognizes both the rights and responsibilities of students and that values each student and encourages appropriate student development.

Student Services include the following:

- Facilitation of problem-solving and communication between families and school staff.
- Leadership and coordination of student services personnel throughout the school district.
- Student records.
- Student accounting and attendance.
- Student discipline, including all matters of exclusion, suspension, expulsion and mandatory reassignment of students.
- Student services reporting to agencies of county, state and federal government.
- Liaison with community agencies in dealing with student health and welfare.
- Enforcement of laws dealing with student attendance and delinquency.
- Student transfers.
- Health services.
- Counseling and social worker services.
- Crisis response.
- Student admissions.
- Safety and security.

*Student Services asked for feedback from LPS teachers, counselors, and administrators regarding the current practices of the child welfare system in the State of Nebraska.

KVC Issues:

1. **Communication:** When the school staff needs to contact a KVC worker the information is frequently not current. Even foster parents and the students comment they don't know whom to contact. One building responded that a student who had a truancy case last year is already skipping classes and the person they were told to contact no longer works for KVC but nobody informed the school or the foster parents that the person no longer worked for KVC. A high school counselor reported that it was two weeks before a phone call was returned even after contacting the supervisor. Staff is not sure who to call if a KVC worker is not available/no longer employed with KVC or their mailbox for phone messages is full. The same issue existed with HHS so lack of communication is not a new issue for schools.

2. **Lack of Information:** KVC workers do not always have current information for the schools about a student's academic, social or personal needs. This is especially a problem for students who are new to LPS. There is not a clear idea in the schools regarding the information the schools can expect to receive or ask for regarding students who are State Wards. KVC workers come to the buildings without release of information forms or they are incorrectly filled out. KVC workers also experience difficulty in getting information from the HHS guardian and there are frequently delays in communication from the legal system as well. Some of the school social workers reported that they sometimes get the feeling from the

KVC workers that instead of being part of a team in the community to help the family, they join the family in being a bit adversarial with the staff/school. This issue was primarily a concern expressed by school counselors, social workers and elementary staff.

3. **Expectations:** Staff, students and parents commented that they are frequently confused about the role of the KVC worker and the role of the HHS guardian and sometimes it is unknown if parents have educational rights or if they have been terminated. Certain documents need to be signed by a legal guardian such as some college applications, etc. Foster parents of high school age students are not always given guidance. Students in the Juvenile Justice System are often not held accountable in a timely fashion when they are not following the expectations that were set forth from the legal system.

ADDITIONAL ISSUES:

1. **Support Services:** Students and families don't always receive support services right away and support services are not always clearly communicated with students, families and/or the school buildings. Students with chronic attendance issues are not monitored and it is unclear as to what support schools will get if they continue to refer students who are absent and what the consequences are for these students. Schools would like to form more of a partnership with OJS and HHS regarding attendance issues. KVC was providing a worker and tracker at each of the high schools but schools report that the KVC staff members are not following up on students or changes in staff have hindered this process.
2. **Partnerships:** Schools, especially elementary schools, would like all stakeholders to be active in the Student Assistance Process and the Special Education IEP process. The KVC workers are more apt to attend the meetings at the schools and HHS workers rarely attend. Schools now hear from some HHS guardians that they should not be contacted or asked to attend meetings.
3. **Mental Health Support:** Many of the students and/or family members are struggling with mental health issues. Schools report feeling that they are not equipped or staffed to deal with these issues yet many students in the State system do not receive adequate services or extended aftercare support. Parents or guardians often do not follow up with medications or services. The aftercare services provided for students and families are inconsistent and these are the students that school staff report need more support than they currently receive.
4. **Other:** School staff report that more students are remaining with families which was seen as a positive as well as a concern when it involves abuse or neglect cases. School social workers and counselors feel that there is not a sense of urgency to help secondary students which in turn can greatly affect student attendance, academic performance and whether or not these students remain in school. Middle school and high school staff stated that it takes too long to get students help who are in abuse situations at the secondary level. The "burden of proof" placed on students often deters them from reporting issues. School staff at the secondary level commented that there is sometimes a lack of concern when abuse issues are reported by school staff especially if a student is over the age of 16.
5. **Information:** School staff all reported there is a lack of communication from all of the stakeholders and teachers reported feeling like they are not informed or comfortable with the current system and they are unsure of how to follow up with concerns they have for students who are State Wards and/or involved in the Juvenile Justice System. Creating a better communication system with fewer layers of bureaucracy would benefit the students as well as creating more of a partnership between the student welfare system and Lincoln Public Schools would in turn help school staff better serve the identified students and families.

