November 30, 2012

Patrick O'Donnell, Clerk of the Legislature
State Capitol, Room 2018
PO Box 94604
Lincoln, Nebraska 68509

Dear Mr. O'Donnell:

In accordance with LB1160, Section, 9, passed by the 102nd Legislature; DHHS hereby submits the report authored by the Center for the Support of Families. The Center subcontracted with Hornby Zeller Associates to complete research related to the report.

While the authors of this report attempted to write an accurate report, there are instances where the information written and the conclusions drawn are not supported by evidence. I believe this is due to the breadth and complexity of the services provided by Protection and Safety, as well as the fact that the evaluator would need to be immersed in our environment on a daily basis to fully understand policy, context, and processes, both legal and operational to accurately report and draw conclusions regarding the Division. DHHS was integral in working with the authors of this report to ensure its accuracy, however, there are two specific instances of error I would like to bring to your attention.

- Page 48 second paragraph, the report states, "The research team received ten years' worth of N-Focus information, six years of Medicaid claims data for state wards and five years of Medicaid authorizations." This is an incomplete list. DHHS/Medicaid also provided the consultant with three years of data related to Medicaid denials for residential placements as requested. DHHS asked the consultant to include this fourth data element in the report as it was used to draw conclusions, but they failed to do so.

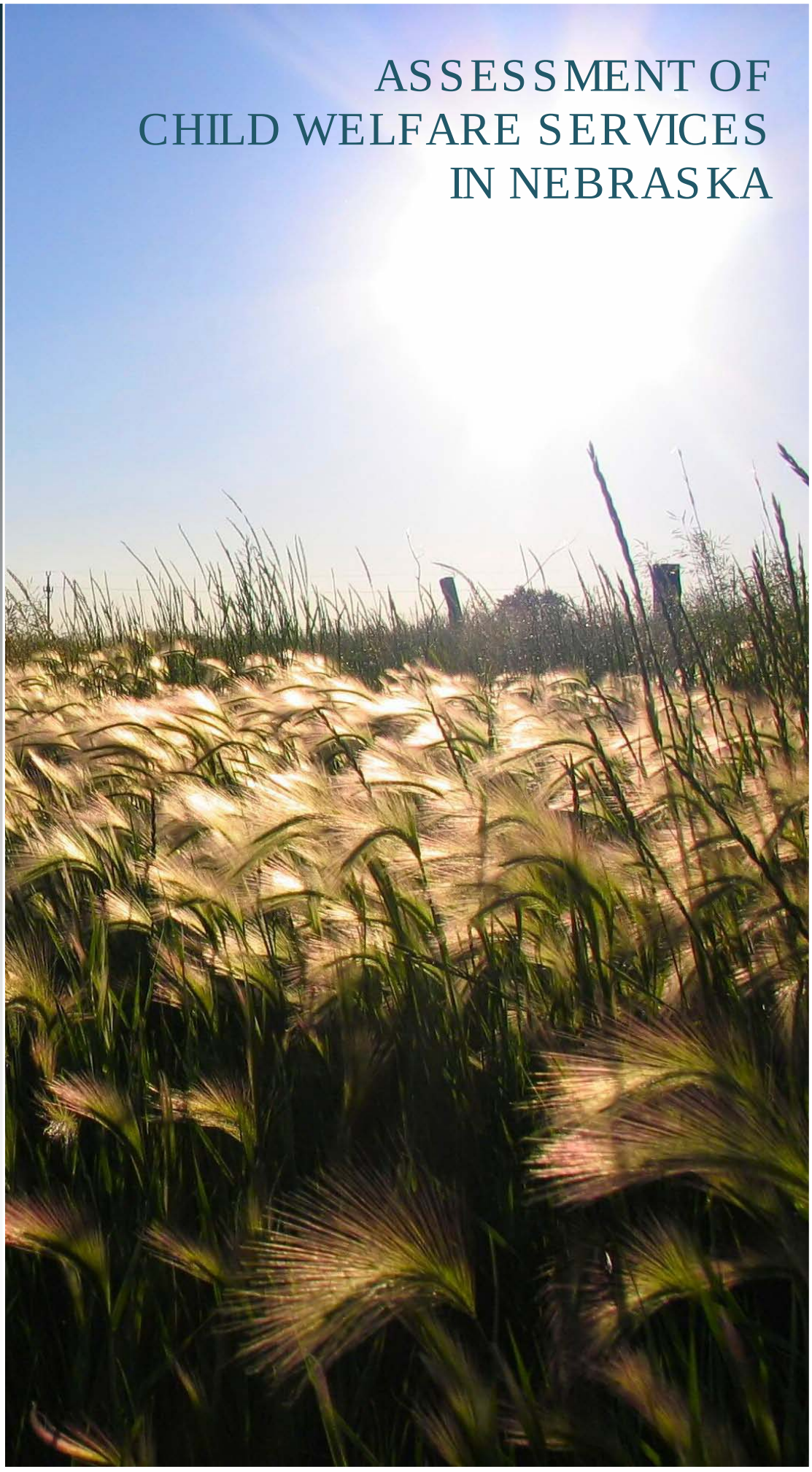
- Page 53 second paragraph, the report states, "If this is the case, residential settings are being used as emergency shelters. The second possibility is that the "first come first served" method of deciding with which provider to place a child …may result in placement levels higher than necessary…" Both of these statements are inaccurate. I want to assure you; DHHS is not using, nor is it allowed to use residential treatment facilities as emergency shelter placements. I would also point out DHHS is unable to unilaterally alter the level of placement a child is in. There are a number of reasons a child would stay at a residential treatment facility for short periods such as the facility being unable to accommodate the youth's needs/behavior, the child needs a higher/lower level of care, a child runs from the facility, and/or data entry errors when selecting the placement type.

These items are a sample of inaccurate information contained within the attached report. If you have additional questions, I would be happy to discuss the report with you.

Respectfully,

Thomas D. Pristow, MSW, ACSW
Director, Children and Family Services
Department of Health and Human Services

ASSESSMENT OF CHILD WELFARE SERVICES IN NEBRASKA



Produced by
Center for the Support of Families

and
Hornby Zeller Associates, Inc.

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Contents

HISTORY OF PRIVATIZATION, A NATIONAL PERSPECTIVE

If “privatized” means non-governmental, the origins of child welfare are in the private sector. Until the twentieth century religious groups and mutual aid societies provided child protection, foster homes and institutional placements.[1] Child protection came into the public domain with the passage of the Social Security Act of 1935. Under Title IV-B of the Act, Child Welfare Services Program, the Children's Bureau received funding to provide grants to states for "the protection and care of homeless, dependent, and neglected children and children in danger of becoming delinquent." Between 1935 and 1961, Title IV-B was the only source of federal funding for child welfare services.

The 1962 Social Security Amendments required each state to make child welfare services available to all children. It further required states to provide coordination between child welfare services (under Title IV-B) and social services (under Title IV-A), which served families on welfare. The law also revised the definition of "child welfare services" to include the prevention and remedy of child abuse. Child protection was bolstered in 1974 with the passage of the Child Abuse Prevention and Treatment Act (Public Law 93-247) which provided federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities. Of note, the statute recognized the role of the private sector by making grants available to nonprofit organizations for demonstration programs and projects.

In 1980 Congress created Title IV-E, separating foster care payments from Title IV-A. As they had in the past, many states used private agencies as child placing agencies to find foster homes and place children; some agencies also played a monitoring function. These costs were claimable under Title IV-E for eligible children. More recent developments in the form of federally authorized waivers began with demonstration projects in 1994 and have been extended to this day under the Child and Family Services Improvement and Innovation Act. The US Department of Health and Human Services is authorized to approve up to ten new demonstration projects each year. Waivers can be important to privatization because they allow states more flexibility in using Title IV-E funds under an approved plan. The federal government penalized Nebraska because it did not have a waiver and yet used Title IV-E funds in its privatization efforts without satisfying case specific claiming requirements.

PRIVATIZATION DEFINED

So what does “privatized” mean? The literature does not provide a single definition. Sometimes the term is used broadly to signify any contracted effort, but it more

[1]Planning and Learning Technologies, Inc., Literature Review on the Privatization of Child Welfare Services, Quality Improvement Center on the Privatization of Child Welfare Services, 2006, p.2

commonly refers to situations where *core child welfare functions have been shifted to the private sector.* These often include assessment and case management. The concept of privatization is evolving, however, to mean that contractors rather than public agencies make day to day decisions regarding the child and family's case. Sometimes, such decisions are subject to public agency review and approval, either at specific time intervals or at key decision points. While privatized contracts used to be based on either fee for service or a set amount to cover a specified scope of work, they now often involve the use of managed care principles and performance based contracts.

Over the past two decades many states and counties across the country have embraced the strategy of privatizing child welfare services, generally with the goal of providing higher quality services at a comparable or lower cost than is possible in the public sector. Some of the most notable are Kansas and Florida but others include Ohio, Oklahoma, Illinois and Missouri. The Quality Improvement Center on the Privatization of Child Welfare Services has issued several cross-site topical papers on child welfare privatization, as has the US Department of Health and Human Services under contract with Planning and Learning Technologies and the Urban Institute. A seminal study conducted by Children's Rights based on the experiences of six states found that public agencies should not expect to save money through privatization, given the real costs of developing, implementing, and overseeing a privatization initiative. Private agencies, however, should expect that public agencies will attempt to control costs and may design programs that shift the risk of financial loss to the private agency.[2] The report warned that greater efficiencies would not necessarily be achieved unless considerable attention was paid to the factors that undermine efficiency in the public sector. The report recommends a phased-in approach and suggests that service capacity be a central focus in the planning and implementation of any privatization effort. That is, privatization itself will not produce successes if treatment services are in short supply or families are not linked to them. The research of these groups has been invaluable in understanding the national state of the art and in placing Nebraska's privatization practices in a national context.

PRIVATIZATION IN NEBRASKA

While Nebraska has a long history of collaborating with the private sector in the delivery of services to children and families who are engaged in the child protective services system, privatization efforts began in earnest about four years ago in response to calls to reform child welfare.

The first step in what was called the Family Matters initiative took effect in June 2009, when the Division of Children and Family Services (CFS) of the Department of Health and Human Services (DHHS) entered into contracts totaling $7 million with six private agencies to develop infrastructure, staffing, and programs to allow private agencies to assume the bulk of the responsibility for providing services to at-risk children and

[2] Children's Rights, An Assessment of the Privatization of Child Welfare Services: Challenges and Successes, New York, 2003.

families. The six contractors were the Alliance for Children and Families (ACF), Boys and Girls Home (BGH), Cedars Youth Services (Cedars), Nebraska Families Collaborative (NFC), KVC Behavioral Healthcare Nebraska, Inc. (KVC), and Visinet, Inc. (Visinet).[3]

The next step, covering the period November 2009 through June 2014, was the awarding of six service contracts -totaling $149,515,887 with only five of the six private agencies, ACF not being included.. These service contracts covered non-treatment services including: out-of-home care, respite care, family supports, transportation, tracker services, electronic monitoring and basic needs. The private contractors were to increase the number of youth transferred to their responsibility from November 2009 until March 2010 and be fully implemented by April 2010.

The lead agencies subcontracted with other private providers to flesh out the needed continuum of services. One of these organizations, the Nebraska Families Collaborative (NFC), together with DHHS, is the subject of a major portion of this report as the lone remaining lead agency.

