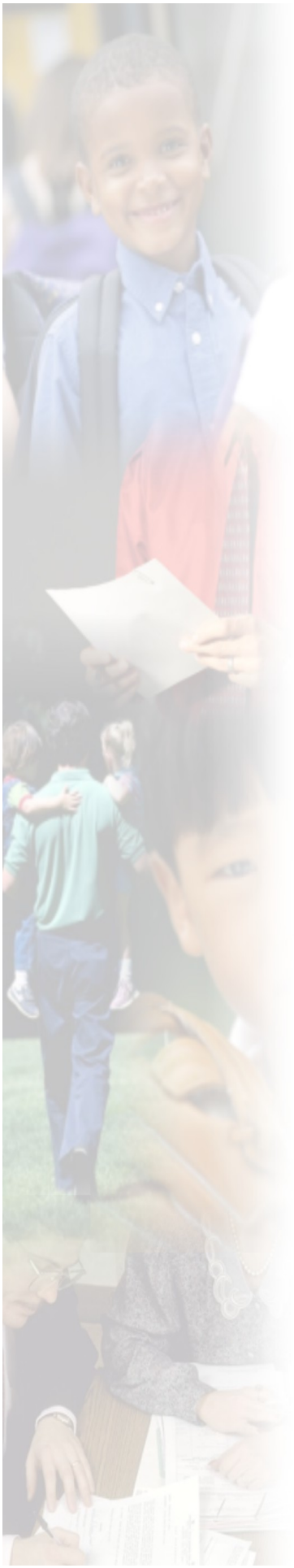
Attachment G

Annual Report 2008

Nebraska Citizen Review Panel for Child Protective Services



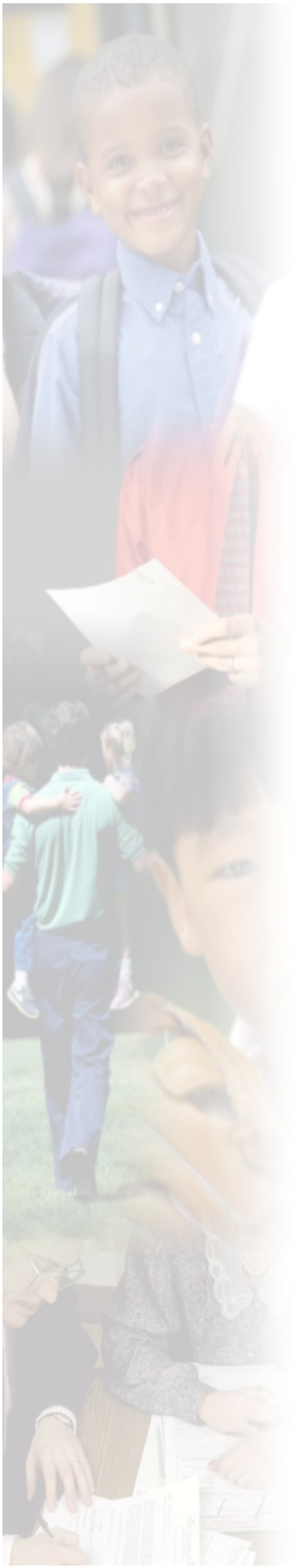
Introduction

Recognizing the importance of citizen input into the child welfare system, federal legislation amended the Child Abuse and Treatment Act (CAPTA) to require each state to create Citizen Review Panels (CRPs) by July 1999 (Administration for Children and Families, 1998). According to the amendment, Citizen Review Panels are to be comprised of representatives from the community, meet at least quarterly, and submit an annual report to the federal government outlining their activities and recommendations (Administration for Children and Families, 1998; Jones, Litzelfelner, & Ford, 2002).

The legislation provided the panels with a broad mandate:

1. To insure that the state was in compliance with the state CAPTA plan.
2. To assure that the state was coordinating with the Title IV-E foster care and adoption programs.
3. To assess the Child Protective Service (CPS) agency in its compliance with the review of child fatalities.
4. To evaluate any other piece of the CPS system which the Citizen Review Panel deemed important.