Good morning. My name is Gregg Nicklas. I am a Co-CEO of Christian Heritage; a non-profit, faith-based, COA accredited organization founded in 1980. We currently have over 100 foster families serving approximately 130 children daily out of offices in Lincoln, Omaha and Kearney.

Let me begin by thanking each of you for taking the time to listen to the testimony being presented today. We sincerely appreciate your efforts to convene, to listen and to gather the facts. We trust that you will then take the necessary steps to assist in assuring the success of Nebraska's Child Welfare Reform.

I would like to encourage three specific steps of action:

First, will you please encourage the Department to assume the "moral" if not legal responsibility of paying providers who had sub-contracts with Boys and Girls Home? (And by paying, I am asking for 100 cents on the dollar.) I represent an organization that is owed $118,937.50 for foster care services provided in August and September of 2010. We paid our foster parents 100% of what they were owed yet the Department has asked us to accept $.35 on the dollar. We pay our foster parents an average of 44% of what we receive. Accepting $.35 would not even cover what we have paid to our foster parents.

In the event that you are unsuccessful in your efforts to "encourage" the Department to compensate foster parents and providers what we are owed for the provision of services to children who are wards of the state, would you please take the bold and courageous step of introducing legislation to assure we are paid? Doing so will not only lessen the financial burden placed on those of us who provided these services; in addition, I believe you will also be taking a significant step in restoring the confidence of Nebraskans in our state system.

Second, I would like to ask you to encourage the Department to RETURN their FC Pay scale, to the level that was in place PRIOR TO their contract with Boys and Girls Home. This scale determines the rate providers are reimbursed for foster care and in turn the amount foster parents receive.

On two occasions I met with the Director of the Children and Family Services Division to convey our concerns about the lowering of payments. Our revenue for the Central Service Area alone dropped $13,000 the first month following the Department's re-assuming the contract after the Boys and Girls contract ended. On both occasions I was told "You are the only provider expressing concern over this issue."

Finally, will you please assure that the lead agencies have adequate funding to cover not only the mandatory contractual requirements but also sufficient funding for providers and foster parents? When lead agencies are under financial duress and when contracts have been terminated, the repercussions have been traumatic; for providers, foster parents and in many cases, the children and families we are serving.

In summary, I am requesting:

1. Payment from the Department to providers and foster parents who served children and families under sub-contract with Boys and Girls. Payment at the rate of 100 cents on the dollar; and if the Department is unwilling to fulfill this obligation, I am requesting that you introduce legislation to assure we are paid.

2. Secondly, I am requesting the Department to RETURN their FC Pay scale, to the level that was in place PRIOR TO their contract with Boys and Girls Home.

3. And finally that the lead agencies have adequate funding to cover not only the mandatory contractual requirements but also sufficient funding for providers and foster parents?

Thank you for your time, your consideration and your courage in taking the necessary steps to assure the success of the reform through competent decision making, adequate funding and reimbursing those who have made sacrifices and provided services with declining compensation.

Families Restored,
Children Filled with Hope
and Prepared for Life.

COPY

December 1, 2010

Mr. Todd Reckling, Director
Division of Children and Family Services
Nebraska Department of Health and Human Services
P. O. Box 95206
Lincoln, NE 68509

Dear Todd:

On behalf of our organization and the children and families we serve I want to thank you for the leadership you are providing for the Department through this difficult transition. We stand with you in believing the improved outcomes will prove to be worthy of the sacrifices of so many. Leadership during these difficult days is not for the fainthearted.

