Nebraska Children's Commission

Thirty-second Meeting
May 19, 2015
9:00 AM – 3:00 PM
Project Harmony
11949 "Q" Street, Omaha, NE 68137

Call to Order
Karen Authier called the meeting to order at 9:02 a.m. and noted that the Open Meetings Act information was posted in the room as required by state law.

Roll Call
Commission Members present: Karen Authier, Beth Baxter, Jennifer Clark, Kim Hawekotte, Gene Klein, David Newell, Debra O'Brien, Mary Jo Pankoke, Dale Shotkoski (9:06), and Diana Tedrow.

Commission Members absent: Teresa Anderson, Holly Brandt, Candy Kennedy Goergen, Norman Langemach, Andrea Miller, and Susan Staab.

Ex Officio Members present: Tony Green, Courtney Phillips (9:13), Judge Linda Porter, and Julie Rogers.

Ex Officio Members absent: Senator Kate Bolz, Ellen Brokofsky, Senator Kathy Campbell, and Senator Patty Pansing-Brooks.

Also in attendance: Bethany Allen, Mandy Bush, Jeanne Brandner, Lynn Castrianno, Alyson Goedken, Vicki Maca, Donna Rozell, Jennifer Skala, Julia Tse, and Nick Zadina.

Consent Agenda Items
Kim Hawekotte made a motion to approve the consent agenda items, the March 17, 2015 Nebraska Children's Commission Meeting Minutes and the Foster Care Reimbursement Rate Committee Nomination Report. The motion was seconded by Jennifer Clark. Voting yes: Karen Authier, Beth Baxter, Jennifer Clark, Kim Hawekotte, Gene Klein, David Newell, Debra O'Brien, Mary Jo Pankoke, Dale Shotkoski, and Diana Tedrow. Voting no: none. Teresa Anderson, Holly Brandt, Candy Kennedy Goergen, Norman Langemach, Andrea Miller, and Susan Staab were absent. None abstained. Motion carried.

Approval of Agenda
A motion was made by Gene Klein to approve the agenda as written. The motion was seconded by Jennifer Clark. Voting yes: Karen Authier, Beth Baxter, Jennifer Clark, Kim Hawekotte, Gene Klein, David Newell, Debra O'Brien, Mary Jo Pankoke, Dale Shotkoski, and Diana Tedrow. Voting no: none. Teresa Anderson, Holly Brandt, Candy Kennedy Goergen, Norman Langemach, Andrea Miller, and Susan Staab were absent. None abstained. Motion carried.

Chairperson's Report
Karen Authier gave a brief chairperson's report. She reminded the Commission that as per the Structure Taskforce's recommendations Vice Chair Beth Baxter would become Chair and a Vice Chair will need to be elected in July. The Structure Taskforce will serve as the nominating Committee. She then invited the Commission members to introduce themselves to Courtney Phillips, the CEO of the Department of Health and Human Services.

DHHS Update
Courtney Phillips, CEO of the Department of Health and Human Services, gave the Commission an update on the Department's activities. She noted that she is in the process of reaching out to stakeholders for feedback to plan priorities for the Department.

Child Welfare Financing Primer Update and Action Item
Karen provided an update on the Child Welfare Financing Primer (Primer). She noted that there had been two release events, one for senators and another for the public. Tony Green stated that the Department is very interested in continuing the dialogue and further discussing the funding system. He noted that the Department was in a period of significant transition while the Primer was developed, and that further discussion could provide clarity to some questions from the Primer. The Commission discussed options for fund-mapping and the legislative study (LR296) that will explore child welfare financing.

Lead Agency Taskforce Update and Action Item
Beth Baxter provided an update from the Lead Agency Taskforce. The Taskforce has met to look broadly at the options for managing child welfare systems across Nebraska. She shared that the Taskforce has looked at the challenges and strengths of both public and private management of the child welfare system. The Department and NFC representatives attended the last meeting to provide information and perspective. The Taskforce will continue looking at the big picture issues that play into the child welfare system, and anticipates having recommendations at the next Commission meeting in July 2015.

Workforce Workgroup DHHS and NFC Response to Recommendations.
Tony Green and Vicky Maca led a presentation of the Department's response to the Workforce Workgroup's recommendations from the March 2015 Commission meeting. They walked the Commission through their efforts to increase retention, incentivize education, and address vicarious trauma. Due to time constraints, the presentation was stopped, and the Commission moved to the next agenda item, with the intention to return to the presentation.

Project Harmony Alternative Response Training
Mandy Bush and Nick Zadina from Project Harmony provided the Commission with an abbreviated version of a training provided to Alternative Response workers. The interactive training included videos, discussion, and a simulation of a home visit on a stage set.

Workforce Workgroup DHHS and NFC Response to Recommendations
Following the training, Tony Green and Vicky Maca returned to their presentation. Dave Newell, Lynn Castrianno, and Donna Rozell provided NFC's response to the Workforce Report. Tony shared that they have determined a way to access IV-E funds for NFC's training. Julie

Rogers noted that the next steps for the workforce workgroup would be to reconvene and determine next steps.

Alternative Response Update
Tony Green and Vicki Maca provided an update on the Alternative Response program. Vicki noted that they strive to understand the behavior drivers and connect families with sustainable community resources. Vicki walked the Commission through a comprehensive presentation that included data and updates.

Barriers to Permanency Report Panel and Discussion
Chairperson Karen Authier noted that the meeting was nearly out of time and there were action items still left on the agenda. Kim Hawekotte and Julie Rogers agreed to continue the panel and discussion until the July meeting.

Community Ownership of Child Well-Being Report and Action Item
Mary Jo Pankoke, Chair of the Community Ownership of Child Well-Being workgroup, led the Commission through the workgroup's report. She noted that there are two recommendations that she would ask the Commission to adopt. Mary Jo Pankoke made a motion that the Commission recognize the Prevention Partnership as a state-level collective impact group as per the report, and that the Commission adopt the definitions for "prevention system" and the three levels of prevention as presented. Gene Klein seconded the motion. Discussion was held. A roll call vote was taken. Voting yes: Karen Authier, Beth Baxter, Jennifer Clark, Kim Hawekotte, Gene Klein, Debra O'Brien, Mary Jo Pankoke, Dale Shotkoski, and Diania Tedrow. Voting no: Dave Newell. None abstained. Teresa Anderson, Holly Brandt, Norman Langemach, Andrea Miller, and Susan Staab.

Legal Parties Taskforce and Action Item
Kim Hawekotte, Chair of the Legal Parties Taskforce, gave a brief update. She noted that the Taskforce would be looking at Unified Family Courts and Jennifer Clark had been working to recruit members from other areas of Nebraska for the Taskforce.

Juvenile Services (OJS) Committee Report and Action Item
Kim Hawekotte, Co-Chair of the Juvenile Services Committee, gave a brief update. She noted that the Committee would have presentations on Medicaid and Magellan Services in June, presentation on evaluation and assessments in July, and may have representatives from Missouri's juvenile justice system present in August.

Probation Report
Jeanne Brandner, Deputy Probation Administrator of the Juvenile Services Division, gave a Probation update. She updated the Commission on interim studies that could affect Probation, and noted that LB500 had passed earlier in the day. Probation is working on a template update for July.

Policy Analyst Update
Chairperson Karen Authier directed the Commission to the written materials for this agenda item, due to time constraints.

Next Meeting Planning
The Commission discussed meeting planning for the July meeting. The new senators would be attending, and members discussed an on-boarding process. Members discussed a possible location, including meeting in a Native community, or a community with an active community collaborative.

Next Meeting Date
The next meeting is Tuesday, July 21, 2015, from 9:00am to 3:00pm.

Adjourn
A motion was made by Kim Hawekotte to adjourn the meeting, seconded by Diana Tedrow. The meeting adjourned at 3:05 pm.

Nominating Committee Report

Report to the Nebraska Children's Commission
July 2015

The Department of Health and Human Services (DHHS) has nominated the following individuals to serve in open DHHS positions on the Foster Care Rate Committee. These positions are non-voting positions.

- Western Service Area: Jerrilyn Crankshaw, Western Service Area Administrator
- Southeast Service Area: Sherrie Spilde, Southeast Service Area Administrator
- Eastern Service Area: Stacey Scholten, Statewide Foster Care Licensing Administrator

The Nominating Committee supports these nominations and recommends their appointment to the Foster Care Rate Committee.

Nebraska Children's Commission

Data, Technology, Accountability, and Reporting Update

July 21, 2015

Members: Karen Authier, Nebraska Children's Home Society, Doug Beran, DHHS-CFS, Michelle Borg, Department of Education, Lynn Castrianno, Nebraska Families Collaborative, Linda Cox, Foster Care Review Office, Sarah Forrest, Office of the Inspector General of Nebraska Child Welfare, Claudette Grinnell-Davis, University of Nebraska at Omaha Grace Abbott School of Social Work, David Newell (Chair), Nebraska Families Collaborative, Kim Hawekotte, Foster Care Review Office.

Workgroup Activities

The Data, Technology, Accountability, and Reporting (DTAR) Workgroup continues to meet to work towards the Commission's statutory duty of identifying the type of information needed for a clear and thorough analysis of progress on child welfare indicators. The Workgroup has focused its initial attention to child safety, child well-being and disproportionate minority representation indicators.

The Workgroup's next steps will be to collaborate with Jennifer Haight from Chapin Hall to plan a data presentation for the Commission's September meeting. In preparation for this meeting, the Workgroup would like Commission members to send answers to the following questions:

1) What kinds of information should the Commission focus on?
2) How should the Commission use information related to this focus?

Please send answers via email to Bethany Allen at Bethany.allen@nebraska.gov.

Lead Agency Taskforce Final Recommendations

July 21, 2015

Report to the Nebraska Children's Commission

Nebraska Children's Commission

Lead Agency Taskforce Final Recommendations

July 21, 2015

Background

The Lead Agency Taskforce ("Taskforce") is a group formed by the Nebraska Children's Commission ("Commission") for the purposes of considering the potential role of lead agencies in Nebraska's child welfare system. The group was formed with representation from all three branches of government and other stakeholder organizations. A listing of members is attached as "Appendix A," and a summary of the Taskforce's activities is included as "Appendix B."

Purpose

The Nebraska Children's Commission has been tasked by statute to "consider the potential of contracting with private non-profit entities as a lead agency" (Neb. Rev. State. §43-4204(1)(a)). The statute states that lead agency utilization must be done in such a way to maximize the strengths, experience, skills, and continuum of care of the lead agencies.

The charge of the Taskforce was to look broadly at the options for management of the child welfare system and services across the state with lead agency contracting as one of the options and render opinions for consideration by the Commission, the Governor, and the Health and Humans Services Committee of the Legislature. The Taskforce agreed that this charge does not include the rendering of an opinion as to the operations and outcomes demonstrated by the Nebraska Families Collaborative, the current lead agency in Nebraska, but to look at the big picture of child welfare management across the State.

Foundational Values

The foundational value the Taskforce used to frame its recommendations is to "do no harm." The Taskforce recognizes that change has the potential to disrupt a system that is still trying to achieve stability. Any change made to the child welfare system will have effects on families and children, the stability of the workforce, and the ultimate ability of the system to achieve the mandates of child safety, permanency, and well-being. Crucial elements of systems level work are a focus on people and a family centered philosophy. Change to the child welfare system must be carefully planned, adequately funded, and designed to achieve specific and measurable outcomes.

The Taskforce also framed its work by recognizing that while the State can delegate child welfare functions, it is also held responsible for the care and placement of children who are wards of the state. This report makes recommendations regarding the complex issues

experienced by states implementing the lead agency model. Those in authority to implement a lead agency structure should consider the broader issues of delegating fundamental child welfare responsibilities.

Components of a Seamless System of Care

The Taskforce determined that the child welfare system in Nebraska should be a seamless system of care. The Taskforce identified seven components of a seamless system of care, and developed recommendations to manage the child welfare system through supporting these seven components. These components are (1) Outcomes and Accountability; (2) Clarification of Roles and Responsibility; (3) Quality Case Management Workforce; (4) Trust; (5) Adaptive and Individualized to Children, Families, and Communities; (6) Coordinated and Flexible Service Delivery Model; and (7) Single Data Repository/Warehouse.

Outcomes and Accountability

The first component of a seamless system of care is outcomes and accountability. A seamless system of care must identify and agree upon clearly defined outcomes. This includes mechanisms to hold stakeholders accountable for achieving or not achieving the identified outcomes.

1. **The Taskforce recognizes the benefits of the Continuous Quality Improvement (CQI) process and recommends that it continue.** Nebraska's Department of Health and Human Services (DHHS) – Children and Families Division has implemented a CQI process, including meeting with staff from each service area and the lead agency pilot project to review data and identify strategies for improvement. The CQI process should continue and any lead agency providing case management services should be included in the process.
2. **Nebraska's child welfare system must make the transition to the new Child and Family Services Review (CFSR) measures as soon as the measures are clarified.** The new CFSR measures better capture the outcomes of the system and the state will be held accountable to these measures.
3. **The agency providing case management services, whether the State or a lead agency, should be responsible for outcomes.** While other partners in the system should be involved in the attainment of the outcomes, ultimately the agency providing case management must be held accountable for attaining or not attaining outcomes for families and children. If the lead agency model is utilized, the outcomes and responsibility should be included in the Request for Bids (RFB) and contract. Expected outcomes should be uniform for all agencies providing case management.

4. **If Results Based Accountability (RBA) will be used, it must work for all players in the system.** An RBA framework will look differently for a lead agency than a contracted service provider. Entities should be held accountable for results that they can impact.
5. **The data that is collected for accountability should be necessary to monitor identified systemic indicators and not require duplicate data entry.** Systemic indicators should be identified to determine what information is necessary and required. Information and data requires caseworker input to collect. Data collection can require large amounts of caseworker time and effort that is spent away from families, and should be minimized as much as possible.
6. **If the lead agency model is utilized, Nebraska must effectively address the challenges to lead agencies accessing Nebraska's existing child welfare information technology system, Nebraska Family On-line Client User System (NFOCUS).** Lead agencies often struggle when lead and public agencies maintain different data and information systems. The lead agency may have invested significant amounts of money in a system that is incompatible, or the existing SACWIS system may not be able to accommodate the needs of the lead agency. Fortunately, other states have tackled this issue and can provide guidance. Some possible solutions include:
    a. Granting secondary access to lead agency staff, including two levels of access. Case managers need case level access to make quality decisions for the children and families they serve, and the lead agency needs access to aggregate data for an internal CQI process;
    b. Creating a search function that is accessible by lead agency staff;
    c. Creating relevant alerts that are available to the lead and public agency staff;
    d. Including the lead agency in systems improvement processes and focus groups;
    e. Addressing SACWIS use in the contract between the lead and public agency;
    f. Making extensive training available to both the lead and public agency employees on the use of the SACWIS;
    g. Lead and public agencies working together to create a common data dictionary so that codes and definitions are standard statewide.

Clarification of Roles and Responsibility

A seamless system of care has clarified roles and responsibilities for each specific position, agency, and stakeholder. Unclear roles create uncertainty, confusion, and mistrust within the system. Effective relationships are fostered when individuals understand and respect their own and each other's roles. Roles should be designed to serve children and families as efficiently as possible. This section addresses a number of legal party issues between

the public agency and lead agency. The Legal Parties Taskforce of the Nebraska Children's Commission is developing recommendations regarding the roles of other legal parties, but the recommendations in this section are limited to lead agency related roles.

1. **A seamless transition plan needs to be created and implemented between the initial assessment workers and case managers.** Families involved in the child welfare system need access to services as soon as possible. Delays between initial assessment and case manager engagement delay the seamless provision of necessary services which in turn ultimately delays permanency for child. Communication between the workers must support the seamless system of care, and not create delays. The process of transition should be collaborative and focused on timely access to services. This recommendation should be implemented regardless of lead agency utilization.
2. **If the lead agency model is to continue, the Legislature must clarify issues of legal custody of children who are state wards.** As per statute, DHHS maintains legal custody of state wards, is responsible for their care, and decision making inherent in case management (Neb. Rev. Stat. §68-1211). Although the lead agency is responsible for daily tasks, important decision making remains with the public agency. For instance, a lead agency caseworker cannot consent to medical treatment.
    a. **Address inefficiencies in legal decision making for state wards.** The caseworker for the lead agency, although appropriately trained and thoroughly familiar with the needs of the family and children, must defer to a DHHS worker with less experience with the family. This structure also contributes to a general confusion on the part of the family about the lead agency caseworker's role. The public agency is in the position of having the responsibility to make the best decision for the family, without the family knowledge and contact of the lead agency worker. Other states have dealt with this issue either through statute or through court order.
        i. **Statutory solutions:** Some States have codified that the lead agency has legal authority over the day-to-day decisions of the family. The State indirectly affects case management through contract requirements and licensing regulation, but the lead agency is given broad authority over the decision making for the family.
        ii. **Judicial solutions:** Other states turn to the judicial branch to determine who should make the legal decisions for vulnerable children who are in the custody of the state. Some states allow the judge the ability to issue a court order giving a caseworker legal authority to assume legal custody of the child. Judges ultimately

decide the disposition of the case and have familiarity with the family and child, so it is consistent with the role to allow judges to determine which agency retains legal custody of the child. However, this option would be unavailable in Nebraska, without a statutory change allowing lead agency caseworkers the ability to take legal custody of a child.

iii. **Public Agency solutions:** Some public agencies employ caseworkers who monitor the cases managed by the lead agency. These caseworkers are familiar with the cases and have the authority, as public agency employees, to make legal decisions for the child who is a state ward. Often, this caseworker does not have the face-to-face contact or familiarity with the family and child, but in a system with effective communication and well-defined roles, this can be workable. The public agency monitoring caseworker can be present in the courtroom to discuss the case and present the public agency's position.

iv. Ultimately, very few states have opted to give lead agencies legal custody of children who are state wards. Under Federal Law and guidelines, the state agency maintains the overall responsibility for the placement and care of the child, including the case plan. Although this does not prohibit the state from delegating case plan activities to a lead agency, it does require significant monitoring and oversight from the public agency. If Nebraska continues the lead agency model, it will be necessary to clarify this issue. Making any changes to the delegation of day-to-day decision making will require thoughtful planning, stakeholder buy-in, and a deliberate implementation process.

b. **Consider liability issues inherent in a lead agency taking legal custody of a child who is a state ward.** Contracts will need to address how the risk and liability will be allocated. Lead agencies do not have the same level of immunity from liability that a public agency enjoys. Increased levels of responsibility for lead agencies will in turn create increased levels of exposure to risk. The increased risk of liability will have a chilling effect on smaller, community based agencies that do not have the legal or financial resources to respond to litigation. Further research should be conducted to determine if Legislation can be created to relieve lead agencies of this potential liability by extending the immunity enjoyed by the public agency.