According to Nebraska's Auditor of Public Accounts:

> The service contract agreements provided for a new form of reimbursement that replaced the previous fee-for-service method of compensation with a risk-based payment system. Instead of earning a predetermined amount for the performance of a specific service, each contractor received a flat monthly fee regardless of the amount or value of services provided. Through December 2010, that flat monthly service fee was divided between direct service and lump sum payments. Direct services were billed through the Nebraska Family Online Client User System (NFocus), and the remaining amount was paid as a lump sum. NFocus is a subsystem that interfaces with EnterpriseOne, the State's accounting system. Starting January 2011, that system of payment was discontinued and the remaining contractors were paid a bi-monthly flat fee.[4]

Within six months two of the providers were no longer serving as lead agencies, one due to bankruptcy, and a third lost its contract due to problems with both management and financing, leaving KVC and NFC. In April of 2010, DHHS began to manage the cases in the Eastern Service Area (ESA) which had been managed by Visinet, keeping that responsibility until October of 2011, when it began to transfer those cases to NFC. The transfer was complete in December 2011. In July 2010 KVC assumed responsibility for the Southeast Service Area (SESA) cases previously managed by Cedars, and in October 2010, after Boys and Girls Home ceased operations, DHHS assumed responsibility for all cases in the Western, Central and Northern Service

[3] Auditor of Public Accounts, Attestation Report of the Nebraska Department of Health and Human Services Child Welfare Reform Contract Expenditures July 1 2009 through March31, 2011, September 7, 2011.

[4] Ibid., p. 2.

Areas. On March 1, 2012, KVC ended its case management contract, ceding its Eastern Service Area cases to NFC and its Southeast Service Area cases to DHHS. This history demonstrates the disarray the system experienced from so many changes in a relatively short period of time.

The Legislative Fiscal Office issued a report in October, 2011, which provided a "Fiscal Overview of Child Welfare Privatization in Nebraska."[5] Its analysis of the early failures of privatization showed the following. The initial contracts were structured as "global transfer" contracts meaning the contractors received a set amount regardless of the number of children served or the cost of services. While the State did not cut its caseworkers both because they had already been spread too thinly and because their focus was to switch towards permanency, the private agencies received funding equivalent to the amount appropriated for services (excluding staff and operating expenses). In addition, the agencies had to cover 12 months of aftercare. Contactors included both a for-profit (Visinet) and not for profits. While the latter had a donor base to fall back on, the former did not and all but one were eventually terminated.

The model was not viable for several reasons. The lead agencies maintained that the costs were higher than projected at the time they signed their contracts, driven largely by the number and expense of youth in foster care, the number of non-court involved cases and treatment costs ordered by the courts and not covered by Medicaid. The situation was exacerbated by two conditions: the "no reject, no eject" provisions meaning the lead agencies had to serve everyone, and their lack of decision-making authority. To help remedy the latter, some case management decision-making was transferred to lead agency contractors in January, 2011 and 77 FTEs were eliminated from DHHS. By then, however, only two lead agencies remained and one of them would be gone just over a year later.

The Legislature's Health and Human Services Committee heard additional concerns regarding lack of documentation in records, failure to pay providers and foster parents fully and promptly, confusion regarding division of responsibilities, client care and staff training, and the need for long-term planning to sustain the child welfare reform initiative.

The January 2012 legislative session began with about four months of hearings and debate about child welfare reform. The legislators ultimately passed bills that created:

- the Children's Commission and Inspector General for child welfare (LB821);
- a requirement for more transparency and reporting on child welfare spending, financial benchmarks, a strategic plan and a separate child welfare budget (LB949);
- a plan for a web-based, statewide automated child welfare information system (LB1160);

[5] Fiscal Overview of Child Welfare Privatization in Nebraska, Legislative Fiscal Office, Health and Human Services Committee LR 37 Report, December 15, 2011.

- increases in foster parent payments, licensing changes and a requirement that the State DHHS apply for a federal foster care demonstration project (LB820); and
- a requirement to bring case management in most of the State back under DHHS and put caseload standards in place (LB961).

As of March 2012, the lone remaining lead agency was NFC who gained a bigger share of the caseload, but only in one service area, albeit the largest: the Eastern Service Area encompassing the city of Omaha and Douglas and Sarpy counties. NFC's contract (called the Service Delivery, Coordination and Case Management Master Agreement) has expanded incrementally since 2009 and now runs until 2014, with the latest version having become effective on July 1, 2012. NFC and its subcontractors are responsible for providing "an individualized system of care for [all] families and their children and youth who are wards of the State of Nebraska involved in the Child Welfare or Juvenile Services System or who are non-court involved children and families involved in the Child Welfare System" in the Eastern Service Area.

PURPOSE OF THIS REPORT

The same bill referenced above which called for a plan for a web-based information system, Legislative Bill 1160, included the request for an evaluation of privatization efforts, and that is the genesis of this study. The bill required analysis of three separate but interrelated topics:

1) the degree to which privatization of child welfare services in the Eastern Service Area of Nebraska has been successful in improving outcomes for children and parents and whether the costs have been reasonable,
2) the readiness and capacity of any lead agency or the department to perform child welfare services and
3) the usage, cost, and outcomes of residential placements within the past three years.

The overarching concern is to determine whether the State should continue with its privatization initiative with public funding and regulation, expanding it to other parts of the State, or whether it should return to a system that is simply publicly operated.

In the context of the legislative mandate, the purpose of this report is to answer three questions:

1) Has privatization improved outcomes and, if so, is the cost reasonable?
2) Does either NFC or DHHS, or both, have the capacity to perform essential child welfare service delivery and administrative functions in accordance with national standards for network management entities?
3) What are the characteristics of the children placed in residential facilities over the past three years and what could have prevented those placements?

In answering the network management question, the report will also, as required by the RFP, identify "strengths, areas where functional improvement is needed, areas with current duplication and overlap in effort, and areas where coordination needs improvement.

RESEARCH TEAM

The evaluation team consisted of the Center for the Support of Families (CSF) and its subcontractor, Hornby Zeller Associates, Inc. (HZA), both of which have provided management consulting services to public child welfare agencies across the country. While CSF has no previous experience in Nebraska, HZA has just completed an evaluation contract with DHHS and continues to work with a private human service organization, the Nebraska Federation of Families for Children's Mental Health. The evaluation contract focused on the Nebraska Family Helpline, Family Navigator and Right Turn Post Adoption/Post Guardianship services. HZA's evaluation began in January 2010 and continued until this fall, with the final evaluation report just recently submitted to the State.

The Federation contract is related to that effort. In the late summer of 2011, HZA contracted with the Federation to build a web-based case management system for its Family Navigator and Family Peer Support programs. Under a renewal of the contract, HZA continues to provide the Federation with support for that system.

REPORT REVIEW PROCESS

On October 22, 2012, CSF delivered a draft copy of this report to DHHS to allow the agency to correct any factual errors which might have resulted either from bad information from some of the informants or from misinterpretations of the information provided. On November 5, representatives of both CSF and HZA met with administrators at DHHS to discuss the agency's comments from its initial review. A second draft was submitted on November 19 to allow DHHS one final set of comments.

After submitting the initial draft, the research team asked DHHS to share it with NFC, again to allow identification of any factual errors. The agency declined to do so. According to DHHS, NFC then sought legislative intervention, although NFC reports that it made no formal request. In any event, DHHS reported receiving a letter from a senator prohibiting it from sharing the report with anyone before it was finalized. The research team formulated additional questions for NFC to clarify issues raised by DHHS in its review but NFC did not have the opportunity to read drafts or independently to identify anything it considered to be either a factual error or even a misleading statement. The experience of the research team is that it is unusual for an organization which is one of the objects of a study such as this not to have a chance to respond to the report prior to its finalization. In the end, however, despite changes made in the

report after the DHHS review of each of the drafts, the findings and conclusions remain those of the researchers, CSF and HZA.

As noted above, this project is designed to address three broad questions.

1) Has privatization improved outcomes and, if so, is the cost reasonable?
2) Does either NFC or DHHS, or both, have the capacity to perform essential child welfare service delivery and administrative functions in accordance with national standards for network management entities?
3) What are the characteristics of the children placed in residential facilities over the past three years and what could have prevented those placements?

While each of these questions requires a different approach and methodology, one element will be common to the first two. Each of these questions implicitly asks for a comparison between NFC and DHHS, first in terms of outcomes and then in terms of network management capacity. NFC, however, operates only within two relatively densely populated counties in eastern Nebraska, while DHHS operates across the entire State. The geography, the demographics of the client populations and the availability of services are all different and are likely to have an impact both on the achievement of positive outcomes and on organizational capacity. In order to maintain as much commonality as possible, therefore, the research team focused its analysis of DHHS on the Southeast Service Area, which is the service area most like the Eastern Service Area in which NFC operates. This necessarily included analyzing some functions carried out in DHHS' central office, and in the outcome analyses statewide results are also shown, but all comparative judgments are made between NFC and SESA.

Beyond the utilization of SESA as the point of comparison, the basics of each methodology are described in the remainder this chapter, with additional details provided in subsequent discussions, where they are relevant to the findings.

OUTCOMES

Outcome Analysis

The first step in analyzing outcomes will be to examine the calculations on some of the measures in DHHS' COMPASS (Children's Outcomes Measured in Protection and Safety Statistics) website. These provide a preliminary measure of the extent to which privatization is associated with improved outcomes, as measured by the Child and Family Services Review (CFSR). This is an appropriate place to begin the measurement because the latest version of the contract between NFC and DHHS holds NFC accountable for achievement of the national standards on the CFSR statewide indicators, and the measurements made in COMPASS are presumably the ones which

will be used to monitor that achievement. Measurements were taken on the selected indicators for each month from September, 2011 through August, 2012.

The other component of the outcome measurement was an examination of the mini-CFSRs. These are case reviews of the same items used in the federal CFSR and provide information not only on safety and permanency outcomes, but also on well-being outcomes. Because many of the individual items in those reviews represent agency effort and process, they can also provide insight into why some of the outcomes are or are not being achieved at an acceptable level. Three rounds of the mini-CFSR were selected for examination: January, 2009 through March, 2010, which represents the very beginning of privatization; January, 2010 through March, 2011; and January, 2011 through March, 2012, which includes the first month DHHS re-assumed case management responsibility in SESA and the first month NFC became the sole lead agency in ESA.

Cost Analysis

Initially, the research team anticipated doing extensive analyses of the costs of providing services both publicly and privately, including an examination of the extent to which either NFC or SESA or both incurred additional costs by having clients return to the system after being served initially. Two things made those analyses superfluous. First were the results of the outcome analyses, which did not provide a clear positive answer that privatization had led to improved outcomes. The analyses could not show that any outcome gains had been made, yet substantial funds had been expended. The answer to the question would seem to be “no,” the costs were not reasonable given what was achieved.

The second reason was related. Early in the course of the project, it became clear that the costs the State had incurred were extraordinarily large. This included all lead agencies but one pulling out of their contracts, several service providing agencies literally going bankrupt and DHHS itself suffering a multi-million dollar federal audit exception because of the way it paid for privatized services, with more disallowances expected. While dollars were involved in all of these cases, dollars did not represent the only costs. Service provider capacity has also been lost, and the sheer level of upheaval has eroded a substantial amount of the trust among agencies, both public and private, which is needed for any kind of system, privatized or not, to operate effectively.

While the answer to the question, “Were the costs of the (improved) outcome achievement reasonable?” is clearly “no,” every conclusion is drawn with cost issues in mind. As has been shown in child welfare privatization efforts elsewhere and discussed above, however, no one should expect the initial costs to be lower than if privatization had not occurred. Indeed, the more reasonable assumption is that additional investments will have to be made for the effort to succeed.

NETWORK MANAGEMENT CAPACITY

The Council on Accreditation (COA) has established standards for network management entities, and similar standards have been developed for similar kinds of agencies in related fields. The research team identified four sets of standards (including DHHS' contract with NFC) with content relevant to this project, selecting specific standards from each one. A complete list of the standards selected for the purposes of this project is found in Appendix A. The determination of whether either NFC or DHHS has the capacity to act as a network manager was made primarily on the basis of the evidence researchers found of compliance with the selected standards. Because the question is one of capacity and not of actual performance, when one or the other agency did not comply with a standard, the research team tried to determine whether it had the infrastructure and resources to do so in the future.