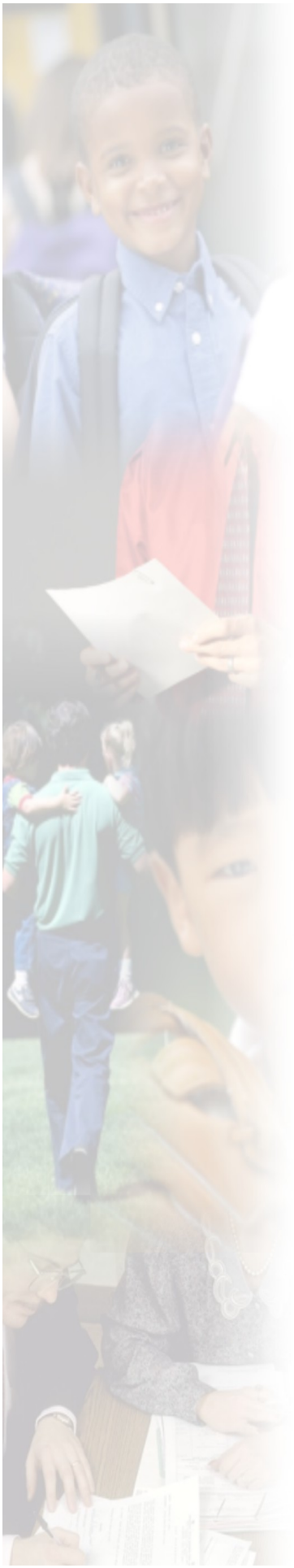
Keeping Children and Families Safe Act of 2003 (formerly known as CAPTA) revised the CRP requirements by requiring each panel to make recommendations to the state on improving the child protection services system. The Department of Health and Human Services System is to respond to the panel in writing no later than six months after the panel recommendations are submitted. The agency's response must include a description of whether and how the state will incorporate the recommendations of the panel to make measurable progress in improving the child protective service system.



Membership

The Nebraska Commission for the Protection of Children serves as the Citizen Review Panel for the state. Members of the Commission are appointed by the Governor and serve as leads for subcommittees that address issues the Commission has decided to focus on. The Citizen Review Panel Committee is one such subcommittee of the Governor's Commission. In 2008, the membership of the CRP expanded to include a balance of child advocates, law enforcement personnel, mental health personnel, public child welfare employees, legislative representatives, and attorneys. The members and their organizational affiliation are:

- Kathy Bigsby Moore, CRP Co-Chair, Voices for Children
- Gene Klein, CRP Co-Chair, Project Harmony
- Shirley Pickens White, CRP Coordinator, NE Dept of Health and Human Services
- Debra Anderson, CRP Staff Support, Project Harmony
- Timoree Adams, NE Legislative Aide
- Karen Authier, Nebraska Children's Home
- Lynn Ayers, Lincoln Child Advocacy Center
- Kathy Belcastro-Gonzalez, Omaha Police Department
- Lisa Blunt, Child Saving Institute
- John Clark, NE Dept of Education
- Mark Ells, Center for Children, Families and the Law
- Mary Frasier-Meints, Uta Halee
- Sherri Haber, NE Dept of Health and Human Services
- Chris Hanus, NE Dept of Health and Human Services
- Liz Hruska, Legislative Council
- Doug Koebernick, NE Legislative Aide
- Gary Lacey, Lancaster County Attorney
- Maria Lavicky, NE Dept of Health and Human Services
- Mary Jo Pankoke, NE Children and Families Foundation
- Todd Reckling, NE Dept of Health and Human Services
- Carol Stitt, Foster Care Review Board
- Mark Unvert, Lincoln Police Department
- Jessica Watson, NE Legislative Aide



History of Citizen Review Panel Activities

In 2006, the Citizen Review Panel focused on Nebraska's Child Protective Service Intake process and priority assignment of new cases being reported. Based on the data reviewed, the Panel recommended that the Nebraska Health and Human Services System conduct a quality assurance review on all cases where reports were screened out and subsequent reports were received.

