Nebraska Children's Commission

Twentieth Meeting
February 19, 2014
9:00 AM – 12:00 PM
Country Inn and Suites, Omaha Room
5353 N. 27th Street, Lincoln, NE

Call to Order
Karen Authier called the meeting to order at 9:03am and noted that the Open Meetings Act information was posted in the room as required by state law.

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

Commission Members absent: Janteice Holston, Martin Klein, and John Northrop.

Ex Officio Members present: Ellen Brokofsky, Hon. Linda Porter, Thomas Pristow, Julie Rogers, Vicky Weisz, and Kerry Winterer.

Ex Officio Members absent: Senator Kathy Campbell, Senator Colby Coash, and Senator Jeremy Nordquist.

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

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

Approval of January 22, 2014, Minutes
A motion was made by Candy Kennedy-Goergen to approve the minutes of the January 22, 2014, meeting as written. The motion to approve the minutes was seconded by Pam Allen. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Norman Langemach, Andrea Miller, Jennifer Nelson, David Newell, Mary Jo Pankoke, Becky Sorensen, and Susan Staab. Voting no: none. Gene Klein and Dale Shotkoski abstained. Janteice Holston, Martin Klein, and John Northrop were absent. Motion carried.

Chairperson's Report
Karen Authier provided a brief chair's report. Karen gave Commission members an update on the status of the Nebraska Children's Commission website and provided a brief overview of the items on the agenda for the day. Karen specifically highlighted information on legislation related to Alternative Response and the coordination with Senator Coash's office and the work that was done by the Community Ownership workgroup on Facilitated Conferencing. Karen concluded her remarks by noting that there would be time on the agenda to talk about the Phase II Strategic Plan Next Steps so that a tentative plan could be outlined.

Public Comment
There were no public attendees who wished to make comments.

Legislative Update
Bethany Connor provided Commission members with a list of Legislative Bills that might be of interest to or have impact on the work of the Commission. Bethany noted that the legislature was in the process of identifying priority bills. Bethany gave a brief overview on the progress of the bills related to Alternative Response (LB503), Guardianship (LB908), Lead Agency (LB660), and Facilitated Conferencing (LB1093). It was also noted that the clean-up bill for needed juvenile justice reform will be handled in LB464. A list of scheduled legislative hearings for the legislation of interest was also distributed.

Foster Care Reimbursement Rate Committee Report
Peg Harriott provided a written progress report on the work of the Foster Care Reimbursement Rate Committee. Peg noted that the committee had intended to bring recommendations and a more specific timeline for development of deliverables for implementation of rates by July 1, 2014, as agreed upon at the January Commission meeting. However, DHHS had provided an implementation plan and had arranged to have a consultant review the proposed foster care rates. Due to this development, the Foster Care Reimbursement Rate Committee decided to delay the process of finalizing recommendations. At Director Pristow's invitation, he representatives of the committee will meet with DHHS and the consultant on the rates. The meeting is scheduled for March. The committee hopes to have final recommendations after that meeting. Peg also noted that Sara Goscha had resigned her position at DHHS and that Thomas had indicated that Nanette Simons had been hired as Policy Administrator and should replace Sara on the Foster Care Reimbursement Rate Committee.

After Peg finished her report, Pam Allen made a motion to appoint Nanette Simons to the Foster Care Reimbursement Rate Committee to fill the DHHS position on the committee that was vacated due to Sara Goscha's resignation from DHHS. The motion was seconded by Candy Kennedy-Goergen. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Norman Langemach, Andrea Miller, Jennifer Nelson, David Newell, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab.

Voting no: none. Janteice Holston, Martin Klein, and John Northrop were absent. Motion carried.

IT Workgroup Report

David Newell provided a brief update on the IT Workgroup. David noted that the workgroup had been focusing on 3 main topics: 1) use of technology; 2) whole population measures; and 3) information sharing across agencies. Dave noted that the committee is made up of subject matter experts from various agencies and that at the February meeting a Department of Education representative was included in the discussions. The committee has continued to meet monthly and has a varied group of participants based on the agenda. The agenda for the next meeting of the committee will include the review of IT related legislation and the review of an IT white paper on other states.

Workforce Workgroup

Susan Staab gave a brief update on the workforce workgroup including handing out a one page document on the key workforce recommendations. Susan noted that she would be working with Bethany to do some additional research on these key recommendations and would have a more substantial document at a future Commission meeting.

System of Care Planning Grant Update

Sheri Dawson, Deputy Director, Division of Behavioral Health, provided an update on the DHHS Systems of Care Planning Project including a handout with key items from the planning process. Sheri noted that the most recent statewide stakeholder's meeting was attended by 200 stakeholders who want to be involved in the planning process. A readiness assessment was completed and is available on the DHHS website. The planning process has been split into several planning groups. The information from the planning process will be used to apply for a system of care grant. It was noted that several Commission members are participating in the planning process. Sheri has agreed to provide updates at future Children's Commission meeting so that the System of Care workgroup and the DHHS planning process can continue to align strategic planning recommendations.

DHHS Report

Thomas Pristow provided a brief update on the IV-E Waiver correction action plan and the work that is being done on Alternative Response (AR). Thomas indicated that DHHS is continuing to move forward on implementation of Results Based Accountability by July 1 and implementation of AR by October 1, 2014. DHHS is working closely with Senator Coash and other stakeholders to make sure these two programs are implemented properly since the programs are key to the IV-E waiver process. Thomas noted that DHHS is also working to implement the pilot program for the Level of Care Assessment for the foster care reimbursement rates and that he didn't have anything else to add to the report that was previously given by Peg Harriott.

Psychotropic Medication Committee Report
Thomas Pristow, Jennifer Nelson, and Candy Kennedy-Goergen provided information on a research proposal that would assess the state of Nebraska's prescribing practices of psychotropic medications to children and adolescents across various age groups and environmental areas of care. The research would specifically look at evaluating prescribing patterns by prescribers and the rate of psychotropic medications prescribed within the past decade. A copy of the research proposal from Hailey Kimball and Margo Lorimer was distributed to Commission members. Candy and Jennifer also indicated that they would like to work with Dr. Fromm from Magellan and the two researchers to enhance the research process. Candy and Jennifer indicated that they would work with the committee to establish a time to meet. It was also noted that Sara Goscha was a member of the Psychotropic Medication Committee and would need to be replaced by Nanette also.

A motion was made by Kim Hawekotte to have the Nebraska Children's Commission's Psychotropic Medication Committee begin meeting again to review the standardized statewide protocol and to provide guidance to the research proposal; that the membership of the committee should be expanded to include the Foster Care Review Office and the Child Welfare Inspector General since each office had data to contribute to the project; and that Nanette Simmons should be added to the committee membership to fill the position previously held by Sara Goscha. The motion was seconded by David Newell. Voting yes: Pam Allen, Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Kim Hawekotte, Gene Klein, Norman Langemach, Andrea Miller, Jennifer Nelson, David Newell, Mary Jo Pankoke, Dale Shotkoski, Becky Sorensen, and Susan Staab. Voting no: none. Janteice Holston, Martin Klein, and John Northrop were absent. Motion carried.

Phase II Strategic Plan Next Steps Discussion
Karen Authier and Beth Baxter led Commission members in a discussion about the next steps that needed to take place for each workgroup and committee to arrive at Phase II of the Strategic plan. It was noted that a lot of work had been done by each of the groups. The Commission members brainstormed ideas for what activities should take place next. The committee also had a brief discussion on whole population measures and the need to consider bringing Deb Burnight back to facilitate a meeting in May with an updated report being looked at in June. A suggestion was also made that the Commission consider moving meetings to every other month.

New Business
None.

Next Meeting Date
The next meeting is Tuesday, March 18, 2014, 9:00am-12:00pm. Information on the meeting location will be sent at a later date.

Adjourn
A motion was made by Kim Hawekotte to adjourn the meeting, seconded by Beth Baxter. The meeting adjourned at 12:03pm.

Board and Commission Vacancies
January - June 2014

January:
- Real Property Appraiser Board
- Commission for Deaf & Hard of Hearing
- Educational Telecommunications Commission
- Commission on Indian Affairs
- Coalition for Juvenile Justice
- NIFA - Nebraska Investment Finance Authority
- Police Standards Advisory Council
- Coordinating Commission on Postsecondary Education
- Power Review Board
- Public Employees Retirement Board
- Tax Equalization and Review Commission

February:
- Capital Facilities Planning Committee
- Board of Engineers & Architects

March:
- Aeronautics Commission
- Advisory Committee on Aging
- Conveyance Advisory Committee
- Foster Care Review Committee
- State Racing Commission
- Veterans Advisory Commission

April:
- Capitol Commission
- Capitol Environs Commission
- Historical Records Advisory Board
- Information Technology Commission
- Professional Practices Commission
- Racial Profiling Advisory Committee
- ServeNebraska/Volunteer Service Commission

May:
- Dry Bean Commission
- Governor's Residence Advisory Commission
- Commission on Latino-Americans
- Motor Vehicle Industry Licensing Board
- Board of Trustees – State College System

June:
- Accountability and Disclosure Commission
- Children's Commission
- Corn Development, Utilization & Marketing Board
- Commission on Housing and Homelessness
- Center for Nursing Board
- Commission on Problem Gambling
- Tourism Commission
- Wheat Development, Utilization & Marketing
- Women's Health Initiative Advisory Council

Your willingness to participate in state government by applying for appointment to a board or commission is appreciated. If you have questions about requirements for any of the boards or commissions listed please contact Kathleen Dolezal in my office at 402-471-1971.

Sincerely,
Dave Heineman
Governor

Questions contact:
Kathleen Dolezal
402-471-1971
Kathleen.dolezal@nebraska.gov
On-Line Application at:
http://www.governor.nebraska.gov/bc/board_comm.html

Nebraska Children's Commission
103rd Legislature 2nd Session List of Bills of Interest
As of March 17, 2014

Priority Bills

Document	Primary Introducer	Status	Description
LB464	Ashford	Select File	Change court jurisdiction over juveniles and indictment procedures.
LB728	Harms	Select File	Change provisions relating to criminal history record information checks for certain employees of the Division of Developmental Disabilities of the Department of Health and Human Services
LB834	Avery	Referral	Change provisions relating to funding for school breakfast programs
LB853	McGill	Select File	Change and rename the Young Adult Voluntary Services and Support Act
LB887	Campbell	Referral	Adopt the Wellness in Nebraska Act
LB901	McGill	Final Reading	Provide for psychology internships through the Behavioral Health Education Center
LB907	Ashford	General File	Provide for supervised release, reentry probation officers, create the Nebraska Center for Justice Research, and change presentence investigations and good time provisions
LB908	Coash	Referral	Change child guardianship, ward, and adoption for child out of wedlock provisions
LB920	Coash	Final Reading	Adopt the Public Guardianship Act
LB923	McGill	General File	Require training on suicide awareness and prevention for school personnel
LB943	Nordquist	General File	Change the minimum wage rate
LB967	Education Committee	E & R Initial	Change provisions relating to state aid to schools and funding for early childhood education programs
LB972	Lautenbaugh	Referral	Adopt the Independent Public Schools Act
LB974	Mello	Select File	Provide duties for certain divisions of the Department of Health and Human Services relating to budgeting and strategic planning
LB999	Ashford	General File	Adopt the Criminal Justice Reentry and Data Act and create the Reentry Programming Board
LB1028	Coash	General File	Change the number of judges of the separate juvenile court as prescribed
LB1103	Education Committee	E & R Initial	Provide for a strategic planning process for education

Nebraska Children's Commission
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Non-Priority Bills

Document	Primary Introducer	Status	Description
LB143	Bloomfield	Indefinitely Postponed	Authorize schools to adopt a child sexual abuse policy as prescribed
LB689	Bolz	Referral	Appropriate funds to the Department of Health and Human Services
LB691	Bolz	Referral	Increase a child and dependent care tax credit
LB694	Seiler	General File	Change provisions relating to unlawful possession of a firearm at a school
LB705	Coash	General File	Change personal needs allowance under medicaid
LB706	Harr	Referral	Change provisions relating to sexual assault, child abuse, sexually explicit conduct, and child pornography and to provide for forfeiture of property as prescribed
LB707	Conrad	Referral	Change provisions and procedures relating to sexual assault, stalking, domestic assault, and use of an electronic communication device and to create the offense of harassment
LB708	Kintner	Referral	Exempt social security benefits from state income taxation
LB724	Lautenbaugh	Referral	Change provisions relating to unlawful possession of a firearm at a school
LB729	Kolowski	Referral	Create the Task Force on Expanded Learning Opportunities for School-Age Youth
LB730	Kolowski	Referral	Change reporting provisions under the Child Protection Act
LB732	Kolowski	General File	Change asset limitation for certain programs of public assistance
LB748	Avery	Referral	Change paternity provisions for a child conceived as a result of sexual assault
LB754	Smith	Referral	Provide funds for career education programs
LB763	Janssen	Indefinitely Postponed	Require reports from state agencies on inefficient programs
LB782	Lathrop	General File	Establish a return-to-learn protocol for students who have sustained a concussion
LB790	Howard	General File	Require training for case managers as prescribed
LB822	Lautenbaugh	Referral	Change provisions relating to sexual assault of a child in the second and third degree

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As of March 17, 2014

LB826	McCoy	Referral	Provide for a study relating to education incentives for high-need occupations
LB860	Nordquist	Referral	Adopt health insurance requirements relating to dollar limits, rescissions, preexisting conditions, and dependents
LB861	Karpisek	General File	Prohibit use and distribution of vapor products and other products derived from tobacco as prescribed and provide an exception and provide penalties
LB864	Mello	Referral	Allocate funds to the Early Childhood Education Grant Program
LB872	Kolowski	General File	Create the position of state school security director and provide duties
LB877	Harr	Referral	Change provisions relating to use of a deadly weapon to commit a felony
LB879	Christensen	Referral	Provide for a permit to carry a concealed handgun in a school
LB898	Legislative Performance Audit Committee	General File	Require reports for public benefit programs delivery system
LB919	Mello	Referral	Create the Open Data Advisory Board
LB928	State-Tribal Relations Committee	Referral	Change provisions of the Nebraska Indian Child Welfare Act
LB931	Bolz	General File	Adopt the Nebraska Mental Health First Aid Training Act
LB933	McGill	General File	Change provisions and define and redefine terms relating to labor trafficking and sex trafficking
LB934	McGill	Referral	Establish the position of Coordinator of Human Trafficking Prevention and provide duties
LB936	Bolz	Referral	Create and provide duties for the State Ward Permanency Pilot Project
LB944	Bolz	Referral	State intent relating to funding for early childhood services
LB947	Lathrop	Referral	Change the minimum wage for persons compensated by way of gratuities
LB952	Lautenbaugh	Referral	Adopt the Working to Improve Nebraska Schools Act
LB955	Dubas	Referral	Adopt the Paid Family Medical Leave Act
LB958	Cook	Referral	Provide for appointment of a student achievement coordinator
LB966	Davis	Referral	Change provisions relating to the averaging

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			adjustment in the state aid to schools formula
LB969	Sullivan	Referral	Change a limitation on appropriations for special education programs and support services
LB984	Sullivan	Referral	Change allocations from the Education Innovation Fund
LB992	Howard	Referral	Create the Early Childhood Data Governing Body
LB1000	Karpisek	Referral	Change provisions relating to parenting plans
LB1009	Haar	Referral	Establish a pilot program relating to problem-based learning
LB1021	Seiler	Referral	Change provisions relating to the sealing of records of a juvenile
LB1026	Bolz	Referral	Create and provide for a Nebraska Educational Trust Fund
LB1034	McGill	Referral	Change provisions and penalties relating to unlawful intrusion
LB1051	Howard	Referral	Adopt the Public Health Leadership and Development Act and appropriate funds to the Board of Regents of the University of Nebraska
LB1059	Lautenbaugh	Indefinitely Postponed	Change membership of learning community coordinating councils
LB1063	Lautenbaugh	Referral	Require juvenile court approval to obtain a juvenile court proceeding transcript
LB1064	Lautenbaugh	Referral	Adopt the Teach for Nebraska Program Act
LB1068	Sullivan	Referral	Change provisions relating to learning communities
LB1069	Sullivan	Referral	Change provisions relating to education
LB1070	Sullivan	Referral	Change provisions relating to state aid to schools
LB1077	Sullivan	Referral	Adopt the Shared Responsibility for Access and Success Act
LB1083	Garrett	Referral	Change job training grant provisions relating to veterans
LB1088	Conrad	General File	Change income eligibility provisions relating to federal child care assistance
LB1090	Conrad	Referral	Adopt the Healthy Families and Workplaces Act
LB1093	Brasch	General File	Change provisions relating to juvenile facilitated conferencing and funding
LB1099	Haar	Referral	Provide for a study relating to state aid to schools
LB1106	McGill	Referral	Change provisions relating to career academies

The Nebraska
Foster Care Review Office
Quarterly Report

Submitted pursuant to Neb. Rev. Stat. §43-1303(4)

Issued March 15, 2014

This quarterly report is provided by the Foster Care Review Office pursuant to Neb. Rev. Statute §43-1303(4) to present relevant data and other information to policy makers and child welfare stakeholders in order to improve conditions for children in out-of-home care.

Executive Summary

The Foster Care Review Office's (FCRO) role under the Foster Care Review Act is to independently track children in out-of-home care, review children's cases, collect and analyze data related to the children, and make recommendations on conditions and outcomes for Nebraska's children in out-of-home care, including any needed corrective actions. The FCRO is an independent state agency, not affiliated with the Department of Health and Human Services, the Courts, or any other child welfare entity.

This quarterly report is provided pursuant to Neb. Rev. Statute §43-1303(4) to provide relevant data and other information to policy makers and child welfare stakeholders in order to improve conditions for children in out-of-home care. In addition to presenting a snapshot of all children in out-of-home care on December 31, 2013, the purpose of this report is to assess the extent to which data indicate that there are signs that the child welfare system is now stabilizing.

To do so, we present data for a specific cohort of youth; namely youth who entered out-of-home care for the first time in 2013. An analysis of this specific cohort of children is important because it more accurately reflects the current system without the effects of changes (such as lead agency changes) that occurred prior to this time. Data for this 2013 cohort are then compared to the cohort of youth who entered out-of-home care for the first time in 2011 and in 2012.