I am writing to request the opportunity of meeting with you. There are two specific items I would like to discuss:

- The termination of the contract with the previous lead agency in Central Nebraska leaves us with receivables for foster care services provided during August and September in the amount of $118,937.50.

  We were pleased to learn the department has withheld a final payment of $1.2 million until an agreement can be entered to direct these funds to providers. However, there is little doubt these funds will be inadequate to cover the amount owed. A number of agencies are considering engaging the services of attorneys to pursue the funds owed; I would prefer not to pursue this course of action. The question I have of you, Todd, is *where does this leave us?*

- Secondly, shortly after the news broke of the termination of the contract with the lead agency in the Central Service Area, I received a telephone call from Charlie Ponec, a representative of the Department in Grand Island. Charlie called to reassure us that the Department would pick up the responsibility of paying us effective October 1st. He indicated contracts would be drafted and forwarded to us. I asked specifically about rates and Mr. Ponec indicated the rates would return to the previous rates paid by the Department.

  When we received the contracts from the Department, the *dollar numbers* in the contract were virtually the same, however, *the FC Pay schedule had been dramatically increased*, which reduces rates. The rates provided through the contract, because of the scale, are **less** than we received from the previous lead agency. Please see the following:

	Boys and Girls Home (per diem and scale)	DHHS (per diem and scale)
Tier 3	$69/day for scores 41+	$69/day for scores 50+
Tier 2	$43/day for scores 28 – 40	$43/day for scores 25-49
Tier 1	$30/day for scores 0 – 27	$32/day for scores 0 – 24

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Would you please match Boys and Girls Home's scale or reestablish the Department's former rate of $69/day @ 42+ on the FC Pay scale?

Many of us conveyed our displeasure of the rates/scales set forth in the contract by the Department. I was informed "They can be readjusted when renewed next October." I found this unlikely and believe communicating with you to be the most likely means of having this issue addressed.

You may wonder if the difference between a score of between 41 and 50 really makes that much difference. Certainly the children at the low end of the scale are not impacted; it is the more difficult behaviors, the older adolescents and our ability to recruit homes for the most difficult youth to place. We have projected an annual loss of $70,000 on the 40 children and youth we serve in the central Service Area for 2011.

Todd, we realize your plate is overflowing and sometimes I wonder if you are ever able to spend time with your family. We are asking for your help with two issues that are HUGE for us. This year we celebrated our 30th Anniversary. Thirty years of working in partnership with the Department and on October 15th received our COA accreditation. We are striving to position ourselves to be valued partners for generations to come. We need your help.

Thank you for your time, Todd. I will contact your office early next week to set a mutually convenient time to meet.

Sincerely yours,

Gregg Nicklas

CC: Mr. Kerry Winterer
Sen. Kathy Campbell

Families Restored,
Children Filled with Hope
and Prepared for Life.

COPY

December 7, 2010

Mr. Todd Reckling, Director
Division of Children and Family Services
Nebraska Department of Health and Human Services
P. O. Box 95206
Lincoln, NE 68509

Dear Todd:

In the letter I sent to you last week pertaining to our concern over the changes in the FC pay scale, reflected in the new contracts for foster care, I wrote, "We have projected an annual loss of $70,000 on the 40 children and youth we serve in the Central Service Area for 2011."

I have since received and reviewed the authorizations for every child/youth placed with us and I was wrong. The annual loss will be **$156,240.** ***More than twice what we had projected.***

Again, we were informed by personnel in the Central Service Area the first of October that the rates would revert to what the Department paid prior to the Boys and Girls Home contracts. They rates did NOT revert. The rates did not remain what they were with Boys and Girls, they have dropped significantly. And what a blow!

Todd, we need your help to address this issue. Can you please return the scale to the previous levels?