Based on the standards selected, the team constructed semi-structured interview instruments as well as a list of documents anticipated to have some of the information needed to determine each agency's conformity with or ability to conform to the standards. Separate interview instruments were developed for administrators in the lead agency, case managers in the lead agency, administrators of the agencies providing services within the network, front-line supervisors in each of the networks and other community partners outside the network.[6] The review of documents was designed to provide hard information on specific topics and a check against the subjective opinions of those interviewed. Ultimately, the determination of whether either or both agencies are capable of acting as network managers is a judgment, and the combination of information from interviews with actors throughout the system and official documents provides two different sources of data with which that judgment can be made.

RESIDENTIAL PLACEMENTS

The principal information on residential placements comes from NFocus. This system provides information identifying the children who have been in residential placement over the past three years, describing them demographically, identifying their reasons for placement, calculating the length of each placement episode, determining the level of each placement setting and exploring cases of out-of-state placements.

Information was also drawn from the State's Medicaid Management Information System showing Title XIX claims for behavioral health services. Information on denials of Medicaid claims was also requested, because only through an examination of what services were not provided to children entering residential care and were provided to similar children who avoided such placements could services effective in preventing those placements be identified. However, the only information on denials DHHS was

[6] See Appendix B for a partial list of those interviewed for the project. Names have been omitted when the research team thought someone might be identified with a particular opinion cited somewhere in the report.

able to provide to the research team had to do with denials of residential care. Moreover, Magellan, who supplied the denials data to DHHS for the research team, reported that it excluded denials in which a different level of care was approved than had been requested. That does not appear to be completely true, since the research team found 37 cases in which residential placement had been denied and the youth later entered a residential setting. In any event, the limitations in the denials data provided restrict what can be concluded and prevent any conclusion about what services are effective in preventing higher level placements.

Perhaps the most fundamental question about the privatization of child welfare services is whether it generates better outcomes for children and families than does a state-operated system. In the request for proposals for this project the question was articulated in an historical way: have outcomes improved since privatization began? In reality, the chaotic beginning of privatization foreshadowed poor results for Nebraska's children and families, regardless of whether private or public agencies were managing cases. Lead agencies cannot be expected to produce positive outcomes for their clients when their costs exceed their revenues to the degree that they are unable to fulfill their basic contractual obligations.

The focus of this chapter, therefore, will be on comparing the outcomes NFC has achieved for its client families with those DHHS has achieved, primarily within the Southeast Service Area. Outcomes represent results that have a direct impact on a client such as returning home to parents or getting adopted. These are distinguished from process measures such as Family Team Meetings and caseworker visits, which are also referenced in this chapter and are intended to generate positive outcomes, but which may or may not do so.

Two types of measures will be used to make the comparison. The first set is taken from the measures DHHS publishes on its COMPASS web page. These measures are the same as those used in the federal Child and Family Services Reviews (CFSR) and are included in the contract between DHHS and NFC. Moreover, the website provides separate estimates of outcomes for NFC and for each of the service areas.

The second set of measures consists of the mini-CFSRs DHHS conducts. These are case reviews modeled after the federal CFSR in each service area. They cover a wider array of issues than the COMPASS measures, which is an advantage, but the results are based on relatively small samples of cases, which is a disadvantage. In addition, many of the items reviewed in the mini-CFSR represent processes rather than outcomes, despite their being labeled as outcomes by the federal government. For example, whether a state (or a service area) is found in conformity with the outcomes on education and physical and mental health is determined by the efforts the agencies make to address those issues, not by the children's actual progress in school or in physical and mental health. For these and other reasons to be discussed below, the results have to be interpreted with caution.

RESULTS FROM COMPASS

The Measures

The measures used in the COMPASS website come directly from the federal CFSR and represent what are referred to as the "statewide indicators." Unlike the CFSR results from the onsite review, which are based on samples of cases, the statewide indicators are calculated from all relevant cases in the State. Prior to the beginning of a new round of the CFSR, the federal government calculates a standard for each indicator. That standard is the 75th percentile of the results from all states at the time of the calculation. That means that if the reviews were held at that time, three-fourths of all states would fail to meet the standard.

Using the syntax provided by the federal government, DHHS not only reproduces these results more frequently than does the federal government; it also produces results for each service area and for NFC. It is then possible to compare results from the State as a whole and from individual service areas to the national standards. DHHS has used these standards as performance measures in its contract with NFC, and for this reason they are an important part of understanding privatization outcomes in Nebraska.

There are six statewide indicators currently in use. The simplest of these are the two safety measures: the absence of recurrent maltreatment and the absence of maltreatment in foster care. To meet the national standard for the first of these, the State (or a service area or lead agency) must ensure that at least 94.6 percent of the children with a substantiated report of maltreatment are free from a second substantiated report within six months of the first one. Nebraska's statewide percentage during the most recent CFSR was 91.3 percent.

The national standard for the absence of maltreatment in foster care is 99.68 percent. This means that at least that percentage of all the children in care during a given year must be free of substantiated maltreatment from a foster parent or facility personnel. This measure counts as maltreated foster children any child in any type of facility who is the victim of substantiated abuse or neglect. Facilities include secure juvenile justice facilities, mental and behavioral health facilities and facilities for the developmentally disabled. In the majority of cases, the residents are not foster children and, perhaps more importantly, neither the child welfare component of DHHS nor the lead agency has any control over these facilities. While the State must address this measure to meet federal requirements, it is not an appropriate performance measure for either state child welfare agencies or lead agencies, should not be used by DHHS as part of its internal accountability system for service areas or contractors and it will not be used in this report.

The other four COMPASS measures relate to permanency and are all "composites," meaning they are statistical combinations of several other measures. By themselves, the composites reveal little about what a state is doing well or not doing well, and even less about why. For that, one must examine the scores for the individual measures

comprising the composites. Here again, some of those individual measures are unsuitable as measures of performance of a state, a service area or a lead agency. This is particularly true of those measures which are retrospective in nature. As has been well documented in the professional literature,[7] retrospective (also called exit cohort) measures take an outcome event, e.g., reunification of a child with his or her family, and look backward to determine whether that event occurred within a specified period, e.g., twelve months, of another event, e.g., the child's entry into care. Measuring performance in this way, however, ignores children who never experience the outcome event, e.g., are never reunified. When those measures are used to guide casework practice, they essentially instruct caseworkers to avoid re-unifying any child who has been in care for more than 12 months and to avoid finalizing the adoptions of any children in care more than two years, because these actions count negatively on the federal measures and therefore on the COMPASS measures. For these reasons, as well as for all the other reasons cited in the literature, no retrospective measures will be used in the following analyses.

The first composite, dealing with the permanency and timeliness of reunification has two measures appropriate for this analysis: exits to reunification within 12 months of a child's first entry into foster care and re-entries into foster care within 12 months of a discharge from care. The 75th percentile for the first of these is 48.4 percent (higher is better); for the second 9.9 percent (lower is better).[8]

Three measures can be utilized from the adoption composite. The first two relate to children who have been in care at least 17 months as of the beginning of the period to be measured and ask, first, how many were adopted within 12 months, and second, for those who were in care that long but not legally free, how many became free within six months. The 75th percentiles are 22.7 percent and 10.9 percent, respectively. The third adoption measure focuses on children who were legally freed for adoption during the previous 12 month period and measures how many of those had their adoptions finalized within 12 months of being freed. The 75th percentile is 53.7 percent.

The third composite deals with children who have been in out-of-home care for a substantial period of time. Two measures are of interest: the percentage of children who have been in care at least two years as of the start of the period who achieve permanency (reunification, adoption or guardianship) within the reporting year (23.7 percent is the 75th percentile) and children who were legally free for adoption at the start of the year and were discharged to a permanent home (75th percentile is 98.0 percent).

[7] See, for example, Courtney, M., Needell, B., and Wulczyn, F. (2004). Unintended consequences of the push for accountability: the case of national child welfare performance standards. *Children and Youth Services Review*, 26(12), 1141-1154; Poertner, J., Moore, T., and MacDonald, T. (2008). Managing for outcomes: The selection of sets of outcome measures. *Administration in Social Work*, 32(4), 5-22; Wulczyn, F., Kogen, J. and Dilts, J. (2001). The effect of population dynamics on performance measurement. *Social Service Review*, 75(2), 292-317; and Zeller, D. & Gamble, T. (2007). Improving child welfare performance: Retrospective and prospective approaches. *Child Welfare*, 86(1), 97-122.

[8] Although the federal government does not calculate standards for the individual measures within a composite, COMPASS appropriately shows the 75th percentile as the benchmark to be achieved.

Finally, the fourth composite deals with placement stability. There are three measures, each of which calculates the percentage of children who have experienced two or fewer placement settings during their time in care. The first focuses on children who have been in care at least eight days but less than 12 months (the 75th percentile is 86.0 percent); the second on children who have been in care at least 12 months but less than 24 months (65.4 percent); and the third on children who have been in care 24 months or more (41.8 percent).

The Results

Safety

Over the 12 months between September of 2011 and August of 2012, Nebraska has experienced something of a U-shaped trend in the occurrence of repeat maltreatment, as shown in Table 1, and that trend is reflected in the numbers for both NFC and the Southeast Service Area, as well. The low points for all three units (the State, SESA and NFC) generally occurred in March and April, meaning that new substantiated reports of maltreatment of children with previous substantiations were more common in those months than they had been earlier or thereafter. While the State and NFC showed slight improvements as early as May, SESA did not do so until July but recovered more strongly at that point.

One of the interesting features of these results is that the time at which the results began to drop was also the time at which NFC assumed control of all of the cases open for service in the Eastern Service Area and DHHS of all the cases in the Southeast Service Area. Up to that point, NFC had been responsible for about two-thirds of the cases in ESA, and the expanded responsibility meant an increase of 50 percent in its caseload. The drop in NFC's performance probably reflects two factors: the impact on clients of a former lead agency which could not afford to maintain its functions and the process of the transition itself.

Unlike the situation with NFC, the same cases were being measured for SESA in February when KVC was doing case management and in March when DHHS was the case manager. Nevertheless, it would not be surprising if the process of making the transition contributed to the temporarily reduced performance. In any event, by July SESA was back to its previous level, while NFC showed a much less robust recovery.

Table 1
Percentages of Children Not Experiencing Repeat Maltreatment within Six Months
75th Percentile = 94.6%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	93.0	92.3	92.1	92.6	92.2	91.4	90.8	90.9	91.7	91.4	92.5	92.0
SESA	91.6	91.3	90.8	92.3	90.9	89.5	89.1	88.6	88.6	88.5	91.3	91.2
NFC	91.1	91.0	90.5	91.5	92.3	91.9	87.7	87.9	89.0	89.1	89.2	88.7

Permanency: Reunification

The trends of children going home within a year of their initial entry into foster care are less clear than those for repeat maltreatment. The statewide figures are better than those for SESA and NFC in every month, but this is not entirely unexpected, because the research team's experience across the country suggests that the depth of child welfare problems often correlates to the level of urbanicity. Perhaps the most notable fact is that SESA began the period with the lowest performance of the three but was also the only one to improve, ending the period performing noticeably better than NFC. This time the period of improvement occurred in conjunction with SESA's assumption of full responsibility for case and network management.

Table 2
Percentages of Children Reunified within 12 Months of First Entry into Care
75th Percentile = 48.4%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	44.8	41.1	43.7	41.0	43.5	43.0	41.6	45.5	43.2	44.1	42.6	41.3
SESA	33.2	28.8	29.4	29.2	27.7	30.8	30.7	38.5	39.6	39.4	37.1	34.8
NFC	40.4	40.8	40.6	38.5	37.9	33.5	30.3	34.0	32.1	34.4	33.9	35.4

The frequency of children re-entering foster care presents the most disturbing outcome trend for NFC. Between September and January the results for SESA, NFC and statewide were all fairly comparable, with some slight but noticeable improvements. In February, however, while the State and SESA continued their steady improvement, NFC more than doubled the percentage of children re-entering care, and it maintained that level throughout the remainder of the 12-month period.