In 2007, in response to Governor Dave Heineman's directives to improve permanency for children in the child welfare system the Panel decided to focus on children in the 0-5 year-old range. They reviewed data provided by the Nebraska Department of Health and Human Services System along with a report provided by the Nebraska Foster Care Review Board. The Panel also conducted an in-depth review of eight cases. As a result of this study, the Panel identified three recommendations. Each recommendation is listed below followed by the response from the Nebraska Department of Health and Human Services System:

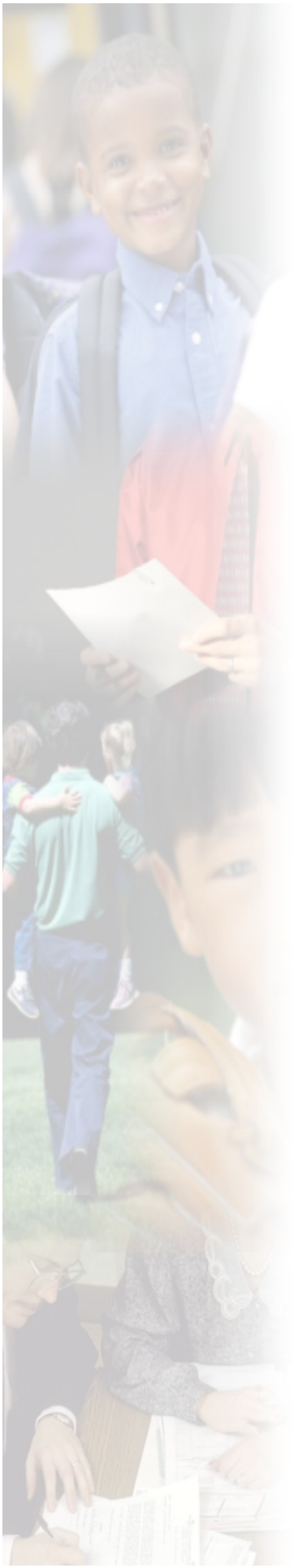
Recommendation 1

The Department of Health and Human Services System (DHHS) should conduct an analysis of the mental health needs of older children in foster care and ensure those needs are being met. DHHS should also do an analysis of measures that can be taken to avoid multiple moves of children in foster care and ways to address the behavioral issues of younger children to minimize the number of moves they experience.

DHHS Response to Recommendation #1

In October 2004, the Nebraska Department of Health and Human Services was awarded a State Infrastructure Grant (SIG) from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) in the amount of $750,000 per year for five years. The grant was designed to help states improve their infrastructure for community-based systems of substance abuse and mental health services for youth and their families. Nebraska's State Infrastructure Grant (SIG) has researched and begun to develop the infrastructure pieces necessary to begin building a system of care. One portion of that grant involves research regarding children who come to the Department's custody as a result of mental health issues.

The Division of Children and Family Services, through SIG-related strategies, has also implemented a process for conducting Comprehensive Family Assessments (CFA) across Nebraska that will establish a standard process for identifying family behavioral health needs. This process is critical for accurately identifying the strengths and needs of children, adolescents and their families.