Data quoted within this quarterly update to the Legislature are derived from the Foster Care Review Office's independent tracking system. Per Neb. Rev. Statute §43-1303 DHHS (whether by direct staff or contractors), courts, and child-placing agencies are required to report to the Foster Care Review Office any child's foster care placement, as well as changes in the child's status (for example, placement changes and worker changes). By comparing information from multiple sources the Foster Care Review Office is able to identify discrepancies. When case files of children are reviewed, previously received information is verified and updated, and additional information is gathered. Prior to individual case review reports being issued, additional quality control steps are taken.

This Report features the following sections:

I. Analysis of All Children Who Entered Out-of-Home Care in 2013, with comparisons to 2011 and 2012.

II. Analysis of All Children in Out-of-Home Care on December 31, 2013.

Through an analysis of recent data the Foster Care Review Office has found the following positive trends:

- **There has been a reduction in the number of placement changes.**
  - 61% of the DHHS wards in care on December 31, 2013, have experienced only one or two placement changes, compared to 49% on December 31, 2012.
- **More children have had one worker, rather than multiple workers.**
  - 17% of the DHHS wards in out-of-home December 31, 2013, had only one worker, compared to 14% of those in care December 31, 2012, and 8% of those in care December 31, 2011.
- **Fewer children are in shelters.**
  - There were 24 children in a shelter on December 31, 2013, compared to 91 children on December 31, 2012.
- **The number of children in out-of-home care declined slightly.**
  - On December 31, 2013, there were 3,903 children in out-of-home care compared to 3,962 on December 31, 2012.

However, the FCRO has also identified the following areas needing improvement:

- **More children are entering care for the first time.**
  - More children entered care for the first time during 2013 (2,250) than during 2012 (1,993).
- **Length of time in out-of-home care remains an issue.**
  - DHHS wards in care on December 31, 2013, were in an out-of-home placement an average of 500 days during this current removal.
  - 42% of DHHS wards had been out of the home for over a year during this removal.
- **The rate of re-entry into out-of-home care needs to be reduced.**
  - Re-entry here is defined as whether the child had ever in their lifetime been in out-of-home care before. Using this measure, the re-entry rate for the state was 38%, which is consistent with prior years.
- **Too many children experience multiple placement changes.**
  - Statewide data shows that 40% of DHHS wards had 4 or more placements over their lifetime.

The following issues previously identified by the Foster Care Review Office and reported on in the March 2012 Quarterly Report still remain an issue:

- The current system of recording which caseworker or lead agency worker is assigned to a child is not consistently reliable. This impacts both the reporting of number of caseworker changes and caseload ratios.
- There needs to be a conduit for the FCRO to report to DHHS and/or NFC when we identify missing or inaccurate data on children's cases so data can be corrected quickly and to facilitate communication on data issues.
- There needs to be better use of automation, edits, and quality assurance reports in the DHHS system. This would improve accuracy and would flag omitted data elements for correction.
    - The recent due date report created for workers and supervisors is an important step in the right direction.

In addition, in early 2014 as more children and youth are being placed under the Office of Probation Administration, the FCRO has identified issues with the reports issued by Probation on the children under its program in out-of-home care. The FCRO is working with Probation to address these reporting issues, and commends its willingness to meet with the FCRO to address these issues.

Therefore, **the FCRO makes the following recommendations to the child welfare system**:

- Continue improvements to ensure that positive trends persist.
- Create collaboration with DHHS and private providers to determine why children are changing placements and what is needed to stabilize children's placements.
- Develop a plan to improve data systems.
- Complete a collaborative analysis of why youth are re-entering out-of-home care to determine next steps.
- Assure children age 13-18 and their families receive needed and age-appropriate services.
- Provide crisis stabilization services in three key areas: 1) as early intervention to prevent a child's removal from the home, 2) when youth transition home to maintain them safely in that home, and 3) to support foster homes and reduce placement disruptions.
- Complete a collaborative analysis of why time in out-of-home care is different across service areas. As part of this analysis, identify the factors that reduce time in out-of-home care.

Section I.
Analysis of All Children Who Entered Out-of-Home Care for First Time During 2013

Are there signs that Nebraska's child welfare system is stabilizing? To examine this we looked at children who entered care for the first time in 2013 and compared that to children who entered care for the first time in 2011 and in 2012.

These cohorts of youth do not include children who had been placed in out-of-home placement prior to January 1st of each year (in other words the 2013 cohort does not include any children who entered care during 2012) or children who were removed in these years but was their second or more removal to out-of-home care. An analysis of these specific cohorts of children is important since it more accurately reflects the current system without the effects of prior removals.

A. Data on Entry into Out-of-Home Care By Age of the Child

Children enter out-of-home (OOH) care for the first time at different rates based on their age at removal, as shown below. While the raw numbers have changed in comparison to 2011 and 2012, the percentages have remained consistent for all age groups. The percentages indicated below are the percent of the total children entering care for the first time during each respective calendar year.

Children Age 0-5

Children aged 0-5 comprised 39% of those who entered care for the first time, which is consistent with data from the past three years.

	Children Age 0-5 Entering OOH Care for the First Time		
	2011	**2012**	**2013**
First quarter (Jan-Mar)	254	210	183
Second quarter (Apr-June)	235	175	217
Third quarter (July-Sept)	263	173	231
Fourth Quarter (Oct-Dec)	242	208	238
Yearly total	**994 (38%)**	**766 (38%)**	**869 (39%)**

Children Age 6-12

Children aged 6-12 comprised 22% of those who entered care for the first time, which is consistent with data from the past three years.

	Children Age 6-12 Entering OOH Care for the First Time		
	2011	**2012**	**2013**
First quarter (Jan-Mar)	136	119	118
Second quarter (Apr-June)	138	81	123
Third quarter (July-Sept)	133	103	140
Fourth Quarter (Oct-Dec)	146	139	104
Yearly total	**553 (21%)**	**442 (23%)**	**485 (22%)**

Children Age 13-18

Children aged 13-18 comprised 39% of those who entered care for the first time, which is consistent with data from the past three years. Children in this age group may be removed from the home due to their own mental health or behavioral issues as well as issues with the care being provided by their parents.

	Children Age 13-18 Entering OOH Care for the First Time		
	2011	**2012**	**2013**
First quarter (Jan-Mar)	295	218	170
Second quarter (Apr-June)	227	210	227
Third quarter (July-Sept)	276	169	228
Fourth Quarter (Oct-Dec)	283	188	261
Yearly total	**1,081 (41%)**	**785 (39%)**	**886 (39%)**

B. Data on the Time of the Year That Children Enter Out-of-Home Care

Nationally, it is not unusual for more children to enter care during the third quarter of year (July-September), possibly due to the start of the school year and teachers reporting their observations of possible abuse. The fourth quarter of the year (October-December) can also be higher, with the numbers influenced by investigations of abuse allegations received in August-September being completed and parents reacting negatively to family stresses as the holidays near. Statistically this is not the case here in Nebraska.

The data in the chart below compares the number of children placed in out-of-home care for the first time during each quarter of the year, and compares 2011, 2012, and 2013. There was an **increase** in the number entering care for the first time in 2013 when compared to 2012. Due to the upward trend in the third and fourth quarter of 2013, the FCRO will closely monitor this data for the first quarter of 2014.

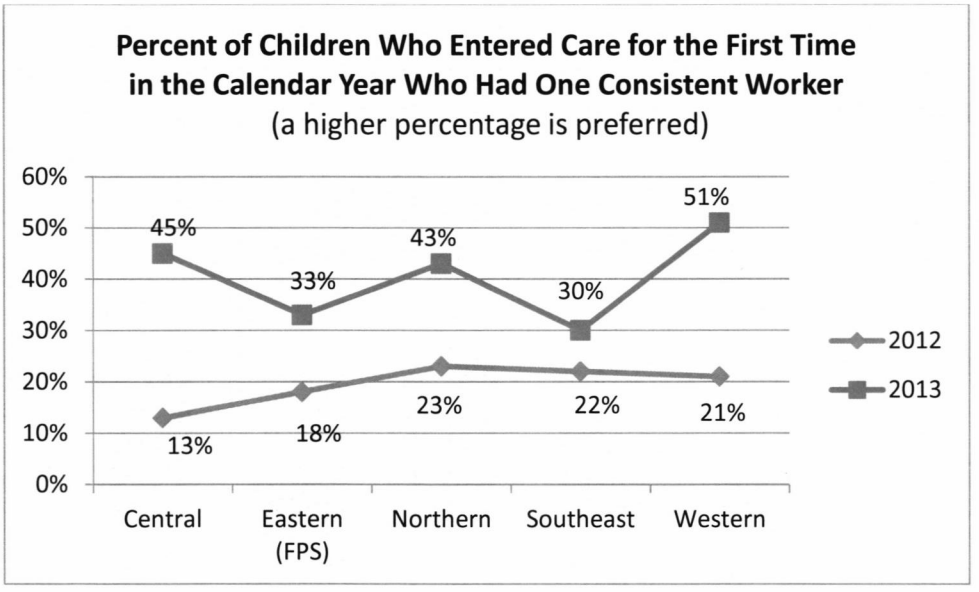
	Children of All Ages Entering OOH Care for the First Time		
	2011	**2012**	**2013**
First quarter (Jan-Mar)	682 (26%)	547(28%)	481(21%)
Second quarter (Apr-June)	600(23%)	466(23%)	567(25%)
Third quarter (July-Sept)	672(26%)	445(27%)	599(27%)
Fourth Quarter (Oct-Dec)	671(25%)	535(27%)	603(27%)
Yearly total	**2,625(100%)**	**1,993(100%)**	**2,250(100%)**

C. Data on Caseworker Changes for Children Removed in 2013

The Foster Care Review Office specifically analyzed caseworker changes for children entering out-of-home care for the first time in 2013 to better gauge current system functioning, since the transition of case management from/to lead agencies occurred prior to 2013. Caseworker stability is directly tied to better documentation and shorter lengths of stay in foster care.

The FCRO compared 2013 caseworker changes to the children who entered care for the first time during 2012. **There was a significant improvement in the percentage of children with one consistent worker.** There was also an improvement regarding the number of lifetime workers for all children in out-of-home care on December 31, 2013 (see page 17), with a number of changes impacting this outcome.

As this chart depicts, all of the Service Areas showed a marked improvement with major improvements in the Central and Western Service Areas.



We will continue to monitor this outcome measure. Historically, across the nation it has been the experience that the longer a child is placed out-of-home, the more caseworkers are likely to have been assigned to the child's case.

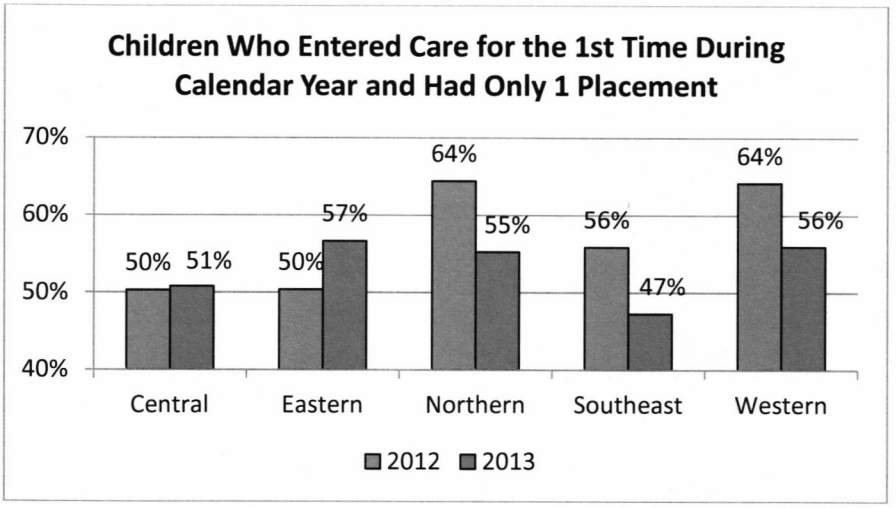
D. Data on Placement Changes for Children Removed in 2013

Nothing is more important to a child than where he or she lives. While some changes may be due to youth moving from more restrictive levels of care to more family like levels, any change in placements (foster homes, group homes, other living arrangements) can be traumatic and can impact the child's education. Many changes are also due to systemic issues.

The following chart details the number of placement changes for children who had entered care for the first time in 2013 and remained in out-of-home care on December 31, 2013. It is difficult to compare this data to the data for all children in out-of-home care on any particular date, as the longer children and youth are in out-of-home care the more likely it is that they will experience placement changes.

Placement Changes by Service Area For DHHS Wards Removed for the First Time in 2013 and Still in Care Dec. 31, 2013						
	Central	Eastern	Northern	Southeast	Western	Statewide
1 placement	51%	57%	55%	47%	56%	53%
2 placements	33%	28%	34%	35%	35%	32%
3 placements	11%	10%	7%	10%	8%	9%
4+ placements	6%	6%	4%	8%	1%	6%
	100%	100%	100%	100%	100%	100%

Compared to 2012, there has been an improvement in the percentage of children with one stable placement since entering out-of-home care in the Eastern service area. The central service area has seen little change. In the remaining service areas the percentage has decreased.



E. Where Children Go When They Leave Out-of-Home Care

We also determined whether children who entered care for the first time during 2013 had left out-of-home care, and if so, where did these children go. The majority of those children return to the parents (91% of those who leave out-of-home care).

Entered and Exited Out-of-Home Care in 2012		
When entered	**Left Care in 2012**	**Reunification with parents**
1st Qtr	296	260
2nd Qtr	213	199
3rd Qtr	154	140
4th Qtr	96	83
Total	**759**	**682 (90%)**

Entered and Exited Out-of-Home Care in 2013		
When entered	**Left care in 2013**	**Reunification with parents**
1st Qtr	264	239
2nd Qtr	269	255
3rd Qtr	217	184
4th Qtr	162	148
Total	**912**	**826 (91%)**

The fact that most children who are able to leave out-of-home care quickly are returned to their parents is important as we examine:

- How Nebraska may be able to prevent the initial removals from home,
- What services are needed by children in out-of-home care and their parents to address past traumas, and
- What types of supports are needed to ensure that reunifications are successful so that re-entries into out-of-home care are significantly reduced?

Section II.
Analysis of All Nebraska Children in Out-of-Home Care on December 31, 2013

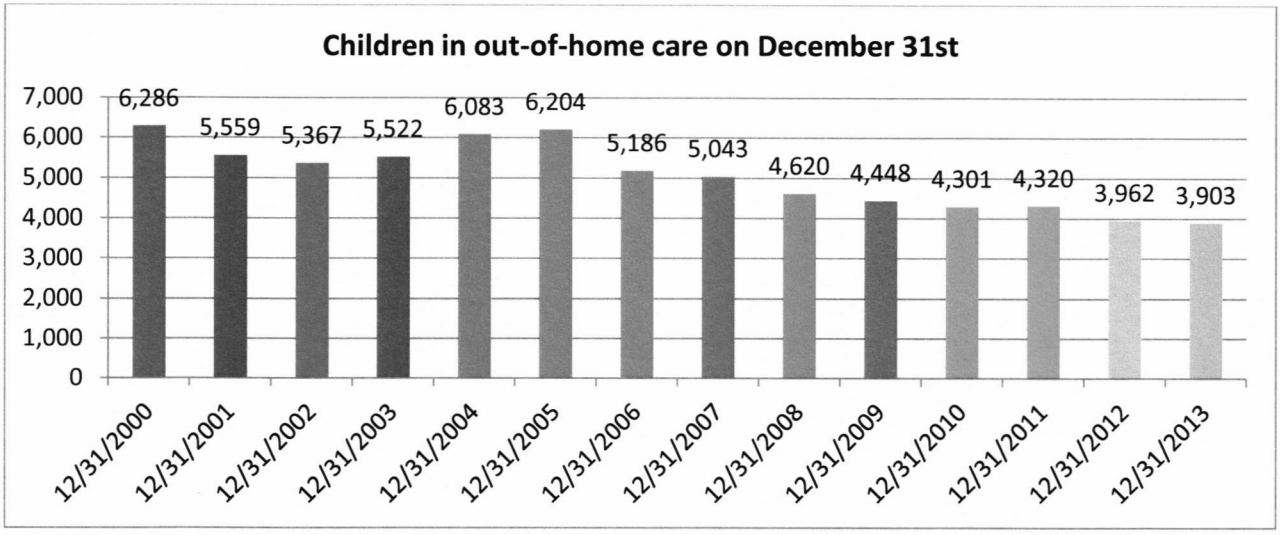
This section includes an analysis of **all** children (age 0-18) who were in out-of-home care (foster homes, group homes, specialized facilities) as of December 31, 2013. The data provided includes **all** children who were removed on or prior to December 31, 2013, and who had not left out-of-home care by that date.

Unless marked otherwise this population includes children under the Department of Health and Human Services (DHHS), the Office of Probation Administration, and those in detention centers as reported to the FCRO Independent Tracking System.

A. Trend Data

Trends - Children and Youth in Out-Of-Home Care

As shown in the following chart featuring point-in-time data, the number of children and youth in out-of-home care on December 31, 2013, declined slightly from the number in out-of-home care on December 31, 2012.[1]



More detailed analysis would assist in identifying needed services for those at risk of an out-of-home placement, in an out-of-home placement, and returning home from out-of-home care. For example, what services can be put in place to prevent removals? A number of children return home quite quickly, so rapidly as to lead to questions regarding whether that child should have been removed from the home in the first place. In addition, we find that many children are re-entering care. Children re-entering care and children entering care for the first time may need different types of services. We encourage readers to consider these types of questions while contemplating the data that follows.

[1] Source for all statistics: Foster Care Review Office Independent Tracking System.