Here are the facts pertaining to the 39 children we served under contract with the Department during the month of November:

a. 13 were dropped from Tier 3 to Tier 2
b. 2 were dropped from Tier 3 to Tier 1
c. 2 were dropped from Tier 2 to Tier 1
d. 4 remained at Tier 3
e. 1 remained at Tier 2
f. 3 remained at Tier 1
g. 2 were placed with us during November at Tier 2
h. 1 entered as an emergency placement
i. 3 were changed from Emergency to Tier 3
j. 2 were changed from Emergency to Tier 2
k. 6 were changed from Emergency to Tier 1

Todd, 17 of the 25 children placed with us at Tier 1, 2, or 3 at the beginning of November, were dropped **at least one level.** This represents 68% of the children in care being dropped. Two of the children were dropped two levels.

When children drop a Tier, it not only impacts our revenue, it lowers the payment received by foster parents. At a time when quality foster parents are so vital to the success of the reform it is not prudent to require them to accept less, which also makes recruitment of new families more difficult.

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The financial implications are as follow:

a. 13 dropped from Tier 3 ($69/day) to Tier 2 ($43/day)
   This represents a decrease of $26/day x 30 days x 13 children = $10,140/month.
   This represents $121,680 annually.
b. 2 dropped from Tier 3 ($69/day) to Tier 1 ($32/day)
   This represents a decrease of $37/day x 30 days x 2 children = $2,220/month.
   This represents $26,640 annually.
c. 2 dropped from Tier 2 ($43/day) to Tier 1 ($32/day)
   This represents a decrease of $11/day x 30 days x 2 children = $660/month.
   This represents $7,920 annually.

Again, the combined results of the change in the FC pay scale resulted in a monthly decrease of $13,020 or $156,240 annually.

How do you expect nonprofits to offset such losses?

We have eliminated two upper level management positions, have frozen salaries of all leadership positions, and have addressed every line-item in our budget. We have cut back on memberships, including my membership in CAFCON, and have virtually eliminated our advertising budget, even though we are committed to recruiting additional foster homes. We are asking our staff to do more and asking our donors to give more. We are seeking increased charitable giving through corporations and Nebraska foundations.

Yesterday when I spoke with a local foundation requesting funding to assist with the impact of Child Welfare Reform, their response was, "It's the Department of Health and Human Services' responsibility to fund the costs associated with foster care."

We are doing our best to hold the line, to actually reduce expenses, to raise funds and to continue our thirty-year commitment to caring for Nebraska's children.

Todd, please help us (and all the providers striving to serve Nebraska's children and families) by returning to your previous rates and scale ($69/day at a FC pay scale of 42+). Or match the rates and scale of Boys and Girls Home. Their rates were as follows:

	Boys and Girls Home (per diem and scale)	DHHS (per diem and scale)
Tier 3	$69/day for scores 41+	$69/day for scores 50+
Tier 2	$43/day for scores 28 – 40	$43/day for scores 25-49
Tier 1	$30/day for scores 0 – 27	$32/day for scores 0 – 24

Sincerely yours,

Gregg Nicklas

CC: Mr. Kerry Winterer
Sen. Kathy Campbell

Christian Heritage
Open Invoices - Boys & Girls Home
As of September 7, 2011

Date	Memo	Class	Aging	Open Balance
BOYS & GIRLS HOME				
08/31/2010	August 27-31, 2010 5 days @ $69.00; DOP: 08/27/2010	Central Foster Care:655 PFC	362	345.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:655 PFC	332	2,070.00
				2,415.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-17, 2010 17 days @ $65/day	Central Foster Care:CFC	362	1,105.00
08/31/2010	August 18-26, 2010 8 days @ $69.00; DOD: 08/26/2010	Central Foster Care:CFC	362	552.00
				1,657.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 30, 2010 30 Tier 2 Days @ $43.00	Central Foster Care:CFC	332	1,290.00
				3,429.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 30, 2010 30 Tier 1 days @ $30/day	Central Foster Care:CFC	332	900.00