3. **If the lead agency model is utilized, the legal party status of the lead agency must be addressed.** Currently, the public agency is a legal party to the juvenile

court case, and attorneys for the public agency may attend the hearing, file motions, and act on behalf of the agency. The lead agency does not have legal standing, and may not participate as a party in the court proceedings. In some states with the lead agency model, there are times when the lead agency involves its own private legal counsel in a proceeding involving a child who is a state ward, including when conflicting interests arise between the state and lead agency, or when a lead agency caseworker is held in contempt of court. This leaves the public agency legal counsel to advocate on behalf of a case plan the agency did not create. Lead agencies incur legal and financial risk and are held responsible for outcomes, and participation in court proceedings could reduce risk and increase outcomes. If the lead agency is given legal custody of the child, it will be necessary for the lead agency to be a party to the case. It is relatively rare for a lead agency to have full legal party status, but some measure of legal standing could alleviate these legal concerns. Nebraska should clarify what level of legal party participation is expected of the public agency and lead agency, and modify statute accordingly.

4. **If the lead agency model is utilized, reduce role duplication as much as possible.** While a lead agency will require oversight, it is imperative that the roles be clearly defined so that the same jobs are not being done at the state and lead agency level. Duplication at the administrative level may be unavoidable. The public agency will have necessary infrastructure such as payroll, human resources, legal and accounting departments. A lead agency, as a separate entity, will require this infrastructure as well. This duplication should be minimized as much as possible.

Quality Case Management Workforce

This includes quality oversight of caseworkers and case managers who serve as representatives to other systems, including the court.

1. **The Lead Agency Taskforce has reviewed the recommendations of the Nebraska Children's Commission Workforce Workgroup dated March 17, 2015, and supports the recommendations.** This document is attached as "Appendix C"
2. **Caseworker salaries should be increased to attract and retain high quality caseworkers.** While the Workforce Workgroup recommends that "Caseworker salaries should be brought in line with regional averages, taking into account variations in caseworker education, experience, and caseload," the Lead Agency Taskforce recommends that Nebraska increase the salary so that it exceeds the regional average.

3. **Caseworker salaries should include differentials based on experience, education, proficiency in second languages, attainment of key competencies, and other relevant factors.** The nature of casework requires a high level of education, skills, and field experience. Casework is an extremely complex and difficult vocation that deeply impacts families and children. Casework should not be seen as an entry level position, and allowing for merit pay increases and salary differentials for education, skills, and other factors allows agencies to attract and retain the best and most qualified candidates.
4. **Case managers must be supported by quality supervisors.** Supervisors play an extremely important role in the child welfare system. They provide necessary support and expertise to case managers. It is important to employ supervisors with Masters of Social Work degrees, and encourage the attainment of Masters of Social Work Degrees. Quality supervisors contribute to retention, job satisfaction, and improved outcomes for children and families.
5. **System stakeholders support caseworkers.** The support of stakeholders impacts caseworker retention. Caseworkers may be employed by a public or lead agency, but come into contact with stakeholders from all systems. For instance, caseworkers spend a significant amount of time in court, and therefore need the support of attorneys, judges, and Guardians ad Litem. Another key component is quality supervisor support for case managers.
6. **Caseworkers should not be required to make unnecessary or duplicate data entries to report data.** This recommendation has been discussed as a part of Outcomes and Accountability, but its impact on caseworkers merits discussion under this component. Casework attracts individuals who are dedicated to families and children, and wish to spend their time actively helping their clients. Many caseworkers struggle to balance work and life while meeting the demands of the families they serve. Adding unnecessary or duplicative data–collection and entry further burdens caseworkers.
7. **If the lead agency model is utilized, the contract must include provisions to ensure a quality case manager and supervisor workforce.** The contract should include staffing requirements, and show how the lead agency will use its creativity and flexibility to foster its workforce. The contract should also include training that is consistent with state and federal requirements, but not necessarily the same training utilized by the public agency.
8. **If case management remains a function of the public agency, addressing the restrictions to increasing caseworker salary and allowing for caseworker salary differentials should be a priority.** Currently, public agency caseworkers are hired at the same rate, regardless of the experience or education of the caseworker. The pay structure presents a challenge in recruiting skilled workers. A case worker may be graduating college with a bachelor's degree and no field

experience and another may have a Master's in Social Work and years of field experience, yet will be offered the same pay for the same job. The effect is that the position of caseworker is regarded as an entry level job, when it in fact requires significant field experience and education. Under the current salary structure, caseworkers are hired at the same rate for the same position. Department of Administrative Services rules and Union contract requirements should be examined and possibly re-structured to allow for changes in salary structure.

Trust

A seamless system of care must include trust supported by follow through, consistency, and champions for the child and family. Families, judges, attorneys, providers, caseworkers, and all stakeholders must trust each other and the system.

1. **Trust is enhanced and supported through transparency at all levels.** Trust can be achieved when it is clear that each stakeholder is open and honest. Transparency is necessary to achieve accountability for measures. Policies and practices should enhance and support transparency in the child welfare system. Trust cannot be mandated, but can be created by consistent achievement of outcomes.
2. **The responsibilities of each role are clearly defined and understood.** Each role and its expectations must be clear at every point in the system. When the responsibilities of each role are clear, stakeholders and families can understand what to expect and how to achieve outcomes.
3. **DHHS-CFS and any lead agency must have a collaborative and constructive partnership.** The relationship between the public agency and lead agency is key in any successful lead agency model. The public agency is reliant upon the lead agency to create case plans for the vulnerable children in the custody of the state. A close and trusting relationship is necessary to achieve outcomes.

Adaptive and Individualized to Children, Families, and Communities

Each child, family, and community in Nebraska has different strengths and needs. A seamless system of care is able to effectively address the unique needs and enhance existing strengths. Many proponents of the lead agency model note that the private status of lead agencies should allow them to be more flexible and use funds in ways that are not available to the public agency.

1. **If the lead agency model is utilized, it must support an adaptive and individualized services array and system of care.** If the State does contract out case management, it should expect that the lead agency will develop services, innovate, and use funds for services in ways that the State cannot. The contract should not be for results that the State could produce without a contract. A lead

agency must be more innovative and able to provide a more individualized services array than the public agency.

2. **If the lead agency model is utilized, DHHS-CFS should tailor the Request for Bids to require the bidders to demonstrate how they will be able to change and improve the child welfare system.** The potential lead agency must show how it would serve the children and families differently while achieving the desired outcomes.
3. **Special attention needs to be paid to the unique needs of each service area, and each service area administrator should be given the necessary flexibility to attend to those needs.** Nebraska is diverse in both geography and population. Each service area has different service needs and resources. Service area administrators have the expertise to understand how to serve the needs of the service area, and should be given the necessary flexibility to achieve outcomes.

Coordinated and Flexible Service Delivery Model

A seamless system of care has a coordinated and flexible service delivery model. The case manager should be the primary representative to the child and the family, ensure the child receives services designed to meet their individual needs, and assist the family in accessing needed services. Service providers need the flexibility to provide the necessary services to children and families without interruption or delay. The system as a whole needs the ability to modulate the services within it.

1. **If the lead agency model is utilized, focus on legal and financial requirements, not process protections.** When lead agencies are held to the same policies and requirements as the public agency, it is difficult to achieve different outcomes. Public agencies often place requirements on lead agencies that are meant to protect the public agency. These process protection policies make flexibility difficult. If the lead agency is being held to the public agency policies, it should be to achieve legal and financial requirements, not process protections for the public agency's benefit.
2. **If the lead agency model is utilized, focus on true outcomes, and not process outcomes.** Process outcomes, like process based protections, limit the flexibility of the lead agency. The lead agency should be responsible for achieving true outcomes for families and children, not for the process they use to achieve outcomes.
3. **If the lead agency model is utilized, allow lead agencies the flexibility to show how they can change and improve the system, and implement the changes.** Lead agencies can be restricted by state policies and rules to the extent that they are unable to operate in an appreciably different way from the State. If lead agencies are not given some measure of flexibility in adherence to state policy, it will be impossible for the lead agency to produce different results.

4. **If the lead agency model is utilized, the state and lead agency must work together to transition cases from initial assessment to ongoing case management.** The state and lead agency must work together from the outset of a family's involvement to coordinate the case plan and begin services as soon as possible for the family.

Singular Data Repository/Warehouse

Decisions throughout all levels of the child welfare system must be made based on timely and accurate information. The system needs mechanisms that allow for the gathering, tracking, analyzing and sharing of essential information in a timely manner. Children and families in the child welfare system are often involved in other systems that have knowledge of and responsibility for other aspects of the child and family's life. A single data repository or warehouse allows for coordination of services through increased information and allows providers access to the information necessary to determine eligibility and need for services. Shared data repositories may also allow for better decision making at the public policy level because more comprehensive information is available. The data repository must include data from all systems that a child may touch, including the Courts, Probation, Medicaid, Developmental Disabilities, Behavioral Health, and Education.

1. **If the lead agency model is utilized, State and lead agency data should be analyzed in the same manner so that the comparison, interpretation and reporting of data is consistent.** All agencies responsible for case management, whether State or lead agency should provide data to the singular data repository. All data should be analyzed consistently, so that accurate comparisons can be made and there are informed decisions made at all levels of the child welfare system.
2. **Common definitions of key measures should be created.** A data dictionary is a necessity for a singular data repository. This allows for the true comparison of data, as it is clear what exactly is being measured.
3. **The way that data is arrived at should be transparent.** Data should be used to measure identified systemic indicators that are clearly defined. All public and lead agencies should be held responsible for the same systemic indicators, and agree on the manner in which data points are determined. This will allow for a consistent understanding of the system's ability to meet outcome measures. This will also prevent public and lead agencies from releasing competing or contradictory data.
4. **Data supports quality case management.** Case level data should be accessible by case managers to support quality decisions for the children and families served.
5. **The data repository should also include a reports feature allowing stakeholders to view their or their organization's performance and make internal system changes.** This allows all stakeholders to monitor their own

performance and make necessary system changes to support improved outcomes. Individualized data reports can allow stakeholders to identify areas to improve upon to support the functioning of the child welfare system as a whole.

Summary

The Lead Agency Taskforce has conducted a thorough and thoughtful review of Nebraska's child welfare system, and in addition to the seven components of a seamless system of care, has identified the following three broad summary recommendations:

1. **The Lead Agency Taskforce believes that the lead agency model can be effective if the seven components of a seamless system of care are present.** Regardless of public or lead agency management, these premises must be fulfilled to have a revolutionarily effective child welfare system.
2. **Those in authority for determining whether lead agencies will be utilized should consider the broader issues of whether or not Nebraska should establish contracts which delegate child welfare responsibilities.** Regardless of lead agency utilization, the State remains responsible for the placement and care of children who are state wards.
3. **Case managers and supervisors are the foundation of the child welfare system.** If the foundation of case workers and supervisors is built, the State will have a strong child welfare system regardless of the structure. Workers should be encouraged to make child welfare case work their profession and lifelong career. Child welfare case work should be professionalized through managed caseloads, reduced paperwork and bureaucracy, respectful environments, and valued workers.

Statement of Appreciation

The Taskforce would like to express appreciation for Chairperson Beth Baxter's leadership and vision; and Policy Analyst Bethany Allen's staff support.

Appendix A

Lead Agency Taskforce Members

Name	Title
Beth Baxter	Administrator, Region Six
Jim Blue	President/CEO, CEDARS
Jennifer D. Chrystal-Clark	County Attorney, Douglas County Juvenile Court
Judge Lawrence Gendler	Judge, Sarpy County Juvenile Court
Candy Kennedy-Goergen	Executive Director, Nebraska Federation of Families for Children's Mental Health
Kelli Hauptman	Co-Director, Nebraska Resource Project for Vulnerable Young Children at UNL, Center on Children, Families and the Law
Norman Langemach	Private Attorney and Guardian ad Litem
Mary Jo Pankoke	President/CEO, Nebraska Children and Families Foundation
RuAnn Root	Director, Court Appointed Special Advocates (CASA) of South Central Nebraska

Resources to the Lead Agency Taskforce

Kim Hawekotte	Executive Director, Foster Care Review Office
Julie Rogers	Inspector General of Nebraska Child Welfare

Appendix B

Lead Agency Taskforce Summary of Activities

Date	Activity
March 6, 2015	The Lead Agency Taskforce ("Taskforce") holds its first meeting. The meeting is spent in a general discussion about the subject matter, creating a purpose statement, and identifying key values.
March 17, 2015	The Taskforce presents a written update of activities to the Nebraska Children's Commission ("Commission"). The Commission reaches the consensus that the Taskforce's work should continue as identified by the Taskforce.
March 24, 2015	The Taskforce holds its second meeting. The meeting is spent creating a structure and framework for creating recommendations. The Taskforce identifies critical system components and issues that need to be addressed by recommendations.
April 1, 2015	Survey created to elicit feedback from the taskforce on the critical system components and other issues to be addressed by recommendations.
April 15, 2015	The Taskforce holds its third meeting. The meeting is spent reviewing the results of the survey. Members identify data and information necessary to create recommendations, and request that the Department of Health and Human Services Children and Family Services Division (DHHS-CFS) and pilot project Nebraska Families Collaborative (NFC) send representatives to the next meeting. The Taskforce also requests that the representatives complete the survey.
May 4, 2015	The Taskforce holds its fourth meeting. Representatives from DHHS-CFS and NFC attend to discuss the survey results and provide the task members with information. The Taskforce comes to the consensus that the next meeting should be spent working to create a final report.
May 19, 2015	The Taskforce presents a written update of activities to the Nebraska Children's Commission.
May 27, 2015	The Taskforce holds its fifth meeting and begins to develop recommendations.
June 30, 2015	The Taskforce holds its sixth meeting. The Taskforce reviews a written draft of information from the previous meeting and develops final recommendations.

Appendix C

Nebraska Children's Commission Workforce Workgroup

May 18, 2015

The Workforce workgroup of the Nebraska Children's Commission has identified two key areas of focus to recruit and retain Department of Health and Human Services (DHHS) child welfare caseworkers in Nebraska: increased salary and compensation and the development of career trajectories. Increasing the professionalism and expectations of front line workers and their supervisors is critical to improving outcomes for children in out-of-home care and in the juvenile justice system. Recommendations are listed in priority order.

Role and Importance of Child Welfare Workers

Child welfare caseworkers are critical to the safety, permanency and well-being of children in Nebraska. Caseworkers must be given the tools necessary to effectively perform their jobs and help vulnerable children and families.

Studies abound on the importance of stable and effective caseworkers. The Foster Care Review Office recently cited two studies in its 2014 annual report, noting that caseworker turnover is consistently associated with delays in achieving permanency and increased numbers of placement.

Caseworkers also play a pivotal role in the experience of the child, especially when the child is in an out-of-home placement. Children experiencing the upheaval of being removed from the home need stable and caring adults in their lives. The repeated change of caseworkers removes an important opportunity to provide vulnerable children with much needed stability and certainty.

The average length of tenure for a caseworker in Nebraska is 3.19 years. This not only leaves a vulnerable population of state wards facing the decreased outcomes associated with caseworker changes, but also imposes a significant fiscal cost on the state. Training associated with hiring a new caseworker ranges between $30,000 and $36,000.

Salary and Compensation

Improved salary and compensation should include bringing caseworker salaries in line with national averages and creating salary differentials. Salary differentials should be available for performance and education. Performance incentives include an increased salary differential for achieving key competencies in casework. Caseworkers should

also continue to receive salary increases when moving from frontline casework to mentor and supervisor roles.

Educational incentives include a salary differential for attaining higher education and loan forgiveness programs. Tuition reimbursement and loan forgiveness is a sub-topic of compensation that is closely linked to retention and recruitment. Higher loan forgiveness for caseworkers employed in underserved areas assists in rural communities attracting and retaining child welfare professionals.

Recommendations:

1. Caseworker salaries should be brought in line with regional averages, taking into account variations in caseworker education, experience, and caseload.
2. A loan forgiveness program for attainment of higher education should be established, with higher loan forgiveness for employment in underserved areas and rural areas.
3. A comprehensive evaluation regarding child welfare caseworker professionals should be undertaken by the Legislature and include the issue of caseworker salary in Nebraska.

Education and Professionalism

The role of child welfare caseworker is of critical importance, and should not be considered an entry level position. Caseworkers are in charge of ensuring that families and children receive services and support and making recommendations to the Judge regarding permanency. It is clear that this pivotal role requires attaining high levels of competency through education, training and experience. It is important to encourage caseworkers to attain levels of higher education, including the attainment of a Master's of Social Work. Incentives may include a salary differential for attaining higher education, loan forgiveness programs, or tuition reimbursement.

Recommendations:

1. A comprehensive evaluation regarding child welfare caseworker professionals should be undertaken by the Legislature and include the issue of incentives to encourage the attainment of advanced degrees, including through loan forgiveness programs.

Career Trajectories

Establishment of career trajectories strengthens retention and professional development. Caseworkers should receive increased salaries for performance and supervisory duties. New job classifications can be based on achievement of key competencies with salary increases at each level. Competencies may include the ability

to work with specific populations, maintain high-risk caseloads, attain cultural competency, or speak multiple languages.

Recommendations:

1. Career steps should be identified with accompanying salary differentials for:
    a. Achieving specialized competencies (expertise with specific populations; high risk caseloads; cultural competency; multiple language proficiency);
    b. When moving from frontline casework to mentor to supervisor roles; and
    c. Education achievement beyond bachelor's degree.
2. Encourage and support the continued efforts of the DHHS and NFC.