Table 3
Percentages of Children Re-entering Care within 12 Months of Discharge
75th Percentile = 9.9% (Lower is better.)

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	14.1	13.6	13.2	13.0	12.6	11.7	11.7	11.5	11.7	11.5	11.6	11.8
SESA	15.2	14.8	14.1	12.9	12.4	11.6	11.0	11.7	11.2	11.7	11.6	12.0
NFC	14.1	13.3	13.9	13.7	13.3	28.9	29.1	27.7	30.0	29.9	28.7	27.3

Although the increase in re-entries began in February, with more than one in four children reunified with their parents coming back into care within one year, it is almost certainly connected to NFC's assumption of responsibility for all cases in the Eastern Service Area, which occurred in March. There are several possible explanations, the most obvious being that the previous lead agency may have sent several children home whose families were not yet ready to keep them safe. Alternatively, the aftercare

services some families received from the previous agency may have been less than they needed or NFC may have had difficulty engaging families in its aftercare program after the transition. It is also possible that there were some changes in the way data were recorded, although it is difficult to see how only one agency's or service area's results would be affected.

There are at least two lessons which might be drawn, at least tentatively, from the results on reunification and re-entry. First, expediting reunification need not result in more re-entries into care. SESA demonstrated that it is possible both to expedite reunification and to reduce the rate of re-entries into care, while NFC experienced fewer timely reunifications and more re-entries.

The second point is about measurement. While every agency—public or private—needs to be held accountable for its performance, the accountability measurements must make sense and must take account of the environment within which the agency operates. NFC will almost certainly experience, for at least another six months (and on some of the measures for several years), the impact of having assumed responsibility for cases initially handled by someone else. Its own performance can, however, be judged fairly only on the basis of cases it did not inherit. The same is true of SESA, where DHHS assumed responsibility for all cases in that service area this past year and where the outcomes on which it is measured in the near future will be affected by work done by a different case management agency.

Permanency: Adoption

The first two adoption-related measures both begin with a population of children who have been in care for at least 17 months as of the beginning of the 12-month period and ask what proportion of them were adopted within the year and what proportion of those not yet freed for adoption became freed within the first six months of the period. Especially on the first of these, SESA showed substantial improvement in the results and NFC substantial deterioration.

During the September to August period SESA was getting fewer than one in five of these children adopted (see Table 4). Beginning in December, one month after it re-assumed case management responsibility that figure jumped to more than one in four and exceeded the statewide figure every month thereafter. NFC, in contrast, experienced a drop of nearly half, from one in six children to just over one in 12, beginning one month before it assumed responsibility for all the ESA cases. For both agencies the patterns are similar if less dramatic when the issue is freeing children for adoption within six months. While it is almost certain that each change had something to do with the assumption of responsibility for cases, it is difficult to identify the nature of that impact, since both SESA and NFC received their new cases from the same lead agency.

Table 4
Percentages of Children in Care 17+ Months Who Get Adopted within the Year
75th Percentile = 22.7%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	22.0	22.8	20.6	24.4	24.2	24.1	24.3	24.2	25.9	24.8	24.4	23.0
SESA	19.2	17.1	16.2	26.9	27.8	28.7	28.7	28.9	29.2	28.1	28.4	28.1
NFC	17.9	18.4	15.9	16.6	16.6	8.7	7.8	9.4	11.4	11.9	11.5	10.9

Table 5
Percentages of Children in Care 17+ Months Who Are Freed within Six Months
75th Percentile = 10.9%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	13.8	13.4	13.1	14.5	13.7	12.5	12.7	12.3	13.3	13.5	13.0	13.3
SESA	15.2	12.2	12.4	14.8	10.5	13.1	12.8	14.0	15.6	16.9	16.8	14.9
NFC	14.7	14.1	14.9	14.5	15.2	14.5	12.4	9.8	9.8	9.7	9.3	10.7

The third adoption-related measure starts with the population of children who were freed for adoption during the previous year and asks how many of those children had their adoptions finalized within 12 months of being freed. While SESA showed the highest percentage of successful cases in every month (see Table 6), its actual performance declined by more than ten percent until the last month reviewed. NFC, on the other hand, began with the weakest performance and saw half of even that level disappear once it took over all the cases in the ESA.

Table 6
Percentages of Children Freed for Adoption Who Get Adopted within 12 Months
75th Percentile = 53.7%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	59.1	54.8	54.8	50.6	51.9	51.9	56.1	54.3	56.3	54.7	54.8	56.5
SESA	71.6	68.0	70.2	63.3	61.0	57.7	64.3	64.7	65.0	63.0	63.4	71.1
NFC	55.6	43.9	50.7	46.5	46.0	32.4	19.3	21.9	24.8	26.2	25.8	23.7

Permanency: Long-term Children

In relation to the federal statewide indicators in general, Nebraska performs better in relation to achieving permanency for children who have been in care for long periods of time than it does in any other area. This is reflected in the COMPASS measures which show that nearly two of every five children who start the year having been in care two or more years are discharged during the year. The State as a whole consistently scores

well above the 75th percentile (see Table 7), and SESA is nearly always above that level.

NFC began the most recent 12 months somewhat below the national norm and then, as with so many other measures here, performance fell substantially in March of 2012. That pattern was not repeated, however, in relation to discharging freed children to permanent homes (see Table 8).

Table 7
Percentages of Children in Care 24+ Months Who Get Discharged to a Permanent Home
75th Percentile = 29.1%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	38.3	38.2	34.8	38.0	37.8	38.0	37.6	37.5	39.1	37.7	38.8	37.1
SESA	31.7	29.4	25.2	32.6	34.2	31.3	33.0	34.3	37.3	36.2	39.2	39.3
NFC	26.7	26.5	25.7	31.1	30.5	21.0	17.9	17.7	20.3	21.0	23.3	22.4

Table 8
Percentages of Children Legally Free Who Get Discharged to a Permanent Home
75th Percentile = 98.0%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	97.3	97.2	97.2	97.9	97.7	97.6	97.7	97.6	97.7	98.0	98.1	97.5
SESA	99.1	98.9	98.9	99.3	98.6	98.7	98.7	98.7	98.8	98.7	99.4	99.4
NFC	93.8	92.2	94.0	96.3	96.5	93.3	97.3	95.1	94.4	96.0	96.1	94.3

Permanency: Placement Stability

Perhaps the most interesting thing about performance in relation to placement stability, i.e., avoiding bouncing children from one setting to another, is that none of the patterns seen with the other measures appears here (see Tables 9 through 11). The State as a whole, SESA and NFC each sometimes reach the 75th percentile in relation to children in care less than one year and sometimes do not, but there are no substantial swings in the results. For children in care longer than that, the standard is rarely met and the longer children stay in care the further from the norm performance appears to be. In fact, the only patterns which appear at all are improvements, mostly over the past six months, for children in care more than two years. There is, however, little difference between NFC and SESA.

Table 9
Percentages of Children in Care Less than 12 Months Who Experience Two or Fewer Placements
75th Percentile = 86.0%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	85.4	86.2	86.8	87.1	86.8	86.7	86.8	86.8	87.0	86.9	86.3	86.4
SESA	84.8	85.3	86.8	87.3	87.4	87.5	87.6	87.2	87.7	88.5	87.6	87.5
NFC	85.2	86.6	87.0	87.9	86.6	84.8	84.6	85.0	85.1	84.7	83.4	82.9

Table 10
Percentages of Children in Care 12-24 Months Who Experience Two or Fewer Placements
75th Percentile = 65.4%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	59.8	59.9	60.2	60.0	59.7	60.2	60.8	61.7	61.8	62.2	62.6	62.5
SESA	60.4	60.9	61.7	60.9	61.4	63.6	64.6	65.8	65.3	64.3	64.9	65.2
NFC	60.5	61.2	60.8	61.7	60.5	61.1	60.2	60.7	61.1	61.5	62.4	61.8

Table 11
Percentages of Children in Care 24+ Months Who Experience Two or Fewer Placements
75th Percentile = 41.8%

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012
Nebraska	31.5	32.5	31.8	32.2	32.4	33.0	33.5	33.6	34.2	34.5	33.9	34.7
SESA	32.2	33.0	31.8	31.7	31.7	31.7	32.4	32.8	34.3	35.5	34.1	34.7
NFC	31.6	33.3	33.0	32.8	34.0	35.2	35.6	36.4	36.2	35.7	36.1	37.0

MINI-CFSR RESULTS

The current contract between DHHS and NFC does not require any specific performance level to be achieved on the mini-CFSR, and that is almost certainly appropriate. Even the federal samples of 65 cases per state are too small to provide valid results for many of the measures, and DHHS' samples of 28 cases in most service areas and 38 in ESA are even smaller. Where the CFSR on-site review and its Nebraska mirror, the mini-CFSR, are useful, however, is in providing more detailed examinations of casework processes that can sometimes explain the results of the statewide indicator measures. With repeated administrations over time, they can also reveal trends which may act as predictors of future outcomes.

The 23 items in the mini-CFSR are classified into seven outcomes, two related to safety, two to permanency and three to well-being. Each of the outcomes and individual items is listed below.

- **Safety Outcome 1:** Children are first and foremost protected from abuse and neglect.
  - Item 1: Timeliness of initiating investigations of reports of child maltreatment
  - Item 2: Repeat maltreatment
- **Safety Outcome 2:** Children are safely maintained in their homes when possible and appropriate.
  - Item 3: Services to family to protect child(ren) in home and prevent removal
  - Item 4: Risk of harm to child
- **Permanency Outcome 1:** Children have permanency and stability in their living situations.
  - Item 5: Foster care re-entries
  - Item 6: Stability of foster care placement
  - Item 7: Permanency goal for child
  - Item 8: Reunification, guardianship or permanent placement with relatives
  - Item 9: Adoption
  - Item 10: Permanency goal of other planned permanent living arrangement
- **Permanency Outcome 2:** The continuity of family relationships and connections is preserved for children.
  - Item 11: Proximity of foster care placement
  - Item 12: Placement with siblings
  - Item 13: Visiting with parents and siblings in foster care
  - Item 14: Preserving connections
  - Item 15: Relative placement
  - Item 16: Relationship of child in care with parents
- **Well-being Outcome 1:** Families have enhanced capacities to provide for their children's needs.
  - Item 17: Needs and services of child, parents, foster parents
  - Item 18: Child and family involvement in case planning
  - Item 19: Worker visits with child
  - Item 20: Worker visits with parents
- **Well-being Outcome 2:** Children receive appropriate services to meet their educational needs.
  - Item 21: Educational needs of the child
- **Well-being Outcome 3:** Children receive adequate services to meet their physical and mental health needs.
  - Item 22: Physical health of the child
  - Item 23: Mental health of the child

To achieve "conformity" on an outcome, 95 percent of the applicable cases have to have substantially achieved the outcome, and achieving the outcome means that a case is rated as a "strength" rather than an "area needing improvement" on the relevant items. For an item to be considered a strength, 90 percent of the cases have to achieve that rating.

During the most recent CFSR in April of 2008, Nebraska was given a "strength" rating on four of the 23 items: repeat maltreatment, foster care re-entry, proximity of placement (to the child's home) and placement with siblings. Only one other item, preservation of connections between children in care and their families, had as many as 80 percent of the cases rated as strengths.

The charts on the following pages provide summary statistics from mini-CFSRs covering three periods: January, 2009 through March, 2010; January, 2010 through March, 2011; and January, 2011 through March, 2012. These periods begin with the onset of privatization and end as privatization ended everywhere except in ESA. The end of these reviews also coincides with NFC's assumption of responsibility for the remaining cases in ESA previously served by other lead agencies and DHHS' assumption of responsibility for all cases in SESA. That history has to be kept in mind when interpreting the results, especially since the results are not broken out by lead agency. It is simple enough, after the first period, to track who was responsible in SESA, but it is not possible to do so in ESA.