LR 37 – Exhibit 15
9-7-11

Date	Memo	Class	Aging	Open Balance
				3,039.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 30-31, 2010 2 days @ $69.00; DOP: 08/30/2010	Central Foster Care:CFC	362	138.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				2,208.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:655 PFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:655 PFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:665 PFC	362	2,139.00
09/30/2010	September 1-8, 2010 7 Tier 3 days @ $69.00; DOD: 09/08/2010	Central Foster Care:665 PFC	332	483.00
				2,622.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
09/30/2010	September 16-30, 2010 15 Tier 3 days @ $69.00; DOP: 09/16/2010	Central Foster Care:655 PFC	332	1,035.00
				1,035.00

Date	Memo	Class	Aging	Open Balance
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-20, 2010 19 days @ $69.00; DOD: 08/20/2010	Central Foster Care:655 PFC	362	1,311.00
				1,311.00
08/31/2010	August 1-5, 2010 5 days @ $65/day	Central Foster Care:665 PFC	362	325.00
08/31/2010	August 6-31, 2010 26 days @ $69.00	Central Foster Care:665 PFC	362	1,794.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:665 PFC	332	2,070.00
				4,189.00
08/31/2010	August 23-24, 2010 1 days @ $69.00	Central Foster Care:CFC	362	69.00
				69.00
08/31/2010	August 24-31, 2010 8 days @ $69.00; DOP: 08/24/2010	Central Foster Care:655 PFC	362	552.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:655 PFC	332	2,070.00
				2,622.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
08/31/2010	August 1-13, 2010 12 Traditional @ $31/day; DOD: 08/13/2010	Central Foster Care:CFC	362	372.00
				372.00
08/31/2010	August 1-30, 2010 30 Agency days @ $69.00	Central Foster Care:665 PFC	362	2,139.00
				2,139.00
09/30/2010	September 23-30, 2010 8 Tier 3 days @ $69.00; DOP: 09/23/2010	Central Foster Care:665 PFC	332	552.00
				552.00
08/31/2010	August 1-10, 2010 9 days @ $69.00; DOD: 08/10/2010	Central Foster Care:CFC	362	621.00
				621.00

Date	Memo	Class	Aging	Open Balance
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00; DOP: 09/17/2010	Central Foster Care:CFC	332	966.00
				966.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
07/31/2010	July 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	393	2,139.00
09/30/2010	September 30, 2010 30 Tier 2 Days @ $43.00	Central Foster Care:CFC	332	1,290.00
				3,429.00
08/31/2010	August 13-31, 2010 19 days @ $69.00; DOP: 08/13/2010	Central Foster Care:CFC	362	1,311.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				3,381.00
09/30/2010	September 27-30, 2010 4 Tier 3 days @ $69.00; DOP: 09/27/2010	Central Foster Care:CFC	332	276.00
				276.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:655 PFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:655 PFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:665 PFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:665 PFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
09/30/2010	September 25-30, 2010 Agency Respite 6 Days @ $69/day	Central Foster Care:CFC	332	414.00
				414.00
09/30/2010	September 20-30, 2010 11 Tier 3 days @ $69.00; DOP: 09/20/2010	Central Foster Care:CFC	332	759.00
				759.00

Date	Memo	Class	Aging	Open Balance
09/30/2010	September 24-30, 2010 7 Tier 3 days @ $69.00; DOP: 09/24/2010	Central Foster Care:CFC	332	483.00
				483.00
09/30/2010	September 24-30, 2010 7 Tier 3 days @ $69.00; DOP: 09/24/2010	Central Foster Care:CFC	332	483.00
				483.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:655 PFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:655 PFC	332	2,070.00
				4,209.00
08/31/2010	August 1-31, 2010 31 days @ $69.00	Central Foster Care:CFC	362	2,139.00
09/30/2010	September 1-30, 2010 30 Tier 3 days @ $69.00	Central Foster Care:CFC	332	2,070.00
				4,209.00
09/30/2010	Respite September 14-16, 2010 Tier 3 days @ $30/day	Central Foster Care:CFC	332	90.00
				90.00
08/31/2010	August 5-31, 2010 27 days @ $69.00; DOP: 08/05/2010	Central Foster Care:CFC	362	1,863.00
09/30/2010	September 1-23, 2010 22 Tier 3 days @ $69.00; DOD: 09/22/2010	Central Foster Care:CFC	332	1,449.00
				3,312.00
07/31/2010	Mileage for Foster Parents	Central Foster Care:CFC	393	983.50
08/31/2010	Mileage for Foster Parents	Central Foster Care:CFC	362	319.00
				1,302.50
Total BOYS & GIRLS HOME				118,937.50
TOTAL				**118,937.50**

