The Nebraska
Foster Care Review Office
Report on the
State Ward Permanency Pilot

Submitted pursuant to LB905 (2014)

Issued January 28, 2016

Foster Care Review Office Report
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Background

LB905 (2014) created the State Ward Permanency Pilot as of July 1, 2014, providing $1,500,000 in general funds. The Project serves state wards who are eligible for services through the DHHS Division of Developmental Disabilities, but do not qualify for priority funding under the Developmental Disabilities Service Act. State wards receiving an enhanced level of care or otherwise assessed to have above-average habilitative needs are to be given priority to participate in the Pilot.

LB905 bill requires that the Pilot collect data on the following:

1. The impact of services provided in the Pilot on the state wards' developmental progress.
2. The total number of state wards participating in the Pilot and their status in the child welfare system.
3. The number of state wards participating in the Pilot who achieves permanency, whether through adoption, guardianship, reunification, or another form of permanency.
4. The level of stability in placements for state wards in the Pilot.
5. The impact on the overall support to families before and after permanency is achieved.

The collected data is to be reported to the Foster Care Review Office. The FCRO is to analyze the data and provide a report to the Health and Human Services and Appropriations Committees every six months throughout the term of the Pilot, which is to terminate June 30, 2016. This is the second such report.

To complete the FCRO report, we discussed each individual case with the child welfare case manager and supervisor to ensure that we had the most current information regarding the youth's needs and status. We also discussed any and all process and systemic issues that have occurred since the Pilot began in July 2014. This data and information was analyzed and made a part of this report.

Data Analysis

Based upon the information received by the FCRO, the following is a summary of the five types of data required to be collected under LB905:

1. **Number of State Wards in Pilot and Current Child Welfare Status**
   Regarding the number of children participating in the Pilot, as of November 30, 2015, there were **43 children** referred to the Pilot and **40 children** actively participated in the pilot. The status for each category of these children is as follows:
   - Developmental disability eligibility determined and state ward status **was** terminated by the court or the state ward reached the age of majority (**20 children**):

As of 11-30-15:

- Average HHS Total custody days – 1,649 days (4.5 years)
  - Average HHS Custody days this removal – 1,262 days (3.4 years)
  - 9 youth had prior removal – average HHS custody days for that removal - 861 days (2.3 years)
- Average number of DHHS placements – 5 (range of 2-23 placements)
- Days in Custody prior to court termination of jurisdiction after DD eligibility funding – 344 days (range 0 to 977 days or almost 1 year)
- FY2015 Average DD Costs Per child - $31,970 (Total - $383,643)
- Average Annual CFS and NFC Costs Per child - $83,927 (Total - $1,678.539)
- **Reasons terminated state ward status:**
  - **7 reached the age of majority**
  - **7 reunified with legal parent**
  - **4 obtained a guardianship**
  - **2 transferred to another agency.**

- Developmental disability services have been approved and implemented but state ward status **is not** terminated by the juvenile court (**20 children**).

As of 11-30-15

- Average HHS Total Custody Days – 1,023 days (2.8 years)
  - Average HHS Custody Days this removal – 544 days (1.5 years)
  - 9 youth had prior removals – average HHS Custody days for that removal – 106 days
- Average number of DHHS Placements – 10 (Range 1 to 33 placements)
- Days in Custody since DD eligibility funding – 582 days (range 6 to 2,100 days) – **This continues to increase since case is not closed**
- FY2015 Average DD Costs Per child - $15,527 (Total - $248,442)
- Average Annual CFS and NFC Costs Per child - $76,929 (Total - $1,538,571)

- Developmental disability services were denied (**1 child**):
  - One youth child was denied due to not meeting eligibility.

- Developmental disability services were offered but family declined the services (**2 children**):
  - One child achieved permanency through an adoption.
  - One child achieved permanency through a guardianship.

2. Number of State Wards Achieving Permanency

There were **thirteen** state wards that achieved permanency by having DD eligibility put into place and their state ward status ended by the courts. This is compared to 4 state wards in March of 2015.