Trends - Length of Time in Out-Of-Home Care and Placement Changes

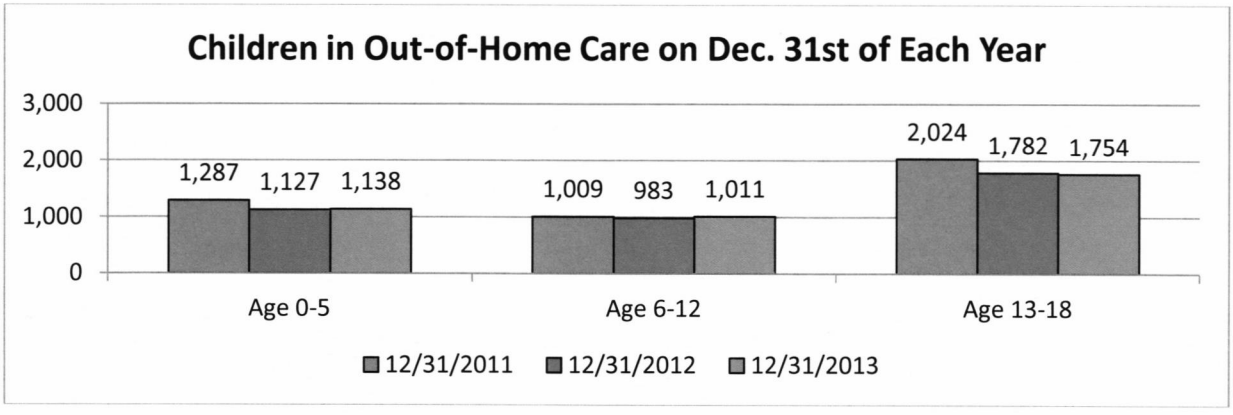
The average length of time children spend out-of-home is decreasing when compared to 2012, but increasing when compared to 2011.

Additional Statistics of Interest				
Category	**12/31/2011**	**12/31/2012**	**12/31/2013**	**Comments**
Children in out-of-home care on this date	4,320	3,892	3,903	*Children in out-of-home care on this particular date, not those in care throughout the calendar year.*
Average days children had been in out-of-home care (excluding prior removals) -- DHHS wards	459 days	515 days	500 days	*The 2013 figure does not include the time in care for youth who transferred to Probation during the last quarter of 2013.*
Median days in care (excluding prior removals) -- DHHS wards	Not available	353 days	319 days	*The 2013 figure does not include the time in care for youth who transferred to Probation during the last quarter of 2013.*
% of children with 4 or more lifetime placements – DHHS wards	46%	46%	40%	
% of children with 4 or more lifetime placements – Probation	Not available	Not available	33%	*Probation began limited reporting on youth in out-of-home placements in the fourth quarter of 2013.*

The age breakdowns of children in out-of-home care at the end of each calendar year since 2011 have remained consistent.

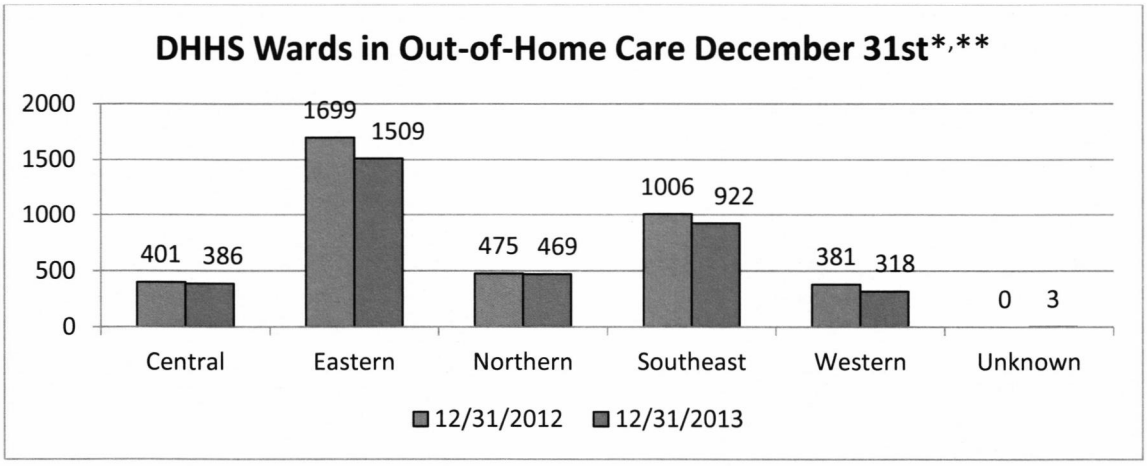
- Children of the Age 0-5 were 30%, 29%, and 29% in 2011, 2012, and 2013 respectively.
- Children of the Age 6-12 were 23%, 25%, and 26% 2011, 2012, and 2013 respectively.
- Children of the Age 13-18 was 47%, 46% and 45% 2011, 2012 and 2013 respectively.

The data clearly shows that whether children are under the care of DHHS or Probation, resources need to be developed and targeted for children in the 13-18 age group since they comprise the largest age group of children in out-of-home care, as shown below.



Trends - Out-Of-Home Care by Service Area

Children in out-of-home care come from every area of the state. The chart below shows the number of children from each DHHS Service Area. The percentage of children from each service area has been consistent. All charts in this document that contain a DHHS service area use the counties of each service area defined in LB 961 (2012). **The chart below does not include children and youth under the Probation Administration.**



*Throughout this document:

The Central Service Area includes Adams, Blaine, Boyd, Brown, Buffalo, Cherry, Custer, Franklin, Garfield, Greeley, Hall, Harlan, Holt, Howard, Kearney, Keya Paha, Loup, Phelps, Rock, Sherman, Valley, Webster, and Wheeler Counties.

The Eastern Service Area includes Douglas and Sarpy Counties.

The Northern Service area includes Antelope, Boone, Burt, Butler, Cedar, Colfax, Cuming, Dakota, Dixon, Dodge, Hamilton, Knox, Madison, Merrick, Nance, Pierce, Platte, Polk, Saunders, Seward, Stanton, Thurston, Washington, Wayne, and York Counties.

The Southeast Service area includes Cass, Clay, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Nuckolls, Otoe, Pawnee, Richardson, Saline, and Thayer Counties.

The Western Service Area includes: Arthur, Banner, Box Butte, Chase, Cheyenne, Dawes, Dawson, Deuel, Dundy, Frontier, Furnas, Garden, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Kimball, Lincoln, Logan, McPherson, Morrill, Perkins, Red Willow, Scotts Bluff, Sheridan, Sioux, and Thomas Counties.

**In the last quarter of 2013, some youth were transferred from DHHS-OJS to Probation. This chart only shows children and youth under DHHS custody as of December 31st of each year.

B. Data on Re-entry Rates

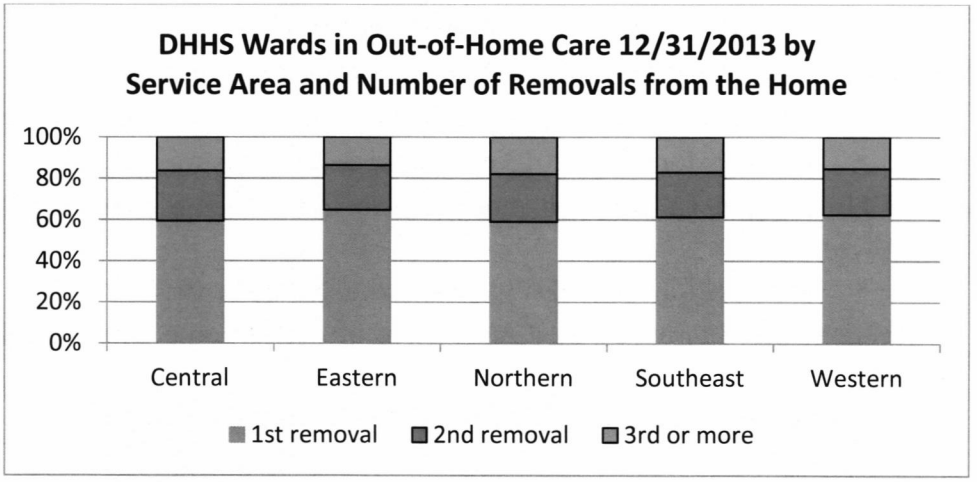
Next, we reviewed how many of the 3,903 children in out-of-home care on December 31, 2013, had previously been in out-of-home care. Every out-of-home entry can cause additional trauma for the child. There can be a number of reasons for re-entry, such as premature reunification, multiple mental health episodes, or the need for adolescents to develop appropriate coping mechanisms as they re-examine earlier abuse or neglect traumas from an adolescent perspective.

There are a number of different ways that re-entry can be measured. For example, some states measure this by how many children re-entered care during a set amount of months following a return to home. The number of months varies, with 6, 12, or 18 months being common. The Foster Care Review Office considered how to best measure re-entries. Because each additional entry into out-of-home care impacts the children regardless of the time span between returning home and re-entering care, the FCRO determined that it would consistently measure re-entries as any re-entry into care throughout a childhood. The following statistics use the FCRO's measure.

For **38% of the children** in out-of-home on December 31, 2013, **it was their second or more times placed in out-of-home care**. The data below shows that this issue is not new. More collaborative efforts are needed to determine the reasons for re-entry so as to avoid unnecessary repeat episodes of "in care."

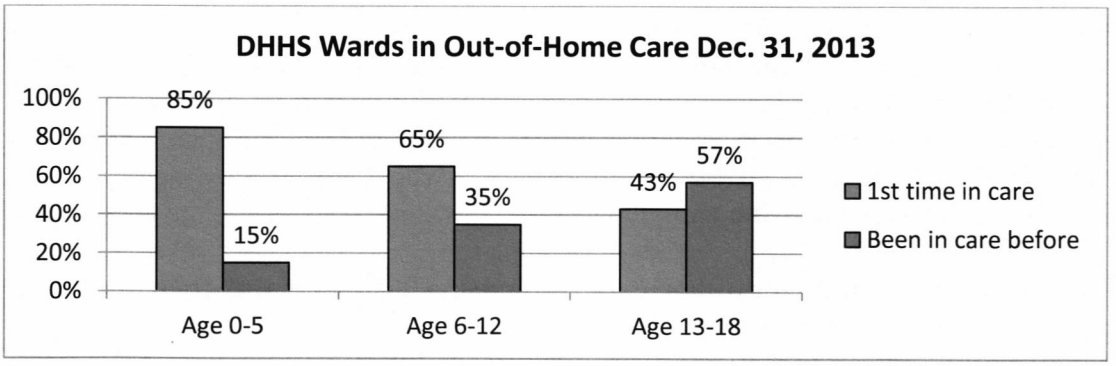
Statewide Percent of Children in Out of Home Care on Dec. 31st who had been in Out-of-Home Care Before					
2008	**2009**	**2010**	**2011**	**2012**	**2013**
40%	39%	39%	37%	38%	38%

Re-entries occur in each of the DHHS Service Areas. The chart that follows illustrates re-entries by geographic region and shows that children are re-entering out-of-home care at about the same rate in each of those regions. In the last quarter of 2013, some youth were transferred from DHHS-OJS to Probation. This chart only shows children and youth under DHHS custody as of December 31st.



Data on the chart below illustrates that **there are stark contrasts between the different age groups in terms of re-entry into out-of-home care**.

- It is positive that fewer very young children (0-5 age group) experience multiple removals.
- Youth age 13-18 are experiencing a higher re-entry rate, signaling the need to develop age appropriate services.
- The percentages in the chart below are statistically unchanged from 2012.



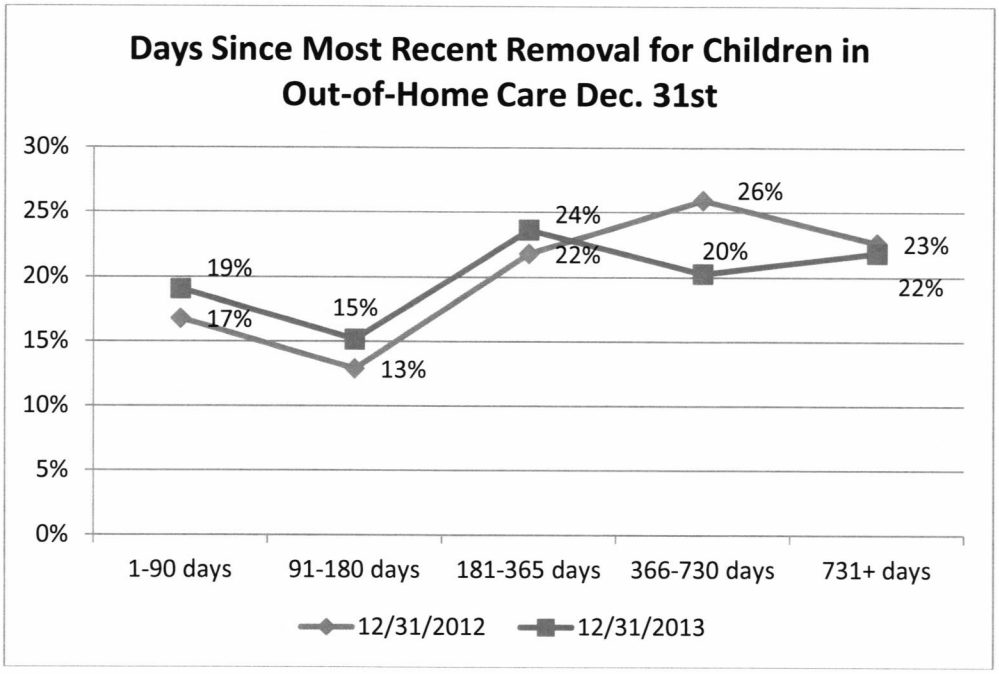
C. Data on Length of Time in Out-of-Home Care

The Foster Care Review Office analyzed length of time in out-of-home placements for youth who were out-of-home on December 31, 2013. We did not include the number of days in out-of-home placement for the 38% percent of children previously described who had been in out-of-home care more than once.

The data on number of days in care during most recent removal shows a "mixed-bag" regarding whether the system is showing signs of improvement.

- **Fewer children have been in out-of-home care for over a year**.
  - 42% of children in care on Dec. 31, 2013, had been in out-of-home care for over a year. This compares to 46% of those in care on Dec. 31, 2012.
- The average number of days varied significantly by the child's age group.
  - Children age 0-5 averaged **fewer** days in out-of-home care than the previous year.
    - 354 days for 12/31/2013 compared to 367 days for 12/31/2012.
  - Children age 6-12 averaged more days in out-of-home care than the previous year.
    - 548 days for 12/31/2013 compared to 508 days for 12/31/2012.
  - Children age 13-18 averaged more days in out-of-home care than the previous year.
    - 513 days for 12/31/2013 compared to 494 days for 12/31/2012.

Here is another way to compare the 2012 and 2013 data:



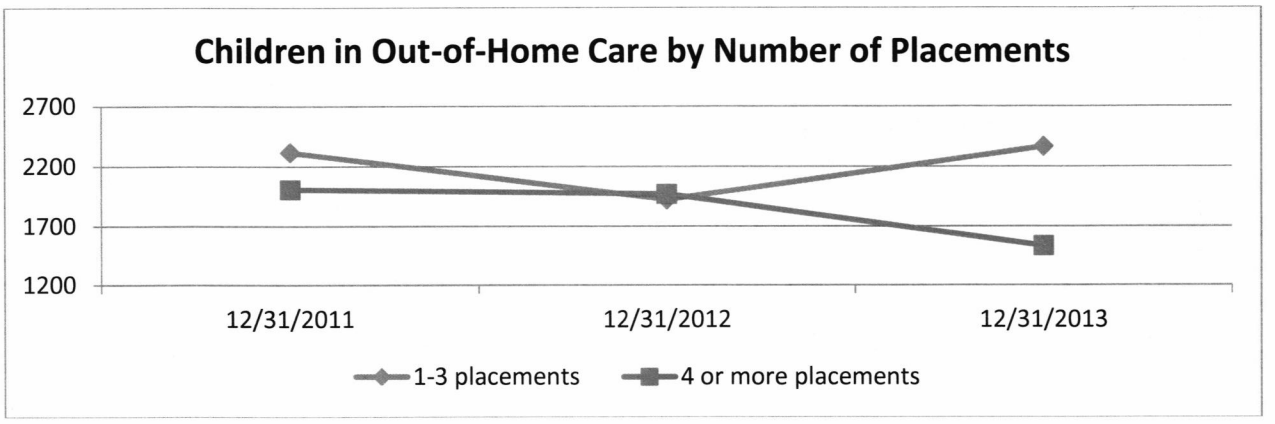
Even with some recent improvements, length of time in out-of-home care has been an issue for many years, and it continues to be an issue for many children and youth.

D. Data on the Number of Placements

Children may be moved between placements (foster homes, group homes, special facilities) while in out-of-home care. Moves might be a positive thing in the case of a youth who needed a high level of care when he/she first entered care and is now progressing toward less restrictive, more family like care. Often moves are due to issues within the system rather than children's needs. In some instances, the cumulative additional turmoil of changing who they live with can be temporarily or permanently harmful for children.

The following chart shows the 3,903 children in out-of-home care on December 31, 2013, by the number of placements they have experienced in their lifetime. This is compared to the population in care on December 31st of both 2011 (4,320) and 2012 (3,982).

The chart shows that there has been a **decrease in the number of lifetime placement changes** experienced for children in out-of-home care on December 31, 2013, when compared to prior years. **This is a positive development.**

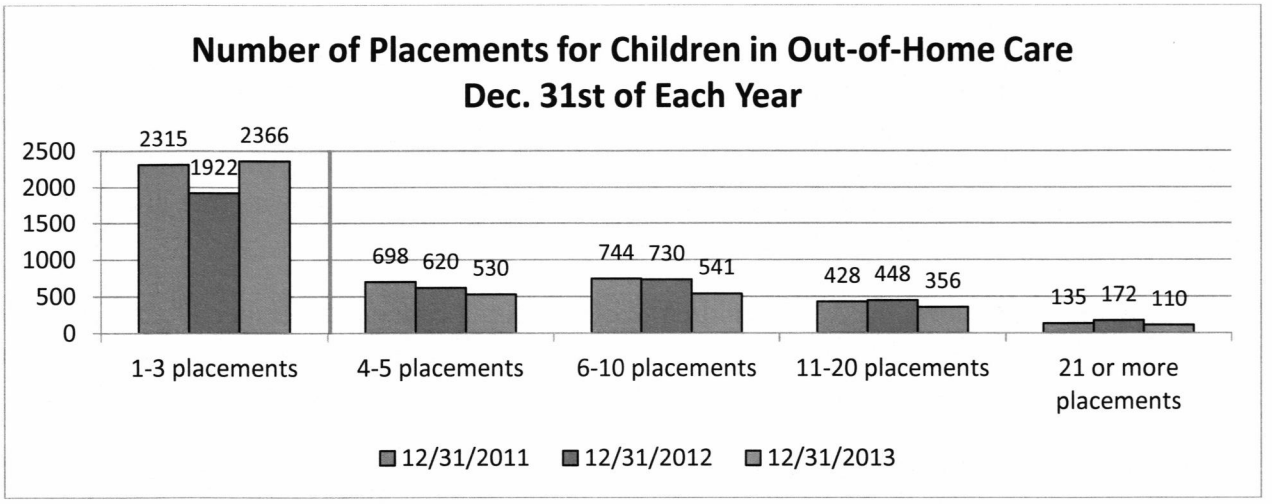


Also positively, there was a slight **increase** in the number of children having only one placement, and **decrease** in those with four or more placements.