Wednesday, September 7, 2011

Re: LR 37, Testimony from Stephanie Jackson

My name is Stephanie Jackson, and on September 15, 2009, my daughter, Jasmine Jackson was taken from me by the Department of Health and Human Services and made a ward of the state due to my addiction to drugs and the situations I was putting her in due to that addiction. She was just 6 months old at that time.

No one who knew me while I was growing up would have ever imagined that I would have become an addict. I grew up in Papillion, in a strict, religious, military household, was in the National Honor Society and earned scholarships for music to both the University of Kansas and the University of Nebraska. I graduated UNL in 2005 and taught private flute and piano lessons for 14 years. I also mentored in schools and worked as a casual mail clerk at the downtown Lincoln Post Office for 8 years.

My life was great – so I thought--until my big brother, Bobby, was killed in a car accident by a drunk driver. To say that my brother was my best friend does not begin to cover how much he meant to me. I was devastated and lost. My life quickly unraveled, and eventually I turned to drugs, which provided a short respite from my grief. Despite a good upbringing and an education, I went from being a productive member of society to being an addict and committing crimes.

I deserved to have Jasmine taken from me in September, 2009. In retrospect, I'm glad that it happened, but it was nearly impossible to handle it at an already horrible time of my life. I spiraled down into even worse drug use.

I didn't even try to get Jasmine back for almost 9 months. I missed Family Court dates, and I couldn't visit her because I couldn't stay sober. I was in and out of jail for drug related offenses, and in March, 2010, the Department of Health and Human Services and Cedars tried to get me to enter treatment, but I turned it down.

However, **they never gave up on me.** When I was released from jail on April 30, 2010, I was a different woman…a woman on a mission to truly turn her life around and get my daughter back. Cedars (who had my case at that time) and DHHS were right there willing to help me in every way possible.

Here is a list of services that Cedars/KVC provided to my husband and me as of May 1, 2010:

--They set up visitation 4 days/week with drug testing before each visit and also on a random basis. The visitation was scheduled around my family's schedule, was flexible, and transportation was provided. The visitation time was gradually increased over time as our case progressed and eventually moved to our home in Lincoln instead of in Papillion where Jasmine had been living. We had excellent supervising workers, and the visits smoothly transitioned to monitored visits and overnights.

--They provided court approved substance abuse treatment at a facility that we could choose from, including Intensive Outpatient, Outpatient, and Aftercare as per the recommendations of our drug evaluations.

--They paid for us to take court approved parenting classes.

--They set me up with psychiatric support.

--They provided us with family counseling along with individual counseling.

--They even helped with stopping the child support orders when our daughter was returned home, and provided our family with summer-long family swimming passes to two pools of our choice.

I have to add that the first and probably the most important service that was provided to us was that KVC was always aware of the Family Court order, helped interpret it for us, and helped us accomplish each and every requirement.

We are currently participating in the aftercare services that KVC has offered to our family too. This includes counseling services and anything else that our family may need in order to continue our positive progress.

On August 22, 2011, our Family Court case was closed, and Jasmine was fully returned back to our care. There are a few things that became clear to me as we went through this whole process. At first I was confused about the role of the DHHS case worker vs. the KVC case worker. Over time it became clear to me that the DHHS worker rarely had time to return my phone calls and wasn't the person involved with the many various details of our case. The DHHS worker heavily relied on our KVC worker to be on top of everything and arrange everything. Cynthia Sobotka, who was our case manager with both Cedars and KVC always returned my calls. She was the person addressing all of our family's concerns and questions and making things happen. She was the person implementing every detail of the judge's order and helping us never lose sight of any aspect of that court order.