During the first of these reviews, the Eastern Service Area was the lowest scoring service area on 14 of the 23 items, and there was no low scorer on two other items because all service areas were perfect. While the standard set for every item was 90 percent, in ESA there were nine items where the percentage of cases handled appropriately was under 50 percent. Issues where the scores were, or should have been, of particular concern included the timeliness of investigations (14 percent); permanency goals for foster children (9 percent); worker visits with parents of children in foster care (22 percent); needs and services for children, parents and foster parents (24 percent); and family involvement in case planning (28 percent). To the extent those results reflected reality, basic casework was not being done.

One year later the story had begun to change. ESA was still the low scorer on 13 of 23 items, but at least some of the scores had changed for the better. Thirty-three percent of investigations (which have always been handled by DHHS) were initiated on time, instead of 14 percent; 29 percent of children's permanency goals were established on time and were appropriate. On the other hand, in only 17 percent of the cases did caseworkers visit parents regularly and only 19 percent of families were involved in their own case planning.

Another year later, ending in April of 2012, the positive changes were more pronounced. ESA was now the low scorer on only four of the 23 items. Half of all investigations were initiated on time, the percentage of families involved in their case planning had nearly doubled and the proportion of parents visited regularly by caseworkers had begun to rise. The overall figures remained far from satisfactory and the general lack of attention to families suggested anything but a family-centered practice, but things did appear to be changing.

CFSR - Service Area & Statewide Item/Outcome Summary Report						
Results Period: 1st & 2nd Qtr - Calendar Year 2010 Period Under Review: 01/01/2009 - 04/01/2010						
AREA	**CSA**	**ESA**	**NSA**	**SESA**	**WSA**	**STATE**
Number of Cases	*28*	*38*	*28*	*28*	*28*	*150*
Item 1	60%	14%	71%	63%	100%	64%
Item 2	100%	100%	100%	100%	67%	92%
Outcome: Safety 1	***60%***	***14%***	***71%***	***63%***	***80%***	***60%***
Item 3	100%	79%	100%	85%	86%	89%
Item 4	82%	61%	79%	61%	64%	69%
Outcome: Safety 2	***82%***	***58%***	***79%***	***61%***	***64%***	***68%***
Item 5	100%	100%	100%	100%	100%	100%
Item 6	69%	77%	75%	94%	100%	83%
Item 7	50%	9%	63%	50%	59%	44%
Item 8	54%	50%	100%	57%	93%	68%
Item 9	25%	25%	100%	25%	67%	38%
Item 10	80%	38%	67%	100%	60%	62%
Outcome: Permanency 1	***44%***	***5%***	***56%***	***13%***	***53%***	***32%***
Item 11	100%	100%	100%	100%	100%	100%
Item 12	100%	80%	100%	71%	100%	88%
Item 13	23%	50%	46%	50%	57%	46%
Item 14	56%	50%	87%	69%	76%	66%
Item 15	54%	38%	80%	64%	70%	60%
Item 16	40%	50%	57%	63%	50%	52%
Outcome: Permanency 2	***38%***	***50%***	***56%***	***50%***	***59%***	***51%***
Item 17	36%	24%	50%	57%	57%	43%
Item 18	30%	28%	57%	50%	50%	42%
Item 19	71%	37%	82%	43%	71%	59%
Item 20	22%	22%	37%	21%	41%	28%
Outcome: Well-Being 1	***21%***	***13%***	***39%***	***25%***	***43%***	***27%***
Item 21	79%	65%	91%	94%	77%	79%
Outcome: Well-Being 2	***79%***	***65%***	***91%***	***94%***	***77%***	***79%***
Item 22	74%	50%	68%	48%	86%	64%
Item 23	67%	61%	91%	100%	100%	81%
Outcome: Well-Being 3	***57%***	***49%***	***65%***	***56%***	***83%***	***61%***

CODES: Items 1 to 20, 22 and 23	
Blue	90% or above
Yellow	85% - 89.9%
Red	Lowest performing Service Area per item and lowest Statewide Item

CODES: Item 21 and ALL OUTCOMES	
Blue	95% or above
Yellow	90%-94.9%
Red	Lowest performing Service Area per outcome

CFSR - Service Area & Statewide Item/Outcome Summary Report

Results Period: 5th & 6th Qtr - Calendar Year 2011
Period Under Review: 01/01/2010 - 04/01/2011
For Items 10 and 20 the PUR is 01/01/2010- 07/01/2011

AREA	CSA	ESA	NSA	SESA	WSA	STATE
Number of Cases	*28*	*38*	*28*	*28*	*28*	*150*
Item 1	60%	33%	67%	64%	100%	61%
Item 2	100%	90%	56%	100%	100%	86%
Outcome: Safety 1						
Item 3	91%	95%	92%	89%	95%	93%
Item 4	82%	45%	75%	50%	75%	64%
Outcome: Safety 2						
Item 5	100%	100%	100%	100%	83%	97%
Item 6	88%	67%	88%	88%	94%	84%
Item 7	38%	29%	63%	50%	56%	46%
Item 8	92%	64%	92%	93%	92%	86%
Item 9	75%	50%	100%	50%	33%	63%
**Item 10	NA	67%	75%	83%	81%	87%
Outcome: Permanency 1						
Item 11	92%	100%	100%	94%	88%	95%
Item 12	100%	90%	100%	67%	50%	89%
Item 13	62%	64%	54%	56%	60%	59%
Item 14	92%	71%	75%	81%	63%	76%
Item 15	73%	63%	73%	57%	29%	62%
Item 16	69%	50%	46%	50%	73%	58%
Outcome: Permanency 2						
Item 17	39%	37%	43%	43%	64%	45%
Item 18	63%	19%	56%	43%	81%	50%
Item 19	86%	45%	71%	46%	93%	67%
**Item 20	49%	17%	43%	27%	68%	39%
Outcome: Well-Being 1						
Item 21	96%	77%	92%	86%	90%	88%
Outcome: Well-Being 2						
Item 22	78%	50%	77%	79%	58%	69%
Item 23	91%	85%	95%	90%	91%	90%
Outcome: Well-Being 3						

CODES: Items 1 to 20, 22 and 23	
Blue	90% or above
Yellow	85% - 89.9%
Red	Lowest performing Service Area per item and lowest Statewide Item

CODES: Item 21	
Blue	95% or above
Yellow	90%-94.9%

CFSR - Service Area & Statewide Item/Outcome Summary Report						
Results Period: 9th & 10th Qtr - Calendar Year 2012 Period Under Review: 01/01/2011 - 04/01/2012						
These are Items that we need to pass in the Program Improvement Plan						
AREA	**CSA**	**ESA**	**NSA**	**SESA**	**WSA**	**STATE**
Number of Cases	*28*	*38*	*28*	*28*	*28*	*150*
Item 1	77.78%	50.00%	88.89%	66.67%	92.86%	75.93%
Item 2	80.00%	100.00%	75.00%	66.67%	70.00%	78.13%
Outcome: Safety 1						
Item 3	100.00%	94.12%	100.00%	66.67%	89.47%	88.75%
Item 4	96.43%	60.53%	96.43%	28.57%	67.86%	69.33%
Outcome: Safety 2						
Item 5	100.00%	100.00%	87.50%	100.00%	100.00%	95.65%
Item 6	93.75%	78.26%	75.00%	73.33%	100.00%	83.72%
Item 7	62.50%	21.74%	56.25%	20.00%	50.00%	40.70%
Item 8	92.31%	58.82%	100.00%	58.33%	90.00%	78.46%
Item 9	85.71%	46.15%	100.00%	57.14%	62.50%	63.16%
Item 10	100.00%	75.00%	66.67%	25.00%	100.00%	68.72%
Outcome: Permanency 1						
Item 11	100.00%	100.00%	100.00%	92.31%	100.00%	98.68%
Item 12	100.00%	83.33%	100.00%	85.71%	90.00%	89.74%
Item 13	64.29%	52.17%	50.00%	30.77%	31.25%	46.25%
Item 14	93.75%	73.91%	75.00%	60.00%	62.50%	73.26%
Item 15	71.43%	43.75%	63.64%	53.33%	58.33%	57.35%
Item 16	57.14%	42.86%	53.33%	50.00%	33.33%	46.75%
Outcome: Permanency 2						
Item 17	64.29%	39.47%	39.29%	39.29%	60.71%	48.00%
Item 18	60.71%	36.11%	42.86%	29.63%	64.29%	46.26%
Item 19	96.43%	47.37%	89.29%	28.57%	75.00%	66.00%
Item 20	57.69%	28.57%	25.93%	11.54%	51.85%	34.75%
Outcome: Well-Being 1						
Item 21	100.00%	83.33%	82.61%	70.59%	82.61%	84.82%
Outcome: Well-Being 2						
Item 22	95.65%	70.83%	72.00%	60.00%	47.06%	70.64%
Item 23	95.45%	86.67%	92.31%	62.50%	70.00%	83.33%
Outcome: Well-Being 3						

CODES: Items 1 to 20, 22 and 23	
Blue	90% or above
Yellow	85% - 89.9%
Red	Lowest performing Service Area per item and lowest Statewide Item

CODES: Item 21	
Blue	95% or above
Yellow	90%-94.9%

Interestingly, while ESA was slowly improving its performance after the initiation of privatization, SESA was going in the opposite direction. During the first of the three years examined here, SESA was the low scoring service area on four of the 23 items, and it achieved 90 percent on seven others. During that initial mini-CFSR, SESA's weak

areas were risk and safety assessments (61 percent), adoption (25 percent), caseworker visits with parents (21 percent) and children's physical health (48 percent).

Two years later, i.e., as privatization ended in SESA, that service area's performance had deteriorated significantly. It was now the low scorer on 15 of the 23 items. Conducting risk and safety assessments, which had been a low score even at 61 percent, had dropped to under 29 percent, and caseworker visits to parents to under 12 percent. Some of those results almost certainly reflect the impact of a lead agency no longer able to fulfill its functions adequately. Others, particularly those related to safety and risk, reflect DHHS' own performance, since those functions were never privatized.

SUMMARY

As noted at the outset of this chapter, the question posed for this project was whether outcomes for children and families had improved since child welfare services had been privatized. Because of the obvious failure of the effort in most parts of the State and with most of the lead agencies, the research team chose instead to explore whether outcomes had improved under the sole remaining private network management agency. With outcome measures now included in the contract between DHHS and NFC, both the answer to that question and the methods used to generate the answer are important.

The answer to the question is not straightforward: the results were mixed. Using the COMPASS measures as they are published on the DHHS website, NFC showed generally lower outcome achievement than either the State as a whole or the Southeast Service Area. Moreover, those achievements seemed to diminish when NFC took responsibility for the cases previously handled by other lead agencies. On specific measures that also occurred in the SESA when privatization ended there.

The mini-CFSR results were dramatically different from those of the COMPASS measures. At the start of privatization the ESA exhibited clearly the worst results of any service area. Two years later its results had improved significantly and those of the SESA had deteriorated. Especially in the Eastern Service Area, it is difficult to connect the results to specific actors, so a reasonable and useful measurement on these indicators may require more stable conditions.

Three general conclusions should be drawn from the analyses in this chapter. First, in relation to the question posed to the research team, it is not at all clear that privatization improved outcome achievement. Nor is it clear that it detracts from that achievement. For that to be known, a more stable situation will have to prevail and measurements will have to be made only of those cases where the lead agency, whether private or public, is responsible for the entire duration of the case.

Second, very few of the outcomes achieved either privately or publicly approach what they should be. The mini-CFSR is especially enlightening in this regard, because it

shows that families are often not provided the casework visits, the services or the involvement in their own case planning that are necessary for successful outcomes. While the next chapter will indicate that many of those interviewed indicated that their agencies deliver services with a family-centered orientation, the mini-CFSR results suggest otherwise. Whether the services are delivered privately or publicly, the approach will need to change if the outcomes are to improve.