Caseloads

Caseload sizes have dramatic effects for both workers and the families they serve. A burdensome caseload is the natural consequence of increased turnover, which in turn creates even more turnover when workers feel they are unable to appropriately manage their caseloads. Caseloads are not just abstract numbers; each case represents the lives of families and children. When caseworkers are assigned too many cases they are overwhelmed, lose their confidence in their ability to effectively perform their jobs, and children and families suffer the effects.

The Workforce workgroup acknowledges the work that has been done by the Legislature in the important step of creating caseload limits for child welfare case workers. DHHS and pilot project Nebraska Families Collaborative (NFC) are required by Neb. Rev. Stat. §68-1207(1) to utilize the workload standards of the Child Welfare League of America. DHHS submits an annual report to the legislature outlining the caseloads of its caseworkers

It is important to perform oversight of these numbers, to ensure compliance. One area that can be improved upon is defining vague terms in the caseload standards. Urban, rural, and mixed urban and rural caseload standards are different, due to the drive time encountered in rural cases. Although the caseloads are different, the terms are not clearly defined. Many caseworkers working in areas defined as “urban,” such as Scottsbluff, also service rural areas and experience significant drive time in managing their caseloads. The workgroup recommends that “rural” and “urban” be defined to be more in line with the caseworker’s experiences of the region served.

Recommendations:

1. Clarify definitions of “urban” and “rural” for purposes of calculating caseloads.
2. Create a technological solution to the complexity of calculating mixed-caseloads.
3. Increase oversight to ensure that statutory caseload limits are followed, and that the caseload limit is reviewed for appropriateness.

4. Utilize legislative oversight to ensure that compliance with the caseloads is maintained.

Vicarious Trauma and Compassion Fatigue

"Vicarious trauma" and "compassion fatigue" are two terms used interchangeably to describe the secondary trauma experienced by caseworkers who witness or hear about the traumatic experiences of the people they serve. The nature of the profession attracts workers who care deeply about families, so daily exposure to traumatic events or stories can have negative effects on caseworkers. Vicarious trauma causes unhappiness and distress in caseworkers, with negative consequences for the worker's family life and job performance. Fortunately, there are excellent services and trainings available to help caseworkers prevent and lessen the effects of vicarious trauma.

Recommendations:

1. Make counseling services available to case workers experiencing vicarious trauma or compassion fatigue.
2. Ensure caseworkers are aware of resources to help with vicarious trauma and fatigue, and encourage the utilization of these resources.
3. Encourage the continued efforts of the DHHS and pilot project NFC in this area.

Training and Work Support

An effective social worker has a number of skills and competencies outside of knowledge of the child welfare system, child development, and family dynamics. Key components of the job include the ability of the caseworker to manage his or her time and organize his or her workload, while maintaining a work-life balance. A new caseworker may not have these skills upon entering the workforce. An effective training program should include information on these skills.

Stakeholders have also identified a need to provide critical thinking training for caseworkers. The role and judgment of caseworkers is critical for all families, especially court-involved families. Communication between judges and caseworkers is imperative. Judges need to be able to rely on caseworkers to explain the decisions and recommendations put forth in court. Judges are often unaware of the decision-making tools such as SDM and various assessments that result in the caseworker's recommendations. Caseworkers need to be able to explain the decision making tool utilized, and how the facts of the case were applied to support the recommendation to the Court.

Recommendations:

1. Training programs for new caseworkers should include professional development in areas such as time management and workload management.
2. Develop and utilize a program to ensure effective communication between judges and caseworkers.
3. Develop and utilize a training program that enhances critical thinking skills.
4. Perform a thorough and comprehensive review of caseworker training and curriculum to ensure that it reflects best practices in the field.
5. Encourage and support the continued efforts of the DHHS and NFC in this area.

Next Steps

After forwarding its recommendations to the Legislature, the workgroup will remain available as a resource to the Legislature and the Nebraska Children's Commission for child welfare and juvenile justice workforce related issues. The Workforce Workgroup requests that a comprehensive evaluation be done to explore the components necessary for a stable, effective and professional child welfare workforce and statutory changes necessary to support the workforce.

The Nebraska
Foster Care Review Office
Quarterly Report

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

Issued March 15, 2015

In Appreciation

As described throughout this document, the work done on the Barriers to Permanency Project would not have been possible without the collaboration and cooperation of the following:

- Office of the Inspector General for Child Welfare, especially Julie Rogers.
- The Department of Health and Human Services, especially:
    - Vicki Maca, Deputy Director.
    - Doug Beran, Research, Planning and Evaluation Administrator.
    - Lindy Bryceson, Filed Operations Administrator.
    - Jerrilyn Crankshaw, Western Service Area Administrator.
    - Kathleen Stolz, Central Service Area Administrator.
    - Mike Puls, Northern Service Area Administrator.
    - Sherrie Spilde, Southeast Service Area Administrator.
    - Camas Steuter, Eastern Service Area Administrator.
    - All the supervisors and case managers for the children involved.
    - Jackie Schmucker, Staff Assistant, who assisted with some spreadsheets.
- NFC (Nebraska Families Collaborative), especially Director of CQI/Data Management Lynn Castrianno, Chief Operating Officer Donna Rozell, and NFC supervisors, case managers, and staff.
- The Court Improvement Project, especially Staff Attorney Kelli Hauptman.
- Intern Leanne Hinrichs, who assisted with some spreadsheets.

Please accept our thanks
on behalf of the Foster Care Review Office
and
Nebraska's abused or neglected children.

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, identify conditions and outcomes for Nebraska's children in out-of-home care, and make recommendations on any needed corrective actions. The FCRO is an independent state agency, not affiliated with the Department of Health and Human Services, the Courts, the Office of Probation, or any other child welfare entity.

This Quarterly Report focuses on the collaborative work done by the Barriers to Permanency Project and features the recently completed report by the collaborative.

One of the recommendations from the FCRO's June 2013 Quarterly Report was the creation of a collaborative process to review cases of children that had lingered in foster care in order to determine their individual characteristics and what was preventing the children from reaching a timely permanency.

By August 2013, the Barriers to Permanency Project (hereinafter referred to as the Project) had been created and a collaborative was formed including the Nebraska Inspector General of Child Welfare, the Department of Health and Human Services (DHHS), Nebraska Families Collaborative (NFC), the Court Improvement Project (CIP), and the Foster Care Review Office (FCRO).

The group looked at children that at a point in time were in out-of-home care for three years or longer. As the group reviewed the cases, they collected data regarding the children's characteristics. It was found that children with serious or chronic conditions tend to remain in an impermanent situation longer than other children, while having some of the highest levels of needs. (page 11)

Then there were staffings with the children's worker and supervisor in which pairs of members of the collaborative interviewed those workers to determine the top barriers to permanency for each case. Final statistics were tabulated.

In summary, the top five barriers to permanency identified by the group included: (page 27)

1. Past case management/supervision issues and practices.
2. County attorney would not, or could not, file a termination of parental rights petition.
3. Court delays, continuance, full dockets, scheduling issues, and related matters.
4. Need for a relative search at the time of removal.
5. Length of time to an appellate decision on a termination of parental rights.

After reflecting on the data collected and the comments made by workers and supervisors, we began to organize and draft this Report. From the beginning we were clear that we wanted this Report to not only help the children who met Project criteria but also to prevent other children from facing prolonged out-of-home care experiences.

Based on discussions of the barriers, the members of the collaborative were asked to provide their input on the top systemic changes that must occur if we are to achieve timely permanency for all children.

Top Systemic Changes Needed

1. **Change to a true rehabilitative model for child welfare.** Nebraska is in the position of having juvenile courts that should be of the rehabilitative model having to work within a prosecutorial or adversarial framework. By definition this puts parents on the defensive when their children are removed from the home – which is precisely the period when you want to engender the most collaboration and problem-solving so that issues can be resolved quickly.

   Nebraska should look at how other states structure their child welfare systems to be rehabilitative. For example, one area to consider is the transfer of legal responsibility from the County Attorney to DHHS attorneys after adjudication. Since DHHS attorneys represent the case manager, the primary person responsible for recommendations to the legal parties, cases could proceed quicker through the legal system. That would require a change in statute to allow DHHS attorneys to file certain legal proceedings such as termination of parental rights petitions.

2. **Improve access to funding, resources, and services throughout all parts of the service array. Do so in a way that does not require an out-of-home placement in order to access services. Reserve out-of-home placements for true safety concerns.**

   a. **Expand prevention services, including those outside the formal system,** so that more children can be safely maintained in the home while addressing issues before they reach a crisis level**.** This is also a key component of a rehabilitative system.

   b. **Find a practical way to blend or braid funding so that families can get the services they need.** Funding is an obstacle to serving children at home, to getting children and families needed therapies, treatments, and services, and to supporting reunification. Funding comes from a variety of different "silos," each with their own often contradictory requirements.

   c. **Develop a crisis/emergency response unit** to work with families that have reunified or at risk for a removal. A crisis tends to happen at night or on the weekends when therapists are not working. Families in crisis need immediate access to defuse the situation until they can get into on-going help. This could help keep more families intact and reduce the trauma for children.

   d. **Re-assess the way that Nebraska interprets Medicaid rules**. The rules are currently interpreted in the narrowest way, restricting access to services. In other states, Medicaid reimburses providers more adequately and will pay for expenses that are denied by Nebraska. Service provider capacity is always an issue, and Nebraska would likely have more providers and different services if it could be more flexible on how it spends available funds.

3. **Stabilize the case management workforce. Determine why vacancies occur**, especially in the rural areas. Use what is learned to stabilize the workforce, and reduce the burden placed on remaining staff when vacancies occur.

4. **Create better case management practices.**

    a. **Put a stronger focus on SDM assessments**[1] for decisions and case progression both within the judicial system and case management system.

    b. **Assure that decisions made by the judicial and the case management systems are trauma informed**.

    c. **Identify and address mental health issues early on,** whether that is for infants, toddlers, or older children.

    d. **Ensure that an extensive family search and engagement process begins immediately upon removal.** Locate and engage non-custodial fathers and extended family/relatives. Determine their suitability as placements.

    e. **Create more placement options** based upon the unique needs of the child**.** We need Nebraska providers to commit to serving all youth and the judicial system needs to stop ordering them out of state. The farther away such placements are, the more difficult to reunify with family or achieve other forms of permanency in a timely manner. Rural areas in particular have a lack of treatment foster homes and professional resource family care.

    f. **Hold parents accountable** and ensure that all services are goal-oriented so that an appropriate decision can be made as to whether substantial changes have been completed to safely care for their children.

    g. **Increase availability of child/adolescent mental health resources.** Children who need higher levels of care often have to leave their communities and support networks to receive the care they need. Also, in rural areas there is a lack of mental health providers. This results in children and families having to travel at some distance, causing children to miss school and activities and sometimes being placed in out-of-home care.

5. **Address legal issues.**

    a. **Improve timely access to the court dockets,** especially in Omaha, for termination of parental rights (TPR) trials, requests for hearings, and to set aside more time for hearings.

    b. **Assist areas of the State where it is difficult for county attorneys to file a termination of parental rights petitions due to the amount of labor or costs.** For example the Western Service Area has difficulty in being able to get more than one TPR filed at a time in some jurisdictions because of the labor intensive requirements. We also have some areas that are concerned about the costs of the TPR and court proceedings.

    c. **Continue to monitor the time for an appellate decision.**

[1] SDM, or Structured Decision Making, is a proprietary set of assessments which has been shown to standardize response to child abuse and neglect reports.

6. **Examine how the state could look at data and information in a continuous, consistent manner.** Develop means for DHHS to have more flexibility and the ability to report out data easily. Start discussions of a possible data warehouse to enable a broader view of data on children in out-of-home care. Information sharing among separate data systems must occur with the goal of determining outcomes and whether children are better off when they exit the child welfare system than when they entered.
7. **Replicate this Project in a few years to determine the extent of any improvements and to identify any new issues.**

In addition to the above recommendations, in this Report you will find a description of common characteristics of children who met Project criteria (3 or more years in out-of-home care), how those characteristics impact children's needs, and a description of each of the top barriers to permanency that were identified by Project participants.

We also point your attention to the next section on changes that have already occurred due to the Project.

CHANGES THAT HAVE ALREADY OCCURRED DUE TO THE PROJECT

In addition to increasing the amount of collaborative brain-storming that is occurring in a number of different venues, some important system improvements have been planned and/or implemented as a result of this Project.

Children whose cases have closed

More than half, **252 (55%) of the Project children achieved permanency or otherwise left foster care** by February 2, 2015. The chart below shows why they exited the system.

	Central	Eastern	Northern	Southeast	Western	Total
Adopted	2	88	4	11	21	**107 (43%)**
Reached age of majority	2	46	2	12	1	63 (25%)
Return to parent or guardian	1	32	1	2	1	37 (15%)
Guardianship	2	25	0	6	2	**35 (14%)**
Transferred to another agency (often Probation)	0	1	1	2	1	5 (2%)
Transferred to adult court	0	3	0	0	0	3 (1%)
Runaway, dismissed by court	0	1	0	0	0	1 (<1%)
Total	**7**	**196**	**8**	**33**	**7**	**251**
Percent of children in the Project that left care	*29%*	*64%*	*29%*	*40%*	*41%*	*55%*

It is critical to note here that the Eastern Service Area was done first (December 2013) and thus those cases have had the most time to return home. The Southeast Service Area was done next (March 2014). The Central, Northern, and Western were then done at the same time (late summer 2014).

Therefore, it would be expected that more children from the Eastern and Southeast areas would have achieved permanency in the period since the Project review of their cases.

Relative search documentation made easier to find

Project members, including DHHS staff, had difficulty finding documentation about searches for relatives, the results of those searches, and whether certain relatives needed to be re-contacted to determine if they might now be suitable placements for the child.

However, during the course of the Project, DHHS developed and has now implemented several computer system improvements including:

- Mechanizing the required notification to the court of worker's contacts with family and making that easier to find.
- Automating the contact letter to selected family members.
- Standardizing where to document family response.
- Providing a visual depiction of family relationships.
- Creating reports to supervisors regarding whether family contacts have been documented on the system in required timeframes.

This is an amazing amount of work in a short period of time. **We congratulate DHHS on this accomplishment**.

Changes in the Court of Appeals

As a result of the issues we have previously discussed and the annual report of the Office of Inspector General for Child Welfare, the Court of Appeals and Administrative Office of the Courts did conduct an internal review of the appeal processes within the appellate courts. As a result of their review, certain processes were changed and the length of time to an appellate decision has been reduced.

Cross-agency discussions on how to apply lessons learned to daily practice

Project findings have been a regular item of discussion in a monthly collaborative meeting with DHHS administration, the Court Improvement Project, the Inspector General for Child Welfare, the Office of Probation Administration, and the Foster Care Review Office. Discussions have been centered on the application of what was learned from the Project to practices in the field.

There have also been discussions between the Foster Care Review Office and Nebraska Families Collaborative (NFC).

Meetings with external stakeholders

DHHS has invited the FCRO to discuss statistical and other findings from FCRO reviews and the Barriers to Permanency Project at its regular meetings with external stakeholders who provide placements and/or services. Discussions will be centered on how external stakeholders are needed to truly impact systemic reform in this area.

ORIGINS AND DESCRIPTION OF THE BARRIERS TO PERMANENCY PROJECT

The Foster Care Review Office's June 2013 Quarterly Report focused on children that had been continuously in out-of-home care for more than two years. That report did not include the months spent in foster care during prior removals. It just considered their current removal from home. Some of the state-wide data in that report included:

- 870 (23%) of the 3,854 children in out-of-home care at that time had been in out-of-home care for 2 years or longer, with 432 of those in out-of-home care for 3 years or longer. [*By the time the Project reviewed cases, there were 455 in care 3 years or longer*.]
- The Eastern Service Area and Southeast Service Area had a significantly higher percentage of children in out-of-home care for two years or longer.

One of the recommendations from the FCRO's June 2013 Quarterly Report was the creation of a collaborative process to review each of these children to determine their individual characteristics and barriers to permanency.

By August 2013, the Barriers to Permanency Project (hereinafter referred to as the Project) had been created and a collaborative was formed including the Nebraska Inspector General of Child Welfare, the Department of Health and Human Services (DHHS), Nebraska Families Collaborative (NFC), the Court Improvement Project (CIP), and the Foster Care Review Office (FCRO).