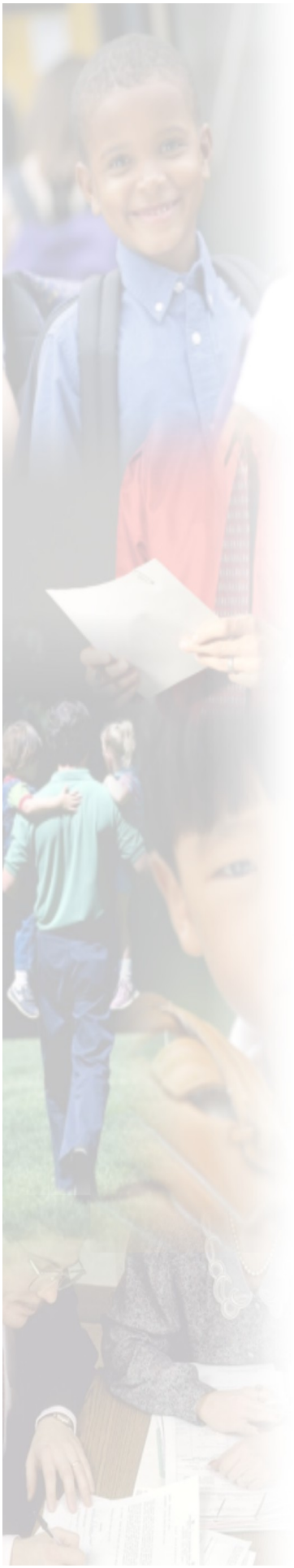


Historically, children's behavioral health services within the Department of Health and Human Services have been across Divisions, with no single entity responsible for the statewide coordination of the child and adolescent behavioral health system. In an effort to reduce fragmentation and increase statewide coordination, the Department designated the position of Children's Behavioral Health Administrator. This position was held by Vicki Maca until recently when Vicki was appointed as the Administrator for Community-Based Services and Children's Behavioral Health. The position of Children's Behavioral Health Manager is currently in the process of being hired and this position will report to Vicki Maca. While the Children's Behavioral Health Manager position is located within the Division of Behavioral Health, this manager will cross Division lines and work collaboratively with each of the Divisions within the Department to coordinate the statewide integration of a system of care specifically for children and adolescents. This State level integration will then be translated to the local level through leadership, policy development, and by providing the State with a single point of contact for systemic issues.

The Divisions are also working together on a Request for Proposals for the Administrative Services Organization provider in the Medicaid and Long-Term Care, Behavioral Health, and Children and Family Services Divisions to improve data acquisition and management capacity. One of the features of this collaborative effort will be the ability to capture and provide data, for the first time in the DHHS's history, regarding children served across the mental health, behavioral health, child welfare and juvenile services programs. It is believed this gives DHHS an opportunity to better assess the needs of all children in State custody.

Through the efforts of the SIG grant, a "data dictionary" has been developed related to children and adolescents with mental health and substance abuse disorders. The "data dictionary" identifies various data elements within the file structure of the Department's NFOCUS database, the Medicaid database (MMIS), and Magellan's interface with Medicaid (Advantage Suite).

In 2007, LB 542 created the Children's Behavioral Health Task Force. The Task Force was charged with creating a plan to meet the behavioral health needs of children, adolescents and their families in Nebraska. The Department's response to the Task Force Recommendations can be found on the Department website at http://www.dhhs.ne.gov/beh/mh/LB542.pdf DHHS's response reflects the current direction to proceed with a comprehensive children's behavioral health system that addresses the needs of children served by the various divisions of DHHS. While currently there are a variety of services offered, there is a heavy focus on high-end services and services delivered to the child when placed out of the family home. DHHS is committed to changing the children's behavioral health system. This reform will include designing and implementing a system of care to serve more children in



their own homes and provide the right level of service to all children served. DHHS envisions a future system of care that addresses all levels of out-of-home care, in-home care, early intervention and prevention services for children and their families. DHHS' response to the work of the Behavioral Health Task Force outlines an intent to develop a true continuum of services that referred to as a "Service Array". The Service Array pyramid includes services such as foster care with "wrap-around" (second from the bottom layer of the pyramid), but also includes group home care with wrap-around and bio-family care with wrap-around services. The next higher layer of care includes children needing a psychiatric residential treatment facility, in-patient hospital stay, detention or Youth Rehabilitation and Treatment Center. The highest level of care includes the secure care facility currently being developed for children who cannot be safely maintained elsewhere. The pyramid symbolizes DHHS' desire to serve children at the right level of care, in the right setting, for the right amount of time, with the right amount of services and supports.