The third conclusion has to do with the way outcomes are measured. If the outcome indicators do not measure the right things, they provide false signals to the agencies about where they need to focus their efforts. Outcome indicators can measure the wrong things either by focusing on the wrong issues or by focusing on the wrong populations. The latter has clearly occurred as NFC and SESA took over the cases from previous lead agencies, making the recent measurements on COMPASS misleading as measures of those agencies' performance. Equally problematic, the wrong issues have sometimes been measured. As the discussion of the federal measures at the start of this chapter suggested, some of the indicators used in the NFC contract (but not analyzed here) are not useful measures of client outcome. While DHHS must pay attention to those measures for federal purposes, its decision to adopt the federal measures as internal tools of accountability without modifying them does not provide appropriate guidance to workers and supervisors.

Perhaps even more important than the invalid measures, however, are those that are missing. One of the explicit goals of the current child welfare administration at DHHS is to reduce the number of children in foster care, yet there is no measure of the placement rate (the number in care per thousand children in the population) which would track progress on that goal on an ongoing basis. As pointed out in its response to this report, DHHS has set goals for this year for reducing the number of children in care by eight percent and the number of children served overall by five percent, but these are not client outcomes and they do not provide a longer term vision of where Nebraska should be in three to five years. Without a benchmark, such as the median placement rate among all states, for measuring every year whether too many of Nebraska's children are living apart from their families, any gains made on this issue are likely to be temporary. What is needed is a permanent standard which reflects an ongoing commitment to preserve families whenever that can be done safely. Like the question of family-centered services and outcome achievement at the levels needed to meet national standards, this is not an issue of public or private administration. It is a question of what is needed for the effective administration of the child welfare system by anyone.

The second major question this report addresses is whether either NFC or DHHS has both the readiness and capacity to manage the network of child welfare agencies. To answer this question the study team identified a set of requirements or performance standards drawn from a number of relevant sources including:

- the Council on Accreditation's standards for Network Administration;[9]
- guidelines for accreditation from the Accreditation Association for Ambulatory Health Care;[10]
- the State of Nebraska's contractual requirements with Magellan of Nebraska;[11] and
- DHHS's contractual requirements for NFC.[12]

The lead agency must have the structure in place to operate and maintain the system of organizations that comprise the child welfare system in Nebraska. This means overseeing multiple aspects of child welfare including case management responsibilities and overseeing the work of contracted service providers. In many respects, this approach of serving as a network manager is similar to serving as a Managed Care Organization (MCO) in the healthcare field, a role which predates network management in child welfare. Due to the similarity in structure, MCO's have served as a model for privatizing child welfare. In developing the standards, two health care-related documents were used: the Accreditation Association for Ambulatory Health Care and the State's contract with Magellan of Nebraska. The Council on Accreditation provides more specifics on network administration and the NFC contract provides specifics on child welfare services in Nebraska.

The standards are divided into two categories: administrative standards and practice standards. Both topics were addressed to ensure that each organization was measured on its ability to administer the system adequately as well as to ensure appropriate completion of the needed service delivery functions. Within each category, the standards are broken into sub-categories relating to specific tasks. The sub-categories are defined in Tables 12 and 13 below and a full copy of the standards can be found in Appendix A.

[9] Council on Accreditation (2008). *Network Administration.* Retrieved on August 13, 2012 from http://www.coastandards.org/standards.php?navView=private&core_id=1212.
[10] Accreditation Association of Ambulatory Health Care (2012). *Accreditation Handbook for Managed Care Organizations.* Skokie, IL.
[11] State of Nebraska Service Contract Award, Contract Number 3352604. Magellan Health, 2008.
[12] State of Nebraska Service Contract Award, Contract Number 4144904. Nebraska Families Collaborative, 2012.

Table 12 Administrative Standards	
Sub-category	**Definition**
Organization and Compliance	Standards regarding the setup of the Lead Agency and the contracted service providers in terms of lines of accountability, compliance with foster care laws and public council, rates for services, disaster plans, insurance coverage and financial stability.
Network Service Providers	Involves the recruitment and application of service providers, communication with providers, grievance systems and guidance from the Lead Agency for providers to operate effectively.
Staffing and Training	Standards regarding the qualifications for staff, staff background checks and training requirements.
Management Information	Information technology standards including a system for housing electronic information, access to the system, a system to back-up electronic data, confidentiality and security safeguards.
Reporting	Involves the timely submission of statements for services provided.
Quality Assurance	Standards for ongoing quality assurance including case reviews and a broad scope quality improvement program. Includes identifying new training needs for staff.
Short and Long-term Planning	Annual review of the agency's initiatives including the goals and objectives, client access to services and availability of service providers. Includes work with the Child and Family Services Review's Program Improvement Plan.

Table 13 Practice Standards	
Sub-category	**Definition**
Intake	Includes standards for receiving referrals for children and families in need of services.
Service Delivery	Standards for case management, access to services, service coordination, compliance with court and policy requirements and reporting of critical incidents.
Placement and Placement Resources	Includes plans for foster home recruitment, foster home licensing and DHHS approval for placement of children.
Outcome Measurements	Involves plans to identify strategies and improvements for increasing safety, permanency and well-being for children. Also involves outcomes, objectives and strategies for financial stability and improved service delivery.
Client Rights	Standards for involving families in their case, filing grievances and choosing service providers. Also contains information on release of information and photos of children.

The remainder of this chapter discusses the cumulative findings from the document reviews and interviews. The discussion is divided between NFC and DHHS, the latter focusing on SESA, and provides information on some of the strengths of each agency as well as some areas in which functional improvement is needed. At the end of the chapter, issues of coordination and duplication of efforts are discussed for both agencies together.

NEBRASKA FAMILIES COLLABORATIVE

The Nebraska Families Collaborative has served as a lead agency in the Eastern Service Area since its inception in 2009. The collaborative was formed by four service providers (Boys Town, OMNI Behavioral Health, Child Saving Institute and Heartland Family Services) and an advocacy organization (Nebraska Family Support Network). NFC's contract with DHHS and the Operations Manual which is attached to the contract include performance measures and the roles and responsibilities of DHHS and NFC. The contract includes the amount DHHS pays NFC for case management.

NFC employs Family Permanency Specialists (FPS) as case managers (similar to DHHS' caseworkers) and does not provide any direct services to children and families. Instead, NFC contracts with service agencies in the greater Omaha area for this purpose. NFC is required to take all cases DHHS refers and is not responsible for investigations of abuse or neglect, for developing safety plans, or for conducting background checks of individuals participating in the safety plan. Statute does not permit NFC to consent to medical treatment of a state ward or to make or change a placement of a state ward without prior approval from DHHS.

Administrative Standards

NFC has established an organizational structure that provides for management of the system that integrates and coordinates services to children and families in the ESA. The Operations Manual and NFC's Policy Manual, New Employee Orientation, New Employee Orientation Resource Book, Family Permanency Specialist Training, Provider Handbook and Strategic Plan weave together policies, procedures and practices that create and maintain a lead agency with the capacity to meet administrative standards.

Organization and Compliance

Organization and compliance standards include demonstrating sufficient financial resources to carry out the terms of the lead agency's contract. While both NFC and the State agree that NFC's revenues and costs do not align with one another, there is strong disagreement as to the reasons. The two parties have made numerous changes in their contract to address the mismatch between revenues and costs, including the move from a flat payment structure to a case rate system which took effect in July of this year, but the basic problem has yet to be resolved.

NFC argues that the issue relates to revenues, which it describes as 1) a fixed monthly administrative fee that is based on 100 percent of fixed administrative costs such as management salaries, 100 percent of direct service costs (subcontracts with service providers) and 50 percent of non-administrative variable costs such as case manager salaries; 2) a variable monthly payment for case management based on rates that are established by DHHS; and 3) contributions from the agencies represented on the NFC

Board. NFC has also hired a Grant Development Director to supplement this revenue with public and private grants. A community needs assessment conducted by the Grant Development Director revealed a need for operational funding, family locator funding, support for family caregivers and for the Independent Living Program for which NFC receives no state funds.

While NFC Board members and management agreed to the new rates which became effective in July of 2012, they also report that these rates are inadequate. According to NFC, the inadequacy of the case rates is due to two issues regarding case expenses and wardship days. First, DHHS requested cost data for in-home and out-of-home cases from NFC and KVC for SFY 2011 but reportedly did not respond to the agencies' request regarding clarification for these categorizations. NFC and KVC used different methodologies to determine which cases were in-home and which were out-of-home, resulting in significantly different costs being assigned to each category of case. NFC's in-home costs were considerably lower than KVC's. Second, again according to NFC, DHHS used "wardship days" to determine rates and defined that as the number of days a child is in the child welfare system, not the number of days the lead agencies were actually responsible for the child. According to NFC staff, DHHS did not use the actual number of days a child was in the system but rather allocated the days to in-home or out-of-home cases based on how costs were allocated to the two types of cases. DHHS then divided the total in-home (or out-of-home) case costs for each agency by the number of in-home (or out-of-home) wardship days to arrive at an in-home (or out-of-home) rate for each agency. For the final contracted out-of-home rate NFC reported that DHHS used the average of NFC and KVC's out-of-home rates, and for the final contracted in-home rate DHHS used NFC's rate (which was lower than KVC's in-home rate).

The result of these calculations, according to NFC, is that neither the in-home nor the out-of-home components of the rates accurately reflect actual costs or actual days NFC has case responsibility. The costs were, on this account, underestimated, and the number of days was overestimated. Currently, the in-home *per diem* component equals $17.02 per family and the out-of-home *per diem* component is $58.98 per child. Both of these are paid over and above the fixed amounts for administrative and non-administrative costs. Using NFC's actual case costs and actual days it has case responsibility, NFC has calculated that the in-home rate would be $21 per family and the out-of-home rate would be $62 per child.

According to NFC, DHHS is not able to compare NFC case costs with DHHS case costs. Because payment of case costs can lag up to six months past the date the case is closed, and because the State uses a cash accounting system, DHHS does not have a way to look back at all case costs.

NFC's independent auditors' report provides an important perspective on NFC's financial stability. KPMG LLP of Omaha conducted audits of NFC's statements of financial position (statements of activities, cash flows, and functional expenses) in 2009, 2010 and 2011 using generally accepted accounting principles. The auditors' report

notes for December 31, 2010 and 2009 and for December 31, 2011 include "substantial doubt" about NFC's ability to remain a going concern in the face of inadequate rates and a lack of obligation for member contributions. Specifically, in the notes to the Financial Statements, December 31, 2010-2011, the auditors' report that,

> "The NFC…has a working capital deficit of $3,257,789. NFC is dependent on funding through its contract with the State of Nebraska and by its members to meet any shortfall. While NFC's members have historically made contributions in amounts sufficient to fund net program service deficits, there is no obligation for such contributions by members in the future. If future contributions by members are not sufficient to fund such shortfalls, NFC would need to seek new funding sources and/or reduce its level of program service. There are no assurances these steps would be sufficient to continue providing its services.
>
> These financial statements have been prepared assuming NFC will continue as a going concern. As a result of the uncertainties described above, these matters raise substantial doubt about the ability of NFC to continue as a going concern." (pp. 7-8)[13]

DHHS has a different explanation of how the current case rates were calculated, although there is agreement that the payments are made in two components, a fixed component and a variable component. There is also agreement that the fixed component includes all administrative costs and half of the case management, or what DHHS calls the "non-administrative" costs, while the variable component consists of direct services costs and the other half of the non-administrative costs.

While the materials related to the rate calculation provided by DHHS do not permit a line-by-line examination of all the calculations and adjustments (there are, for instance, conflicting estimates of the number of wardship days attributed to both NFC and KVC), it is fairly simple to determine how the final step was taken. In short, NFC's rate for direct services for out-of-home cases is equal to the weighted average of NFC's and KVC's (both ESA and SESA) direct service costs for out-of-home care in SFY 2011, while the other costs, i.e., the direct service costs for in-home cases, the non-administrative costs and the administrative costs, are equal to NFC's costs for each of those categories.