As a reminder, national research suggests that children who are moved four or more times tend to have more significant mental health challenges as a result of continued instability in their lives.

- 11% of children ages 0-5 have been in four or more placements over their lifetime.
- 31% of children ages 6-12 have been in four or more placements over their lifetime.
- 61% of children ages 13-18 have been in four or more placements over their lifetime.

There are many children who have experienced multiple changes, as illustrated in the chart below. The vertical red line separates those with 4 or more placements, since experts have found that number of changes can be detrimental to many children.



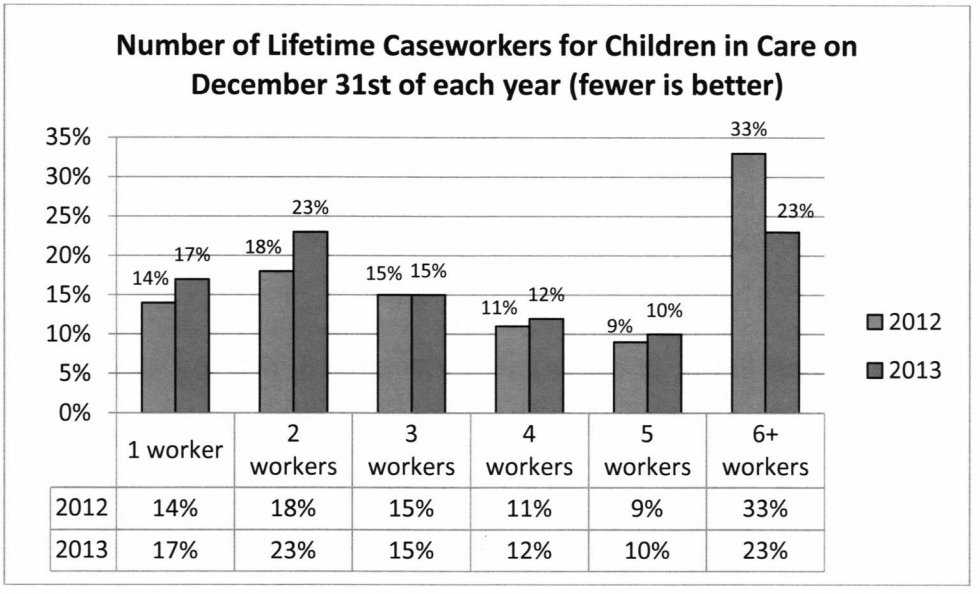
Analysis will continue each quarter to gauge improvements, and the Foster Care Review Office continues to advocate for children to experience placement stability.

E. Data on Caseworker Changes per Child

Some level of caseworker turnover is inevitable, but recent years have greatly increased the number of caseworker changes that children and families have experienced. Each change increases the likelihood of lost documentation and delays as caseworkers become familiar with the individual needs of those involved in each of their new cases. Therefore it is important to consider this data.

The following shows the lifetime number of caseworker changes (or FPS changes for the Eastern area) that DHHS wards in care on December 31, 2013, had experienced as reported by DHHS to the Foster Care Review Office.[2] This was compared to DHHS wards in out-of-home care on December 31, 2012. The charts in this section do not include youth under Probation, only DHHS wards.

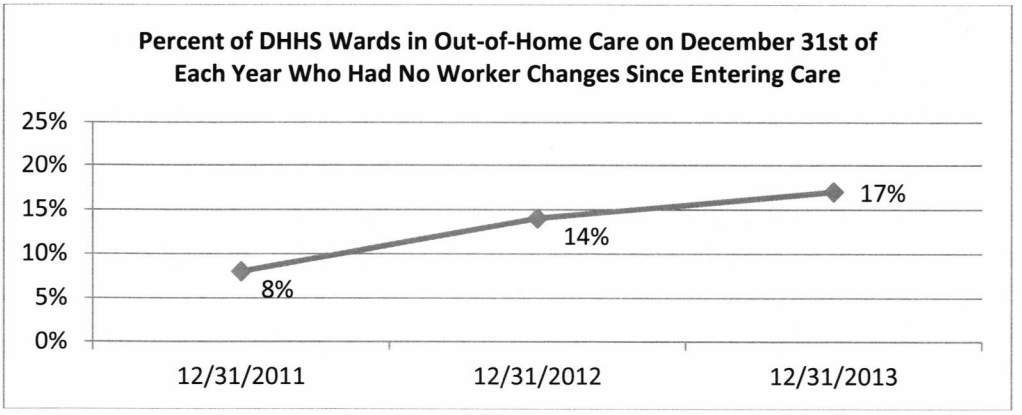
The percentage of children who have experienced caseworker stability has increased statewide, which is a positive thing. For example, 17% have had only one worker compared to 14% in the prior year.



	1 worker	2 workers	3 workers	4 workers	5 workers	6+ workers
2012	14%	18%	15%	11%	9%	33%
2013	17%	23%	15%	12%	10%	23%

[2] *Important consideration:* There are issues with how DHHS reports caseworker and FPS changes to the Foster Care Review Office. This information is generated by DHHS from their N-FOCUS system. There is no clear audit trail of case manager or FPS changes currently available on the N-FOCUS system. This leads to the concern of the potential inaccurate reporting of changes, either under or over. DHHS must create a cleaner, clearer audit trail on N-FOCUS or develop a manual process to properly report on this very important systems issue.

The next chart shows the improvements in cases with one worker consistently throughout the child's out-of-home care experience.

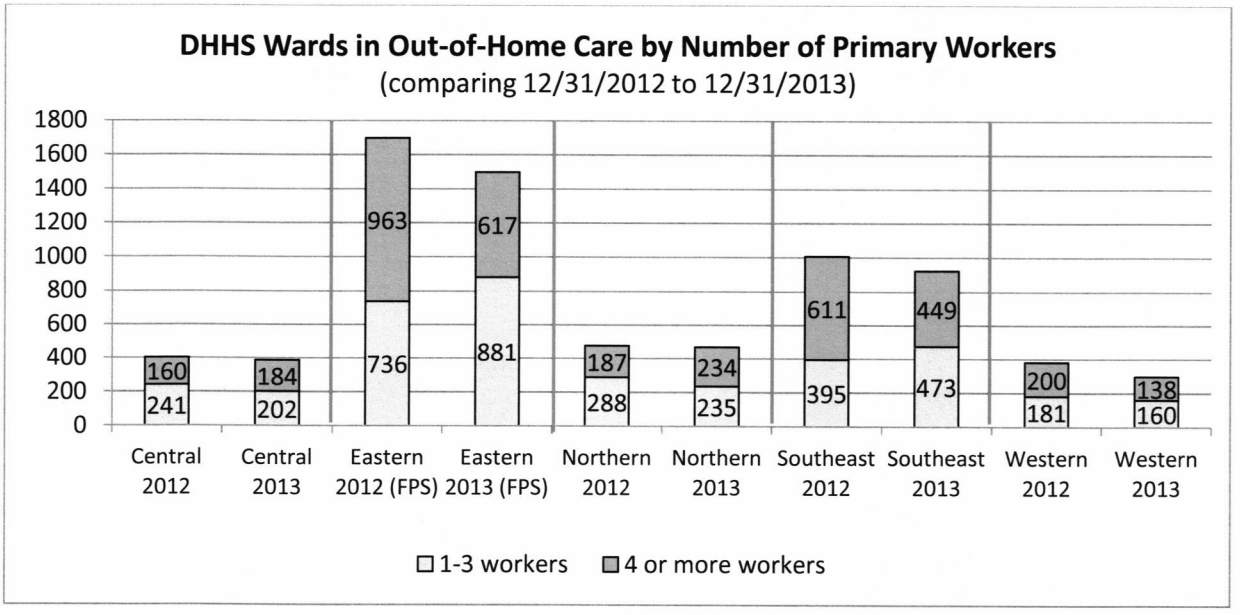


By service area

The data was then sorted by DHHS service area in order to determine if the improvements were isolated to a particular geographic area. The next chart includes both the number of children by worker changes and also the percent of the total cases for that service area. The category FPS (Family Permanency Specialist) change refers to changes in lead agency workers who serve as children's primary workers in the Eastern area of the state.

In the two most populous areas of the state there have been some marked improvements.

- In the Eastern area, last year only 43% had 1-3 workers, this year 58% had 1-3 workers.
- In the Southeast area, last year only 39% had 1-3 workers, this year 51% had 1-3 workers.



By age

Changes in persons with whom they interact can be more traumatic for younger children, so we also looked at the number of caseworker changes specifically for children under age six. **We found improvement in the number of children age 0-5 with one worker** (15% in 2012 and an increase to 20% in 2013), **and in the number of children age 0-5 with only two workers** (23% in 2012 and an increase to 33% in 2013).

Benefits of worker stability

Worker stability increases the likelihood of complete documentation of parental progress or lack thereof, which is important information that forms the evidence used by courts, DHHS, and other stakeholders to determine case direction. National research clearly shows that under stable case management children's cases tend to progress through the system faster.

A possible side benefit of greater workforce stability is that more workers are able to meet with the children on their caseload at least once every month. Monthly contacts can promote the children's safety in placement and during visitation, as well as assist the child in healing from any trauma caused by abuse, neglect, and removal from the parents. The federal goal is 95% compliance.

According to DHHS statistics regarding documented monthly caseworker-child contacts:

- **In October 2011 the rate was 45%**
- **In October 2012 the rate was 85%**
- **In October 2013 the rate was 95%.**

The FCRO congratulates DHHS on this achievement.

Reasons for workforce related improvements

There are a number of factors that, in combination, have led to greater workforce stability. A few of these include:

1. A slight lowering of caseloads by DHHS, which may lead to greater worker job satisfaction and retention.
2. DHHS no longer changing workers when children go from in-home to out-of-home care.
3. The DHHS CQI (Continual Quality Improvement) process, where there is a continual review of statistics and case management activity, and input by the Foster Care Review Office and other stakeholders.
4. The SDM (Structured Decision Making) processes that DHHS is using to help guide caseworker decisions and improve worker contacts with their supervisors.
5. The slight decrease in the length of time children are in out-of-home care, since the longer a child is placed out-of-home the greater the likelihood that he or she will experience worker changes.
6. Stabilization regarding state utilization of a lead agency in the Eastern area, so both state and lead agency workers may feel more job security.
7. Increased scrutiny by the Children's Commission and the Legislature.

The Foster Care Review Office commends everyone who has worked to reduce the number of worker changes that children and families experience.

F. Data on Type of Placements

When children cannot safely live at home they need to live in the least restrictive placement, most home-like temporary foster placement possible in order for them to grow and thrive. The chart below compares where children in out-of-home care were living on December 31st of 2011, 2012, and 2013.

- In 2013, foster and relative homes, the least restrictive, accounted for 70% of the children who are placed in out-of-home care. This is comparable to previous years.
- There has been a decrease in the use of group homes, going from 15% in 2011 to 11% in 2013.
- There has also been a decrease in the use of shelter care, which is explained in the section following this chart.

Types of Placement for Children in Out-of-Home Care						
Placement Type	**Children 12/31/2011**		**Children 12/31/2012**		**Children 12/31/2013**	
Foster homes	1,987	46%	1,855	47%	1,749	45%
Relatives	1,053	24%	945	24%	1,062	27%
Group homes	650	15%	434	11%	428	11%
Detention/YRTC	369	9%	314	8%	362	9%
Psychiatric Residential Treatment Facility (PRTF)	27*	< 1%	129	3%	101	3%
Institute for Mental Disease	n/a	n/a	2	< 1%	6	< 1%
Other psychiatric	n/a	n/a	19	< 1%	5	< 1%
Emergency shelter	72	2%	**91****	2%	**24****	1%
Runaway	99	2%	80	2%	67	2%
Independent living	44	1%	40	1%	48	1%
Other	19	<1%	53	1%	51	1%
Total	**4,320**	**100%**	**3,962**	**100%**	**3,903**	**100%**

* PRTF became a placement type in July 2011, with some placements meeting that licensing criteria thereafter.
** See section on shelter care below.

G. Data on Shelter Care Placements

Some children are placed in an emergency shelter pending a more permanent foster placement. Best practice would be for shelters to be used for a short period of time. **There is some good news in regard to use of shelters: On December 31, 2013, there were 24 children in a shelter placement, as compared to 91 children on December 31, 2012.** The FCRO finds this is a positive change and commends everyone who helped to make this happen.

Some practice changes to note: Per DHHS, as of July 1, 2013, shelter placements are to provide a triage and assessment component to assist in determining appropriate placement matches for the children. In other words they are to help determine which caregiver characteristics are best

suited to meet the individual child's needs. Also, children can only remain in shelter placement for 20 days. Any longer time period requires the DHHS Director's approval. The FCRO finds these are positive changes that likely have contributed to recent improvements.

Summary

The Foster Care Review Office looks forward to continuing collaboration with the Department of Health and Human Services, the Office of Probation Administration, the Inspector General, the Courts and staff of the Court Improvement Process, the Lead Agency, the Nebraska Children's Commission, the Legislature, Service Providers, Foster Parents, and other stakeholders/interested advocates and members of the public, in order to address the child welfare system issues identified in this update and in our previous annual report.

The Foster Care Review Office has other statistics available in addition to those found in this quarterly report. Please feel free to contact us at the address below if there is a specific topic on which you would like more information, or check our website for past annual reports and other topics of interest.

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www.fcro.nebraska.gov

Juvenile Services (OJS) Committee

Report to the Nebraska Children's Commission
March 18, 2014

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

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

Committee members:

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

Resources to the Committee:

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

Meeting Dates:

January 14, 2014 March 11, 2014

Activities:
The Juvenile Services (OJS) Committee met on March 11, 2014, to continue the next phase of planning. The following issues were covered at the meeting:

Committee Membership:
Marty Klein and Ellen Brokofsky informed committee members that the official work of the committee, as outline in LB 821 and LB 561, was technically completed with the December 2013 report. However, they also noted that as indicated in the report there was still work to be done and the Nebraska Children's Commission had given approval for the committee to continue meeting. Since many committee members had only officially committed to the first phase of the planning, committee members were asked if they planned to continue servicing on the Juvenile Services (OJS) Committee. Members in attendance were asked to indicate if they planned to continue on the committee and if they had anyone they would suggest be added as a resource to the committee. Suggestions were made to add a county representative and to invite additional subject matter experts as the committee worked through the next phases of strategic plan development. Subject matter experts will be invited to meetings based on the topic on the agenda to be covered. Leesa Sorensen was also asked to send an e-mail to all committee members asking about their continued service on the committee. Any changes to the membership of the committee will be brought to the Children's Commission at a later date.

Strategic Planning:
The Juvenile Services (OJS) Committee continued development of the Phase I Strategic Recommendations issued in December 2013. The committee discussed the original plan of dividing the committee into five workgroups, but decided instead to devote more time as a full group to further develop the general framework and next action steps for each workgroup. The committee will be utilizing a standardized analysis chart to complete the next phase of the strategic plan. The committee will determine at a later date how the sub-committee process will be utilized.

The committee decided to start their planning process by looking at the recommendations related to Community-based programs at the April 8, 2014 meeting. The committee will look at Standardized Program Evaluation Protocol (SPEP) Design as the next issue to develop.

Workforce recruitment and stability: Key Recommendations

Staff Recruitment

- Increase requirements for frontline staff
- Recruit in and outside the state of NE
- Employ selection tool using success criteria for initial hiring

Training and Development

- Guidelines for GALs and all other collaborative entities clearly defined, communicated and strictly followed
- Stay on track with the DHHS Protection and Safety & Juvenile Services New Worker Training outline
- Develop (or adapt existing) training for specialists (at a minimum SMEs) in categories of child welfare and juvenile justice
- Increase mentors (per current DHHS plan) to get to the 51 needed across state
- Broaden education to include judges and others in training

Retention

- Follow caseload reduction plan
- Increase expectations for and accountability of supervisors
- Develop and implement retention strategy to be reviewed and measured (turnover reduction and staff development)

Salary and Compensation

- Consider new job classification to compare and increase salaries
- Continue differential for mentors
- Bigger increase for becoming supervisors

Career Trajectories

- Three to four years in the "trenches" and apply selection tool to determine supervisor readiness and success in role
- Stepped levels for caseworkers determined by achieving key competencies and excellent performance. (eg. A senior level caseworker or levels 1, 2, 3, and 4. Salary increase would be part of increasing the level.)
- Tuition reimbursement and load forgiveness with strictest guidelines for those serving in most difficult areas (language challenges, geographic challenges)
- Education incentive (eg. MSW)

Workforce Work Group

Report to the Nebraska Children's Commission

March 18, 2014

The Workforce Work Group of the Nebraska Children's Commission has been tasked with the goal of fostering a consistent, stable, skilled workforce serving children and families. Work group members include Julie Rogers (Child Welfare Inspector General), Thomas Pristow (Director of Division of Children and Family Services), Janteice Holston (Young adult previously in foster care), Dr. Vicky Weisz (Center on Children, Families and the Law), Hon. Linda Porter (Lancaster County Juvenile Court Judge), Ellen Brokofsky (State Probation Administrator), and Susan Staab (State or Local Foster Care Review Board Member). One specific task underneath this goal is to develop a retention plan for caseworkers.

Caseworker turnover negatively affects children's outcomes. A chart listing the consequences of both worker retention and turnover is attached at Appendix A. When a caseworker is unfamiliar with the case, it can lead to continued hearings, lack of appropriate services, and lack of case management and planning. New caseworkers are less likely to be familiar with the services available in the community, which puts children at risk of repeat harm. Current Nebraska caseworker turnover rates are attached at Appendix B.