Another **seven** wards reached the age of majority (legal adulthood) during the Pilot implementation from March 2015 through December 1, 2015. This should not be considered permanency achieved due to the effects of the Pilot but these young adults are now receiving Developmental Disability services.

3. **Level of Stability in Placements for those Children accepted into Developmental Disability Services.**
   Twenty four youth (62%) did not experience a placement change since entering the pilot program. Placement changes often have a negative impact on youth that can include: disruptions in the youth's educational plan, loss of relationships, increased isolation and vulnerability and additional trauma. Prior to entering the pilot, those same 24 youth on average experienced 7 placement changes.

4. **Impact of Services on State Wards' Developmental Progress**
   - Provides a system response that connects the specialized developmentally disabled services with youth who are also being served in the child welfare system.
   - The goal of permanency is to exit wards from the foster care system, ideally, to reunification with their family, adoption, or guardianship. Habilitative supports can provide the stability to permit successful permanency.
   - Youth involved in the pilot experienced greater placement stability. Research has shown that "youth who experience minimized placement changes are more likely to experience fewer school changes; less trauma and distress; less mental health and behavioral problems; increased probabilities for academic achievement; and experience a lasting positive relationship with an adult."
     Placement Stability in Child Welfare Service, Northern California Training Academy The he Center for Human Services, Placement Stability Literature Review, August 2008

5. **Impact on Families before and after Permanency**
   This information in the future will be included on each child's Individualized Personal Plan but it is not currently available due to being in the early stage of the Pilot.

Process Concerns

In the FCRO Report dated March 24, 2015, various **process concerns** were discussed. Since March of 2015, numerous meetings have occurred discussing various solutions to these process issues. This is an update into the status of these various process issues. The information in "red" below is supplied by the Department of Health and Human Services.

1. **Initial communication issues and lack of fully collaborative efforts between DHHS/DD and DHHS/CFS** regarding the Pilot. As "sister agencies" there should be cross-educational trainings both for child welfare case managers and for developmental disability service coordinators so that each understand the specific requirements and responsibilities. It is our understanding that this cross-training has started but a plan needs to be developed to ensure that this educational piece continues. By truly educating all staff, better communication will occur. All stakeholders interviewed did state that

communication has improved in the past couple of months so the FCRO does want to acknowledge and give credit for important changes.

Update as of December 30, 2015: The Department of Health & Human Services now holds weekly cross divisional meetings to discuss cases with cross divisional programming to ensure maximizing resources to the benefit of the individual. Notification across divisions is occurring to ensure consistency in service delivery. Assigned staff are invited to meetings across divisional lines to discuss service provision and planning for the individual.

2. **Lack of effective documentation and communication regarding specific reasons for denial of DD eligibility or when developmental disability funding is to begin.** Currently, when a child is denied developmental disability benefits, the denial letter does not contain specific information as to the reasons for denial. This makes it extremely difficult to determine the best course of action to take in the best interest of the child. Also, once eligibility is determined and funding is available there needs to be communication between DHHS/DD and DHHS/CFS as to when DD services are set to begin.

   Update as of December 30, 2015: A redesign of the application and eligibility determination process is occurring within the Division of Developmental Disabilities (DDD). A team of internal and external stakeholders (PTI Nebraska, ARC, etc.) are redesigning the application process. The application for Developmental Disabilities will be a fillable PDF online until the changes can be made to integrate the application into ACCESS Nebraska. We are also redesigning the notice of decision to ensure that the individual/legal representative are notified as to why the individual does not meet eligibility criteria for services from the Division of Developmental Disabilities.