Two points were considered:

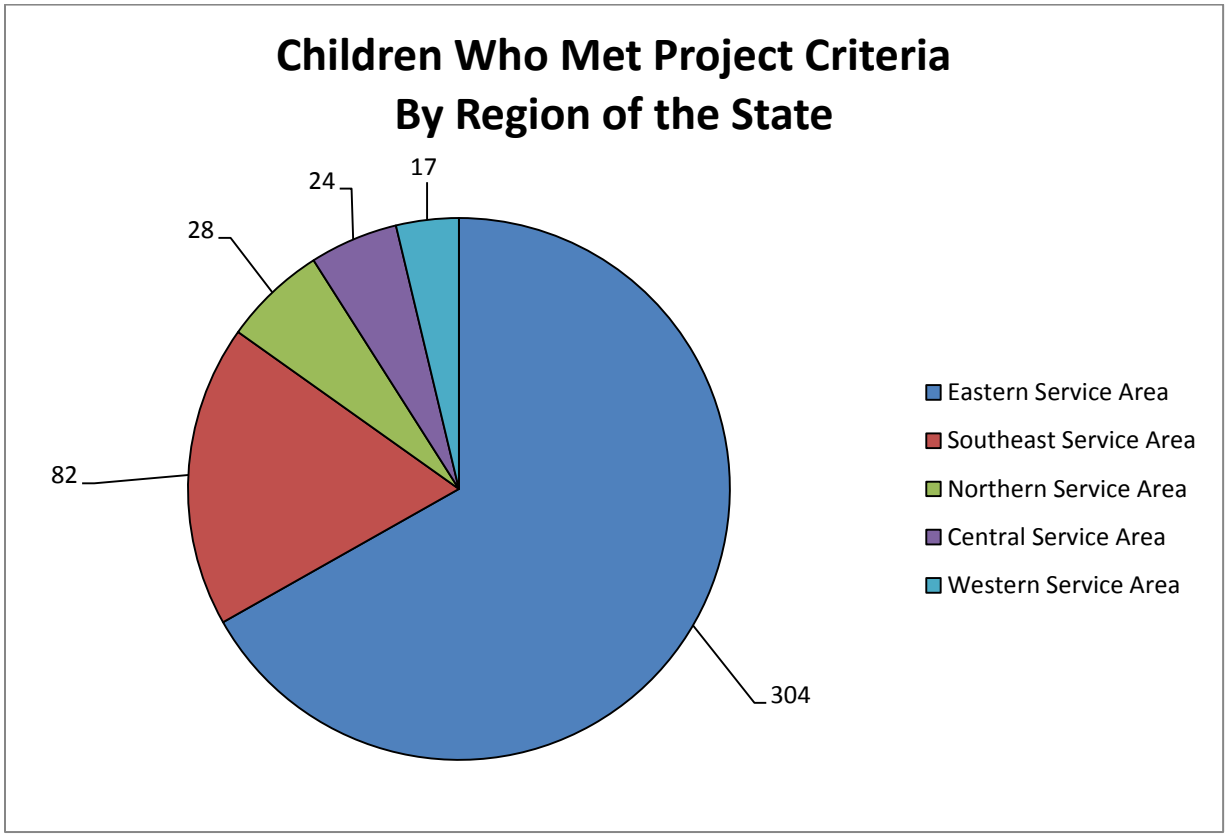
1. ***Were there particular characteristics common to many of the children who had been in out-of-home care for 3 years or longer? If so, what can we learn from that?***
2. ***What specific barriers still exist that impede permanency for these children?***

Due to the size of this undertaking, the Project started with the Eastern Service Area (Douglas and Sarpy Counties), continued with the Southeast Area, and then proceeded to the remainder of the state. Statewide, there was an intense examination of the cases of 455 children. Appendix A contains a description of the process used to review each of these children in the Project. The rest of this report describes the children who met Project criteria and the barriers identified.

At the beginning of the Project, it was the belief of the Project members that:

- Every system is set up to get the outcomes they are currently getting – meaning that to change the outcomes we will need to identify the "what" in the system that is helping to create those outcomes and then develop strategies to change the system. The outcomes are representative of the deeper system issues.
- Lessons learned from reviewing and assisting these children to achieve permanency can be applied to the cases of other children in the child welfare and juvenile justice systems.
- Lessons learned should be applied to the creation of policy recommendations to improve permanency outcomes for children in out-of-home care.

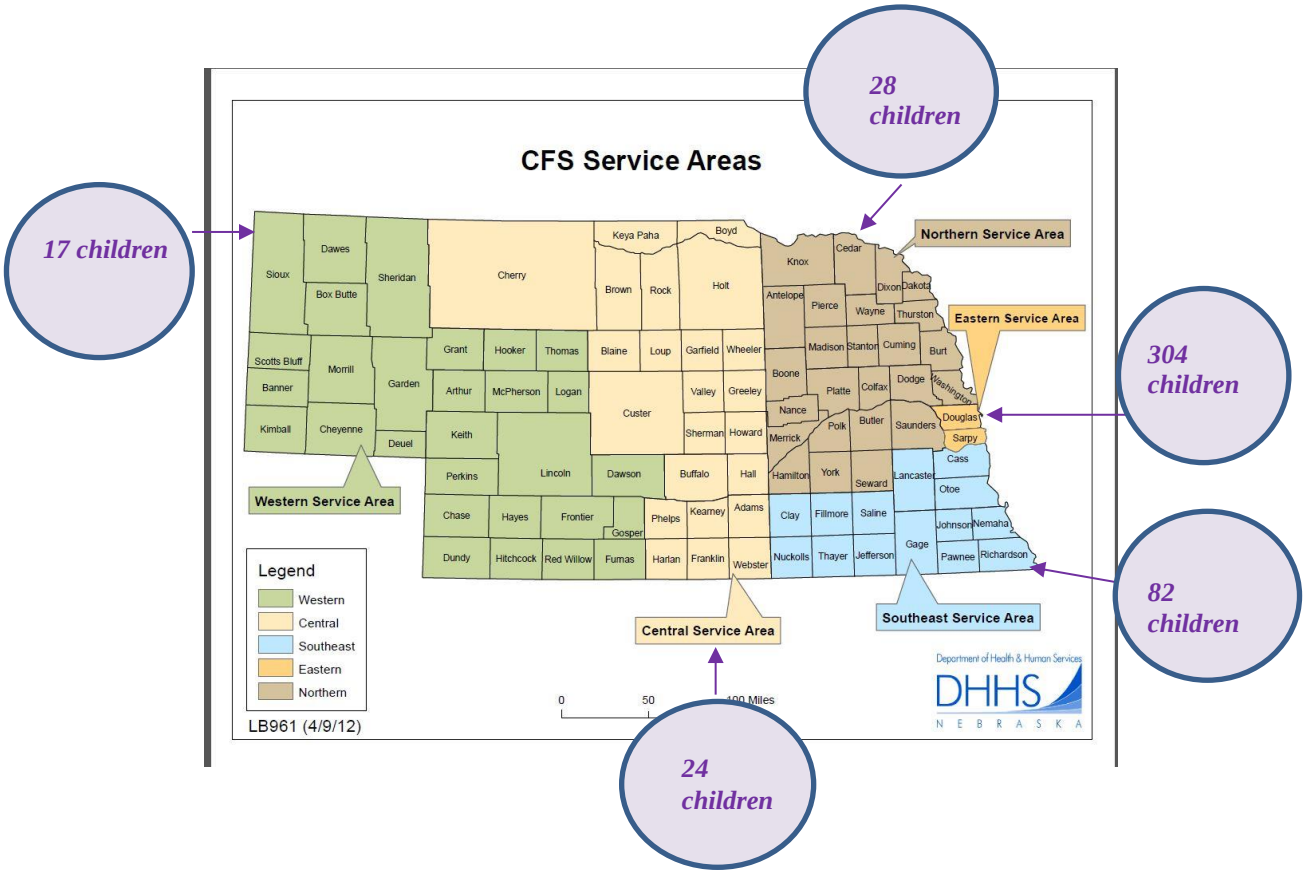
The chart below shows the geographic distribution of children who met the Project's criteria; that is, children who were in out-of-home care for 36 months or longer at a point in time.



CHARACTERISTICS OF CHILDREN IN THE PROJECT

GEOGRAPHIC DISTRIBUTION

All five DHHS service areas were included in the Project, with the number who met the Project criteria of continuous out-of-home care for three years or longer from each area shown below.



Data was collected from each service area. It was found that there were some commonalities in the barriers to permanency and in the child characteristics, and some distinct regional differences. One example of differences can be found in the next chart, which compares children in care 3 years or longer to the population of all children in out-of-home care in that respective Service Area.

	Central	Eastern	Northern	Southeast	Western
All Children in out-of-home (OOH) care on7/1/2014, regardless of how long	11%	**46%***	13%	24%	9%
3 years or more in OOH care at the time Project criteria was applied (spring/summer 2014)	5%	**67%***	6%	18%	3%

*** The Eastern area had 46% of all Nebraska children in out-of-home care, but had 67% of the children in care for 3 years or longer.**

DEMOGRAPHICS

Age

Since only children older than 36 months of age could be included in the Project (they needed to be in out-of-home care that long), it was assumed that few children age three to five would be in this group. Nonetheless, **9% of the children in the Project were under age six,** which would be most of their life in out-of-home care; 34% of the children were age 6-12; and, 57% of the children were age 13-18.

The following chart shows the age groups of each child in out-of-home care by individual service areas.

Age group	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	1	32	1	6	1	41 (9%)
Age 6-12	10	115	8	19	2	154 (34%)
Age 13-18	13	157	19	57	14	259 (57%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

So the natural question is how the above percentages compare to the general population in out-of-home (OOH) care. The following chart shows this for each region. The percentages will not equal 100 because children age 0-2 could not have been in out-of-home care for 3 years or longer.

Age group	Central		Eastern		Northern		Southeast		Western	
	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015	% in Project	% in OOH care 2/1/2015
Age 3-5	4%	13%	11%	10%	4%	11%	7%	12%	6%	12%
Age 6-12	42%	30%	38%	35%	29%	32%	24%	32%	12%	34%
Age 13-18	54%	28%	52%	29%	68%	29%	68%	29%	82%	24%

*The percentages above do not equal 100 because ages 0-2 did not meet the Project criteria.

Race

Minority children are overrepresented in the out-of-home population as a whole, and thus it was expected that they would be overrepresented in the Project as well (see the December 2014 FCRO Annual Report and the September 2014 FCRO Quarterly Report for more information on racial overrepresentation in out-of-home care).

However, as outlined next we did find **some differences** that were beyond what was expected. This first chart looks at race for each of the Service Areas.

Race	Central	Eastern	Northern	Southeast	Western	Total
American Indian	3 (13%)	16 (5%)	1 (4%)	3 (4%)	3 (18%)	26 (6%)
Asian	0	0	0	1 (1%)	0	1 (<1%)
Black	4 (17%)	129 (42%)	6 (21%)	11 (13%)	0	150 (33%)
Hispanic	3 (13%)	0	1 (4%)	NA	0	4 (1%)
Mixed	NA	13 (4%)	NA	7 (9%)	NA	20 (4%)
Unknown	1 (4%)	15 (5%)	0	10 (12%)	0	26 (6%)
White	13 (54%)	131 (43%)	20 (71%)	50 (61%)	14 (82%)	228 (50%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Ethnicity	Central	Eastern	Northern	Southeast	Western	Total
Hispanic	6 (25%)	32 (11%)	1 (4%)	2 (2%)	1 (6%)	42 (9%)
Non-Hispanic	18 (75%)	272 (89%)	27 (96%)	80 (98%)	16 (94%)	413 (91%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

The next analysis was to compare the general population of all children in Nebraska (census data); the population of all children in out-of-home care regardless of length of time; and the population of children that had been out-of-home three years or longer. In the next chart, only the four races available in U.S. Census data are included, so the totals do not add up to 100%. As depicted in the chart, Black children are removed at a higher rate and remain in out-of-home care at a significantly higher rate.

Race	**% of all Nebraska Children per Census**	**% of all children in out-of-home care 2/1/2015** (regardless of time in care)	**% of the children in out-of-home care for 3 years or longer**
American Indian	2%	8%	6%
Asian	2%	<1%	<1%
Black	6%	19%	**39%**
White	86%	62%	53%

Looking specifically at Black children from Douglas County (just Douglas County, not the full Eastern Service Area):

Race	% of all Douglas County Children per Census	% of all in out-of-home care 2/1/2015 (regardless of time in care)	% in the 3 years in care group
Black	13%	21%	48%

Due to this disparity, we have included a special section on Douglas County later in this report.[2]

PARENTAL MARITAL STATUS

After reviewing children from the Eastern Service Area, it was determined that the Project should collect information on parental marital status for the rest of the state. The Project found that for the 151 children from the Southeast, Northern, Central, and Western Service Areas:

- 49% of the parents were single, never married.
- 41% of the parents were divorced, widowed, or separated.
- 10% of the parents were married.

PARENTAL RIGHTS

Under Federal statutes, as codified in Neb. Rev. Stat. 43-292.02, when children have been in out-of-home care for 15 of the past 22 months the courts must hold a hearing to determine if a termination of parental rights should be sought. Under the federal/state law, the only exceptions are: 1) if it is documented it is not in the best interests of the child, 2) if the only reason the child is in care is parental incarceration; 3) if the child is placed with a relative; 4) if the parent has not been given opportunity to address the issues that caused the child to be removed from the home; and 5) if the only reasons that the child is in care is the parent is financially unable to provide health care needed by the child. Otherwise the county attorney (prosecutor) must consider bringing forth a petition to terminate the parental rights.

Before a termination trial can ensue, the prosecutor needs to make sure there is sufficient evidence to prove: 1) that termination is in the child's best interests, and 2) that one or more of the grounds of parental unfitness described in Neb. Rev. Stat. 43-292 exist. Parents have full due process rights, as one would expect with so serious a matter. After the termination trial, it is common for there to be an appeal of the decision.

The following charts, one for the mother and one for the father, show the status of parental rights on the date of the Project review.

One third of the parents had intact parental rights even though their children had been in out-of-home care for 36 months or longer. The collaborative did not collect data on whether an exception to filing a termination had been granted. **Over half of the parents no longer had parental rights.**

[2] **See Appendix C for more information about the children from Douglas County.**

Mother's Rights Status	Central	Eastern	Northern	Southeast	Western	Total
Intact	7 (29%)	94 (31%)	10 (36%)	27 (33%)	8 (47%)	146 (32%)
Relinquished	11 (46%)	80 (26%)	7 (25%)	32 (39%)	1 (6%)	131 (29%)
Terminated	5 (21%)	79 (26%)	8 (29%)	19 (23%)	7 (41%)	118 (26%)
Mother deceased	0	9 (3%)	1 (4%)	3 (4%)	1 (6%)	14 (3%)
Unable to determine at time of Project review*	1 (4%)	40 (13%)	2 (7%)	1 (1%)	0	44 (10%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

*Documentation of parental rights was not found at the time of the file reviews.

Father's Rights Status	Central	Eastern	Northern	Southeast	Western	Total
Intact	8 (33%)	102 (34%)	9 (32%)	24 (29%)	6 (35%)	149 (33%)
Relinquished	7 (29%)	39 (13%)	7 (25%)	23 (28%)	4 (24%)	80 (18%)
Terminated	5 (21%)	86 (28%)	10 (36%)	23 (28%)	4 (24%)	128 (28%)
Father deceased	1 (4%)	21 (7%)	1 (4%)	6 (7%)	2 (12%)	31 (7%)
Unable to determine at time of Project review*	3 (13%)	56 (18%)	1 (4%)	6 (7%)	1 (6%)	67 (15%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

*Documentation of parental rights was not found at the time of the file reviews.

PRIMARY PERMANENCY OBJECTIVE

The following shows the primary permanency objective for the children on the day of the in-person Project review with the child's caseworker. The permanency objective is the stated goal of the plan that is written by DHHS and presented to the court. The court may accept the plan as written, modify that plan, or wholly replace that plan.

In almost two-thirds of the children's cases, the permanency objective was adoption/guardianship which leads one to question why these children have still not achieved permanency.

Plan objective	Central	Eastern	Northern	Southeast	Western	Total
Adoption	13 (38%)	118 (39%)	12 (43%)	42 (51%)	6 (35%)	191 (41%)
Guardianship	3 (13%)	58 (19%)	4 (14%)	28 (34%)	6 (35%)	99 (22%)
Reunification	3 (13%)	54 (18%)	4 (14%)	5 (6%)	2 (12%)	68 (15%)
Independent Living	5 (21%)	38 (13%)	5 (18%)	6 (7%)	2 (12%)	56 (12%)
Other/unknown	0	36 (12%)	3 (10%)	1 (1%)	1 (6%)	41 (9%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

CHRONIC CONDITIONS OR IMPAIRMENTS, AND TRAUMA

The Project population had a higher percentage of children with a mental health diagnosis, behavioral health issue, physical/orthopedic impairment, or developmental disability than is found in the general population of children in out-of-home care. **As shown in this section, children with serious or chronic conditions tend to remain in an impermanent situation longer than other children, and they also have some of the highest levels of needs**.

Childhood trauma has been linked to many acute and chronic conditions, such as those mentioned above. About childhood trauma:

- Experts in childhood trauma recognize that some mental health issues can stem from adverse childhood experiences such as abuse, neglect, and instability in caregivers.
- Behavioral issues can be an understandable reaction to past traumatic experiences, including experiences in the foster care system – such as being moved from caregiver to caregiver, having to discuss sensitive details of their lives over and over again every time the caseworker attached to their case changes, the uncertainty of when or if they will see their parents or siblings, frustration over educational delays, and the like.
- Behavioral issues are not always related to a mental health diagnosis, though they can be linked in some cases.
- Mental health and/or behavioral issues can make it more difficult to parent the child, and can create issues in finding persons to adopt or provide guardianship if the parents are unable or unwilling to provide care.
- Although measuring the extent of trauma each child experienced was beyond the scope of the Project, trauma was certainly an underlying issue.

More research is needed to determine if the children in the Project who had mental health or behavioral issues entered out-of-home care with these issues or if those issues were exacerbated by the length of time in the uncertainty of "temporary" foster care. The Southeast Service Area was the only service area where caseworkers and supervisors recognized and identified that the after effects of children's trauma was a barrier to permanency and included it with other barriers statistically identified; however, children's trauma was a recurrent theme throughout all the Project reviews.

Funding or subsidy issues were often seen for children with chronic or recurrent mental health, medical, or developmental needs.

Mental health/behavioral health

Impact – Half (48%) of the children's cases in the Project involved a child with a mental health diagnosis by a professional as documented in the DHHS/NFC file.
In comparison, 32% of all children in out-of-home care reviewed statewide by the FCRO during the first half of 2014 (regardless of time in care) had a mental health diagnosis.

Mental health diagnoses cover a range of conditions. A few of the more common include: depression, oppositional/defiant disorder, attention deficit and disruptive behavior disorders,

feeding/eating disorders, separation anxiety disorders, mood disorders, dissociative disorders, sleep disorders, etc.

The following shows the distribution of children with a mental health diagnosis by service area.

Child with a mental health diagnosis	Central	Eastern	Northern	Southeast	Western	Total
Yes	5 (21%)	142 (47%)	14 (50%)	45 (55%)	11 (65%)	217 (48%)
No	19 (79%)	162 (53%)	14 (50%)	37 (45%)	6 (35%)	238 (52%)
Total	24	304	28	82	17	455

There were regional differences in the distribution by age group for children found to have mental health issues. It is unclear why the age group differences exist but it could be that the older the child is the more time to collect assessment data to support a diagnosis.

A larger concern is that 7 (3%) children aged 3-5 had a mental health diagnosis and 66 (30%) children aged 6-12 had a diagnosis. We do need to question the reason and basis for these types of diagnosis at such a young age of the child.