There are a number of factors that contribute to the successful retention of caseworkers. It is difficult to separate each factors, as they are all inter-related. An illustration of the inter-related factors is included at Appendix C. For instance, an increase in salary will have beneficial effects on turnover not just because the worker now earns more, but because the worker also feels more valued and supported. While the problem is complex, the work group focused on two key areas to improve caseworker retention; compensation and career trajectory.

Salary

Salary is an important consideration in increasing workforce retention. Many workers make the difficult choice of leaving the social services field in order to secure a higher salary. The work group recommends that child welfare and juvenile justice workforce salaries be reviewed and brought in line with current national levels of pay. While Nebraska is in line with National entry level pay, there is significantly less room for advancement as the caseworker continues his or her career. In order to incentivize continued service and education, salary differentials should increase as the caseworker's skills and knowledge increase. A comparison of National and Nebraska pay rates is included at Appendix D, and the State of Nebraska's pay plan for Child and Family Service workers in included at Appendix E.

Loan Forgiveness

The work group considered loan forgiveness as a method of incentivizing entry into the field and higher education. Many caseworkers incur significant debt to finance their education, and struggle to pay off student loans. The work group has researched loan forgiveness programs in other states as possible structures for the State of Nebraska. Further research into the programs is necessary to determine the appropriate solution. Attached at Appendix D is an overview of loan forgiveness programs in other states.

Career Trajectory

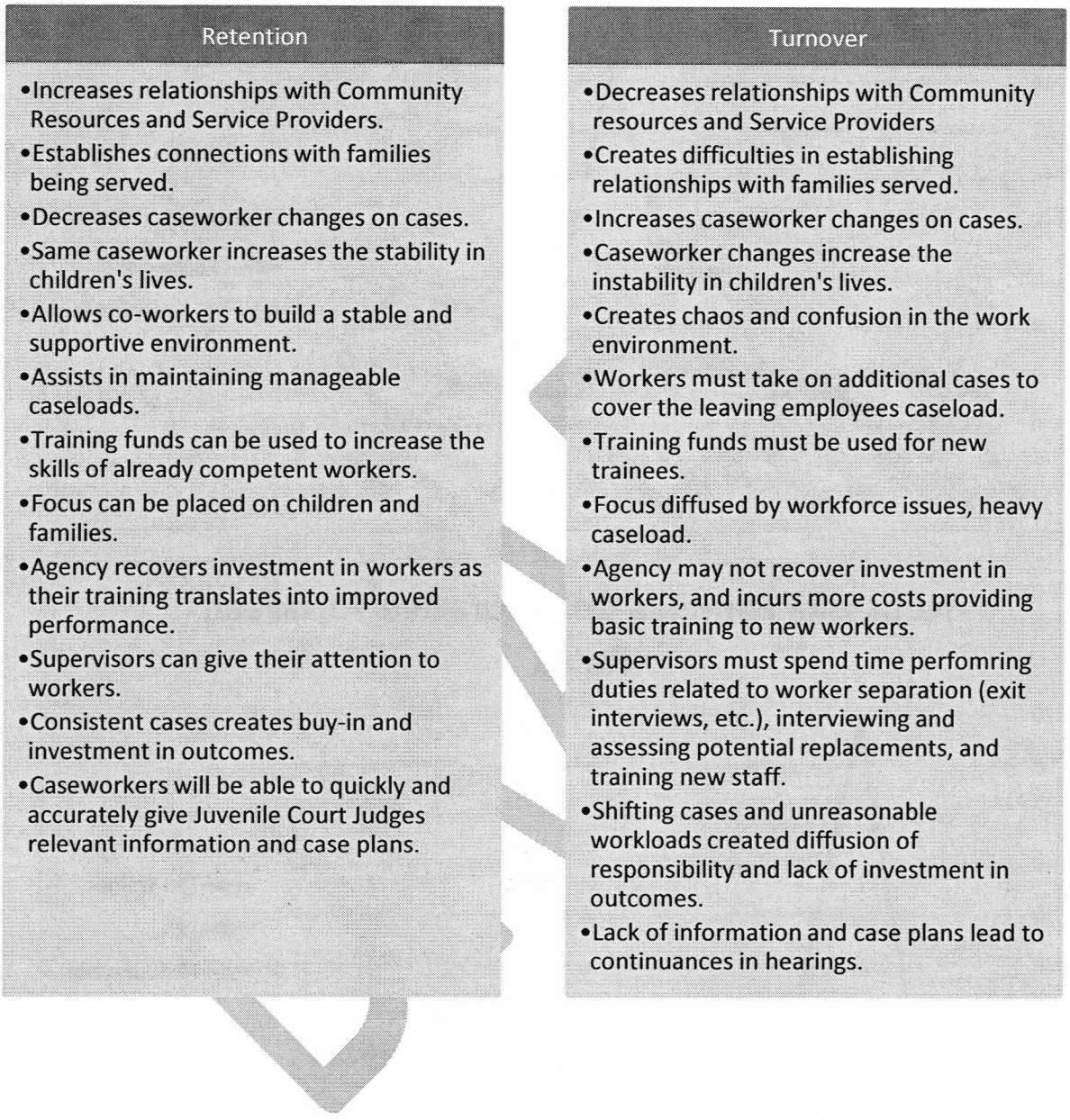
The work group recommends that careers have a well-defined trajectory with salary differentials for promotions and education. Quality of supervisors is a key factor affecting case worker job retention, satisfaction, commitment and performance. The work group recommends that additional career tiers and salary differentials be added to the casework function. For instance, a caseworker may be designated as "Social Worker II" after successfully managing a full caseload and demonstrating excellence in professional competencies. This would include a salary differential commensurate with skill and education. After achieving key competencies in the front line role, workers should be offered larger salary differentials when they assume the role of the supervisor.

Recommendations

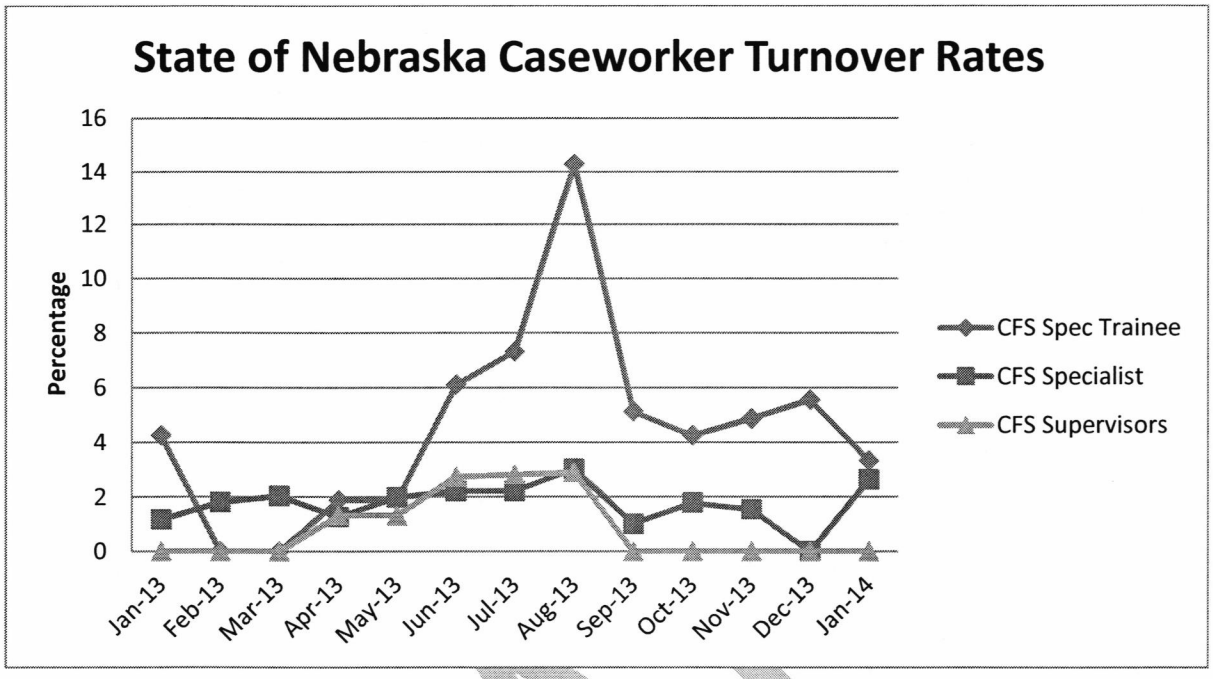
The Workforce Work Group recommends that the salaries of social services workers be reviewed and brought in line with national and surrounding state averages. Career trajectories should also be examined to ensure that workers receive promotions and corresponding increases in salaries for mastering key competencies and attaining higher education. Although worker retention is a complex issue, these two areas will result in increased worker satisfaction and retention of skilled workers.

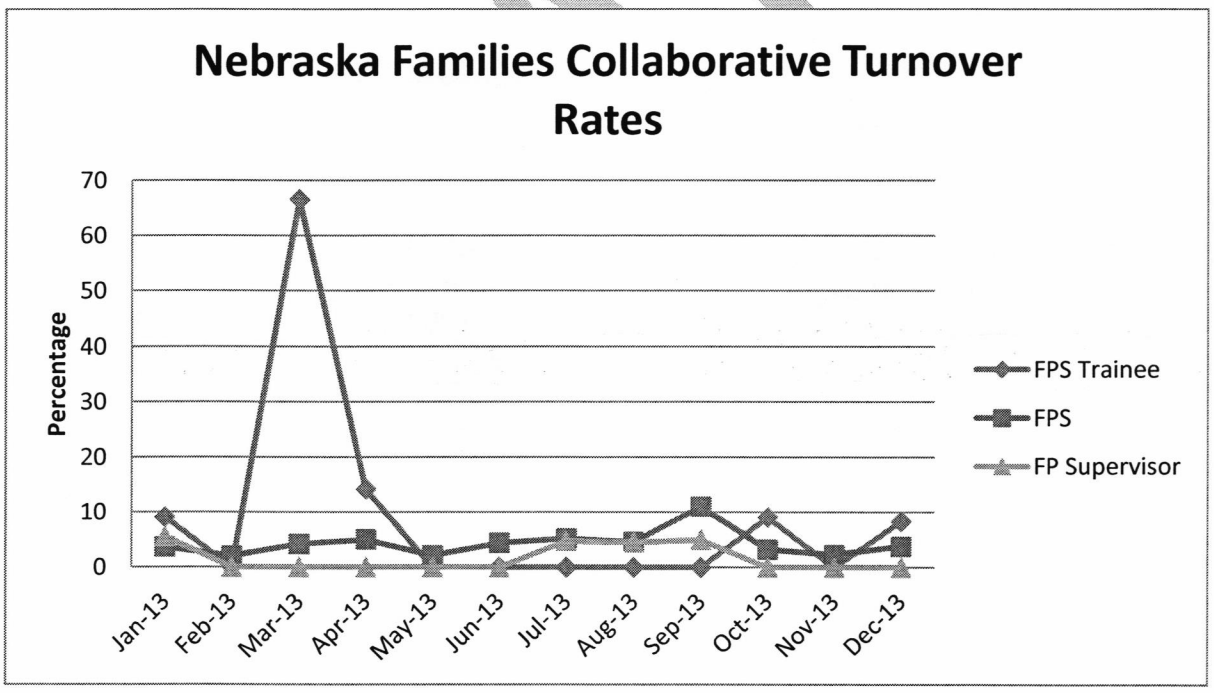
Appendix A

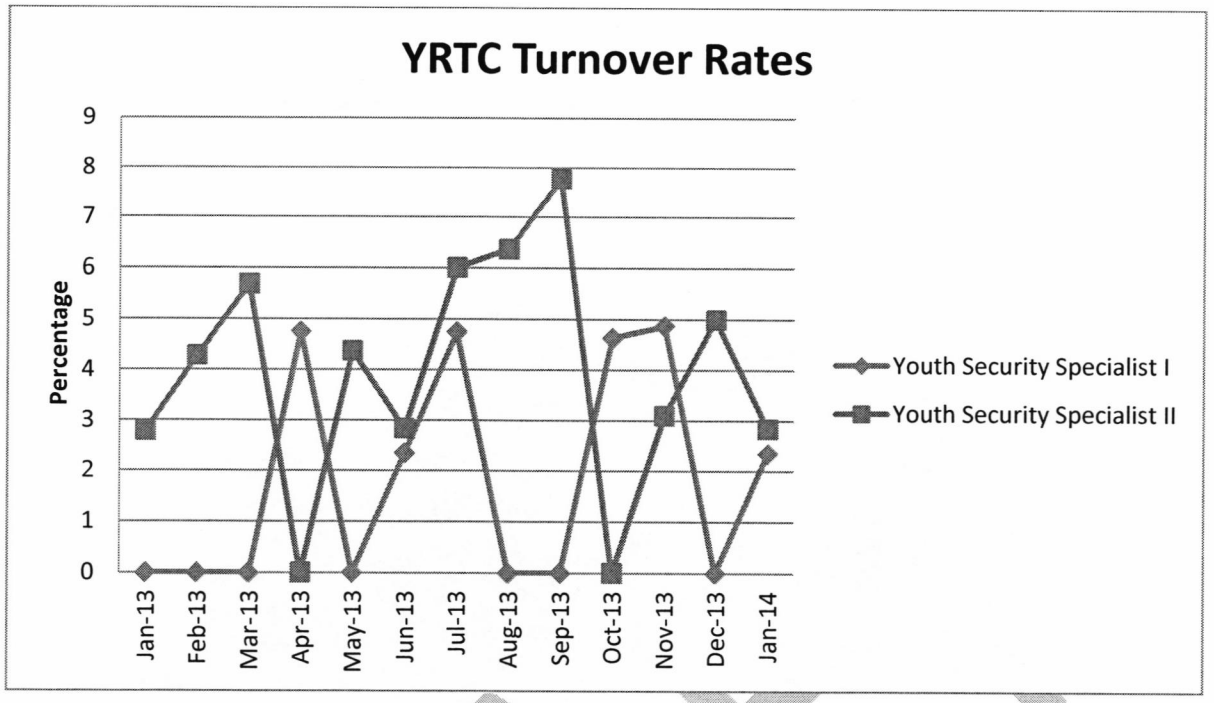
Effects of Worker Retention and Turnover

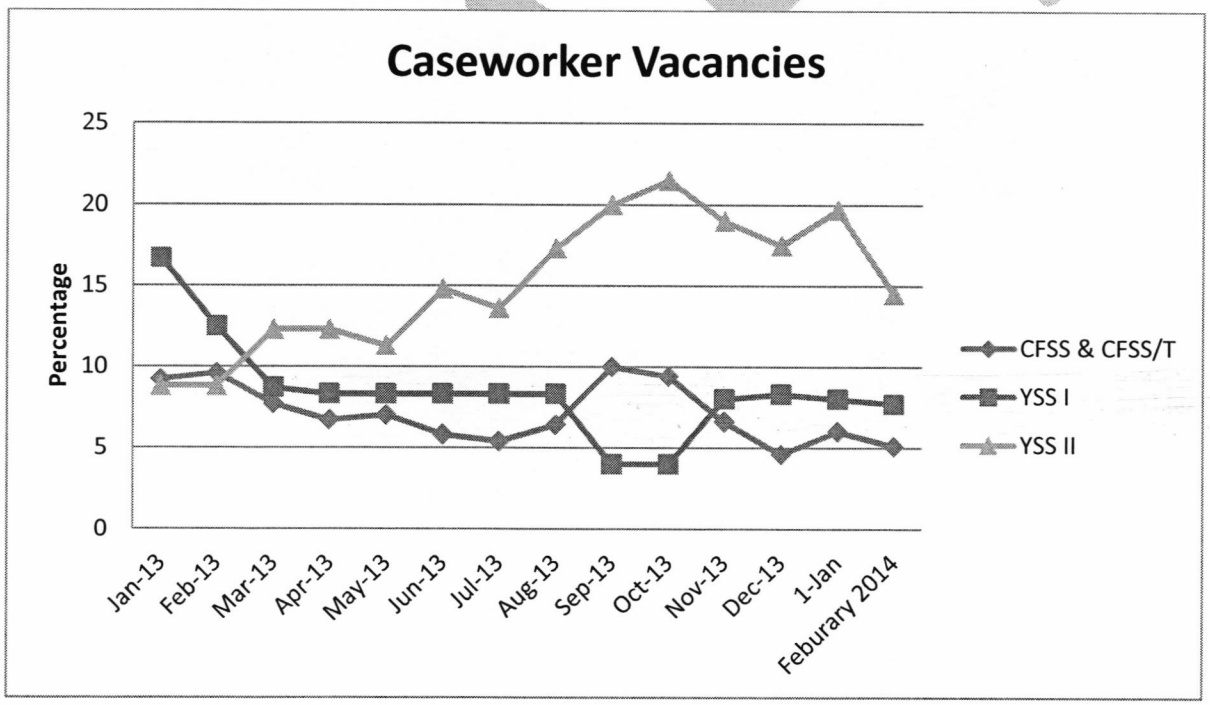


Appendix B


State of Nebraska Caseworker Turnover Rates
Percentage
16
14
12
10
8
6
4
2
0
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
CFS Spec Trainee
CFS Specialist
CFS Supervisors


Nebraska Families Collaborative Turnover Rates
Percentage
70
60
50
40
30
20
10
0
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
FPS Trainee
FPS
FP Supervisor