If there is a problem with that methodology, it is that NFC's direct service costs for out-of-home care were higher than those of KVC, while NFC's costs in all other categories were lower. In fact, according to documentation provided by DHHS,[14] it appears that NFC's non-administrative and administrative costs were even lower than DHHS' own costs in those categories. Because the rates are supposed to represent

[13] KPMG LLP, Nebraska Families Collaborative: Financial Statements, December 31, 2011 and 2010 (With Independent Auditors' Report Thereon). Omaha, NE. July 18, 2012.

[14] Administrative and non-administrative costs for SFY 2011 were provided by the Department in the Nebraska Department of Health and Human Services Case Rate by Component document prepared in December 2011.

reimbursement, i.e., they should not exceed expenditures, it is reasonable on the face of it to limit the direct service costs for in-home services, non-administrative costs and administrative costs to the amounts NFC actually spends. Reducing its costs for the direct services costs of out-of-home care below its level of expenditures can, on the other hand, be expected to create a problem.

The justification for making that reduction lies with the statutory limitation that the rates DHHS pays for purchased services not exceed "those prevailing in the state or the cost at which the department could provide those services." By using the weighted average of NFC and KVC costs for the direct costs of out-of-home care, DHHS has implicitly used the "prevailing in the State" criterion, but by the time those rates were implemented, July of 2012, KVC was no longer a lead agency. The only rate "prevailing in the State" for lead agencies was NFC's. Treating the rate of a lead agency which could not afford to continue the service with that rate as part of the prevailing rate ensures that the system will be underfunded.

Although the rates for non-administrative costs reflect NFC's actual expenditures, there is also a potential problem with those rates. As will be discussed below, NFC has not been meeting the caseload size standards required in the contract which took effect in July of this year. In order to meet those standards, NFC will have to incur additional non-administrative costs which are not foreseen in the existing rates.

Without considering whether accrual versus cash accounting or the methods for counting wardship days have depressed the rates, it seems clear that at least both the rates for the direct service costs of out-of-home care and the rates for non-administrative costs will underestimate NFC's actual expenditures in SFY 2013. If NFC's arguments about those other issues is valid, the issues may be even larger. Whether the problem lies with the rates or the expenditures, however, is a question that can only be resolved if there are clear definitions of allowable costs and a subsequent audit.

Network Service Providers

NFC has developed contractual relationships with service providers to deliver coordinated services that are family-centered and that focus on continuity of care. The NFC Service Delivery Model identifies roles and responsibilities for DHHS, NFC staff and subcontractors. The FPS is responsible for engaging the family and developing the case plan with the family; DHHS approves the case plan. The service provider subcontract incorporates the Provider Handbook, which describes service types and how services are family-centered.

For example, Family Support Services emphasize skill development/acquisition to improve family functioning, and Intensive Family Preservation emphasizes skill development and linking families to formal and informal supports. The Wraparound approach is used to facilitate family access to necessary supports and resources. DHHS's state-specific outcomes that relate to CFSR indicators, the Nebraska

Performance Accountability Measures, are incorporated into subcontracts. The subcontractor agreement includes requirements that the service providers participate in quality improvement activities, and that they be accredited, have a plan to meet national accreditation standards or initiate a plan in a reasonable period of time (if accreditation is required under NFC's contract with DHHS).

Despite the structures for sound contractual relationships, interviews with service providers consistently revealed a need for improved communications between themselves and NFC staff. Service provider staff at all levels noted the need for improved communication between FPS staff at NFC and service provider case workers (often referred to as "front line workers"). In particular the providers want more information about cases at the initial referral, better communication about when Family Team Meetings and court dates are scheduled, and more ongoing communication about policy and staff changes at NFC. While service providers and NFC staff alike agreed that external changes created a chaotic environment that has made day-to-day operations difficult, a clear message to NFC was to improve communication, especially between FPSs and front line workers.

Staff and Training

NFC's capacity to meet standards for staff qualifications, background checks and training requirements appears to be solid. Position descriptions articulate education and experience requirements, and the Policy Manual includes a policy on background checks that are conducted during the post-offer/pre-employment process and also on a recurring basis at least every two years. This includes criminal history, driving record, social security number, education, personal and employment references, health screen, abuse registries and fingerprints (if required for the position).

Both NFC and the service providers report a strong interest in providing training to their staff, and this translates into a wide range of training opportunities, especially for service provider caseworkers and FPS case managers. NFC and service providers respond to training needs as they arise and provide both in-house and external training. Examples of trainings held recently include testifying in court, immigration issues, and adoption. Nearly all of these trainings are held in-house, whether at NFC for NFC employees or at service providers for their respective employees.

A consistent theme in interviews with service providers is the need to train FPSs. FPSs are required to hold a bachelor's degree, but the degree does not have to be in human services, and two years' experience in case management services is preferred but not required. NFC's FPS training is based on the training DHHS provides through the University of Nebraska's Center for Children, Family and the Law, with some modifications to reflect NFC policies and practices. DHHS has approved this curriculum. However, in interviews with service providers, the quality of FPS training and supervised field experience was questioned, and the general lack of experience of FPSs was noted, as well. Service providers reported that some FPSs do not schedule required Family Team Meetings, some do not notify service providers of court dates, and some do not review files completely before making recommendations for referrals.

High levels of staff turnover at NFC present challenges for both service providers and families. With its rapid expansion, NFC hired staff from other lead agencies and from DHHS and provided its own staff with opportunities for advancement. This left many vacancies, especially in FPS positions. NFC has begun advertising nationwide to meet this need, although vacancies still exist.

Management Information

NFC's Information Technology Security Policy addresses such issues as access management, login monitoring, business associate agreement, emergency access procedure, data storage and transmission security, and data integrity. Boys Town provides significant management information support. NFC has developed a system for managing information that responds to internal case management and workflow needs through individual spread sheets to track actions, performance and outcomes in each department.

NFC is enhancing its management information through the purchase of FAMCare software which will be in use by December 2012. FAMCare is a web-based case management system that also includes modules for real-time productivity metrics, alerts for upcoming deadlines, and financial billing. According to NFC, service providers will have access to FAMCare through web portals. As with its current system, however, NFC will not be able to upload FAMCare data to NFocus, so some information will continue to be entered twice by NFC staff.

Quality Assurance

NFC's Performance and Quality Improvement (PQI) Plan establishes a structure that includes the Director of PQI and Network Administration and management positions designed to ensure quality in network service providers, foster care services, case records, and service utilization. The Community Advisory Board provides recommendations to the Board of Directors regarding service coordination and delivery, and the Program Quality and Service Committee assists the Board of Directors in developing and monitoring strategic initiatives, quality assurance and risk management. The Board of Directors reviews performance measures monthly, including those established in the contract with DHHS and in NFC's Strategic Plan.

To monitor process and outcomes, NFC conducts various case reviews. Supervisors conduct structured case reviews with FPSs once every 60 days. NFC also conducts case reviews of subsections of the served population at the request of DHHS or other stakeholders. For example, NFC along with DHHS and outside stakeholders have conducted case reviews of children who have been in care for longer than six months to try to identify trends. Although NFC has no participation in the mini-CFSRs that are conducted, they are reviewing cases that now use Structured Decision Making and report results to DHHS.

NFC utilizes spreadsheets and other methods to track internal efforts and performance measures on a day-to-day basis. This information is used to assess both practices and outcomes. NFC utilizes the PDCA cycle (Plan, Do, Check, Act) for rapid cycle improvement processes. NFC also believes that FAMCare will enable data tracking to improve quality assurance.

Short and Long Term Planning

NFC's 2010-2014 Strategic Plan includes strategies that address financial sustainability and stability, information management, workforce development and retention, service array, NFC Board structure, communication and COA accreditation. The NFC Board receives a monthly progress update on the plan as well as progress toward performance measures. The plan's objectives are specific and measureable, and the plan assigns responsibility to individuals for each objective. For example, the plan has an objective to demonstrate and measure fiduciary stewardship of public funds through tracking, reporting and analysis. One implementation step is to perform a "monthly detailed analysis of expenses as part of the financial reporting process [to the Board], to determine the appropriateness and reasonableness of expenditures," and the Finance Director is responsible for implementing this beginning January 1, 2012.

Another objective is to define specific unmet information management needs, and an implementation step is to "determine additional NFC [information management] needs to effectively support ongoing organizational needs. The PQI Administration and Network Director was responsible for implementing this beginning November 1, 2011, and this was completed on March 1, 2012.

Practice Standards

Service Delivery

The Operations Manual and the contract between DHHS and NFC establish standards for case management. The Family Permanency Specialist training and ongoing training and supervision convey these standards to FPSs. Supervisors track case management requirements such as holding a monthly Family Team Meeting, and work with the FPS to make adjustments when necessary. Families are included in the development of the case plan.

NFC assigns cases according to whether they are court-involved or not. If a case is court-involved, it is assigned to a team based on which court will hear the case. This allows team members to "specialize" in the way a particular court functions. It also means that when a court-involved case first comes to NFC it is not assigned to an FPS, but rather to a Family Engagement Specialist who starts the process for preparation for court (the first seven days of the case). Once the case has been assigned to a court, the case is transferred to an appropriate FPS.

Once assigned a case, the FPS makes recommendations to NFC's Utilization Management (UM) department which ultimately determines which referrals will be made. UM staff are familiar with services and contracted service providers, and they contact service providers via phone or email to make a referral. NFC staff report that to the extent possible, families are provided a choice in service provider, and when a family is dissatisfied with services the FPS works with the family and provider to determine whether the services can be modified to meet the family's needs or whether another service provider should be engaged.

UM makes referrals for foster home placements by sending an email "blast" to all foster home agencies, and placement is on a "first come first served" basis. Service providers reported that this does not always result in proper placements, due largely to the fact that foster homes are in short supply and agencies sometimes respond to the email even though they do not have an appropriate placement.

NFC has placed emphasis on ensuring that FPSs are trained to prepare court reports, attend court hearings and testify. NFC also created four new Court Liaison positions to fill a need to build NFC's capacity around court procedures. These staff provide training, technical assistance, and a second level of review of the court report, attend hearings if a supervisor is not able to do so, and generally coordinate issues around the court hearing and report. They changed the format of the court report and developed a spreadsheet for internal tracking (e.g. timeliness of court reports, case closures and to what permanency objective), and the results have been promising. NFC reports it has received considerably fewer "concerns" per month from DHHS regarding court cases since internal tracking was implemented.

As a way to increase coordination of services, NFC provides aftercare for families and children whose cases have closed. Aftercare serves the dual purpose of continuing to assist families and preventing some cases from re-opening. In another area of coordination of services, NFC is working to prevent families from becoming court involved. The newly created Cultural Liaison and the Family Liaison positions are charged with connecting families with informal networks and community services and other resources. This includes services (such as mental health services) that are reimbursable through Medicaid and which do not require a court order for reimbursement. Their work complements the work of FPSs on non-court cases.

FPS caseloads do not yet meet legislative requirements, which are 1:17 for in-home placements, 1:16 for out-of-home placement and 1:10 for mixed cases (one or more wards at home and one or more wards out of home within the same family). NFC hopes to be in compliance by the time of this report. The problem is linked to FPS training and experience and to performance measures. If NFC hires inexperienced FPSs to lower caseloads, this will not necessarily result in improved outcomes for children and families. As discussed above, NFC has begun recruiting nationwide, which may help alleviate the problem.

Placement and Placement Resources

One consequence of the recent statutory requirement that all foster homes other than kinship homes be licensed is that there are fewer placement options. Service providers and NFC staff alike noted the tremendous need for more foster homes, especially for teens and for children with behavior problems. Recruitment for foster homes is competitive, and service providers have several strategies to recruit and retain foster parents: support groups, respite care, babysitting during required trainings, 24/7 availability to answer questions and address concerns, more staff to support foster families.