Age group of child with a mental health diagnosis	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0 (0%)	7 (5%)	0 (0%)	0 (0%)	0 (0%)	7 (3%)
Age 6-12	0 (0%)	53 (38%)	4 (29%)	8 (18%)	1 (9%)	66 (30%)
Age 13-18	5 (100%)	82 (58%)	10 (71%)	37 (82%)	10 (91%)	144 (66%)
Total	5	142	14	45	11	217

Mental health diagnosis is not always related to a behavioral issue, though they are linked in some cases. Behavioral health is discussed next.

Behavioral health

Impact – Half (47%) of the children's cases involved a child with a behavioral health issue/diagnosis.
In comparison, 37% of children reviewed statewide by the FCRO during the first half of 2014 had a diagnosed trauma condition that could lead to behavioral issues.

Behavioral issues are not always related to a mental diagnosis, though they are linked in some cases. These are not children who are occasionally "naughty," rather these are children who are reacting to some very negative early life experiences and need help coping.

Behavioral issues can include: inappropriate actions/emotions under normal circumstances; tantrums uncommon for children of that age; difficulties with developing normal relations with teachers, peers, or caregivers; feelings of fear and anxiety; being hostile, irritable or

uncooperative; obsessive-compulsive behaviors; panic attacks; refusing to follow rules; being aggressive; being withdrawn; and general unhappiness.

Behavioral issues can make it more difficult to parent or give care to the child, and can create issues in finding persons to adopt or provide a guardianship for the child if the parents are unable or unwilling to provide care.

The following shows the distribution of behavioral health diagnosis by service area.

Behavioral issue	Central	Eastern	Northern	Southeast	Western	Total
Yes	8 (33%)	128 (42%)	19 (68%)	51 (62%)	10 (59%)	216 (47%)
No	16 (67%)	176 (58%)	9 (32%)	31 (38%)	7 (41%)	239 (53%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

There were regional differences in the distribution by age group for children with behavioral issues. For example, the teenage population was 57% of the children in the Project, but 71% of them had a behavioral health issue.

Age group of child with a behavioral issue	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	6 (5%)	0	2 (4%)	0	8 (4%)
Age 6-12	1 (14%)	35 (27%)	7 (37%)	10 (20%)	1 (10%)	54 (25%)
Age 13-18	7 (88%)	87 (68%)	12 (63%)	39 (76%)	9 (90%)	154 (71%)
Total	8	128	19	51	10	216

Medical - Physical/orthopedic impairment

Impact – A quarter (24%) of the children in the Project had a physical or orthopedic impairment.

In comparison, 6% of children reviewed statewide by the FCRO during the first half of 2014 had a speech or language impairment, and 2% had a physical or orthopedic impairment.

The following shows the distribution of physical/orthopedic impairment by service area.

Medical or physical issue	Central	Eastern	Northern	Southeast	Western	Total
Yes	4 (17%)	70 (23%)	7 (25%)	20 (24%)	6 (35%)	107 (24%)
No	20 (83%)	234 (77%)	21 (75%)	62 (76%)	11 (65%)	348 (76%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Some of the differences in percentages between areas may be a result of the small number of children in the Project from some of the service areas.

There were some regional differences in the distribution by age group for children with physical/orthopedic issues.

Age group of children with a medical or physical issue	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	7 (10%)	0	2 (10%)	0	9 (8%)
Age 6-12	2 (50%)	29 (41%)	4 (57%)	4 (20%)	0	39 (36%)
Age 13-18	2 (50%)	38 (54%)	3 (43%)	14 (70%)	6 (100%)	63 (59%)
Total	4	70	7	20	6	107

Development disabilities

Impact – One seventh (13%) of the children in the Project not only experienced abuse and/or neglect, but also the challenges of developmental delays and/or disabilities.

In comparison, 2% of children reviewed statewide by the FCRO during the first half of 2014 were found to have a confirmed clinical developmental disability diagnosis. This does not mean that the child had been found DD eligible at the time of the FCRO review, but does lead to the question as to whether the DD system is more appropriately situated to meet the needs of these children.

Children with disabilities may not be able to express the trauma they have experienced, and they may not be able to benefit from many therapies that are based on a certain level of cognition. The following shows the distribution of developmental disabilities in the Project by service area.

Developmental disability diagnosis	Central	Eastern	Northern	Southeast	Western	Total
Yes	3 (13%)	29 (10%)	6 (21%)	16 (20%)	4 (24%)	58 (13%)
No	21 (88%)	275 (90%)	22 (79%)	66 (80%)	13 (76%)	397 (87%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Some of the differences in percentages between areas may be a result of the small number of children in the Project from some of the service areas.

As shown in the following chart, there were some regional differences in the distribution by age group for children with developmental disabilities, but this does appear to be a state-wide issue.

Age group of children with a developmental disability	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	1 (3%)	0	2 (13%)	0	3 (5%)
Age 6-12	1 (33%)	12 (41%)	2 (33%)	5 (31%)	0	20 (34%)
Age 13-18	2 (67%)	16 (55%)	4 (67%)	9 (56%)	4 (100%)	35 (60%)
Total	3	29	6	16	4	58

Serious learning issues

Impact – One-fifth (21%) of the children had a critical learning issue as described in the caseworker narratives on N-FOCUS.

We have no directly comparable statistic for the general population of children in out-of-home care.

Critical learning issues can impact not only those with a developmental disability diagnosis but also additional children whose level of impairment does not meet the strict criteria for a developmental disabilities diagnosis.

Why do so many children in foster care have learning problems? Most children in foster care have lived in chaotic, stressful environments prior to their removal from the home. Some have had pre-natal and/or post-natal exposure to alcohol and/or drugs. Some moved often, even during the school year. Some did not get the early childhood stimulation needed to grow and thrive – such as parents reading to children or teaching concepts like colors, letters, and numbers. Some, even in early elementary school, had parents that did not ensure their regular school attendance. These children often begin their formal education at a significant disadvantage.[3]

Further, children that are experiencing separation from their parents, adjusting to a new living environment, and often adjusting to a new school, can experience too much stress to properly concentrate on their education.

The following describes some targeted educational services for children that many of the children in this category may qualify for.

- **Special education**. About 9% of the nation's school children receive special education.[4] For children reviewed by the FCRO during the first half of 2014, we found that 26% of school-aged children were enrolled in special education.
    - Although children are placed in out-of-home care, in Nebraska their parents retain legal rights to determine aspects of their children's education. This causes delays

[3] The Nebraska Department of Education found in school year 2011-12 that fourth grade students who were absent less than 10 days averaged a score of 108/200 in their standardized math test, while children who were absent over 20 days averaged 83/200. Similarly in reading children absent less than 10 days scored 113/200 while students absent over 20 days averaged 91/200. By grade 8 the differences are even more pronounced.

[4] US Dept. of Education, The Condition of Education, 2009.

in a child's receiving special education services, especially if the child does not remain in the same school system. Parents that are upset with the system may refuse to authorize educational testing or services, especially if they suspect it was an educator that reported the abuse that led to the child's removal. While a surrogate parent can be appointed to represent the child, this involves delays.

- **IEP**. The IEP, or individualized educational plan, is part of the Individuals with Disabilities Education Act (IDEA). A team considers the strengths of the child, concerns of the parents, results of the most recent assessments, and the academic, developmental, and functional needs of the child, and develops a plan to assist the child.
- **Early development network (EDN)**. A child is eligible for EDN services if he or she is not developing typically, or has been diagnosed with a health condition that will impact his or her development. Parents must consent to an EDN referral for children age birth through three years of age. Often parents of children in out-of-home care refuse to provide their consent.

The following shows the distribution of learning issues by service area.

Learning issue	Central	Eastern	Northern	Southeast	Western	Total
Yes	4 (17%)	54 (18%)	11 (39%)	19 (23%)	6 (35%)	94 (21%)
No	20 (83%)	250 (82%)	17 (61%)	63 (77%)	11 (65%)	361 (79%)
Total	**24**	**304**	**28**	**82**	**17**	**455**

Some of the differences in percentages between areas may be a result of the small number of children in the Project from some of the service areas.

There were some regional differences in the distribution by age group for children with learning issues, but this does appear to be a state-wide issue that greatly impacts the teen-age population.

Age group of children with a learning issue	Central	Eastern	Northern	Southeast	Western	Total
Age 3-5	0	1 (2%)	0	0	0	1 (1%)
Age 6-12	0	13 (24%)	3 (27%)	4 (21%)	1 (17%)	21 (22%)
Age 13-18	4 (100%)	40 (74%)	8 (73%)	15 (79%)	5 (83%)	72 (77%)
Total	4	54	11	19	6	94

PLACEMENT INFORMATION

Placement type

If children cannot safely live at home, then they need to live in the least restrictive, most home-like temporary placement possible in order for them to grow and thrive. The following chart shows the restrictiveness of placement on the date of the Project review for the 455 children and compares the percentages for each type to the entire population in out-of-home care at a point in time.

Type	Project children	In OOH June 30, 2014
Least restrictive *	329 (72%)	88%
Moderately restrictive **	43 (9%)	5%
Most restrictive ***	47 (10%)	5%
Runaway	2 (<1%)	1%
Other/unable determine	34 (7%)	<1%
Total	455	

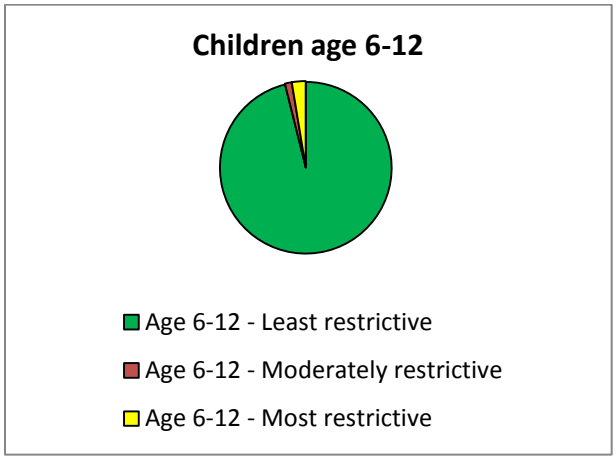
* Least restrictive includes relative placements, foster family homes, agency-based foster homes, developmental disability homes, and supervised independent living.

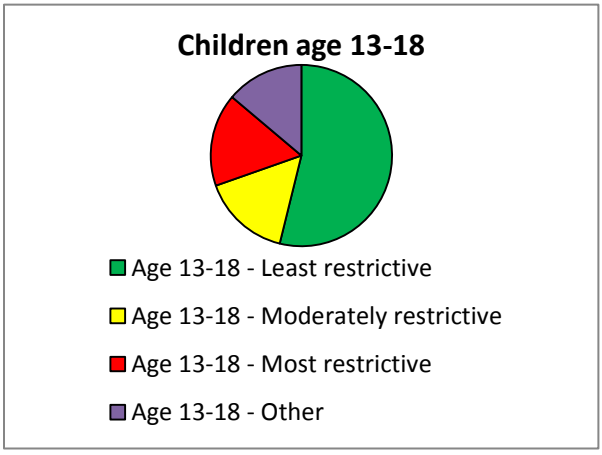
** Moderately restrictive includes group homes and boarding schools.

*** Most restrictive includes medical facilities, psychiatric residential treatment facilities, youth rehabilitation and treatment centers at Geneva and Kearney, youth detention centers, and emergency shelters.

As expected, more of the children that had been in care for 36 months or longer would be in the more restrictive settings than would be true for the general population in out-of-home care. For example, children who qualified for the Project were in the more restrictive placements at double the rate of the group of all children in out-of-home care.

There are differences by age group, as the following pie charts illustrate.[5] Children do best in families, so the use of congregate (group) care for the teen-age populations needs to be further analyzed. For example, is the level of treatment driven by the needs of the child or the lack of less restrictive placements such as foster homes that are equipped to meet these children's needs.





[5] **Additional information is available in Appendix D.**

The next chart gives the placement numbers by service area. It is positive that 100% of the children age 3-5 and 96% of the children age 6-12 were in foster homes,

Least Restrictive	By Service Area					Total
	Central	Eastern	Northern	Southeast	Western	
Age 3-5	1	32	1	6	1	41
Age 6-12	10	112	6	18	2	148
Age 13-18	10	85	9	28	8	140
Moderately Restrictive						
Age 3-5	0	0	0	0	0	0
Age 6-12	0	1	1	0	0	2
Age 13-18	0	26	3	10	2	41
Most Restrictive						
Age 3-5	0	0	0	0	0	0
Age 6-12	0	2	1	1	0	4
Age 13-18	2	24	2	12	3	43
Other/unknown						
Age 13-18	1	22	5	7	1	36

Placement changes

Impact – 82% of the children have been moved between caregivers (foster placements) 4 or more times, and 42% have experienced 10 or more such changes.

In comparison, 30% of all children in out-of-home care Feb. 1, 2015, had 4 or more placements, and 9% had 10 or more changes.

National research indicates that children experiencing 4 or more placements over their lifetime are likely to be permanently damaged by the instability and trauma of broken attachments.[6] Broken attachments may include more than just to their caregivers as children who change placements are also likely to change schools, teachers, and peers.

In contrast, children that have experienced consistent, stable, and loving caregivers are more likely to develop resilience to the effects of prior abuse and neglect, and more likely to have better long-term outcomes.

Members of the collaborative were able to gather information on the number of placements per child (as of the date of the Project review) for 374 children of the 455 children in the Project. This is a valid sample as they came from each of the service areas and represent 82% of the children in the children in the Project.

As part of the process, the placement histories for the children were printed out. Project reviewers manually verified the number placements, excluding placements with parents and

[6] Some examples include: Hartnett, Falconnier, Leathers & Tests, 1999; Webster, Barth & Needell, 2000.

duplicative placements. An example of a duplicative placement would be if the child was placed with the "Smith" foster family as an emergency placement, and after a few days the "Smith" foster family became the on-going caregivers – in such a case, "Smith" would not be counted twice. The types of placements that were counted included foster family homes, agency-based foster homes, developmental disability homes, supervised independent living, group homes, boarding schools, medical facilities, psychiatric residential treatment facilities, youth rehabilitation and treatment centers at Geneva and Kearney, youth detention centers, emergency shelters, and runaway episodes that were over 24 hours in duration.

The statistics below are based on the 374 children whose placement history was available.

- As expected, **most children in the Project had experienced high numbers of placements, with an average of 11 placements and a median of 8 placements**. Many also had a high number of placements in the moderately or restrictive categories, such as group homes, PRTF's and other institutional types of care.
- Even the youngest children have had their placements disrupted many times during their time in out-of-home care (**20 of 32 young children, or 63%, were moved more 4 or more times**).

The charts below give more details.

	By Age Group			
Number of Placements	**Age 3-5**	**Age 6-12**	**Age 13-18**	**Total children**
1-3 placements	12 (38%)	36 (27%)	13 (6%)	61 (16%)
4-9 placements	18 (56%)	78 (59%)	59 (28%)	155 (41%)
10-19 placements	2 (6%)	15 (11%)	66 (31%)	83 (22%)
20-29 placements	0	3 (2%)	54 (26%)	57 (15%)
30 or more placements	0	0	18 (17%)	18 (5%)
Totals	**32**	**132**	**210**	**374**

The next chart shows the same children by service area.

	By Service Area					Total
Placements	**Central**	**Eastern**[7]	**Northern**	**Southeast**	**Western**	**children**
1 placement	0 (0%)	7 (3%)	2 (7%)	4 (5%)	1 (6%)	14 (4%)
2-3 placements	4 (18%)	34 (15%)	0 (0%)	-9 (12%)	0 (0%)	47 (13%)
4-9 placements	12 (55%)	105 (45%)	6 (21%)	27 (36%)	5 (29%)	155 (41%)
10-19 placements	4 (18%)	43 (19%)	11 (39%)	17 (23%)	8 (47%)	83 (30%)
20-29 placements	1 (5%)	31 (13%)	8 (29%)	14 (19%)	3 (18%)	57 (15%)
30 or more placements	1 (5%)	12 (5%)	1 (4%)	4 (5%)	0	18 (5%)
Totals	**22**	**232**	**28**	**75**	**17**	**374**

[7] **NFC provided some CFSR data for the Eastern Service Area. These placement counts utilizing CFSR data would not have included detention or runaway episodes and, therefore, are not included here as that would not be consistent with the way that placements were counted in all the areas of the State or the way placements are counted in the above charts. See Appendix E for this CFSR placement count data.**

It makes sense that the longer a child is in out-of-home care the greater the likelihood of that child experiencing multiple changes in caregivers/placements. The following summarizes some of the reasons children move from one foster home, group home, or specialized facility[8] to another.

1. It can be challenging to be the caregiver of a traumatized child, and to manage the traumatized child's reactive behaviors. Behaviors that were adaptive and protective in the home of origin where there were threatening situations may be maladaptive when children are in a safe environment. Without an understanding of the effects of past traumas, behaviors can be misinterpreted as pathologic.[9] As children are moved from placement to placement, children may exhibit more and more challenging behaviors.
2. There may not be an appropriate placement available that is equipped to meet that child's particular needs when the child needs to be removed, so inevitably those children end up being moved, sometimes multiple times.
3. At times there are delays in making permanency decisions. This increases the probability that the child will experience more transitions to different placements. "Placement drift" has detrimental effects to children's sense of stability, to their educational progress, and to their mental and physical health. Therefore, any delay to decision-making needs to be purposeful and temporary.
4. There may be issues with getting treatment approvals for children that need to be in a higher level of care, or that appropriate transition services where not put into place when a child moves from a treatment level of care to a lower level of care.
5. Some children are moved because a relative has been identified, sometime months after the child was placed into care. The children may, or may not, have a relationship with this person.
6. Some relative placements have not been given explicit information about whether, or to what extent, parents can have contact with their children while under the relative's supervision, or on how to deal with other common inter-familial issues. This has led to some children being moved from the relative's care.
7. Some foster parents "retire" or withdraw from serving as a foster parents. They do so for a variety of reasons. For example, some quit after years of service to reach other life goals, some quit because of changing family situations, and some quit due to frustration with what they perceive as a lack of support.
8. Some placements changes are ordered by the legal system based on the children's behaviors rather than upon the well-being of the child.

[8] See the prior section on placement types for a more complete explanation as to types of placements that may be included.

