Nebraska Foster Care Review Board

Report on Child Welfare Reform

Issued December 2010

From the FCRB Executive Director…

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

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

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

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

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

Definition of the Reform

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

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

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

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

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

Pre and Post Reform Data Comparison

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

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

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

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

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

New Issues Identified Since Implementing Reform

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

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

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

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

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

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

Inadequate foster parent reimbursement

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

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

Description of the Children and Families Affected by Reform

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

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

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

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

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

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

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

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

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

SERVICE COORDINATORS AND SAFETY:

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

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

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

CONCERN:

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

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

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

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

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

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

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

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

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

3. Service Coordinator Training:

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

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

4. Service Coordinator Retention:

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

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

IMPACT:

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

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

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

Case examples:

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

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

<u>RECOMMENDATIONS:</u>

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

PLACEMENT SAFETY AND APPROPRIATENESS:

CONCERN:

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

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

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

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

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

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

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

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

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

IMPACT:

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

RECOMMENDATIONS:

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

Case examples:

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

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

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

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

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

SAFETY and SUPERVISION OF PARENTAL VISITATION:

CONCERN:

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

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

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

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

IMPACT:

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

RECOMMENDATIONS:

- Contact the DHHS caseworker immediately regarding any safety concerns.

Case examples:

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

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

Case examples (cont.):

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

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

DECREASED SERVICE CAPACITY

CONCERN:

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

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

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

Foster Parents

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

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

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

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

Service Providers

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

IMPACT:

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

[2] The 2008 statewide assessment for the federal audit found the 2008 rates were problematically low.
[3] Lower foster parent and relative caregiver pay scales have been adopted by KVC and the Nebraska Families Collaborative. See Appendix B – Foster Parent Payments by State.

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

Case example:

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

RECOMMENDATIONS:

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

OVERSIGHT

CONCERN:

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

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

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

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

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

Self oversight is needed to improve these outcome measures.

IMPACT:

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

RECOMMENDATION:

For DHHS

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

For the Judiciary

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

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

The Foster Care Review Board Response to the Reform

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

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

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

The FCRB's Recommendations for Next Steps

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

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

> "*In states that have privatized, private agencies struggle with the same issues that public agencies do such as obtaining adequate services, reducing caseloads, and reducing turnover. More money would increase the availability of services whether spent through the public or private sector, but merely hiring a middle man to manage services does neither.*"
>
> "*Even with privatization, the state must both 1) maintain oversight of each case and 2) monitor contract performance and outcomes. Across the country, in those states that have privatized, public sector administrative costs continue to grow for this very reason.*"
>
> Center for Public Policy (March 2005)

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

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

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

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

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

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

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

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

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

Conclusion:

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

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

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

Appendix A – Reform Timeline

Governor Heineman Announces Directives

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

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

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

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

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

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

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

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

Private Agencies Assume Service Coordination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

July 2010: Change of contracts.

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

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

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

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

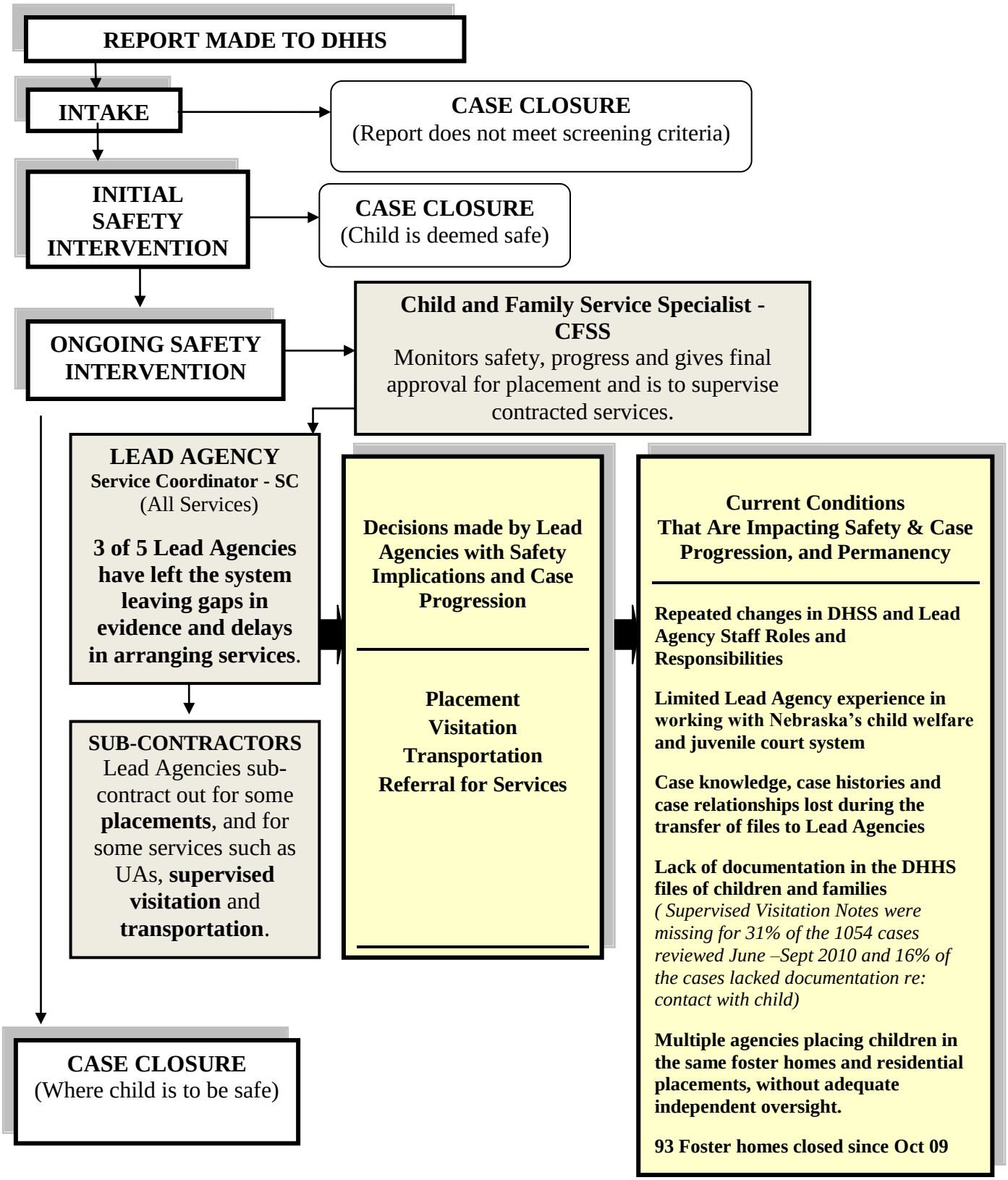
November 15, 2010: Governor Heineman weighed in on reform, noting that both state and lead providers have to do a better job in the future.