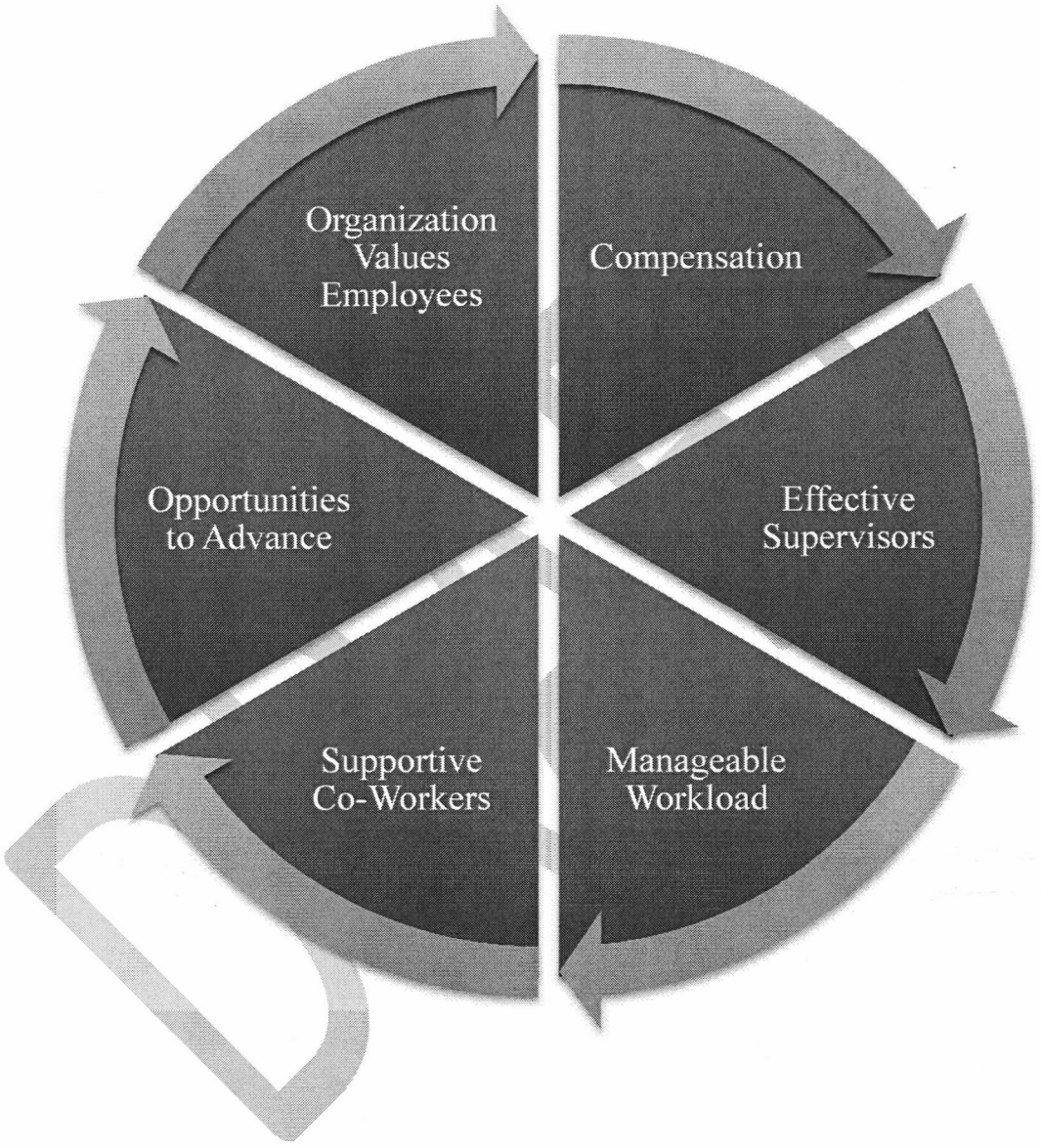




Source: Department of Health and Human Services – Division Children and Families, *Protection and Safety CQI Report.* February 2014.

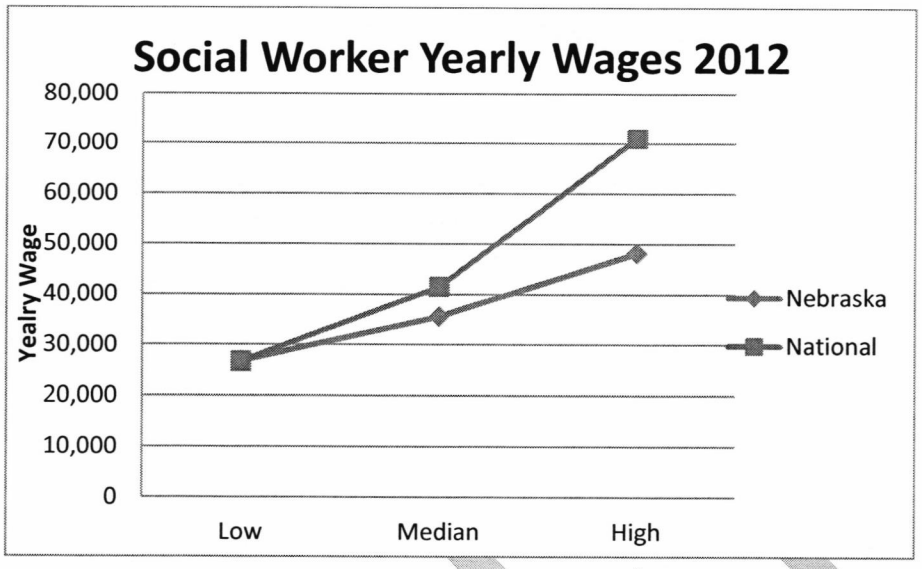
Appendix C

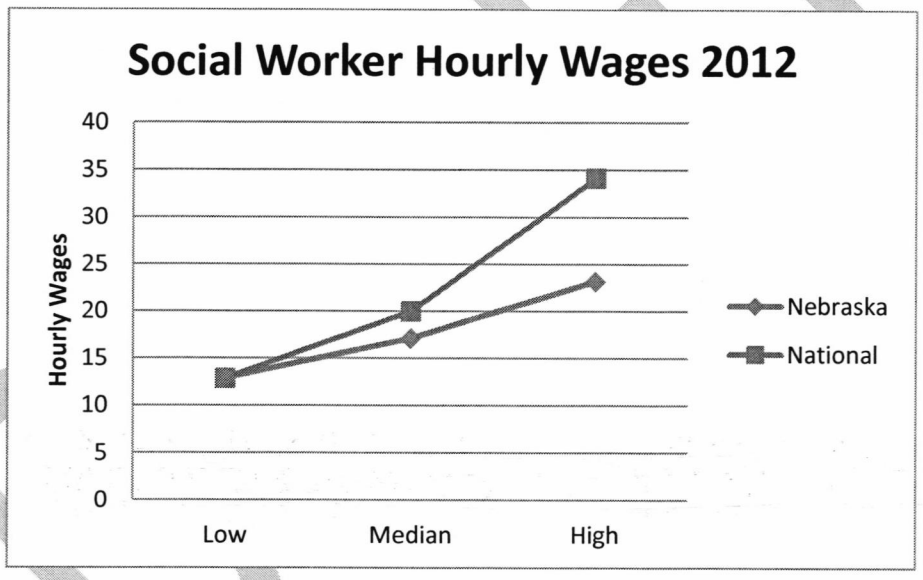
Characteristics of Organizations with High Social Worker Retention



Adapted from: Institute for the Advancement of Social Work Research, *IASWR Research Brief – Child Welfare Workforce Series.* July 2005.

Appendix D





Source: U.S. Department of Labor Employment and Training Administration

Appendix E

State of Nebraska Pay Plan, July 1, 2013

Title	Minimum hourly Rate	Minimum Permanent Hourly Rate	Midpoint Hourly Rate	Maximum Hourly Rate
Child and Family Outcome Monitor	17.953			26.001
Child and Family Services Specialist	16.700			24.187
Child and Family Services Specialist Supervisor	21.372			32.058
Child and Family Services Specialist Supervisor	21.372	22.441	26.715	32.058
Child and Family Services Specialist Trainee	14.452			20.931
Certified Master Social Worker	20.552			30.258
Certified Master Social Worker Supervisor	23.755	24.943	29.694	35.632

Source: Nebraska Administrative Services, *Classification and Pay Plan* State Personnel Division, July 1, 2013.

Appendix F

Student Loan Forgiveness Programs

State	Program Name	Program
Florida	Child Welfare Student Loan Forgiveness Program (Title XXIX, Chapter 402.401)	Eligible students are enrolled in full-time undergraduate of graduate social work programs with declared intent to work in child welfare at DCFS or a contracting agency for at least the number of years for which a forgivable loan is received. Undergraduate students are eligible for a maximum of no more than $4,000 per academic year for a maximum of two years. Graduate students are eligible for a maximum of $8,000 per academic year for a maximum of two academic years.
Illinois	Child Welfare Student Loan Forgiveness Program (Title 23, Chapter XIX, Section 2769)	Eligible students are enrolled in full-time undergraduate of graduate social work programs with declared intent to work in child welfare at DCFS or a contracting agency for at least the number of years for which a forgivable loan is received. Undergraduate students are eligible for a maximum of no more than $4,000 per academic year for a maximum of two years. Graduate students are eligible for a maximum of $8,000 per academic year for a maximum of two academic years.
Iowa	The Primary Care Recruitment and Retention Endeavor (PRIMECARRE)	Eligible applicants are clinical social workers (LISW) with full or part time employment with a public or non-profit facility located in a federally-designated health professional shortage area (HPSA) for a minimum two year contract period. Candidate selection is based on a ranking of community need, the applicant's history of debt assistance, and the applicant's evidence of community commitment and personal experience in rural settings. Up to $50,000 per year is available for full time eligible

		applicants and up to $25,000 per year is available for part time eligible applicants. Award amounts vary based on available federal allocations and state matching funds and applicant scores.
New York	NYS Licensed Social Worker Loan Forgiveness Program	Eligible applicants must be NYS residents for at least one year, licensed to practice social work in New York State, and have at least one year of qualified service as a licensed social worker in a critical human service area for at least 35 hours a week during the calendar year prior to application. The maximum award under this program is $26,000 or the applicant's outstanding student loan (whichever is lesser). Awards are disbursed in annual payments for each year of qualified service. Annual disbursement will be in amounts of $6,500, or the outstanding loan amount, whichever is lesser.
North Carolina	Health, Science and Mathematics Student Loan Program	This program is a scholarship/loan that allows recipients to pay back the loan in either cash or service. Eligible students are North Carolina residents who have been promoted to the third, fourth, or fifth year of an approved undergraduate program fulltime and have a financial need. Service eligible to repay loan is one calendar year of employment in North Carolina in a designated shortage area for each calendar year of the loan. Students enrolled in associated degree programs may receive $3,000 per year for two years. Undergraduate students may receive $5,000 per year for two years. Master's level students may receive $6,500 per year for two years, and Health Professional/Doctoral program students may receive $8,500 per year with a maximum of $34,000.

REPORT TO
NEBRASKA CHILDREN'S COMMISSION

MODEL FOR COMMUNITY OWNERSHIP OF CHILD WELL-BEING

Submitted by the Community Ownership of Child Well-Being Workgroup

INTRODUCTION

This model was developed based on input gathered through five community listening sessions held in May and June 2013, research presented to the Nebraska Children's Commission by Dr. Deborah Daro on June 18, 2013, and research on collective impact conducted by FSG. The model is adaptable to any size community and can also be used successfully on a regional basis as evidenced by the Panhandle Partnership which includes 11 counties in the Panhandle. It is based on the premise that no single organization can create large-scale, lasting social change alone. There is no "silver bullet" solution to systemic social problems such as juvenile crime, child abuse and neglect, school dropout, teen substance abuse, teen pregnancy, etc.; and these problems cannot be solved by simply scaling or replicating one organization or program. Strong organizations are necessary but not sufficient for large-scale social change. It requires organizations—including those in government, the private sector, and nonprofit sector—working collaboratively toward a shared vision for child well-being and shared outcomes for all children. The model outlined in this document is designed to help communities build strong collaborations that are necessary to support community ownership of child well-being and the achievement of better outcomes for children.

PRINCIPLES

- Improving the well-being of children is the opportunity and responsibility of the entire community. It requires cross-sector collaboration involving nonprofits, government, businesses and the public sharing responsibility and working together for a shared vision for change.
- Prevention efforts build on what already exists, honoring strengths and current evidenced-based and evidence-influenced efforts and engaging established organizations.
- Community priorities and outcomes are developed through ongoing assessment, data sharing and collaborative processes.
- Broad-based community collaborations function in an environment of reciprocity and cross-system understanding.
- Change is community wide. Outcomes and evaluation strategies are identified for direct service clients, the larger population, collaborative functioning and system change.
- Creates common expectations for "all" children and empowers residents to accept responsibility for change.
- Creates an open sharing environment in which residents are engaged in supporting each other and in creating a community of wellness and safety for all children.

OUTCOMES

- Improvements in child well-being for the general population. Measured by priority indicators aligned with children are safe, healthy, ready and successful in school and supported in quality environments.
- Children do not enter the child welfare system
- Family protective factors are enhanced
- Increased Informal supports
- Parent engagement and leadership is enhanced
- A broad-based community collaborative that holds members accountable and is focused on collective impact. Measured by collective impact indicators
- Public and private systems function to maximize opportunities for children and families, support prevention, support informal support systems and works to prevent the need for more intense levels of intervention

NECESSARY COMPONENTS OF COLLABORATIVE INFRASTRUCTURE:

- Community collaboration focused on child well-being that is developed by a broad base of community stakeholders and residents.
- The community collaboration is a public/ private partnership that blends funding streams to work across partnering organizations and address the gaps in services.
- Establishment of a 501(c)3 or utilization of another neutral "backbone" organization that is not in competition for funding and supports the decisions made by the collaboration.
- Agreed upon policies and procedures for the collaboration that facilitates decision making, communication, sharing of data and mutual support and accountability.
- The backbone organization must exemplify the characteristics and functions of a backbone. It acts as a portal for state/federal public/ private grants and does all of the backroom work to blend and leverage funding streams, support continuous communication, and facilitate assessment, planning, evaluation, and implementation.
- Training for leadership development, community inclusion, systems change strategies, and the tools used in assessment, planning and evaluation.
- An outside coach skilled in collaboration to support the development and work of the community collaboration.
- The collaboration integrates and serves as a collaborative for Substance Use Prevention Coalitions, Juvenile Justice Coalitions, Child Abuse Prevention teams, Systems of Care for Mental Health, Early Childhood Collaborations, Early Learning Connection Partnerships, Home Visiting Coalitions, and other collaborative efforts required by funding and related to the outcomes for child well-being.
- Braiding of public and private funding plus flexible funding is needed for prevention.

PHASES OF DEVELOPMENT: COMMUNITY COLLABORATION FOCUSED ON CHILD WELL-BEING

PHASE ONE: INITIATE ACTION

- **Identify Champions, Funders and Partners to focus on Child Well-Being**. Participants include DHHS, Public Health, Early Childhood, Schools, City, Faith-based Organizations, Behavioral Health, Nonprofits, Courts, Police, Parents, Volunteers, etc.
- **Assess and Analyze Community Landscape**. The broad-based collaboration conducts a community-wide needs assessment and service array process to establish strengths, gaps and needs.
- **Facilitate Community Outreach**. The community establishes mechanisms for inclusive participation (above) including those who are least likely to participate or to have an ongoing voice

PHASE TWO: ORGANIZE FOR IMPACT

- **Create Backbone and Collaborative Infrastructure**. Establish a 501©3 or align with another neutral backbone organization that serves as coordinating body and fiscal agent and supports an infrastructure that includes collaborative bylaws, procedures, policies, workgroups, org chart, membership-owned decision making that promotes participation from all entities. The backbone organization retains neutral facilitation/coordination, is transparent and exists to focus on the needs and outcomes of the collaborative. The backbone acts as a portal for state/federal public and private grants and does all of the backroom work to blend and leverage funding streams to support evidence-based practices, continuous communication, and the facilitated planning, evaluation and reporting.
- **Create Common Agenda**. The collaboration creates a vision for the well-being of all children. Using the service array and data assessment, protective factors are mapped to develop and support a community-owned priority plan that everyone can work on for prevention. The model depends on community ownership of the plan/outcomes. The priority plan cannot be directed or predetermined on where to focus efforts; it needs to be based on the community's gaps and strengths and established priorities. The collaboration develops and through braided funding implements a plan for prevention that addresses multiple risk factors for all children and families.
- **Engage Community and Build Public Will**. These data and other assessment information are utilized to make the case for how everyone in the community is needed to reach the child well-being outcomes.
- **Establish Shared Metrics/Shared Accountability to Outcomes**. The collaboration establishes performance measures for strategies and population measures for child well-being. (Mark Friedman RBA).

PHASE THREE: SUSTAIN ACTION AND IMPACT

- **Support Implementation/Alignment to Goals and Reinforcing Activities.**
  - Training to establish a process for selection of evidence-based practices and evidence-informed practices that fit the needs and outcomes of the target population.
  - Training for professional workforce provided to all community providers/ members.
  - Actions focus on changing the community context (e.g. power and influence, real family engagement, family-centered practices, cultural inclusion, family-friendly policies, etc.) in order to create the "we" in communities.
  - Disproportionality rates in systems used to develop practices for inclusion and a safe environment to address concerns.
  - The coordinated service delivery system focuses on the gaps where families fall through the cracks, builds positive parent-child interaction, enhances the Protective Factors, provides community informal supports and inclusion so higher systems of care are not utilized.
- **Collect, Track & Report Progress**
  - Members of the collaboration establish a continuous quality improvement cycle including assessment, planning and implementation, evaluation and sustainability process.
- **Focus on Sustainability**
  - Collaboratives do not focus on the sustainability of programs. Instead focus on sustaining outcomes. Resources are enhanced for community organizations rather than creating competition for scarce resources. A shared community fund development plan based on the priority plan is created.
  - The collaboration is a public/private partnership that blends funding streams to support the work across partnering organizations and to address the gaps that public funding streams create due to eligibility criteria.

BARRIERS TO COMMUNITY OWNERSHIP FOR CHILD WELL BEING:

- Need flexible funds to afford communities the opportunity to fill gaps and to braid funds as needed.
- Establish, encourage and honor one comprehensive community planning process which services multiple system needs.
- Establish and honor one collaborative evaluation process. Many times federal grants require this and it is possible to have more than one occurring in a community at the same time. If the state/community partners could agree on and implement one process, then future state grants could help fund the one process rather than many.
- Especially in greater Nebraska, consult communities before establishing policies and practices.
- Rural vs. urban issues—gather input from small communities as well as big communities.
- Work through legal barriers to serving families that are subjects of screened out child abuse and neglect intake reports. Reaching these families is an essential component of communities' prevention strategies.
- Provide networking and peer mentoring opportunities for communities.
- Funding for prevention efforts is key. Funding should encourage collaboration in communities rather than competition. Having funding flow through the community collaborations promotes collaboration and community buy-in which helps with sustainability. Allow for local decision making as much as possible.
- Let local areas define themselves. Do not force partnerships.
- Need organization such as NCFF to continue to provide technical assistance to communities and to support development of collaborations. Funding has helped but boots-on-the-ground technical assistance and support has been valuable.
- The State should think about funding indirect costs to support backbone organizations.
- There is a Summit for every issue—have one summit to work across systems for prevention.