[9] Helping Foster and Adoptive Families Cope with Trauma, the American Academy of Pediatrics.

All stakeholders in the "child welfare system" need to ask themselves, if a child was moved to different caregivers 10-40 times, how much damage did the system itself inflict on these children?

Therefore, is it any wonder that some of these children are unable to trust adults or develop the positive bonds with caregivers that are necessary for permanency to be possible?

BASED ON CHILD CHARACTERISTICS THE FOLLOWING NEEDS STILL EXIST

1. The need to acknowledge and mitigate as best as possible the impact of trauma on children.
2. The needs to improve access to mental health and behavioral health services that utilize trauma-informed practices for children so that issues can be addressed prior to becoming a crisis and to prevent removals that occur only to access services. Consideration should be given to ensure that some of the funds available to the Behavioral Health Regions are earmarked for children services.
3. The need to ensure there are appropriate services provided based on children's assessments as early as possible including the development of appropriate in-home community-based services.
4. The need to ensure that payment sources are available for children and youth with a wide array of behavioral problems, regardless of managed-care/Medicaid denials. Consideration should be given to the use of braided and blended funding alternatives.
5. The need to continue and develop a quality assurance system for all services that are goal and outcome-driven.
6. The need to work with providers and the judicial system to determine the reasons for a change in placement and what services should be available to stabilize placements. If a placement move is needed, ensure that all stakeholders are conducting these moves to minimize trauma to the child including the educational impact a move might have on a child.
7. The need to continue to develop and implement a more individualized approach to foster parent recruitment and training.
8. The need to identify appropriate relative and kinship placements at the time of the children's initial placement in foster care, and provide those placements with needed supports.

MOST FREQUENT BARRIERS TO PERMANENCY

The purpose of the Project was to determine the systemic barriers to children reaching "permanency" – that is, returning to their biological family that have been equipped to provide them safety and well-being, or if that is not possible to provide the children an adoptive or guardianship family or other permanent arrangement.[10] The point was not to "point fingers" but rather to learn what actions could be taken to reduce impediments to permanency in the future, and to reduce unnecessary time in out-of-home care.

Barriers to permanency generally fell into the following categories:

- Casework.
- Legal and court process issues.
- Difficulties in meeting the child's needs.
- Parental actions/inactions.
- Funding/subsidy.
- Other issues.

Multiple barriers (up to 3) could be selected for each child reviewed in the Project. Only barriers currently impacting the children's cases were selected.

The following describes the top five barriers to permanency statewide. Regional variances, if significant, are also described for each of the particular barriers. In many cases the parents were no longer involved with the child's case, either through relinquishment or termination of rights, thus the number of children with current permanency barriers due to parental action/inaction was low and did not fall within the top five barriers.

BARRIER #1	**Past case management/supervision issues and practices** **Impact: 30% of the children in the Project**

Stable case management with adequate supervision is critical to ensuring children's safety while in out-of-home care, and is critical for children to achieve timely and appropriate permanency. A stable workforce reduces the number of times that children must discuss very private and often painful issues with a stranger. It allows workers time to ensure children's safety, and help children achieve a timely and appropriate permanency.

Many children in the Project had been in care since before privatization began in November 2009. The rapid nature of changes within the child welfare system between November 2009 and mid-2012 de-stabilized case management and supervision in many ways.[11] Vacancy rates increased. During vacancies other workers were asked to take on overly heavy caseloads. As a

[10] The definition of "permanency" has been agreed to by both DHHS and the FCRO.

[11] A timeline of major changes can be found in Appendix H of the FCRO Annual Report issued December 1, 2013.

result, those workers understandably were only able to focus on the crisis situations, and had little time to work towards permanency or foster parent support in their other cases. With a rapid influx of new workers, supervision became more difficult. Roles changed throughout privatization resulting in periods of confusion and re-training, some resources were lost due to payment and other issues, and infrastructures needed to be built or re-built.

Any and all significant changes in legislation can and usually does impact workforce stability. For example, LB561 and LB464 did directly impact case managers within the child welfare system. Any legislative changes must be viewed through the lens of how it could impact this important workforce.

During the Project, we interviewed the current caseworker for each child's case. It was all too common for these workers to say something to the effect of "I don't know what happened in the beginning, I've only had the case for the last few months."

Some examples of case management issues/practices could include:

- Lacking knowledge of case history needed to determine service provision and creating appropriate case plans and goals based on the family's needs.
- Creating case plans that lacked the specificity needed regarding services, timeframes, and tasks to hold parents and the system accountable.
- Being unfamiliar with the quality and availability of needed services.
- Gaps in the transmission of information between staff assigned to the case.
- Not providing courts information needed to improve case progression or requesting needed court hearings.

Nothing can be done to change the past – but lessons can be learned to improve case management, and efforts can be made to go forward as expeditiously as possible with cases stymied by past issues.

The following chart shows by service area the number of children in the Project whose case was still being impacted by past case management issues and practices.

	Central	Eastern	Northern	Southeast	Western	Statewide
Past case management	14 of 24 (58%)	60 of 304 (20%)	22 of 28 (79%)	33 of 82 (40%)	9 of 17 (53%)	138 of 455 (30%)

While the percentages do vary by service area, much of that variance is a function of the low number of children from rural areas who met Project criteria. Nonetheless, every area of the state is still impacted by past case management practices.

The following needs still exist:

1. The need to address initial worker training and on-going worker training to ensure it provides the practical knowledge needed by workers on a day-to-day basis.

2. The need to determine caseworker vacancy rates and effective ways to increase worker retention which could include adequate public and private supports and mentoring.
3. The need to determine how to mitigate the impact on families when vacancies occur so that knowledge transfer occurs seamlessly and children and families have the least disruption possible by the change in caseworker.
4. The need to make use of exit interviews to determine measures that could impact caseworker change.
5. The need to ensure that supervisors have adequate supports and training so they, in turn, can better support their staff.
6. The need to determine supervisor vacancy rates and how to mitigate the effect of supervisor changes on the workforce.
7. The need to consider and implement recommendations and observations offered by the Workforce Development Workgroup of the Children's Commission. [12]
8. The need to consider the caseworker retention recommendations made by the Office of Inspector General of Nebraska Child Welfare in its September 2014 Report, such as:
    a. Create salaries that are competitive with states in the region.
    b. Provide incentives for workers and administrators to pursue formal education in social work.
    c. Increase continuing education opportunities.
    d. Ensure caseloads are manageable.
    e. Ensure caseloads are consistent with statutory requirements.

BARRIER #2	**County attorney would not, or could not, file a termination of parental rights (TPR) petition** **Impact: 22% of the children in the Project**

Parents have a fundamental right to the care, custody, and control of their children – but that right must be balanced with children's critical need for safety, stability, and permanency. Termination of parental rights is the most extreme remedy for parental deficiencies. With a termination, the parents have lost all rights, privileges, and duties regarding their children and the child's legal ties to the parent are permanently severed. To ensure due process and that parental rights are not unduly severed, the level or degree of evidence needed is higher than in other parts of abuse or neglect cases. There are also different provisions for children that fall under the Indian Child Welfare Act (ICWA).

[12] The Workforce Development Workgroup is charged with fostering a consistent, stable, skilled workforce serving children and families. As part of this mission, the group is to benchmark the state with the lowest worker turnover, develop a plan for retention of frontline staff, develop a retention plan for workers, address morale and culture, address education and training, clearly define point persons and roles, conduct a comprehensive review of caseworker training and curriculum, develop a pilot project for guardians ad litem, and hire and adequately compensate well-trained professionals.

Severing parental ties can be extremely hard on children, who in effect become legal orphans; therefore, in addition to proving parental unfitness under Neb. Rev. Stat. §43-292 the prosecution must also prove that the action is in children's best interests.

There are a number of related factors that were identified for this barrier, including:

1. Termination trials require extensive trial preparation. Some have likened it to the time needed for a murder trial.
2. There are capacity (training and resource availability) issues for county attorneys. Some county attorneys are part-time and don't have the hours available to pursue these actions, and some do not have a high level of experience or training in this complicated field.
3. Caseworkers (DHHS or NFC) did not effectively document the evidence the county attorney needed to make a termination of parental rights petition successful or due to case manager changes were not available. County attorneys need to provide evidence of both parental unfitness and the action being in the best interests of the child.
4. Guardian ad litems failure to file a termination of parental rights petition as permitted under Nebraska statutes.

The following chart shows by service area the number of children in the Project whose case was still being impacted by county attorneys or guardians ad litem not filing a termination of parental rights petition. While the percentages do vary by service area, much of that variance is a function of the low number of children from rural areas who met Project criteria.

	Central	Eastern	Northern	Southeast	Western	Statewide
TPR not filed	2 of 24 (8%)	67 of 304 (22%)	8 of 28 (29%)	17 of 82 (21%)	6 of 17 (35%)	100 of 455 (22%)

The following needs still exist:

1. The need to ensure that all legal parties including the juvenile courts are effectively utilizing the statutorily required 12 month permanency planning hearings and 15 month exception hearings. These hearings should be held on the record where all parties are held accountable so that the best interests of children are being met. Data should be collected on the utilization and outcomes from these hearings. The review of these outcomes should include the legal conflict that arises when a juvenile court makes a legal finding that reasonable efforts towards reunification are no longer required such as what must a county attorney or guardian ad litem do and how does this determination affect the juvenile court's ability to hear the termination trial.
2. The need to ensure that timely and relevant staffings are occurring between case managers and county attorneys when the child has been in out-of-home care 15 months to determine if sufficient evidence is present for the filing of a termination of parental rights pleading.
3. The need to ensure appropriate utilization of mediation services including termination of parental rights pre-hearing conferences and other alternatives such as counseling for parents.

4. The need to explore the ability of other legal parties, such as HHS attorneys, to proceed with termination of parental rights actions

BARRIER #3	Court delays, continuances, full dockets, scheduling issues, and related matters Impact: 20% of the children in the Project

This is a broad category that includes:

- Court dockets (schedules) being full so that it is not possible to schedule a court hearing in a reasonable timeframe.
- Sometimes only a limited, too-short, period of time is available for a hearing on any particular day so it must be continued, sometimes multiple times, delaying the finalization of court orders and case progression.
- When there are changes in the parties assigned to the case, such as when caseworkers or guardians ad litem change, these persons may not be ready for the child's next scheduled hearing, so hearings are rescheduled. This creates delays.
- Not using the 12-month permanency hearings as a pivotal point during which it is determined if reunification remains a viable option or whether alternative permanency for the child should be pursued. (See also barrier #2). The permanency hearing, whenever possible, should be the moment where case direction is decided. Each of the children in the Project should have had at least 3 such hearings, yet permanency has yet to be achieved.

Workers from the Eastern Service Area interviewed during the Project expressed that based on their experiences court delays and scheduling issues were a chronic issue. In other areas of the State, workers said that continuances could occur, but not as often or as chronically.

The following chart shows by service area the number of children in the Project whose case was still being impacted by court issues.

	Central	Eastern	Northern	Southeast	Western	Total
Court issues, such as delays, continuances, full dockets, etc.	2 of 24 (8%)	68* of 304 (22%)	3 of 28 (11%)	17 of 82 (21%)	2 of 17 (12%)	92 of 455 (20%)

*We looked more intensely into the court issues in the Eastern Service Area for some children (40 of the 68) where it was identified as a barrier. That information is found in Appendix B.

The following needs still exist:

1. The need to complete a more thorough study as to the reasons and solutions regarding court continuances and other delays.
2. The need to continue the work of the Court Improvement Project regarding the tracking of relevant judicial time limits.
3. The need to thoroughly study the impact of a prosecutorial model within a rehabilitative court system.

BARRIER #4	**Need for a relative search at the time of removal to find a placement that is willing to provide permanency and/or to maintain family connections** **Impact: 18% of the children in the Project**

The Nebraska Family Policy Act (Neb. Rev. Stat. §43-533) states that when a child cannot remain with their parent, preference shall be given to relatives as a placement resource. Relative care is in place to allow children to keep intact existing and appropriate relationships and bonds with appropriate family members, and to lessen the trauma of separation from the parents.

If a maternal or paternal relative or family friend is an appropriate placement, children suffer less disruption and are able to remain placed with persons they already know that make them feel safe and secure. Thus, relative care can be especially beneficial when children have a pre-existing positive relationship with a particular relative.

Relatives must be identified early in the case, rather than months or years after the child has been in out-of-home care. Even if there are reasons that they cannot be the primary caretaker for the child, there can often be a benefit to the child of maintaining contacts. For example, if the grandmother lacks the physical health to do the day-to-day care of a preschooler, that child may still have positive bonds with her that are important to maintain for that child's mental health and well-being.

During Project reviews of the case files from the Eastern Service Area there was no readily available documentation of relative searches for many of those children, but we had not compiled statistics on the frequency of this. We found that there was a lack of consistency to where information could be documented, some of which was deep into the narratives (written case notes) and thus not easy to find. We recommended that there be a consistent place for such documentation within N-FOCUS. Changes were made, and for future cases, some of the documentation issues have been resolved by changes to N-FOCUS and practice changes. Due to these changes, there will now be the ability to appropriately document this important case manager function.

After reviewing the case files in Eastern Service Area, we felt it was important that for the other areas of the state we compile figures regarding documentation.

This is what we found with regard to documentation on N-FOCUS:

Relative search Documented	Central	Eastern	Northern	Southeast	Western	Total
No	1		0	1	2	4 (3%)
Unable find doc	15		4	28	4	51 (34%)
Yes	8		24	53	11	96 (64%)
Total	**24**		**28**	**82**	**17**	**151**

After the case file research was completed, we then interviewed each assigned case manager. During that process we determined for how many cases the lack of relative searches was impacting permanency.

	Central	Eastern	Northern	Southeast	Western	Total
Lack of Relative Search	0 of 24	73 of 304 (24%)	0 of 28	11 of 82 (13%)	0 of 17	84 of 455 (18%)

The following needs still exist:

1. The need to ensure that a relative/kinship placement is not selected simply because of biological connections, but rather because it is a safe, appropriate placement that is in the child's best interest.
2. The need to identify and recruit relatives, kin and non-custodial parents within the first 60 days of a child's placement including assessing the appropriateness of their previous relationship with the children and their ability to safely care for the children, so that delayed identification of these prospective placements does not result in unnecessary moves.
3. The need to identify and establish paternity in a timely manner so the father and paternal relatives can be considered.

BARRIER #5	**Length of time to an appellate decision on a termination of parents rights** **Impact: 12% of the children in the Project**

After a juvenile court has found that there are grounds to terminate parental rights, in many cases the parent's attorney or county attorney will appeal the termination decision. This is entirely within their due process rights.

However, during the time (often months) between the juvenile court terminating parental rights and a decision from the appellate court, permanency is "on hold." Adoptions or guardianships cannot be finalized, putting the children and their potential adoptive/guardianship parents in limbo. Courts may not hold review hearings until the appellate decision is returned, even though

they should be monitoring the children's case during that time and ensuring that the children are receiving needed services.

The cases in which the appeals process delayed permanency by service area:

	Central	Eastern	Northern	Southeast	Western	Total
Time to appellate decision	1 of 24 (4%)	47 of 304 (15%)	0 of 28	7 of 82 (9%)	1 of 17 (6%)	56 of 455 (12%)

Many of the concerns regarding the length of the appeal process have been addressed by the appellate courts. The appellate courts did complete a thorough analysis of its appeal processes and changes were made that have greatly impacted the time period a case is on appeal. We commend the appellate courts for their prompt acknowledgement and resolution of this issue.

The following needs still exist:

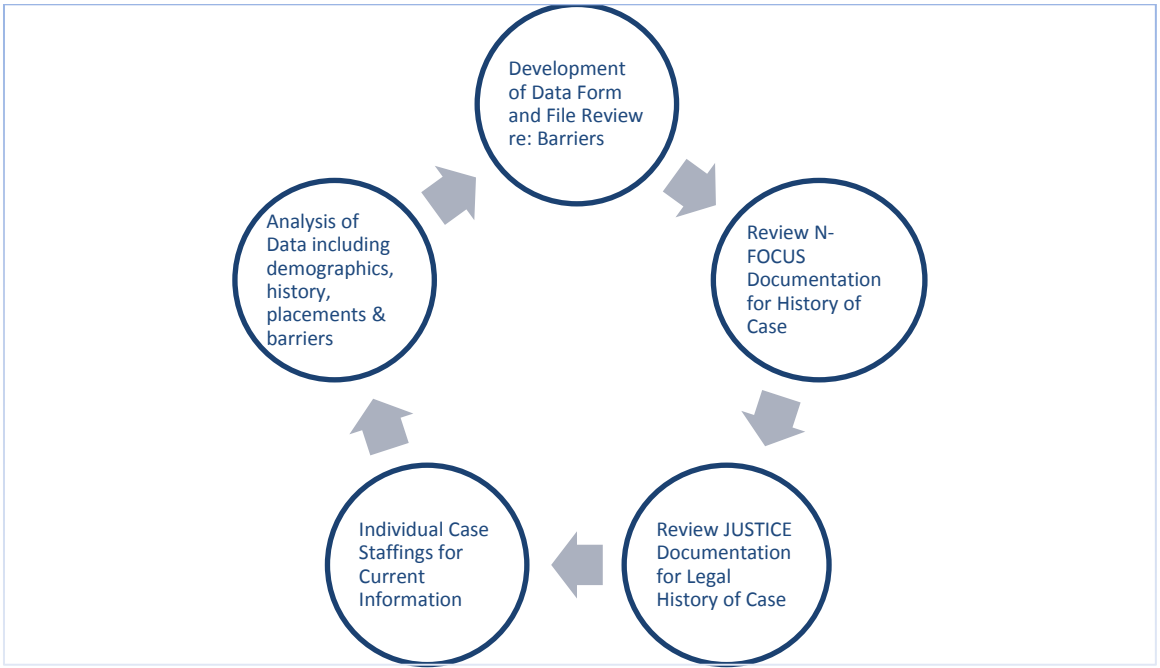
1. The need to continue efforts to prioritize the completion of appellate decisions and reduce the time before a decision is reached including a yearly analysis regarding the appeal time period.
2. The need to research the effectiveness and impediments of the Iowa appeal statutes with regard to juvenile court cases.