3. **There were no specified time frames communicated regarding when DHHS/DD must respond to an application requesting DD eligibility**. State regulations require that once eligibility is determined, notification must be sent within 14 calendar days. There are no time periods set in State regulations regarding the time by which DHHS/DD must determine eligibility. DHHS/DD documents state that DD has 30 days from either the receipt of all documents by DHHS/DD or 90 days after a DHHS/DD service specialist is assigned. These are very difficult time periods to compute or to even know when these events have occurred. In some cases in this Pilot, the eligibility process took so long that evaluations needed to be re-done. This caused further delays for some of these children. DHHS/DD only accepts evaluations that are valid within a one year time period.

   Update as of December 30, 2015: The Division of Developmental Disabilities (DDD) is reviewing the work processes associated with determining eligibility to identify areas that can be simplified or streamlined. DDD will be reviewing what information is needed to determine eligibility, utilizing a release of information attached to the application which will allow DDD to obtain the information directly from the source such as schools, etc. DDD is reviewing the standard nationwide and is considering following the requirements outlined for Medicaid eligibility which is 60 days from receipt of the application for individuals applying under the disability category for Medicaid.

4. **Many of the children involved in this Pilot have co-occurring issues** such as lower cognitive abilities and mental/behavioral health issues. This does complicate treatment and service selection when the children have multiple issues. It also has impacted the ability to find appropriate placements for these children, thereby, delaying the ability to receive developmental disability services.

   Update as of December 30, 2015: While it is accurate that these children may have co-occurring issues there have been systematic changes in the Division of Medicaid & Long-Term Care that have broadened the resources available to children and their families by authorizing and expanding the provision of behavior modification services to children which are funded by Medicaid. The majority of individuals who receive residential services from DDD funding are adults. Children who received DD services are typically served in their own home unless they have a complex medical or behavioral need that require expertise 24/7. DD service providers agreeing to provide residential services to children must locate and train staff to serve a specific child's needs in many cases.

Systemic Concerns

In the FCRO Report dated March 24, 2015, various **systemic concerns** were discussed. Since March of 2015, numerous meetings have occurred discussing various solutions to these systemic issues. This is an updated into the status of these various systemic issues. The information in "red" below is supplied by the Department of Health and Human Services.

1. **There are major philosophical differences and a lack of systemic processes between DHHS/DD, DHHS/CFS, and DHHS/Medicaid in regard to how decisions are made**. Some of these differences are dictated by federal and state law but not all of these differences are so dictated. These are "our" children and not just children in one system or another.
   - DHHS/CFS, for instance, is required to put the best interests of the child first with the belief that children grow best in a family setting and not in congregate care. DHHS/CFS services for these children are prescribed by a court process. On the other hand, DHHS/DD can and does utilize congregate care settings. For example, a child that was in a licensed foster home willing to become an enhanced family home but DHHS/DD would only fund if the child was moved to a congregate care setting. Each agency should be focused on meeting the best interest needs of the child through a "trauma-focused" lens that mitigates the number of placement changes.
   - There is not currently a team approach to each individual child's care. DHHS/CFS, DHHS/DD and DHHS/Medicaid representatives need to triage each case in order to determine which system can best serve that child's individual set of needs. This type of triage system should occur for any and all children and not just the children involved in this Pilot. It should also occur at the preventative level or at the time of a call to the DHHS/CFS Hotline and not just once the juvenile court is involved.

Update as of December 30, 2015: While DHHS/CFS promotes permanency for children, across some of the other divisions of DHHS, parents and legal representatives are prohibited from becoming paid caregivers for their minor children or children they have legal responsibility for.

Children who receive services through the DHHS/DD receive habilitation services that are wrapped around where the child lives. The family is responsible to provide living arrangements directly, or through room and board payments, or rental/lease agreements. Parents who receive adoption or guardianship subsidies are not eligible to be the paid care providers of their children similar to biological families. Any foster family could become an extended family home if they had a DD provider willing to support them.

At any time, when DHHS/CFS is aware that a child may be eligible for services from DHHS/DD they can and have contacted DHHS/DD directly to verify potential eligibility. DHHS/DD will review if priority status funding is appropriate and available.