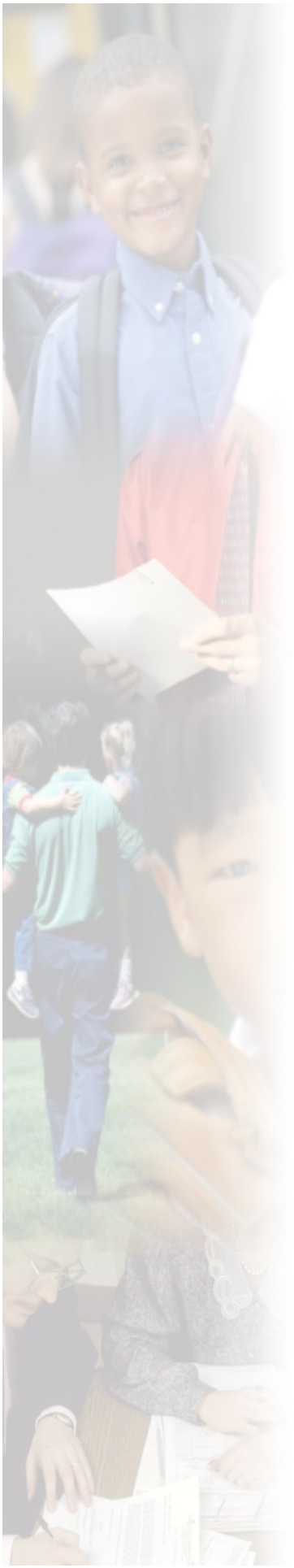
Lastly, in February of 2008, DHHS submitted an application to the Substance Abuse and Mental Health Service Administration (SAMHSA) for a five-year Systems of Care (SOC) grant, which, if awarded, will provide resources to develop further the current service array.

Recommendation 2

All of the efforts and funding for home visitation managed by the Department of Health and Human Services should be coordinated through the Prevention Partnership which is comprised of the Child Abuse Prevention Fund Board, Prevent Child Abuse Nebraska, and the Department of Health and Human Services. These efforts should also be connected to implementation of the statewide child abuse prevention plan.

DHHS Response to Recommendation #2

The Prevention Partnership can and should play a key role in supporting evidence-based practices that reduce the risk of child abuse and neglect. Coordination and/or facilitation of reviews of the literature, evaluation of models, and establishment of standards for maintaining integrity of Home Visitation models are components of that supportive role. There is a wide range of outcomes that Home Visitation models address, such as infant mortality, early childhood development, and maternal health. As specifically related to the Panel's recommendation regarding coordination, the Departments' Divisions of Children and Family Services and Medicaid and Long Term Care jointly released a Request for Proposals (RFP) for Home Visitation Programs in January 2008. As a result, the Department issued five contracts for a total of $933,000 in the first year of funding and $1,600,000 in the second year to provide Home Visitation programs in fifteen (15) areas of the State.



This funding is the highest amount of funding for Home Visitation programs in the Department's history. The areas of the State served by these Home Visitation programs include Douglas, Sarpy, Lancaster, Hall, Merrick, Howard, Nance, Burt, Cuming, Madison, Stanton, Wayne, Thurston, Dixon and Cedar counties. DHHS continues collaboration in the management of these contracts. While the Department will not be turning the coordination of efforts and funding of Home Visitation programs over to the Prevention Partnership, the Partnership will review reports, outcomes and achievements of the Home Visitation contractors to assist the Department.

Recommendation 3

The Department of Health and Human Services should review the contracts for supervision of visits to ensure they are getting quality services and that reports describing the interaction between the child and parents are generated for each visit. Supervision of visits should be conducted in a way that combines visitation and skill building.