BARRIERS 6-10

Other barriers identified in the top 10 included:

Ranking	Topic	Impact
6	The child's current mental health issues	11% of the Project children
7	The child's current behavioral issues	10% of the Project children
8	Paternity issues	10% of the Project children
9	Placement issues	7% of the Project children
10	Issues between separate juvenile courts/county courts and district courts regarding child custody decisions	7% of the Project children

Appendix A - Methodology
Process Utilized by the Barriers to Permanency Project



Data Collected by Barriers to Permanency Project

A common data form was jointly created and used in the Project review of each of these individual cases. The information was collected from N-FOCUS, JUSTICE and paper file reviews. The data collected included:

1. Basic case identifiers
2. Demographics of child and family
3. Legal status history
4. Reasons entered out-of-home care
5. Current permanency goals
6. Status of parental rights including fathers
7. Current placement type
8. Placement history
9. Number of removals from parental home
10. Child characteristics/services

The process also included the creation of a common set of barriers. Barriers fall into these categories:

1. Legal Barriers (ex: ICWA, custody, immigration, paternity or no termination of parental rights filed)
2. Court/Legal Parties Barriers (ex: appeal of termination, delays/continuances, fragmented court system)
3. Parent/Guardian Barriers (ex: mental health, substance abuse, incarceration, refusal to take child back)
4. Subsidy/Funding Barriers (ex: adoption, guardianship, DD funding)
5. Child Barriers (ex: severe mental health, DD, child behaviors)
6. Placement Barriers (ex: current placement unwilling to provide permanency; lack of support in placement, relatives unwilling to provide permanency)
7. Case Management Barriers (ex: number of case managers, need family finding, lack of effective case management throughout life of case, lack of effective current case management, lack of independent living services)

Once the Project review of the case files were completed, the Barriers to Permanency Project team met with the assigned case manager and his/her supervisor for each child reviewed in order to thoroughly discuss the progression of the case. These meetings included the use of a uniform questionnaire regarding the current status of the case and their opinions and concerns regarding the history on the case. The information gained from these interviews along and the completed data forms were used as the basis for determining the barriers for each child involved in this Project.

Appendix B –
Further Analysis of Eastern Service Area Cases
Involving Judicial Systemic Concerns

As part of these individual case file Project reviews of children in care for 3 years or longer, specific cases were identified as having a barrier of "fragmented court system" or "court delays".

A further analysis of cases identified with these specific barriers was completed by the FCRO and CIP for the Eastern Service Area. This further analysis involved 19 cases involving 40 children. More than one concern was found in some of these 19 cases.

The relevant data for the three main categories with subcategories are as follows:

Court Delays

No review hearings every 6 months	-	4
Review hearings started but not completed	-	2
No permanency hearing at 12 months	-	4
Hearings continued for more than 14 days	-	5
Time to complete adjudication Hearing	-	2
Time to complete TPR trial	-	2
Time to complete guardianship	-	1

County Attorney/Guardian ad Litem

Failure to file timely TPR	-	7
Failure to timely file Father's adjudication	-	5
Inactive legal parties	-	1

Miscellaneous

Child request to age-out	-	1

Based upon the above, some observations and considerations for changes include the following:

1. Identification of putative and bio-father's at the pre-conference hearing to include either timely legal proceedings regarding the father or placement of the children if appropriate.

2. Ensure all court review hearings and permanency hearings are meeting the statutory requirements to include when other legal matters are before the court and when a case is on appeal.

3. Accountability by the court ensuring that all legal parties to a case are meeting their ethical and statutory responsibilities.

Appendix C –
Racial Disproportionality in Eastern Service Area

There is racial disproportionality regarding children in foster care across the state. However, the difference was larger than expected in the Eastern service area. Consider the following:

- 13% of the children in Douglas County are Black per the US Census.[13]
- 21% of the children from the ESA in out-of-home care on an average day, regardless of length in time in care, are Black.
- **51% of the children in the Barriers to Permanency Project from the ESA are Black.**

The following details some possible explanations for this variance.

Poverty

One speculation as to why there is such disproportionality in Douglas County was that poverty might be a larger factor than in other areas. According to the most recent US Census[14] estimates:

- In Douglas County 48% of Black female householders with children are below the poverty line, compared with 30% of the White female householders.
- In Douglas County, 5% of the Black children were in married households, compared to 83% of White children.

- In comparison, in Lancaster County 64% of Black female householders with children are below the poverty line, compared with 42% of White female householders.
- In Lancaster County, 3% of the Black children were in married households, compared to 87% of White children.

A note here: there are far fewer Black families in Lancaster County as compared to Douglas County. Nonetheless, poverty alone may not explain the discrepancy.

Age

By age group within the Eastern Service Area:

- 47% of the children in the 0-5 age group were Black.
- 55% of the children in the 6-12 age group were Black.
- 49% of the children in the 13-18 age group were Black.

In other words, there were very slightly more Black children than expected in the 6-12 age group, and very slightly less in the 0-5 and 13-18 age groups. As one Project member said, "*it isn't all those naughty teenagers*."

[13] 2013 per American Fact Finder.
[14] 2013 per American Fact Finder.

Type(s) of barriers identified

Further delving into differences in the Eastern area, the Project found that:

- 75% with an issue regarding paternity identification were Black; 25% were other races.
- 69% whose placement was unwilling to provide permanency were Black; 31% were other races.
- 69% with an adoption subsidy issue were Black; 31% were other races.
- 66% who needed a relative search in order to locate possible relative placements were Black; 34% were other races.
- 63% of children where the county attorney had failed to file a TPR were Black; 37% were other races.
- 63% of children with their own law violation that needed to be addressed prior to permanency being achieved were Black; 37% were other races.

At the same time, for some barriers there were fewer Black children than expected. For example:

- 38% with an immigration barrier were Black; 62% were other races.
- 33% with current, severe mental health issues were Black; 67% were other races.
- 32% where court delays were an identified barrier were Black; 68% were other races.

Appendix D –
Further Details on Placement Types by Age

AGE 3-5

Age 3-5 Placement type	By Service Area					Total children
	Central	Eastern	Northern	Southeast	Western	
Least restrictive						
Relative foster home	0	6	1	2	0	9
Pre-adoptive foster home	0	4	0	2	1	7
Child-specific foster home	0	3	0	0	0	3
Licensed foster home	1	0	0	2	0	3
Agency-based foster home	0	19	0	0	0	19
Total	**1**	**32**	**1**	**6**	**1**	**41**

100% of the children age 3-5 were in the least restrictive forms of placement.

See the following pages for other age groups.

AGE 6-12

Age 6-12 Placement type	By Service Area					Total children
	Central	Eastern	Northern	Southeast	Western	
Least restrictive						
Relative foster home	3	15	1	2	1	22
Pre-adoptive home	0	11	0	7	1	19
Child-specific home	0	3	2	5	0	10
Licensed foster home	7	1	3	4	0	15
Agency-based foster home	0	80	0	0	0	80
Continuity foster care	0	2	0	0	0	2
Subtotal	**10**	**112**	**6**	**18**	**2**	**148**
Moderately restrictive						
Center for developmentally disabled	0	1	0	0	0	1
Group home	0	0	1		0	1
Subtotal	**0**	**1**	**1**	**0**	**0**	**2**
Most restrictive						
Residential treatment facility	0	0	1	1	0	2
Psych Residential Treatment	0	2	0	0	0	2
Subtotal	**0**	**2**	**1**	**1**	**0**	**4**
Total	**10**	**115**	**8**	**19**	**2**	**154**

96% of the children age 6-12 were in the least restrictive forms of placements.

AGE 13-18

Age 13-18, Placement type	By Service Area					Total children
	Central	Eastern	Northern	Southeast	Western	
Least restrictive						
Relative foster home	0	12	2	8	1	23
Pre-adoptive home	0	4	0	2	0	6
Child-specific home	1	4	2	3	2	12
DD family home	0	4	1	0	2	7
Licensed foster home	8	1	4	15	3	31
Agency-based foster home	0	60	0	0	0	60
Independent Living	1	0	0	0	0	1
Subtotal	**10**	**85**	**9**	**28**	**8**	**140**
Moderately restrictive						
Group home	0	20	3	10	2	35
DD Center	0	2	0	0	0	2
DD group home	0	3	0	0	0	3
Boarding school	0	1	0	0	0	1
Subtotal	**0**	**26**	**3**	**10**	**2**	**41**
Most restrictive						
Detention facilities or YRTC	0	17	0	5	1	23
Emergency shelter	0	4	0	1	0	5
Residential Treatment Facility	2	0	2	6	1	11
Pediatric Hospital	0	0	0	0	1	1
Psych Residential Treatment	0	2	0	0	0	2
Psychiatric hospital	0	1	0	0	0	1
Subtotal	**2**	**24**	**2**	**12**	**3**	**43**
Other						
Runaway	0	0	0	2	0	2
Other	0	0	3	5	1	9
Unclear	1	22	2	0	0	25
Subtotal	**1**	**22**	**5**	**7**	**1**	**36**
Total	**13**	**157**	**19**	**57**	**14**	**260**

54% of the children age 13-18 were in the least restrictive forms of placement; 16% were in moderately restrictive placements; 18% were in the most restrictive, and the remainder were runaways or their placement type as of the date of the Project review was undetermined.

Appendix E –
Eastern Service Area Alternative Placement Counts

The following is information provided by NFC as an alternative way to count placements based upon federal CFSR data for the Eastern Service Area. Unlike the measures used elsewhere in this report, CFSR placement counts do not include detention episodes, runaways, certain hospitalizations, etc.

	By Age Group				
Number of Placements	**Age 3-5**	**Age 6-10**	**Age 11-15**	**16-18**	**Total children**
1-3 placements	17	43	18	10	88
4-9 placements	17	41	41	34	133
10-19 placements	0	1	15	51	67
20-29 placements	0	0	2	13	15
30+ placements	0	0	0	1	1
Totals	**34**	**85**	**76**	**109**	**304**

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 and quarterly reports and other topics of interest.

Foster Care Review Office
Kim B. Hawekotte, J.D., Director
521 S. 14th, Suite 401
Lincoln NE 68508
402.471.4420

Email: fcro.contact@nebraska.gov
www.fcro.nebraska.gov

2015 Index Bills Referenced to HHS Committee Status

STATUS of 2015 Bills Referenced to the HHS Committee						As of 5/29/2015
Hrg Date	**LB/LR #**	**Introducer**	**Priority**	**One-liner**	**Status**	**IPP'd**
1/28	12	Krist		Suspend medical assistance provided to persons who become inmates of public institutions	General File	
1/30	19	Krist		Change provisions relating to laboratory certification under the NE Safe Drinking Water Safety Act	General File	
3/4	21	Krist		Provide requirements for rate increases for providers of behavioral health services as prescribed	General File	
1/23	23	Krist		Change the Engineers and Architects Regulation Act	Passed	
1/21	27	Krist		Create a reporting requirement under the Vital Statistics Act when parenting time is established or modified	In Committee	
2/27	28	Krist		Adopt the Radon Resistant New Construction act	General File	
1/29	34	Howard		Adopt the Carbon Monoxide Safety Act	Passed	
1/21	37	Krist		Adopt the Prescription Drug Safety Act and change and transfer pharmacy, prescription, and drug provisions	Passed	
1/29	46	Watermeier		Change provisions of the statewide Trauma System Act	Passed	
1/28	77	Nordquist		Require a Medicaid state plan amendment for family planning services and state intent relating to approp. for the Every Woman Matters Program	General File	
2/12	80	Gloor	Gloor	Provide, change, and eliminate anesthesia and sedation permit provisions under the Dentistry Practice Act	Passed	
2/26	81	Cook	Cook	Change provisions relating to eligibility for child care assistance	Passed	
1/21	87	Campbell		Change membership and reporting requirements of the Nebraska Children's	Passed	

STATUS of 2015 Bills Referenced to the HHS Committee						As of 5/29/2015
Hrg Date	**LB/LR #**	**Introducer**	**Priority**	**One-liner**	**Status**	**IPP'd**
				Commission		
2/6	89	Campbell	Campbell	Change provisions relating to aid to dependent children	Vetoed AM into LB607	
1/23	90	Campbell		Change provisions for directed review under the Nebraska regulation of Health Professions Act	Passed	
1/22	107	Crawford		Eliminate integrated practice agreements and provide for transition-to-practice agreements for nurse practitioners	Passed	
1/28	129	Harr		Require criminal background checks for applicants for an initial nursing license	Passed	
1/29	146	Crawford		Provide for disposition of unclaimed cremated remains in a veteran cemetery	Passed	
2/6	147	Crawford		Change provisions relating to asset limitations for public assistance	In Committee	
1/30	148	Crawford		Provide for medical assistance program coverage for certain youth formerly in foster care	In Committee	
2/20	196	Campbell	Speaker	Change provisions of the Rural Health Systems and Professional Incentive Act	Passed	
2/19	199	Howard	Howard	Provide for stipends for social work students	Passed	
3/6	211	Kolowski		Authorize chiropractors to provide school entrance physical examinations and visual evaluations	In Committee	
3/6	235	Howard		Adopt the consumer protection in Eye Care Act	General File	
3/4	240	Hansen	Speaker	Change provisions relating to a behavioral health pilot program	Passed	
2/19	243	Bolz	Bolz	Create a pilot project relating to family finding services	Passed	
3/5	258	Nordquist		Adopt the Interstate Medical Licensure Compact	In Committee	
3/5	264	Morfeld	Morfeld	Provide for issuance of credentials under the Uniform Credentialing Act	Passed	

STATUS of 2015 Bills Referenced to the HHS Committee						As of 5/29/2015
Hrg Date	**LB/LR #**	**Introducer**	**Priority**	**One-liner**	**Status**	**IPP'd**
				based on military education, training, or experience		
3/6	287	Haar		Change provisions relating to licensure of interpreters for the deaf and hard of hearing	Passed	
2/19	296	Kolterman		Require the Department of Health and Human Services to provide notification after removal of a child	Passed	
2/12	315	Howard	Speaker	Change provision relating to Medicaid recovery audit contractors	Passed	
2/5	320	Bolz	HHS Committee	Adopt the Aging and Disability Resource Center Act	Passed	
3/11	333	Gloor		Adopt the Health Care Services Transformation Act	In Committee	
2/18	335	Mello		Create and provide duties for the Intergenerational Poverty Task Force	IPP	5/29 AM into LB607
2/27	346	Krist		Require a Medicaid state plan amendment to cover children's day health services	In Committee	
2/4	353	Campbell		Change credentialing provisions for nursing home administrators	In Committee	
2/4	366	Pansing Brooks		Change the personal needs allowance under the Medical Assistance Act	Passed	
3/5	369	Riepe		Change provisions relating to impaired credential holders under the Uniform Credentialing Act	In Committee	
2/26	370	Riepe		Provide for an amendment to the Medicaid state plan relating to the dyslexia treatment	In Committee	
2/5	405	Davis		Create the Alzheimer's and Related Disorders Advisory Work Group and provide for a state plan	IPP	5/29 AM into LB320
3/11	411	Cook		Change provisions relating to the Supplemental Nutrition Assistance Program	In Committee	

STATUS of 2015 Bills Referenced to the HHS Committee						As of 5/29/2015
Hrg Date	**LB/LR #**	**Introducer**	**Priority**	**One-liner**	**Status**	**IPP'd**
2/5	440	Morfeld		Provide for a study of rates for care by an Alzheimer's special care unit as prescribed	In Committee	
2/19	441	Bolz		Change provision relating to the bridge to independence program	IPP	5/29 AM into LB243
2/11	452	Hilkemann	Speaker	Provide advertising requirements under the Uniform Credentialing Act	Passed	
2/11	471	Howard		Change provisions relating to prescription drug monitoring	In Committee	
2/25	472	Campbell	HHS Committee	Adopt the Medicaid Redesign Act	General File	
2/18	490	Watermeier		Adopt the Provider Orders for Life-Sustaining Treatment Act	In Committee	
3/4	499	Krist		Provide Duties for the Department of Health and Human Services relating to behavioral and mental health services	In Committee	
3/4	500	Howard	Speaker	Require application for Medicaid state plan amendment for multisystemic therapy and functional family therapy	Passed	
3/11	516	Bolz		Create the Brain Injury Council and the Brain Injury Trust Fund and provide powers and duties	In Committee	
3/18	518	Riepe		Provide for changes to the medical assistance program	In Committee	
2/6	543	Harr		Provide for certification of community paramedics and reimbursement under Medicaid	In Committee	
2/26	547	Campbell	Speaker	Change provisions of the Quality Child Care Act	Passed	
3/18	548	Campbell		Adopt the Surgical Assistant Practice Act	In Committee	
2/20	549	Campbell		Adopt the Health Care Transformation Act	In Committee	
2/27	557	Kolowski		Redefine a term under the Nebraska Clean Indoor Air Act	In Committee	
2/11	567	Johnson		Permit transfer of prescription	In	

STATUS of 2015 Bills Referenced to the HHS Committee						As of 5/29/2015
Hrg Date	**LB/LR #**	**Introducer**	**Priority**	**One-liner**	**Status**	**IPP'd**
				information between pharmacies as prescribed	Committee	
2/18	607	Mello	Speaker	Adopt the Home Care Consumer Bill of Rights Act	Passed	
3/18	631	Scheer		Change Medicaid provisions relating to acceptance of and assent to federal law	In Committee	
2/25	650	Nordquist		Encourage hospitals to offer vaccinations	In Committee	
3/5	LR41	Campbell		Urge the Nebraska congressional delegation to support efforts in Congress to establish a national training center in highly infectious diseases at the University of Nebraska Medical Center	Passed	

REPORT ON THE PRIORITIZING
OF INTERIM STUDY RESOLUTIONS
Pursuant to Rule 4, Section 3(c)

COMMITTEE: Health and Human Services DATE: May 27, 2015

The following resolutions were referred to the Committee on Health and Human Services. The committee has prioritized the resolutions in the following order:

Introducer	**Resolution No.**	**Subject**
McCollister	306	Medicaid
Campbell	304	Children's behavioral health
Campbell	248	Human trafficking
Coash	242	Developmental Disabilities and child welfare
Campbell	300	Child welfare - Out of state placement
Campbell	52	Child maternal death review
Campbell	292	Child welfare - Kinship assistance
Gloor	22	Health care – patient centered medical homes
Mello	259	Early childhood education - Home visits
Mello	275	Child care affordability
Howard	231	Prescription Drug Monitoring Program
Crawford	185	Behavioral health professional workforce
Kolterman	181	Public assistance and workforce
Watermeier	298	Emergency Medical Services
Harr	310	Community Paramedic
Harr	312	Children's behavioral health
Campbell	291	Health - Stroke designation
Campbell	250	HHS Committee issues

Hall County Community Collaborative

The Hall County Community Collaborative (H3C) has been working since 2005 to develop and sustain infrastructure and build relationships necessary for prevention system change. This work has been undertaken with funding and technical assistance from the Nebraska Children and Families Foundation. The objective is to create a functional, sustainable, effective broad-based collaboration to enhance collective impact. The collaborative is comprised of community and county stakeholders representing a wide cross-section of agencies, organizations, businesses, public entities, and individuals. Violence Prevention and Juvenile Justice work is braided with that of the Hall County Collaborative to provide a continuum of services for youth ages 0 to 26 years of age in an effort to increase protective factors and reduce risk factors in youth and families.