Here are some of my other observations as we worked our way through the process of getting our daughter back:

--Over the course of the 2 years our case was open, the judge's court order would change in little ways. For example, one order would require family counseling, and then the next order would not. There was some confusion about this and how to know which court order to follow. In general we always looked to the most recent court order, but we also did the requirements of the past court orders.

--I also noticed a big difference in various substance abuse treatment centers. One facility that I went to was excellent, but my aftercare had to be done through another facility, and it wasn't nearly as helpful. This made me wonder if there are any kind of statistics kept on these different court approved substance abuse treatments centers and their "success" rates. I have no idea if there is a way to compare and rate different treatment facilities, but in my opinion, it would be a good idea to do so. I would think that the state would have an interest in seeing how their money is being spent at each facility and how they vary from each other. This information may also be useful in what KVC recommends to different individuals too.

--My final concern has to do with caseloads. We were blessed to have some wonderful workers from Cedars and KVC involved with our case, and although they did an excellent job, it became apparent at times that their caseloads may have been too high. I hate to see people who seem to have a passion for what they are doing and truly helping families get burnt out and consider leaving their positions because they are overworked, not to mention that it would help the families currently in the system if the case managers could spend more time with each case, working with a smaller caseload.

In conclusion, our family was so blessed to have KVC help us bring our daughter home and get our case closed. Although neither my husband nor I started off cooperating

with the State to get our daughter back at first, **no one gave up on us.** They didn't judge us when we weren't initially doing the right things, although I'm sure that they were disappointed. They were patient with us, and when we were ready to do what was being asked of us, KVC was right there to help us every step of the way. I have no doubt that we would have been overwhelmed if our case manager didn't help us work through the process. KVC made a huge difference in our family's life. We are together today because of their help, and that means everything to me.

Sincerely,

Stephanie Jackson

338 S 28th Street

Lincoln, NE 68510

I promised this gentleman that I would distribute at next hearing

LR 37 – Exhibit 17
9-7-11

TRUELL, MURRAY & MASER M.G.

ATTORNEYS AT LAW

35

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Associates:
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August 3, 2011

Sen. Michael Gloor
District 35, Rm 1523
PO Box 6509
Lincoln, NE 68509

Re LR37

Dear Mike:

I regret I could not stay at the legislative hearing in Grand Island, but as you know an attorneys life is governed by the court calendar.

Before I start relating my concerns about child welfare in Nebraska, let me give you a little history of my experience. I am a co-chairman of the Mental Health Board for Hall County, holding that position since the untimely demise of our friend, John Brownell. I have shared the position with Rachel Daugherty approximately two years following my ascension to Chairman. I previously had been the substitute Chair for John. Rachel became my substitute and she and I with the agreement of Judge Livingston decided to work in an alternating basis. I have also been involved in the court juvenile system for thirty years. When I first started, DHHS had three case workers for Hall County. And one of them acted as manager. Needless to say that has mushroomed. We now have more managers than that.

I was fearful about the "privatization" of child protective services from the beginning. My fears were well founded after the agency started. On several occasions, court approved plans of treatment based upon the "caseworkers" recommendation, and approved by the immediate superior, could not be implemented because the caseworker had no authority to make such a recommendation even though approved by a supervisor. The problem was, that the caseworker had several supervisors. For the program to be approved it had to go through each one. The caseworkers ended up spending more time on the computer getting plans approved than they did with the kids they were to help. More than once, the needs of the child were denied because of a failure to clarify agency approval from all the supervisors.