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

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

APPENDIX B

DHHS INTERVENTION AND SAFETY SYSTEM / REFORM



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

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

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

COMMUNICATION AND DOCUMENTATION AFFECTS SAFETY DECISIONS MADE BY LEAD AGENCIES

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

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

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

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

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

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

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

Appendix C – Foster Parent Payments

Most states fall short of researchers' recommendations

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

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

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

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

Appendix D – CFSR Result Comparison

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

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

Federal findings – Area Needing Improvement ×
Strength*

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

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

Federal findings – Area Needing Improvement ×
Strength*

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

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

Federal findings – Area Needing Improvement × Strength*

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

Systemic Factors and Items	**Nebraska**		**Kansas**		**Tennessee**		**Florida**	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Well Being Outcome 1: Families have enhanced capacity to provide for children's needs	**32.0×**	**32.3×**	**76.0×**	**65.6×**	**52×**	**35.4×**	**62×**	**24.6×**
Item 17: Needs/services of child, parents, and foster parents	56×	40×	Not Reported	69×	56×	38.5×	72×	29×
Item 18: Child/family involvement in case planning	26×	39×	Not Reported	75×	65×	39×	53.1×	35×
Item 19: Caseworker visits with child	60×	65×	Not Reported	73×	92*	63×	75.5×	80×
Item 20: Caseworker visits with parents	44×	30×	Not Reported	64×	68×	26×	69×	31×
Well-Being Outcome 2: Children receive services to meet their educational needs	**86.1×**	**76.5×**	**93***	**91.5×**	**82.2×**	**83.3×**	**78.9×**	**82.5×**
Item 21: Educational needs of child	86×	77×	Not Reported	91×	82×	83×	78.9×	83×

Federal findings – Area Needing Improvement × Strength*

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

Systemic Factors and Items	**Nebraska**		**Kansas**		**Tennessee**		**Florida**	
	Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength		Percent Achieved/Strength	
	2002	2009	2001	2008	2002	2008	2001	2008
Well Being Outcome 3: Children receive services to meet their physical and mental health needs	**55.3×**	**62.3×**	**78×**	**85.5×**	**69.4×**	**66.1×**	**74×**	**61.4×**
Item 22: Physical health of child	73×	77×	Not Reported	92*	89*	91*	85.1×	79×
Item 23: Mental health of child	66×	70×	Not Reported	88×	71×	63×	76.3×	67×
Estimated Annual Penalty for not meeting Federal Standards	$264,696	$366,580	$415,056.42	$134,088	$1,488,696	$1,522,580	$2,951,544	$3,365,779
Highlights of Findings								
# of National Standards met	2 of 6 standards.	1 of 6 standards.	3 of 6 standards.	3 0f 6 standards.	1 of 6 standards.	2 of 6 standards.	2 of 6 standards.	2 of 6 standards
# of outcomes substantially achieved	0 of 7 outcomes.	0 of 7 outcomes	2 of 7 outcomes.	0 of 7 outcomes.	0 of 7 outcomes.	0 of 7 outcomes.	1 of 7 outcomes.	0 of 7 outcomes
#of Systemic factors where substantial conformity was achieved	3 0f 7 systemic factors.	5 of 7 systemic factors.	6 of 7 systemic factors.	4 0f 7 systemic factors.	4 of 7 systemic factors.	5 of 7 systemic factors.	5 of 7 systemic factors.	4 of 7 systemic factors.

Federal findings – Area Needing Improvement ×
Strength*

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

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