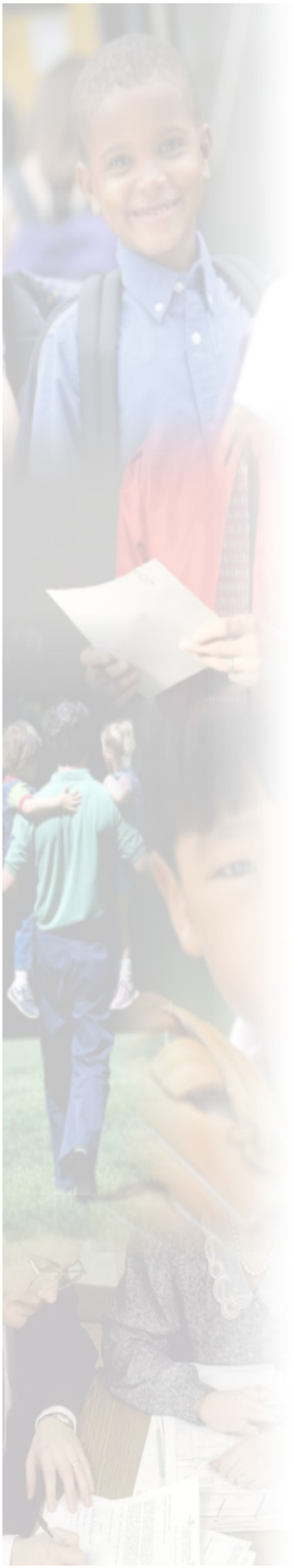
DHHS Response to Recommendation #3

Discussions occurred with a small group of Family Support and Visitation Only Service (FS-VOS) contractors that approached DHHS administration about the current visitation only service. As a result of those discussions and information from other entities changes to the rate and reporting requirements of the visitation only service were offered to the providers of FS-VOS.

Contracted providers of FS-VOS were offered the opportunity to amend their contract to include a rate increase if they were willing to complete the additional requirements of completing and submitting a typed, "Monthly Visitation Summary" form on each family served.

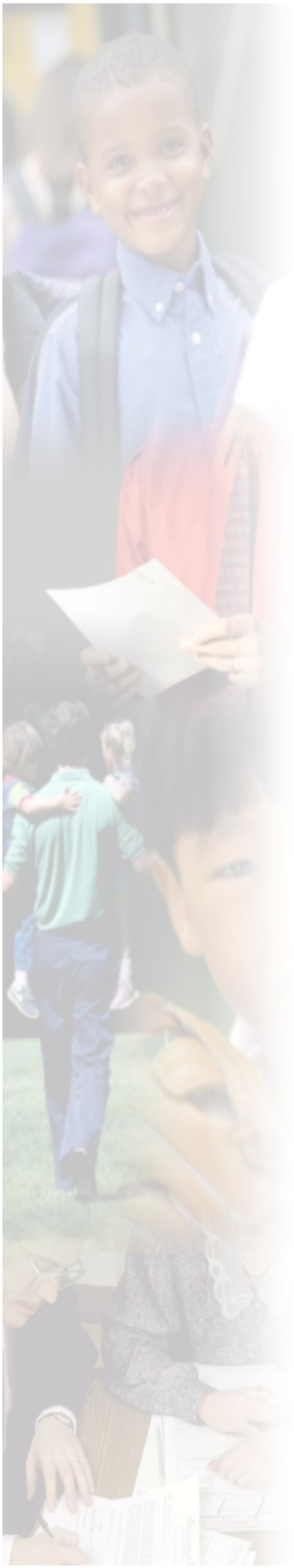
As of November 1, 2007 there were five (5) providers who chose to amend their contracts. Six (6) additional providers followed suit in November and one (1) in February. Thirteen (13) providers chose not to amend their contracts at this time.

In March 2008, the Division of Children and Family Services announced the release of a Request for Bids (RFB) for the provision of a continuum of Safety and In-Home services to children who are at risk of removal from the family home or to prepare a family for return of a child to the home. One of the services emphasized in the RFB is Supervised Visitation. Through the RFB, bidders are asked to describe the evidence base for the model of services proposed. If the service is not supported by evidence or promising practice, the bidder is asked to note attempts to locate information as confirmation of that position and cite information to support the service and service approach.



The bidders are also asked to develop a quality assurance and data system plan to assure program fidelity to the evidenced based models selected and data collection related to family functioning and bidder performance related to the Federal Child and Family Service Review outcomes. In describing the quality assurance and utilization management/review system, the system must, at a minimum, include the following elements: request of services - date and time; response of service provider - date and time; intervention requested; location of service; length of service; criteria met for services; status of all required documentation, comments or notes, as appropriate; outcomes of services delivered.

There is also a quality management component in the Request for Bid for the Administrative Services Organization (ASO) provider for Medicaid and Long-Term care, Behavioral Health and Children and Family Services that was released in February 2008.