2. **There is no uniformity between the requirements for a DHHS/CFS licensed foster home and DHHS/DD enhanced family home**. Licensed foster homes have very specific state regulations that require, for example, home studies and background checks. DHHS/CFS has contracts with non-profit agencies and internal staff to ensure that these regulations are being met through oversight. DHHS/DD Enhanced family homes are certified but not licensed and with some state regulations. Consistency should occur between DHHS/CFS and DHHS/DD to ensure a smooth transition of homes between these two systems. In fact, the Pilot found that it can take several months for a DHHS/CFS licensed foster home to be recognized as a DHHS/DD enhanced family home. This further delays DHHS/DD funding. As a system, we need to develop and implement a common set of requirements for the best interest of this vulnerable population.

   Update as of December 30, 2015: It is correct that there is not a constant requirement between the licensing requirements of DHHS/CFS and the certification requirements of DHHS/DD. Courtney Phillips, CEO, has indicated that it is her desire to simplify and streamline processes for consistency across divisions wherever possible however complex federal and state regulations often dictate the strenuous requirements for licensing.

   Extended Family Home as defined by DHHS/DD means a residential living arrangement where an individual pays room and board, and the Department pays for residential services. The family may be an individual surrogate family, who is an employee of the developmental disability provider, or who subcontracts with the developmental disability provider to deliver residential services.

3. **Many DD funded children reside in DD group homes**. Since many of these DD homes are less than four beds, the home does not need to be licensed as a residential child caring facility. One question that we need to ask is who provides the oversight regarding these homes. DD requirements come into play when there are four or more people placed in this type of setting. This is one of our most vulnerable populations so we need to ensure that their needs are being met including oversight over these types of placements.

   Update as of December 30, 2015: Courtney Phillips, CEO, supported moving the surveyors positions previously located in the DHHS/DD to the DHHS/Division of Public Health to ensure transparency and consistency in certification/licensing processes and citations in both licensed and certified settings.

4. **There are no clear guidelines or rules regarding who gets notice of the DHHS/DD denial and who can appeal a denial by DHHS/DD when the denial involves a state ward**. This is especially true when the parental rights of the state ward have been terminated. There is no biological parent to receive DHHS/DD denial notice or to effectuate an appeal. This leads to question if DHHS/CFS can appeal a denial decision made by DHHS/DD. If DHHS/CFS can't appeal a denial by DHHS/DD, who is truly advocating for the best interest of this child in these situations? A court-appointed guardian ad litem could possibly fulfill this role but most guardian ad litems feel that this requires a special court order vesting with them the power to make these decisions. That is even assuming that the guardian ad litem is notified of any denial which they usually are not. Even if parental rights are intact, who can assist the parent in the appeal process or at least educate them on the appeal process. Is this outside of the duties and responsibilities of a DHHS/CFS case manager? There are no clear processes or procedures with regard to these roles to ensure due process occurs.

   Update as of December 30, 2015: A Notice of Decision is sent directly to the individual or their legal representative. A Notice of Decision can be appealed by the parents, guardian ad litem or any other advocate on behalf of the individual. On November 4, 2015, a written guidance entitled "State Ward Developmental Disabilities Services Eligibility Procedure Guide" was issued by Courtney N. Phillips, CEO.

5. **There are no clear guidelines or rules regarding who can be accepted as a guardian for a DHHS/DD eligible child.** Under DHHS/DD requirements, if a child receives DD funding and does not reside in the parental home or parental rights are no longer intact, there must be a guardian arranged to accept financial payment. This guardian cannot be the DD placement nor can it be anyone who has a "conflict of interest" with the child. In some cases, DHHS/DD has defined this to be any person who knows the child or the placement which makes it extremely difficult to locate such a person. Many cases in the Pilot are pending DHHS/DD funding until a guardian can be located and approved. DHHS/DD stated that this requirement is part of the DHHS/Medicaid waiver. As a system, we need to thoroughly research this

area and determine how these situations can and should be handled to meet the needs of the children and families as well as meet legal requirements.