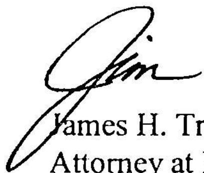
At the hearing you referred to "risk based" services. Obviously, from the discussion the risk was financial in nature, when the "risk" should be the child. Appropriate programs are denied due to cost, without giving the court, the caseworker or the child an alternative suggestion for treatment. The system has turned into a modern day *Oliver Twist*, with our children asking for "more please", and being deprived based upon corporate profit. Social equality cannot, as has been shown over and over again, be provided by the private sector. Government must provide social equality. If government wished to be in the position of *in loco parentis*, government should take the financial risk associated with being the parent. One does not expect the daycare provider to provide counseling services for a young child. Why should government expect an agency to shoulder a burden of unknown quantity. The funds available are limited, but by designated contract areas for specific amounts, different children with similar needs, can be treated differently because of the availability of funding. At least with a unified system, all our children will have the same opportunity, however great or small, available.

The system as adopted has, instead of helping our children, created several layers of management doing the same thing in different places and creating different results, even for the same child. Funds are not used to train the caseworkers, but equip offices and acquire personal property which has already existed within the governmental system. The turnover of caseworkers was staggering. In once recent case, within a period of five months, three case workers had been in place. Because the law requires a semi-annual review when a child is out of home, I had the opportunity of only meeting two of them. Such turnover again places our children at risk - not the agency. Why the turnover? Pay! The agency would not pay a living wage, and required caseworkers to work up to 60 hours per week, on a salary, not an hourly wage.

We are no longer losing our children when they fall through the cracks in being tracked. We are losing our children because the system cannot provide for them.

Thank you for your attention. Please feel free to share this with other members of the committee.

Very truly yours,



James H. Truell
Attorney at Law

JHT/sjl

Johnson, Diane

From: james holt [mentalhealth54@yahoo.com]
S nt: Wednesday, September 07, 2011 2:21 PM
To: Johnson, Diane
Cc: Melanie Williams; Theresa Barron-McKeagney
Subject: LB37 hearings

I was unable to give my testimony at the hearing on lb37 this date and it was suggested that I send in written testimony. I am a Licensed Independent Mental Health Therapist and I practice in Lincoln and Omaha. My first feelings of today's hearings was disappointment. I did not hear from any of the individuals giving verbal testimony about the role that the Therapist plays in the families and children that are being effected by the Privatization Reform. I see time and time again the lack of adequate clinical assessment from so called providers (HHS, KVC, NFC) that would, in fact, lessen the number of children being placed out of their families homes. When I hear that there are "safety concerns" from Casemanagers, I don't see a Safety Plan identifying the safety risks and, more importantly, what the solution is to reducing and/or eliminating the concern. As a Therapist, I don't get communication from the casemanagers regarding my treatment and when I do attempt to communicate with them, their follow through is less than adequate. Wrap around services would be a better solution in most cases that I experience, than taking the child or children out of the parent(s) home. Another concern that I will share is the children of color who are taken and placed in foster homes of another culture, specifically African American Children. I have nothing against Caucasian foster homes, except that when a child of color is taken and placed in a caucasian home, their knowledge of the cultural needs, in most, if not all cases that I have been involved in is lacking. The child's hair and skin is effected by the lack of the appropriate hygienic products. In addition, the child's story is different and is not respected. Let's face it, there are cultural differences between African Americans and White Anglo Saxons that need to be respected. Also, the extended family is many times not allowed contact with the child, which impacts the family system in a negative way. Finally, during the testimony today, I heard a "success" story from a mother who was "addicted" and her thoughts of KVC was very postive. While her experience may have been positive, I experience more families of color that the story is just the opposite. They are not given "time" to get their lives together. In fact, I have been told by parents that KVC and DHHS workers have discussed Termination of Parental Rights BEFORE REASONABLE EFFORTS have been tried. I think that it is shameful that a system that states their mission is to keep children and families together is doing just the opposite. Finally, I respect the Legislative Committee's attempt to better the system. The one observation that I left with today is, Where is diversity on the committee? I don't see it being representative of the system in which the problem lies. Please inform me on this, if you would please. I thank you for the opportunity to testify in any forum and request that I be put on the invited list for the Omaha hearing.

Thank you

James Holt, MSW,LCSW,LMHP, LIMHP