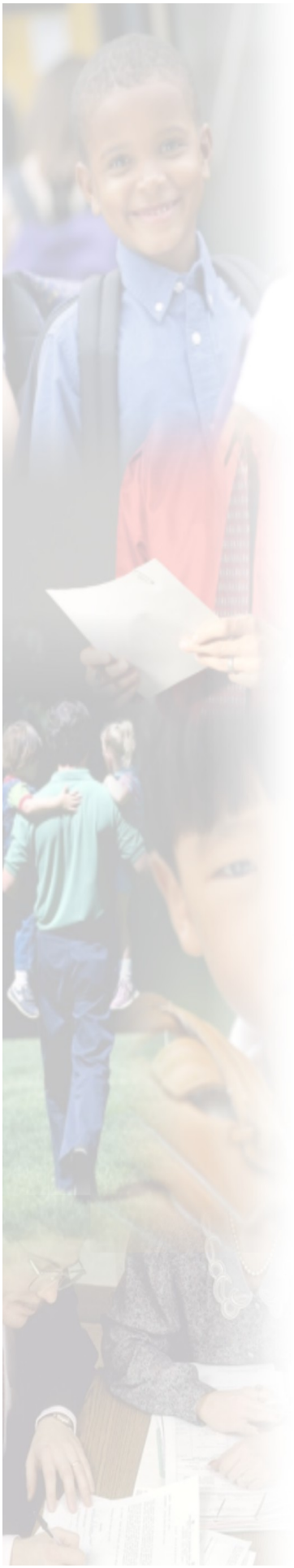
2008-2009 Priority Issue

In a planning session designed to focus CRP activities for 2008-2009, Panel members identified several child welfare-related issues, and of those, the following was prioritized and affirmed by the Governor's Commission for the Protection of Children. Focusing on one issue will enable the Panel the opportunity to identify, review, and analyze detailed information about the intake and initial assessment of child abuse and neglect cases managed by the Department of Health and Human Services System.

DHHS should conduct a Quality Assurance review on all cases where reports were screened out and subsequent reports received, including an analysis of the overall process of screening/ accepting reports. Some of the specific questions to be addressed include:

- How many reports of abuse, neglect or dependency are made to the intake hotline in one year?
- How many of those reports (per year) were screened out?
- What factors led to them being screened out?
- Were services offered or referrals made?
- How is resource & referral information documented?
- Is there any follow up to determine if services are utilized?
- What percentage of those that were screened out did DHHS receive subsequent reports on?
- How many (or %) of the subsequent reports are screened out?
- Of those screened out that later received a subsequent report and were not screened out – did they have the same intake worker or different intake workers?
- What percentage were Priority I, II, and III's?
- When a call is received, what is the procedure to determine if a previous call has been received on this case? Is it apparent immediately or does it require the intake hotline worker to access a different screen?
- Has the implementation of the safety model impacted the number of reports that are screened out?
- Does type of caller make a difference in accepting or screening out? Example: Physicians' calls tend to be accepted rather than screened out.

The Panel will work closely with Nebraska Department of Health and Human Service staff to identify available data that cover these questions. Data questions will be framed to accurately reflect what occurs both at Intake and Initial Assessment. These data will be collected for calendar year 2007 and quarterly throughout '08 and '09.



Future Citizen Review Panel Activities

The Citizen Review Panel is cognizant of other issues that merit attention. Future CRP activities may include the following:

- The Citizen Review Panel is concerned about the mental health needs of children who are in the custody of the Department of Health and Human Services System. Recently, the Department of Health and Human Services System partnered with the University of Nebraska-Lincoln to study children who are made state wards in order to access mental health treatment. The Panel will request the data that result from this research in order to review the mental health needs of state wards. It is expected that this activity will begin in 2009.

- Five Panel members recently attended the national Citizen Review Panel Conference in St. Paul, Minnesota. As a result, the Panel may develop an infrastructure for the Nebraska Citizen Review Panel. This could include the creation of a web-site, by-laws, membership requirements, and templates for administrative processes. It is anticipated that an enhanced structure and organization may enable the Panel to focus even more significantly on child welfare issues important to the citizens of Nebraska.