Update as of December 30, 2015: DHHS/DD does not have a written policy to prohibit those who know a child or the current placement of the child from being the guardian for a DHHS/DD eligible child. DHHS/DD does not advocate for every child to have a guardian. DHHS/DD supports the rights of individuals to make their own decision whenever safely possible to do so. When persons find themselves unable to make responsible decisions about their finances, property, living situations or care, the courts may appoint a guardian or conservator. Court-appointed guardians/conservators manage the personal and/or financial affairs of vulnerable persons who can no longer protect themselves.

Education is required for those serving as guardians and or conservators for individuals in Nebraska. If an individual has questions or input regarding guardianships or conservatorships, send an email to nsc.guardianconservator@nebraska.gov.

6. **Further research needs to be completed into whether there is a disincentive to adopt state wards with developmental disability issues.** Any monthly adoption subsidy is substantially less than payment as an enhanced family home and the adoption subsidy ends when the child reaches age 19. Do we as a system need to consider some type of blended or braided funding for these children to ensure permanency is achieved?

   Update as of December 30, 2015: The child may also be eligible to receive a payment from the Social Security Administration that can be utilized to meet their needs or assist with a room and board or lease payment as an adult. Payment authorized by the DHHS/DD is to provide habilitation services to the individual. Presently, DHHS/DD prohibits the payment of family members for habilitation services regardless of age. DHHS/DD defines family member as the parent, spouse, or child of the individual in services or a person of the same relation by marriage.

7. **Clarification of the determination of DHHS/DD priority funding.** DHHS/DD regulations state that priority funding is given to (a) individuals who need immediate intervention to prevent imminent physical harm caused by abuse or neglect; lack of medical care; or lack of food, housing or clothing or (b) individuals for whom immediate intervention by the Department is needed to prevent harm to themselves or others. These definitions would appear to include the majority of children within the child welfare system that meet DHHS/DD eligibility requirements. This has not been the case since the position has been taken that once a child is a state ward in the child protection system; they are no longer in imminent physical harm or needing immediate intervention. This is clearly a question of timing regarding the application for DD services. Again, if there was a team approach between DHHS/CFS and DHHS/DD at the initial entry into the child protection system, a decision could be made regarding which system can most appropriately meet the needs of this child and family.

Update as of December 30, 2015: DHHS/CFS and DHHS/DD are in discussions to determine how referrals to DHHS/DD could occur if DHHS/CFS determined that the child is already DD eligible but remains unfunded for services a request for priority funding could be submitted or an application for DD eligibility would be submitted rather than court involvement requested by the court attorney office.

Improvements have been made as evidenced by the information above but this is just the first steps and these improvements need to continue. The following are recommendations offered by the FCRO that need to continue to ensure we are truly meeting the best interest and needs of this vulnerable population.

1. When a potentially DD eligible child comes to the attention of child protection system, ensure that the vulnerable child is screened by DHHS/CFS and DHHS/DD for eligibility promptly and that appropriate services prioritized. For many such families, neglect is a combination of exhaustion and a need for supports. Getting children and families into appropriate services (such as respite care, educational services, personal assistance, and assistive technologies) could reduce the risk of future neglect or abuse and assist in keeping children safe.
2. Increase communication across silos within Department of Health and Human Services. There needs to be the development of a true team approach which includes a breakdown of artificial barriers to assist families in need. Ensure that DHHS/CFS Specialist understand the DD System and vice versa. There needs to be clear guidelines as to who is responsible for ensuring that the needed services are being appropriately applied for the benefit of these children. This would also include educating external stakeholders regarding the special needs of children with a developmental disability and communicating the application and eligibility rules clearly and effectively.
3. Determine how there could be a meaningful appeals process if DD services are denied and then work to build such a process. This process needs to be effectively communicated to all external stakeholders that work with these children.

The FCRO appreciates the assistance from DHHS/CFS and DHHS/DD on the completion of this report and we look forward to continuing to analyze additional data from the Pilot.

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.

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