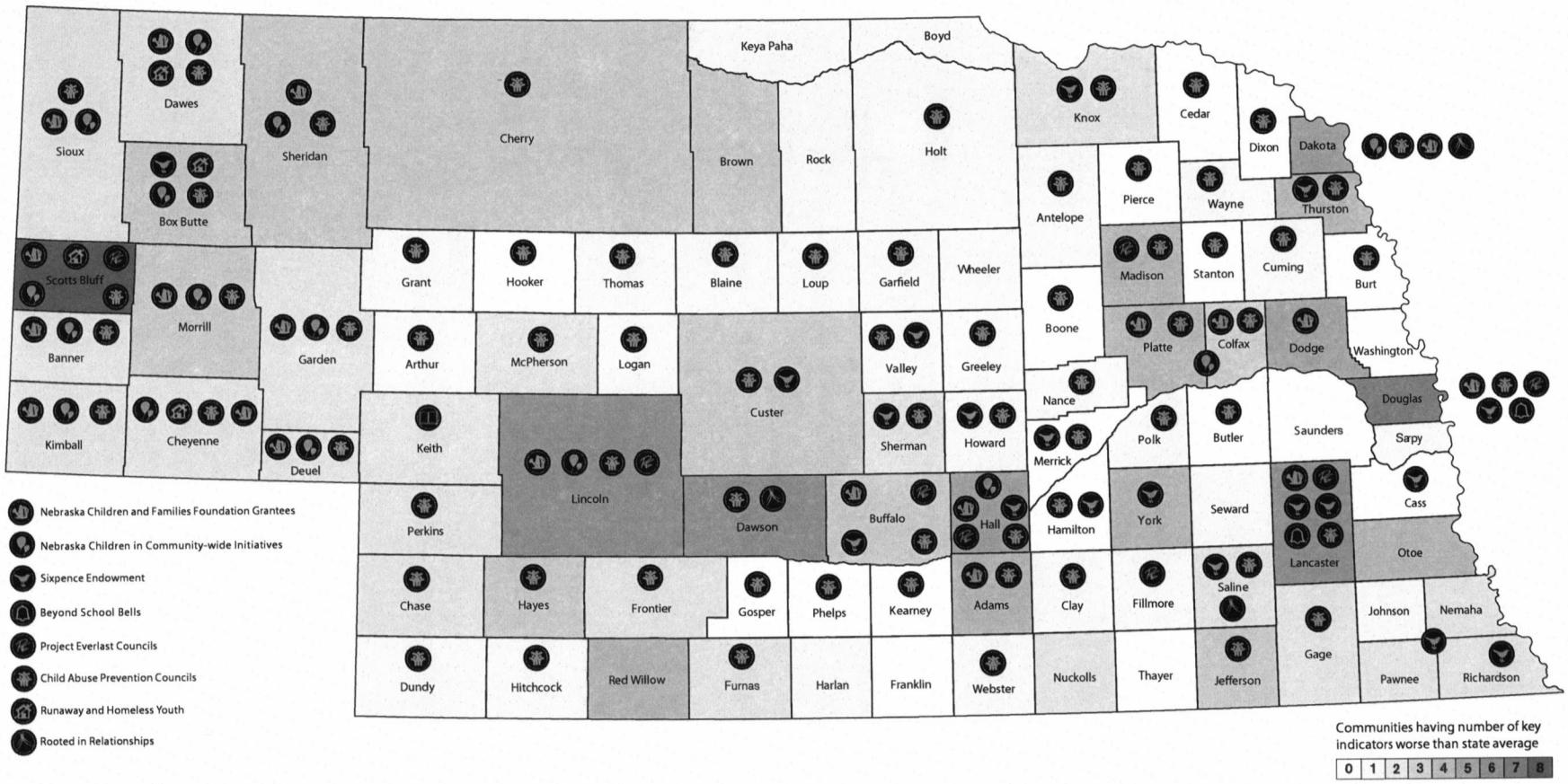
Nebraska Impact at work

Nebraska's at-risk communities and investments made by Nebraska Children and Families Foundation

Nebraska Children and Families Foundation evaluates the landscape of issues facing vulnerable children and families based on key risk indicators, including:

- Juvenile arrests
- Poverty
- Graduation rate
- Infant deaths
- Number of state wards
- Child abuse and neglect
- Births to teen parents
- English as a second language

With this data in hand, Nebraska Children and Families Foundation scans the state for the areas of greatest need, where the community is ready to engage in a collaborative initiative and where outside support and investments will maximize the difference made to the community's children. From there, we review and determine what investments should be leveraged for the greatest benefit.



Child Well Being Protective Factors and Service Array Assessment Matrix

Protective Factor	Service Array			
	Basic Needs	**Healthcare Access and Promotion**	**Child and Youth Development**	**Family Development**
Nurturing and Attachment		17. Home Visits to Parents of newborns		
Family Functioning and Resiliency			24. School Based Personal Safety Curriculum 27. Youth Employment Opportunities 29. Substance Abuse Prevention	32. Family Support Center 33. Neighborhood Service time Banks 35. Child Centered Mediation 36. Life Skills Training/Family Functioning
Child Development and Knowledge of Parenting		17. Home Visits to Parents of newborns	21. Educational Services for Children 22. Early Intervention-Special Needs 23. Head Start or Other Early Childhood Education 26. Mentoring for Children and Youth	34. Parent Education Classes 38. Mentoring for Parents/Adults
Social Supports			30. Youth Leadership/Positive Youth Development	39 Parents Anonymous/Support Groups
Concrete Supports	1.Cash Assistance 2. Food Assistance 3. Utilities Assistance 4, Clothing Assistance 5. Housing Assistance 6. Child Care Resources 7. Child Care Assistance 8. Transportation Assistance 9. Employment Assistance 10.Living Wages	11. Children's Health Insurance Programs 12. Uninsured Children 13. Primary Child Health Care 14. Primary Adult Health Care 15. Child Dental Care 16.Prescription Drugs 18. Nutrition 19. Opportunities for Physical Activity	20. Crisis Nurseries 25. Before and After School Programs 26. Mentoring for Children and Youth 28. Youth Crisis Alternatives	31. Crisis Stabilization Services 37. School Community Family Resource Workers

Service Array Summary 2010 - 2012

Key Findings: Child Well –Being (CWB) communities identify key priorities based on a gap analysis (Service Array Analysis) to address several common target areas including:

- **Transportation**
- **affordable preventive health and dental services**
- **addressing needs of under- or un-insured children (basic needs),**
- **teen pregnancy,**
- **addressing social emotional needs in youth, children and families,**
- **addressing family engagement across programs**
- **building collaboration capacity across programs**

Supporting Evidence

All CWB communities participated in the service array assessment process. The purpose of this assessment was to analyze the strengths and gaps of services in the community. The following provides a description of the priority areas that were identified by the communities to target community action that was based on this gap analysis. Five areas will be described including: children and youth safety and development, health promotion and disease prevention, basic needs, family development and system development. Within each area commonalities between communities were found and will be discussed.

Basic Needs

Common Priorities: **Transportation** was a priority for the majority of the communities (80%). The primary issue was access with communities identifying the need for more bus stops, longer hours of public transportation, and more direct routes for families. Cost also played a role in access.

Unique Priorities included: monitoring unemployment services, housing management, and meeting the basic needs of all youth.

Children and Youth Safety and Development

Common Priorities: Focusing the Collaborations' efforts around child and **youth programs** was an emphasis of the majority of the communities (80%). This included identification and sustaining programs for youth with an emphasis of collaboration among youth programs and community organizations. Additionally, communities were interested in addressing youth substance abuse, both assessment and treatment. Four communities expressed their interest in **expanding services for early childhood programs**.

Unique Priorities included: developing before school programs and sustaining school programs, increase community education about children's and youth safety and development, and enhancing authentic relationships between youth and adults through SPARKS's conversations.

Health Promotion and Disease Prevention

Common Priorities: Three themes emerged as priorities in this area. Four communities identified as a primary need, **affordable preventative health** (e.g., family practice, mental and behavioral health services to meet with **social emotional needs of youth, children and families**) and dental services. Related to this was the need to ensure services for both the **uninsured and the underinsured**. Two communities prioritized **efforts to reduce teen pregnancy** and emphasis on adolescent sexual health.

Unique Priorities included: identification of qualified medial interpreters and access to specialists, e.g., obstetrics.

Family Development

Common Priorities: Addressing **family engagement**, including how to successful recruit families and continually engage them to increase family protective factors was a priority for two communities. Most of the priorities identified were unique for each community.

Unique Priorities included: redesigning how current family education opportunities were delivered, identifying ways to sustain school-community based resource teams, establishing crisis stabilization services for children birth through 10, formalizing relationships with family mentors, increasing the number of cultural and linguistic competent services and increase access to services.

Collaboration Development

Common Priorities: The service array assessment and other community assessments identified the need to build and strengthen community collaboration by establishing infrastructure (e.g., operating procedures, training) and a common work plan to strengthen their community's prevention plan.

Shared Focus for Six Child Well Being Communities

- **Reducing Child Abuse and Neglect and Keeping Children out of the Child Welfare System.** All communities have goals to increase Protective Factors and improve family resources to prevent child abuse and neglect.
- **Ready for Results Based Accountability.** All communities have developed broad-based collaborative infrastructures to support increased accountability of community systems (for population outcomes) and performance (for targeted outcomes). Local collaborations include representation from child welfare, behavioral health, public health, and many others.
- **Local Strengths and Gaps Documented.** All communities have completed assessments and planning to develop prevention plans, as summarized below.

- **<u>Implementation of Evidence Based Practices with Measures.</u>** All communities have begun implementing their prevention plans and are working with local and state evaluators to measure outcomes.

Individual Community Focus Areas for 2012-13

1. **Panhandle**
    - Increase assets in young adults (Search Institute Developmental Assets)
    - Support older youth system of care (youth leadership, host home, permanency)
    - Increase school engagement through Families & Schools Together model (ages 3-6 and 10-14)
    - Support MIECHV home visitation and early childhood system of care
    - Provide Circle of Security Parenting classes for all levels of prevention
    - Develop community response and service system for non-court involved families

2. **Fremont**
    - Improve early childhood education & school readiness
    - Improve parent support for children's social emotional development (through Parents Interacting with Infants, Parent Child Interaction Therapy, etc.)
    - Prevent children entering the system (through work with child welfare toward specific preparation for Community Response)
    - Develop community response and service system for non-court involved families

3. **Grand Island**
    - Increase school engagement through Families & Schools Together model
    - Increase before and after school opportunities & parent engagement through Families & Schools Together
    - Support MIECHV home visitation and early childhood development (TBD)
    - Increase permanency for older youth

4. **Platte-Colfax**
    - Improve parenting and family support
    - Improve parent support for children's social emotional development (Parents Interacting with Infants, Parent Child Interaction Therapy, etc.)
    - Improve early childhood education/care and school readiness (ages 0-8)

5. **Dakota**
    - Improve parenting and family support
    - Improve parent support for children's social emotional development (Parents Interacting with Infants, Parent Child Interaction Therapy, etc.)
    - Increase resources for before and after school and explore development of community-based student assistance teams

- Explore improvements for school readiness, including address of challenging child behaviors (home, preschools, schools)
- Support MIECHV home visitation

6. North Platte

- Improve resources and system for mental health (as related to parenting, child care, community violence/abuse)
- Improve parent support for children's social emotional development (Parents Interacting with Infants, Parent Child Interaction Therapy, etc.)
- Improve children's social emotional development and school readiness (ages 0-8)
- Support MIECHV home visitation
- Develop resources and system for trauma informed care (use of models such as CBITS and Zones of Regulation)

Update and Celebrate!

Fremont Early Childhood Coalition

July 12, 2013

1

Welcome

Scott Jensen
Fremont Area Medical Center
&
Nebraska's First Lady
Sally Ganem

2

Mission

- The mission of the Early Childhood Coalition is to lead our community to develop and support each child in achieving developmental milestones and lifelong success.

3

Video: Collaboration

- Fremont Collaboration Video: http://youtu.be/BSC7FZdKpEQ

4

Fremont Early Childhood Coalition

Progress Update

Jennifer Skala
Nebraska Children and Families Foundation
&
Shawn Shanahan
Fremont Area United Way

5

About NCFF

- NCFF Animation Video: http://youtu.be/e79K9w0MUQQ

6

Child and Family Well- Being Data

	Dodge county	Nebraska
Percent of Unemployment	5.4	4.7
Percent Poverty under Age 5	28.4	16.8
Percent Births to Teen Mothers	9.8	8.4
Percent Proficient Reading at 3rd Grade	63.9	71.1
Percent Graduated High School	83.9	90.0
Rate of Child Abuse and Neglect per 1,000	13.8	11.4
Rate of Domestic Violence per 1,000	5.2	2.9
Median Household Income	42,829	49,342

PRIORITY PLAN – Health

- Transportation
  Develop local infrastructure and referrals
- Enhance telehealth capacity
- Bilingual, culturally sensitive services
- Enhance social emotional connections/ supports for families
- Community Health Clinic

We're STARTING | We're PROGRESSING | We're ROLLING

PRIORITY PLAN – Basic Needs

- Create ordinances for landlord standards
- Increase low income housing
- Provide in home quality child care 24 hours
- Prevention of utility shut-offs and create referrals for support

We're STARTING | We're PROGRESSING | We're ROLLING

PRIORITY PLAN – Child and Youth Development

- Before and After School/Summer
  a. Develop Summer program
  b. 21st Century funding
- Early Childhood
  a. Educating Consumers
  b. Increase Quality EC – Training and curriculum
  c. Sixpence Endowment funding

We're STARTING | We're PROGRESSING | We're ROLLING

PRIORITY PLAN – Basic Needs

- Address gaps in access – food, housing, utilities
- Provide education and supports - Bridges out of Poverty
- Build assets in families

We're STARTING | We're PROGRESSING | We're ROLLING

PRIORITY PLAN – Family

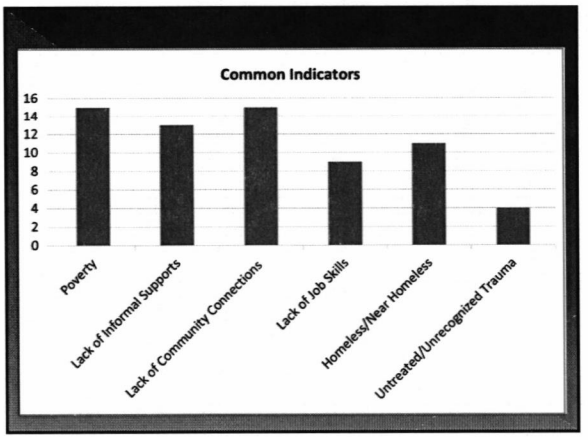
- Community Response for Prevention
- Centralized Crisis Line – Boys Town
- Support and Education for Families – Pathfinder, Care Corp and others
- Informal Supports – Befriend, peer groups
- Father Engagement
- Develop a Mobile Crisis Team

We're STARTING | We're PROGRESSING | We're ROLLING

Priorities for Collaboration

- Community infrastructure for prevention
- Common Assessment Tools
- Shared Outcomes
- Seamless service coordination for families
- Increased communication and coordinated service delivery between sectors
- Shared Staff Training and capacity
- Shared processes and mechanisms for accountability between organizational Partners
- Shared Data Management Information Systems

We're STARTING | We're PROGRESSING | We're ROLLING



Return on Investment

$ 25,000 = $2,088M ($417K+ year)

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Why this works for Fremont

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Judge Vampola

Community Response

- Description of Community Response
- Number of Families
- Number of Partners

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State Partner Acknowledgement and Priorities

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Thomas Pristow
Director of Children and Family Services
Nebraska Department of Health and Human Services

Functions of Collective Impact

1)	**Common Agenda**	Common understanding and approach
2)	**Constant communication**	Transparency, Trust, common vocabulary
3)	**Mutually Reinforcing Activities**	All partners share the benefits of the outcome
4)	**Backbone Organization**	Structure must reflect desired change
5)	**Shared Measurement Systems**	Common way of measuring and sharing results

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What's working?

- Identification of issues
- Agencies working together
- Funding
- Relationships that have been built
- organized way to get people involved and an opportunity to be proactive versus reactive.
- New opportunities in the community
- The collaboration provides creative solutions
- Ability to access resources for families more quickly
- Increased funding
- Internal changes to organizations to create better infrastructure for collaboration

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Structure Must Reflect Desired Change

- Participants/Inclusive Membership
- Shared Leadership (Defined roles, parameters and responsibilities)
- Shared Decision Making Process
- New Policies and Procedures/Bylaws
- Work groups, sub groups, committees
- Shared and Braided Resources

What needs to be worked on?

- Keeping sight on the issues and not chasing money
- Developing a system of sustainability
- Sharing data and focusing on the collective outcomes

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What Board Members Need to Know

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Amber Barton
Fremont Area United Way
Board President

What's the future?