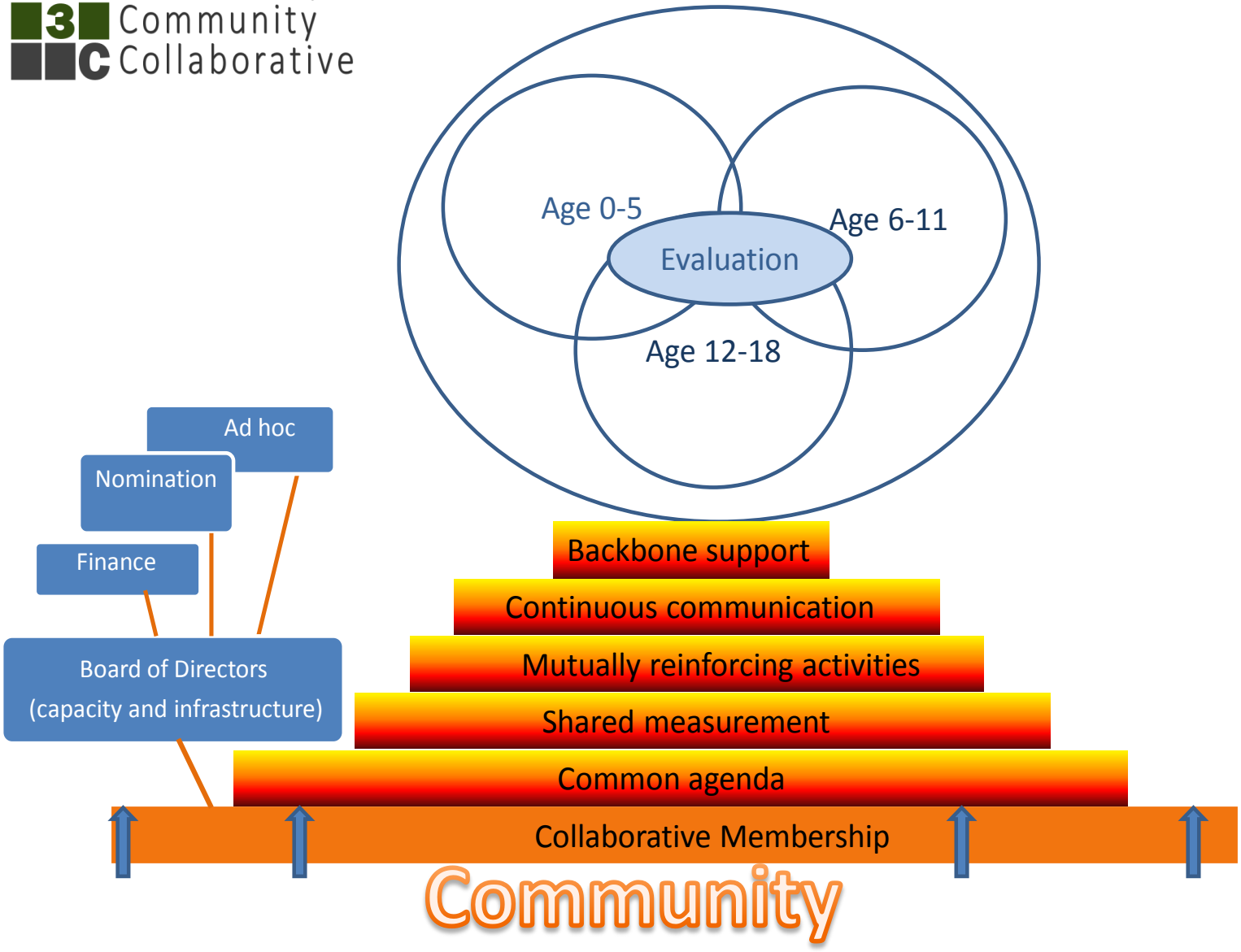
H3C members meet every other month to build Collective Impact, learn leadership skills, support sub-committee work, address gaps and needs in services to children and families, create project partnerships, network, and promote requests and offers. There are four sub-committees of the H3C that work to develop the system of care for children ages 0 to 5, 6 to 11, 12 to 18, and Transitional Youth ages 16 to 24. Transitional Youth include those who are or who have ever been involved in the state welfare system. Each of these committees meets at least four times per year and have a committee facilitator and/or co-facilitator. The sub-committees enable additional community members to be involved in the work of the collaborative specific to their interest.

The Hall County Community Collaborative incorporated and received Non-profit 501(c)(3) status with the IRS in 2014. Until a transition can occur for financial management, Central District Health Department acts as fiscal agent for the Hall County Collaborative, dedicates a portion of time of a staff member for data collection and day-to-day support, manages accounting/audit/grant reporting, provides a percentage of Directors' and Officers' Insurance, and works with the Hall County Collaborative Board of Directors, which represent five different sectors of the community to assure diversity of representation. The Board provides oversight of grant funds, monitors the financial structure of the collaboration, approves invoices/reviews financial statements/supports the fiscal agent, and enhances the collaborative capacity of the organization by processing new opportunities or requests to the organization.

Joni Kuzma, Kuzma Consulting, contracts with the H3C to provide collaborative consultation for H3C to build collaboration capacity, assist in information flow and integration of work between the committees, assist with collaboration building, maintain collaborative documentation suitable for grant reports, research opportunities support the goals, vision and mission of the group, and manage implementation processes for new projects.

A website is still under construction but will be used to provide H3C information, local-state- and federal data, and Collective Impact information. www.h3cne.org

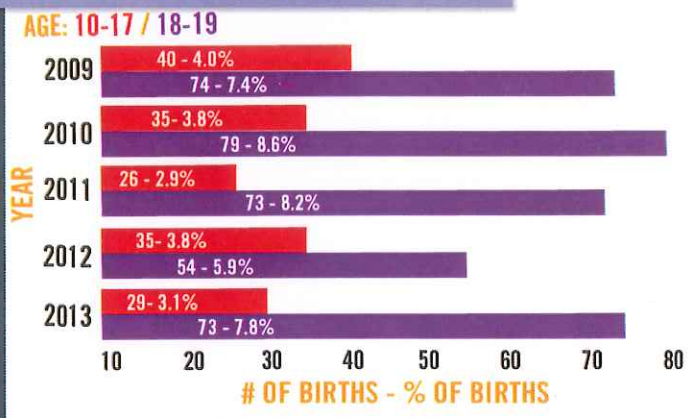
Hall County Community Collaborative



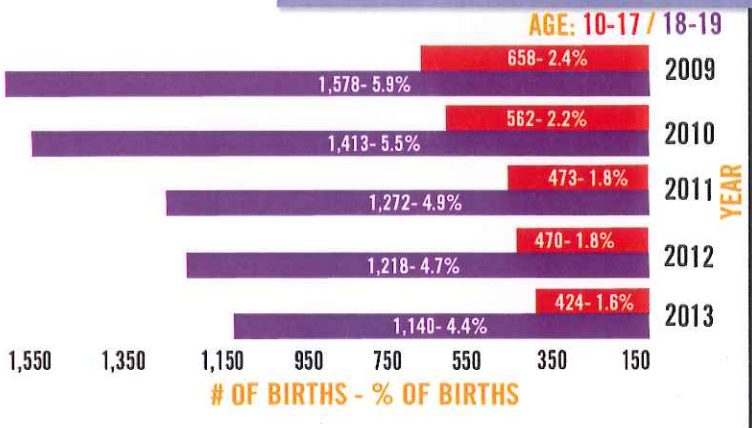
TEEN BIRTHS IN HALL COUNTY

HEARTLAND UNITED WAY

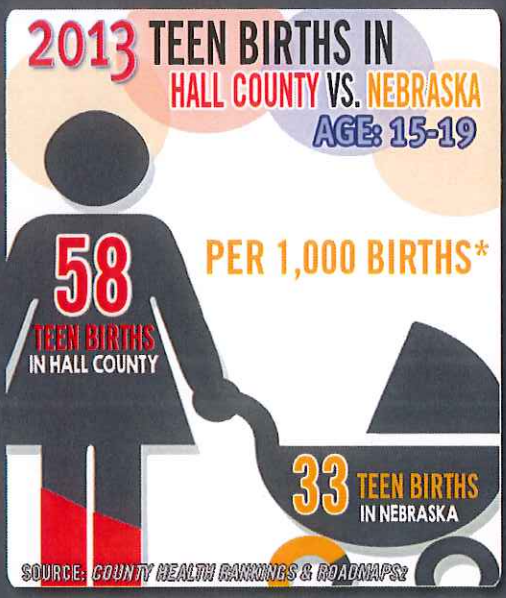
BIRTHS BY AGE IN HALL COUNTY, 2009-2013

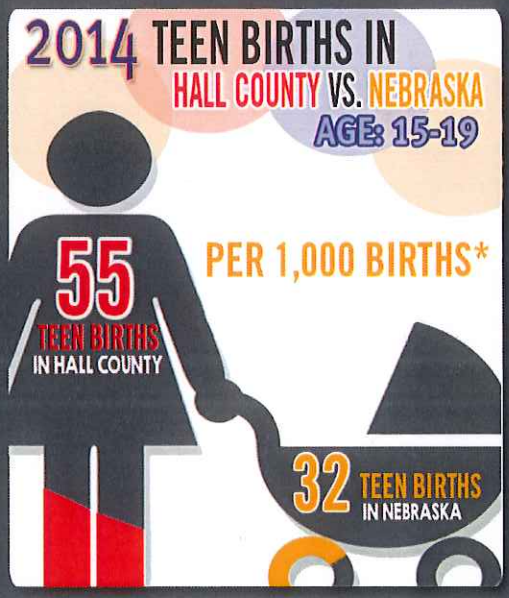


BIRTHS BY AGE IN NEBRASKA, 2009-2013

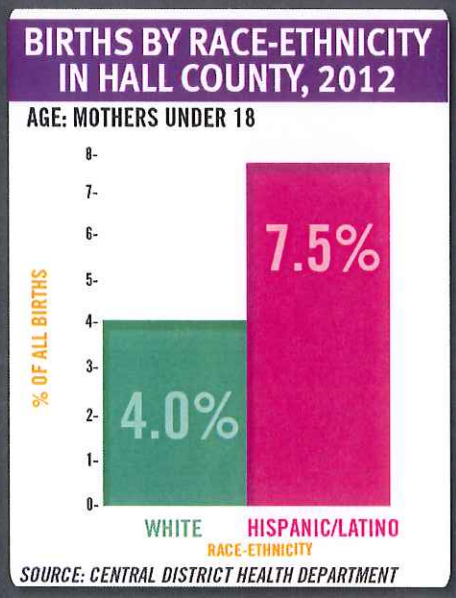


SOURCE: *VOICES FOR CHILDREN1*





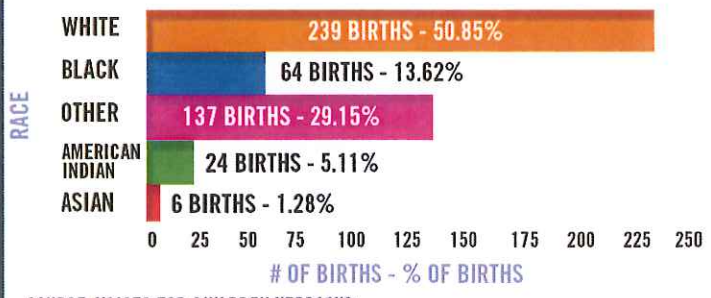
BIRTHS BY RACE-ETHNICITY IN HALL COUNTY, 2012



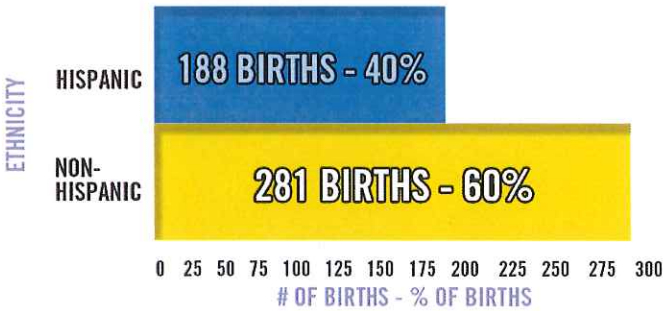
SOURCE: CENTRAL DISTRICT HEALTH DEPARTMENT

BIRTHS BY RACE OR ETHNICITY IN NEBRASKA, 2012

RACE OF MOTHER - AGE: 10-17



ETHNICITY OF MOTHER - AGE: 10-17



SOURCE: *VOICES FOR CHILDREN NEBRASKA1*

LIVE UNITED
United Way

1. Data provided by National Vital Statistics System and drawn by Nebraska Department of Health and Human Services.
2. Data provided by National Vital Statistics System and drawn by National Center for Health Statistics.

* *Teen births are the number of births per 1,000 female population, ages 15-19.*

January 22, 2013

Karen Authier, Chairperson
Nebraska Children's Commission

Dear Karen Authier,

Please accept the attached report from the Foster Care Reimbursement Rate Committee (FCRRC) for the July 2015 Children's Commission meeting. Unfortunately, I am not able to be present at the meeting but Lana Temple-Plotz from the FCRRC has agreed to report on the committee actions in my place.

The Foster Care Reimbursement Rate Committee (FCRRC) has had two meetings since the last report to the Children's Commission: April 17, 2015 and July 8th, 2015.

Both meetings focused on the following two tasks:

- Review of the Foster Care Rate Implementation
- Group Home Rates: development of a methodology for DHHS to unbundle group home rates to assist with reporting of IV-E funds.

I am pleased to report that a sub-committee developed a methodology for unbundling group home rates that met DHHS's request of the Commission and Foster Care Rate Committee. This task has been completed.

In the process of doing the work on the group home rates, it became evident to all there is additional work for the FCRRC in the area of group home rates that could be of benefit to both providers and contractors (DHHS, NFC and Probation). The inadequate funding of group home services and the concern of proposed licensing regulations that are not cost neutral has the potential to destabilize the system of care available for children if not addressed. Our report advances two recommendations from the FCRRC to the Children's Commission for review and action. Both items are a result of the committee's work on the Group Home Rates.

Respectfully,

Peg Harriott

Peg Harriott
Chairperson
Foster Care Reimbursement Rate Committee

Foster Care Reimbursement Rate Committee
Report to the Children's Commission
July 10, 2015

The Foster Care Reimbursement Rate Committee (FCRRC) has had two meetings since the last report to the Children's Commission: April 17, 2015 and July 8th, 2015.

Both meetings focused on the following two tasks:

- Review of the Foster Care Rate Implementation
- Group Home Rates: development of a methodology for DHHS to unbundle group home rates to assist with reporting of IV-E funds.

I. Review of Foster Care Rate Implementation

One year after implementation of the new Foster Care Rates and Nebraska Caregiver Responsibility Tool (NCR), DHHS, NFC and Probation reported on the implementation and outcomes. The information gleaned helped identify what is working well and what might be improved upon going forward. The committee was pleased to see general agreement between NFC and DHHS on the percentages of individuals identified within each of three levels of care. Two sub-committees are being reactivated: one to look at the base rate and one to look at the NCR tool and levels of care. In addition, a survey of foster parents is in the planning stages to identify what is working well and what can be approved on going forward from foster parent's perspective.

The Foster Care Rate committee is gearing up for the required July 1, 2016 report to the Children's Commission and Legislature (as outlined by LB530). The Foster Care Rate Committee has identified a target date of March 2016 for initial recommendations to be sent to the Children's Commission. This report will include any recommendations for changes to the foster care rates.

II. Group Home Rates

At the November 2014 meeting, the Children's Commission assigned to the Foster Care Rate Committee the task of working with DHHS to unbundle the group home rates to assist with reporting of IV-E funds. A sub-committee was led by co-chairs: Doug Kreifels, DHHS and Cindy Rudolph, Cedars CFO. Sub-committee members included representatives from providers, DHHS, NFC and Probation. A financial methodology was developed that was agreeable to the committee members and reviewed and supported by the greater Foster Care Rate Committee. DHHS reports that the methodology meets their needs. This task was completed at the July 7th, 2015 meeting by the Foster Care Rate Committee.

In the process of completing this task, it became obvious to the group home sub-committee and FCRRC members the group home rates are inadequate to meet the basic costs of doing business. In addition, proposed licensing regulations by the DHHS Division of Public Health will have significant financial implications that impact providers and the DHHS Division of Children and Family.

Two motions were made and approved by the Foster Care Rate Committee to advance to the greater Children's Commission.

- The Foster Care Rate Committee asks the Children's Commission to recommend to DHHS that a fiscal analysis be done for any proposed new licensing regulations, and if they are not cost neutral to provide adequate funding to address the fiscal impact of the required licensing regulations.

- The Foster Care Rate Committee asks the Children's Commission support for the FCRRC to further advance the work on group home rates by using the agreed upon methodology to establish recommendations for group home rates.

The next meeting will be scheduled in early September 2015.