- There will truly be change in the underlying problems which are evident in statistics.
- The change will not be based on just one grant or one project, but as a result of the collaboration.
- The collaboration will be able to address additional priorities for prevention

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Congrats and Next Steps

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Shawn Shanahan
Fremont Area United Way
&
Dr. Doug Christensen
Chair, Board of Directors, NCFF
Former Commissioner of Education,
Nebraska Department of Education

Next Steps

- Gather feedback and work priority areas for Collective Impact
- Training Schedule
- Update Service Array Plan
- Share evaluation data
- Get Involved: Donna Meismer fremontuw4@omni-tech.net

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Video: Congrats from Dr. Christensen

- Dr. Doug Christensen's Video http://youtu.be/UNI-AHpoh0k

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Wrap Up & Invitation

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Scott Jensen
Fremont Area Medical Center
&
Mayor Scott Getzschman

Training Schedule

- Protective Factors and Family Centered Practices on July 24 (Lincoln)
- Outcome Accountability on July 25 (Lincoln)
- Service Array Plan – October 11
- Power and Influence/Collaborative Skills – September 13, 2013
- Social Marketing Training – November (TBD)
- ToPs Strategic Planning – December 6, 2014
- Cultural Inclusion/Bridges out of Poverty – January (TBD), 2014

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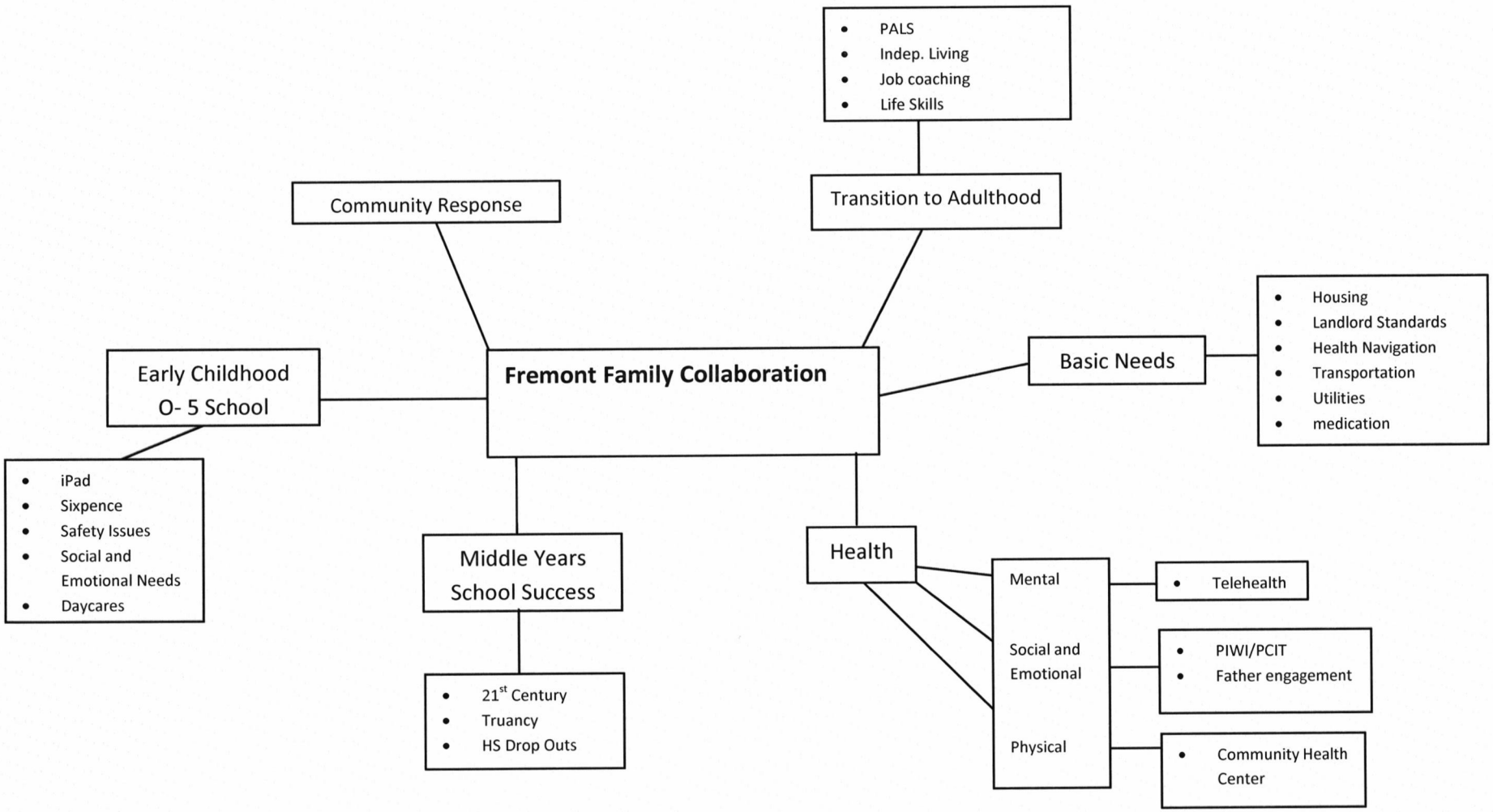
Fremont Family Collaboration
Community Response
Transition to Adulthood
PALS
Indep. Living
Job coaching
Life Skills
Early Childhood
O- 5 School
iPad
Sixpence
Safety Issues
Social and Emotional Needs
Daycares
Basic Needs
Housing
Landlord Standards
Health Navigation
Transportation
Utilities
medication
Middle Years
School Success
21st Century
Truancy
HS Drop Outs
Health
Mental
Telehealth
Social and Emotional
PIWI/PCIT
Father engagement
Physical
Community Health Center

Backbone Effectiveness: 27 Indicators

Guide Vision and Strategy	• Partners accurately describe the **common agenda** • Partners **publicly discuss / advocate for** common agenda goals • Partners' **individual work is increasingly aligned** with common agenda • Board members and key leaders increasingly **look to backbone** organization for initiative support, strategic guidance and leadership
Support Aligned Activities	• Partners **articulate their role** in the initiative • **Relevant stakeholders** are engaged in the initiative • Partners **communicate and coordinate** efforts regularly, with, and independently of, backbone • Partners report increasing levels of **trust** with one another • Partners increase **scope / type of collaborative work** • Partners improve **quality** of their work • Partners improve **efficiency** of their work • Partners feel **supported and recognized** in their work
Establish Shared Measurement Practices	• Shared **data system** is in development • Partners **understand the value** of shared data • Partners have robust / shared **data capacity** • Partners **make decisions** based on data • Partners **utilize data** in a meaningful way
Build Public Will	• Community members are increasingly **aware** of the issue(s) • Community members express **support** for the initiative • Community members feel **empowered** to engage in the issue(s) • Community members increasingly **take action**
Advance Policy	• Target audience (e.g., influencers and policymakers) is increasingly **aware** of the initiative • Target audiences **advocate** for changes to the system aligned with initiative goals • Public **policy** is increasingly **aligned** with initiative goals
Mobilize Funding	• Funders are asking nonprofits to **align** to initiative goals • Funders are **redirecting funds** to support initiative goals • **New resources** from public and private sources are being contributed to partners and initiative

Source: FSG and Greater Cincinnati Foundation

Prevention System = Three Levels of Prevention for Increased Family Protective Factors

Child and Youth Span/Child Well Being (CWB) Strategy: • Parents/Youth as Partners • Increased Trust and Open communication • Ready and Inclusive Communities • Shared Assessment, planning and Implementation, Evaluation process • Identified Community Needs and Gaps – Basic Needs support • Shared Data and Accountability for Outcomes • Infrastructure and Technology • Shared and Braided Resources • Sustainability of Outcomes • Leverage of private and public dollars • Increased capacity of workforce • Prevention System – partner awareness of services available	Age Span	Primary Prevention = Universal Strategies	Secondary Prevention = High Risk Population Targeted Strategies	Tertiary Prevention = High Need Individual Strategies
	19 and older parents and all ages of children	Safe Kids Summer Reading program – Library LFS – Lutheran Family Services Love and Logic	Family Planning NPPD - Nurturing Parenting Program Parents as Teachers BeFriend	Care Corps FSW - Family Support Work visits IFP -Intensive Family Preservation visitations Parents Forever Three Rivers family therapy programs Pathfinder Services Region 6 Professional Partners Parent Child Interaction Therapy Early Childhood Mental Health CPP - Child & Parent Psychotherapy
	9 - 18 Older Youth System of Care (16 – 24)	Public Education	TeamMates Three Rivers Teen Parenting Program	
	0 – 8	MOPS - Mothers Of Pre-Schoolers Dodge County Head Start Every Child Read to Read – Library Parents Interacting With Infants (PIWI)	BBBS - Big Brothers Big Sisters PBS - Positive Behavior Support Save the Child Program Early Childhood Development	

• Referral System for services for families • Cross Training and capacity of multidisciplline professionals		Quality Early Childhood Care Early Childhood Mental Health Home Visitation Baby Talk Dolly Parton Imagination Library	Early Steps - Save the Children HALO Operation Good Start - Goldenrod Hills Program Healthy Families High Scope Home Visits - Goldenrod Hills Home Visitation Books for Babies Head Start Early Childhood Mental Health Coventry Medicaid Home Advocacy HV - Home Visits - for Development Disabilities WIC - Women and Infant Children	

Community Response Program - Fremont

Family contacts Donna or churches

- Partially complete Intake Form - send form to case manager
- Determine if family is qualified for the program

If qualified, case management agency identified

- Finish completing the Intake Form with family

Set meeting with family to completed assessments and identify goals

- Family Well-Being Assessment - set goals
- Budget Form completed
- Pre - Protective Factor Survey completed

Agency partners identified

- Case management agency contacts Donna to discuss which partners to involve
- Family meeting set with referral agencies

Team meetings held

- Team meeting within 30 days of intake
- Documentation of process maintained

Case closure meeting at the end of 90 days

- **Complete forms and send to Donna (then to Barb)**
  - Case Closure Form
  - Post - Protective Factor Survey (excel spreadsheet)
  - Family Satisfaction Survey handed to them (with envelope to mail to Barb)

Follow-up with family at 6 and 12 months

- Were their goals still met?
- Did the services help them?
- Do they need any additional help?

NCFF Results Based Accountability Measure

Strategy: Community Response Project **Category:** Primary Prevention

	Quantity	**Quality**
Effort	# of families that participated in program # of sessions with families # of families re-referred to project	% of families that rate the project as family-centered and are satisfied with the program.
Effect	# of families that did not enter the CPS system # of families that identified at least 3 informal supports by discharge from the project. [Case Closure Form] % of goals completed by families. (Based on post FWA-completion of Family Goal Attainment checklist in Case Closure form)	% of parents reporting improved: (1) access to concrete supports, (2) informal supports and (3) family functions (FRIENDS)

Outline for Community Ownership for Child Well Being Presentation

Overview Community Ownership Model Principles and Practices – Mary Jo

Phases of Development with Fremont Story – Jenny and Fremont Collaborative Leaders

- Phase 1:
  1. Child Well Being outcomes and indicators (importance of establishing results, indicators and alignment of strategies for Child Well Being, share Nebraska Map)
  2. Service Array Assessment common gap and barriers across NE (5 minutes and how it worked in Fremont) – Fremont shares findings and data points
- Phase 2:
  1. New way of doing business compared to how we used to do business. Fremont will share their priorities, how they have addressed the barriers and gaps (above) and created a common community plan and collective impact infrastructure. They can also discuss Org chart, board role, the financing, braiding and leveraging questions that the commission members had.
  2. Provide Visual of Alignment of systems (education, early childhood, public health, child welfare, juvenile justice) for child well being/prevention (handout and discussion in Fremont)
- Phase 3:
  1. Outcome Accountability - Outcomes and Data for Continuous Quality Improvement.
     1. Population (CWB) and performance measures (e.g. Protective Factors)
     2. Strategies implemented with training, fidelity and change in outcomes– Community Response, PIWI and pcit

State level barriers to community ownership and what more is needed – CWB workgroup members

AM2163 – Introduced by Krist March 3, 2014

Filing Procedures and Transfer Mechanism

For a juvenile to be arraigned in a country or district court, the accused must have been under the age of eighteen and over the age of fourteen when the alleged offense was committed. The offense must be either a Class I, IA, IB, IC, ID, II, or III felony, or a traffic offense as defined in Section 43-245.

At the time of the arraignment arraignment, accused must be advise that

1. If they are under 18 years at time offense was committed that
2. Accused may move the county or district court, at any time not later than thirty days after arraignment, unless permitted otherwise for good cause show, that the jurisdiction would be waived to the Juvenile court,
3. If case was transferred to the county or district court from juvenile court, there may be no transfer back to juvenile court.

Motions to transfer

1. Within thirty days of arraignment
2. County or district court shall schedule hearing within 15 days
3. Customary rules of evidence shall not apply at the hearing
4. Accused shall be represented by attorney
5. §43-276 criteria applies
6. Court shall consider all evidence and reasons presented by both parties
7. The case shall be transferred to juvenile court unless a sound basis exists for retaining the case in district or county court
8. County or district court shall set forth findings for the reason for its decisions
9. Complaint, indictment, or information may be used in the place of a juvenile court petition
10. County or District Court making the order shall order the accused to the juvenile court and designate where the juvenile shall be kept pending the determination by the juvenile court
11. Juvenile will be adjudicated by Juvenile court under the Juvenile Code

DHHS, Office of Probation Administration, and IV-E Funding

DHHS shall enter into an agreement with the Office of Probation Administration to act as a surrogate of the DHHS to administer title IV-E state plan for children that the office has placement and care of, to obtain federal reimbursement of allowable maintenance, administrative, and training expenses.

Office of Probation Administration has placement and care responsibilities for juveniles in out of home case who are juvenile as described in subdivision (1), (2), (3)(b) or (4) of Section 23-247

1. Develop a case plan
2. Periodic review of appropriateness of placement and plan
3. Case plan must include
    a. Assessing family strength and needs
    b. Identifying and using community resources
    c. Periodic review and determination of continued appropriateness of placement
4. Court shall provide copies of evaluations reports and evaluations of the juvenile to the juvenile's attorney and county or city attorney prior to any hearing in which the report will be relied upon.

Original Jurisdiction of Juvenile Court

Juveniel Court Shall have exclusive original jurisdiction over

1. Any juvenile described in subdivision (3) of section 43-247 (abuse neglect(
2. Any juvenile who is under 16 years of age at the time of the alleged offense was committed and the offense falls under subdivision (1) of section 43-247(misdemeanor or infraction)
3. A parent, custodian or guardian of any juvenile described in 43-247
4. A juvenile who has been voluntarily relinquished to DHHS or any child placement agency licensed by DHHS (as per 43-106.01)
5. Any juvenile under the age of 14 where the alleged offense falls under section 2 of 43-247 (felony)

Concurrent Jurisdiction of Juvenile Court with District or County

1. Juveniles prosecuted under section (4) of 43-247 (traffic offense)
2. Any proceedings under (6) [TPR], (8) [juvenile who is ward at inception of guardianship and guardianship has been disrupted or terminated], (9) [adoption or guardianship proceedings for a child over which the juvenile corut already has jursidction under another provision of the Nebraska Juvenile Code], or (10) [paternity or custody determination for a child over which the juvenile court already has jurisdiction] of 43-247
3. Juvenile moving for transfer under 29-1816

YRTC Placement after July 1, 2013

1. Alleged that juvenile has exhausted all levels of probation supervision and options for community based supervision and section 43-251.01 has been satisfied, a motion for commitment for YRTC may be filed

2. Motion must set forth specific factual allegations that support the motion
3. Juvenile is entitled to a hearing before the court to determine validity of allegations
4. Burden of proof is on state – preponderance of the evidence that – all levels of probation supervision have been exhausted, and all options for community based services have been exhausted, and placement at YRTC is necessary for the protection of the juvenile or person or property of another or it appears the juvenile will fless jurisdiction
5. Court will notice OJS
6. OJS will notice interested parties upon plans for release of juvenile and re-etnry plan will be created

OJS is responsible for transportation to and from YRTC

Payment of Costs for Juveniles

Payment of costs for juveniles under (1), (2), (3)(b), or (4) of section 43-347

1. The county for the period of time prior to adjudication
2. Office of Probation Administration for period after adjudication until termination fo court jurisdiction; time period prior to adjudication for a juvenile on probation and is alleged ot have committed a new violation or is subject to a motion to revoke probation, and preadjudication evaluations and preadjudication placements that are not detention; and

Juveniles Placed on Probation Subject to Supervision of Probation Officer

Whenever a juvenile is placed on probation subject to supervision of probation officer, Office of Probation administration is deemed to have placement and care for the juvenile

1. Court orders initial placement and level of care, and may solicit a recommendation from the Office of Probation Administration
2. Status of juveniles in out of home placement will be reviewed no less than every six months by the court
3. OPA may transition juvenile to less resitrctive placement or same level fo restriction, after filinfd a notice of placement change and providing to the court and interested parties at elast 7 days before making the change.
4. Immediate placmenet change authorized id juvenile is in hamful or dangerous situation and approval of court sought within 24 hours.

Jurisdiction until Age of 21

Court may retain jurisdiction until youth reached the age of 21, if continuation is in best itnersts of juvenile and juvenile fives his or her informed consent

Evidence Based Practices

OJS will begin implementing evidence based practices, policies, and procedures by January 15, 2016, as determined by the office, and will provide a report to Governor, Legislature, and Chief Justice of the Supreme Court each year on Nov.1

Community Based Juvenile Services Aid Program Funding

Community Based Juvenile Services Aid Program, aid recipients shall prioritize programs and services that will divert juveniles from the juvenile justice system, reduce population in detention, and assist in transitioning juveniles from out-of-home placement

1. Funds received under this program shall be used exclusively in implementing and operating programs or the provision of services identified in aid recipient's juvenile services plan.
2. Funds cannot be used for constructing secure detention facilities, secure youth treatment facilities, capital construction or the lease or acquisition of facilities, programs, services, treatments, evaluations, or other services not based or grounded in evidence based practices, principles, and research .
3. Commission may approve pilot projects that authorize the use of such aid, or office equipment, office supplies or office space.
4. Nebraska Commission on law enforcement and criminal justice

AM2164 – Ashford, March 3, 2014

Investigation

After reports, investigations must be immediately commenced by the attendance officer of the school.

The school board (not district) will have a written policy on attendance and this amendment would require an annual review of the policy.

Services to Address Barriers to Attendance

1. Verbal or written communication by schools officials with the person or persons with legal or actual charge of the child.
2. Meeting or meetings between school attendance officer, a school social worker, school administrator (or designee), person with legal or actual control of child, and the child when appropriate to address the barriers to attendance. Result of the meeting or meetings shall be to develop a collaborative plan to reduce barriers. Plan shall consider but not limited to:
    a. Illness related to physical or behavioral health
    b. Educational counseling
    c. Emotional counseling
    d. Referral to community agencies for economic services
    e. Family or individual counseling, and
    f. Assisting family with other community services.

Reporting to the County Attorney

1. School may report when the school has documented the efforts required by this amendment and the collaborative plan has not been successful and the child has been absent more than 20 days per year.
2. School will notify family in writing prior to referring child to county attorney.
3. Illnesses that make attendance impossible or impracticable shall not be the basis for a referral to the county attorney.

Council on Student Attendance

Changes the "Truancy Intervention task Force" to the "Council on Student Attendance"