Shelter placements are often the result of this foster home shortage: judges order shelter care for youth with behavior problems who have been refused by foster and group homes. Two agencies who provide emergency shelter services for teens reported that in some cases teens stay in the shelters for months.

NFC developed the Permanency Program to address a gap in capacity at NFC in the area of adoption. NFC is also looking for ways to support kinship homes, in particular a way to provide support in the first 30 days during which the home study is completed, which is between when the child is placed in the home and when the referral to a service provider occurs.

Summary

If one leaves aside the issue of financial stability, when measured against the standards for network management agencies, NFC demonstrates the capacity to perform essential child welfare service delivery and administrative management functions, including case management. That was also the judgment of DHHS' report to the Health and Human Services Committee of the Legislature dated September 15, 2012.[15] To date, this has not translated into outcomes that either meet the standards set for achievement or are better than those generated by DHHS. That may, however, be due at least in part to the frequent changes that have occurred during the privatization process, including NFC taking over responsibility for cases previously managed by other lead agencies and therefore being measured on work done by others. Without a resolution to the financial stability question, however, the question of whether outcomes can improve may be moot. Areas needing improvement are listed in the tables below.

[15] Department of Health and Human Services, Division of Children and Family Services (2012). 43-4408. Pilot Project Monitoring and Functional Capacity. Retrieved on September 20, 2012 from http://nebraskalegislature.gov/FloorDocs/Current/PDF/Agencies/Health_and_Human_Services__Department_of/305_20120914-124702.pdf

Table 14
Administrative Standards

Area Needing Improvement	Description
Financial stability	NFC is not a sustainable organization in the long-term given the current rate structure and NFC's existing expenditures and its need to increase non-administrative costs to achieve caseload size standards.
Training	NFC should focus training efforts especially on FSPs and incorporate meaningful field experience. NFC should also consider providing the training to service provider staff to increase consistency in the service delivery model throughout the ESA.

Table 15
Practice Standards

Area Needing Improvement	Description
Service Delivery	NFC should place an emphasis on providing adequate information when making referrals to service providers so that the providers can respond quickly to referral requests and make appropriate placements in the case of foster homes. In general, NFC should work with service providers to address communication problems.
Placements	The system for placing children needs to be restructured to provide more information and time for child placing agencies. This will likely result in better matching of children and available placements and therefore fewer future disruptions.

Department of Health and Human Services

Numerous changes have occurred within the Nebraska Department of Health and Human Services (DHHS) since privatization began in 2009. A number of those changes have resulted in the increased capacity of DHHS to serve as the administrator of child welfare and the Department's capacity to oversee the contract with NFC if privatization is to continue. Despite this, there are still areas in which a need for improvement remains.

Administrative Standards

While DHHS appears to have the structure in place to satisfy the standards related to administration, there are several areas that stand out as particular strengths for the Department as well as several areas that need improvement. For the most part, the Department has protocols and practices in place to ensure that staff qualifications are met, background checks are completed and that electronic information is protected and backed up. Although the current state of the service provider contracts, training and some aspects of quality assurance appear to require some improvement to allow the Department to administer the system effectively, the recent changes to the

Department's organizational structure, improvements to provider contracts and quality assurance efforts are emerging as strengths for the Department. Those areas that stand out as strengths and areas needing some improvement – organizational structure, service provider contracts, staff training and quality assurance – are discussed in greater detail below.

Organizational Structure

In the time since privatization was first initiated, the central office of Nebraska's Department of Health and Human Services has experienced a restructuring of positions, including the creation of several new positions. Recently, a Service Area Administrator was hired for each of the five child welfare service areas in the State. The Administrators report to the Deputy Director of Child and Family Services (CFS), which is a new position under the current leadership of the Department. The Department has hired new administrators for the Quality Assurance and Policy units, both of which are new roles that are still developing. The Financial Administrator, who serves as the liaison between the State financial department and CFS, as well as the Special Project Administrator for the Director, who works on all the major initiatives, are also new roles for the Department. This revamping has given the Department a clearer direction and allowed it to develop more specific goals.

With the addition of Service Area Administrators, the central office allocated many administrative tasks to the individual service areas. This has allowed each service area to tailor administration of certain tasks to what works well for that service area. The central office staff provide a framework for the administrative tasks but allow the service areas to execute them in a way that will fit the needs of that particular area. Interviews revealed positive communication between the central office, the service areas and service providers, with many DHHS service area-level staff and contracted service provider staff stating that it is easy to build a rapport and communicate with staff both at the service area and the central office. Particularly compared to when services were privatized in SESA, communication from the top-down and the reverse was viewed by those interviewed as a strength for DHHS. Staff and providers report being able to call anyone, anytime and get a response.

Service Provider Contracts

With the exception of those providers contracted with NFC in the Eastern Service Area, DHHS has moved to statewide contracts with its service providers, meaning that the contracts require providers to offer services statewide, not solely in one service area. This was designed to eliminate the "turf war" for services that some staff mentioned and to provide uniform services across the State. To help with the transition in contracts, DHHS created a Provider Panel which includes representatives from contracted agencies across the State. The Panel has assisted in developing statewide rates for the services. Although the uniform rates resulted in a decrease in payment in some areas, reportedly almost all providers have agreed to them. The Panel is also reportedly

improving consistency in contract administration throughout the State and in performance measurement.

With the structural changes to the central office, the Department has begun to make changes for increased accountability and improved quality assurance and performance measures, yet the contracts with individual service providers have no system for verification that the families are receiving the services that the providers report administering. Although providers send individual client updates to caseworkers, the billing information goes to the Resource Development (RD) unit which reportedly does not see the individual client reports to ensure that those services were actually provided. The RD unit only confirms the authorization dates for the services provided. Similarly, payment to placement providers is automatic (there is no billing system) based on the information in NFocus. This means that the State is relying on NFocus being up to date in terms of placement changes, although there is no guarantee that it is. In addition, the entire billing system, according to service provider interviews, takes a long time to reconcile. According to several service providers, although DHHS pays providers on time, the payment is often inaccurate and requires much reconciliation after the fact.

In addition to the lack of verification of services provided under contract, the service providers have limited to no quality assurance requirements or outcome measures built into their contracts. DHHS does not hold providers accountable to outcomes for clients nor does it conduct unannounced site visits. To increase quality assurance with contracts, the State is planning on switching to results based accountability contracts which build in some performance measures that service providers will be required to meet.

Many of the recent changes within DHHS have not only increased DHHS's capacity to serve as a network manager, but have also increased its capacity to manage the contract with NFC, if privatization is to continue in the ESA. The Department has changed NFC's overall role in contract monitoring and quality assurance. Whereas at the onset of privatization NFC was an active participant in managing the contract with the State, NFC is now treated more like a contracted provider. This means that NFC is treated similar to other service areas and contractors in terms of outcomes and quality assurance instead of helping to dictate terms of the contract and outcomes.

Training

Both SESA staff and service providers expressed concerns regarding the training provided to DHHS caseworkers. Interviewees reported that the training is not monitored and that it is too short in duration.

Training is a contracted service for DHHS, provided by the Center for Children, Family and the Law at the University of Nebraska in Lincoln. As discussed above, there is limited to no accountability or quality assurance when it comes to contracts and this includes training. Aside from not having a formal system for measuring the quality of

the contracted training, DHHS also lacks a requirement that new caseworkers pass an examination demonstrating the knowledge needed to take on a caseload.

Similarly, several staff and service providers expressed concerned that the training duration has been decreased over time. Training reportedly used to be three months long, but it has been reduced to five weeks. DHHS' response to these critiques was that, not only had the training not been abbreviated, it now represented a year long process. The written material provided as part of that response, however, make it clear that those making the complaints in the interviews and the DHHS administrators were talking about different things. The staff and service providers were addressing classroom training, while the agency administrators' response included initial classroom training, field work with a mentor and more formal subsequent training whose content and extent are determined by the Service Area Learning Team, which includes the trainee, the trainee's supervisor, the Field Training Specialist and the mentor. The complaints seemed to focus attention solely on the initial classroom training, ignoring the later efforts.

Quality Assurance

In another, larger effort to improve quality, DHHS has developed a statewide Continuous Quality Improvement (CQI) Team and restructured its approach to quality assurance to begin to monitor processes and outcomes. Although quality assurance is still an area needing improvement for the Department, steps have been taken to increase accountability. The CQI Team, consisting of Quality Assurance staff from DHHS, the Service Area Administrators, the President and Chief Executive Officer of NFC and Quality Assurance staff from NFC, monitors performance continually through monthly meetings focusing on the issues that emerge from the data collected by the State. Based on the performance data, the Team identifies the processes that, if improved upon, would likely improve outcomes. Examples include monthly contacts with children and families, conducting Family Team Meetings regularly, timeliness of required documentation such as court reports and placement changes and federal compliance measures. The CQI Team monitors performance and service delivery for each service area, including NFC. The Team works to develop plans to address the issues and to ensure that the plans are successful.

To help further guide the Department and its new initiatives after restructuring, the leadership at central office created and implemented a Strategic Focus for 2012 to 2015. The Focus outlines the Department's approach for future undertakings including the shift to performance based contracts, the implementation of differential response, increased training, the work of the Provider Panel and multiple other improvements to the system.

As part of the restructuring discussed above, the Department has begun to develop outcome measures to assist with budgeting. These measures include indicators such as "Decrease the incidence of child abuse and neglect in Nebraska." The measures will allow financial staff to measure performance in relation to the funds expended.

Because they are tied to the budget, the Performance Measures are tracked cumulatively for the State and not by service area.

Central office staff have also begun to conduct more frequent personnel compliance checks with NFC and the SESA's contracted service providers. According to interviews with service providers in the SESA and NFC staff, DHHS is coming to review personnel files for staff education requirements, background checks and training more than they ever have before. This is important in ensuring that children are receiving services from qualified individuals who are able to provide services of high quality.

Practice Standards

DHHS's process for intake, service coordination, court requirements, policy requirements and reporting appear to be satisfactory and meet the requirements of the standards. Whereas the Department reports it employs evidenced-based, family-centered practices that utilize the least restrictive approach, there is some evidence to suggest that not all caseworkers value this approach to casework. The mini-CFSR results on casework contacts with families and on family involvement in case planning suggest very inadequate levels of family-centeredness. There is also room for improvement with client rights, placement resources and processes for placing children and outcome measures. Service delivery, placement resources, outcome measures and client rights are all discussed in greater detail below.

Service Delivery

To serve families effectively, Department staff report using evidence-based practices, employing a family-centered approach to casework and report utilizing services that are the least intrusive. Recently the Department adopted the use of Structured Decision Making (SDM) which, according to staff, is just one example of the use of evidenced-based practices. Many staff agree that the adoption of SDM is the strongest aspect of child welfare in Nebraska at this time. The SDM tools guide caseworkers in creating a plan, specifically in ensuring that no potential areas of concern are overlooked. It is also helpful in closing cases where there is lower risk, thus controlling the number of children in care.

Staff all reported that, with the exception of court-ordered services, the family drives the case plan and modifications to the plan. Families participate in Family Team Meetings and are given an opportunity to choose service providers outside of the agency. The Department's caseworker training curriculum, its administrative and programmatic memos, and the Nebraska Health and Human Services Manual all direct caseworkers to employ a family-centered approach to casework.

Several DHHS staff reported that they attempt to "pile on" services and/or maintain more frequent contact with the families than normal in an attempt to reduce the number of children coming into care. The Nebraska Health and Human Services Manual encourages the use of "community and neighborhood based" services as well as the

provision of services "in the family home when appropriate."[16] Despite this, Nebraska still has a high number of children in state custody.

Although service providers, like state caseworkers, are required to use evidenced-based practices, the Department provides little to no guidance in terms of selecting evidenced-based practices. A few staff and service providers reported concerns that these approaches were not being employed by those outside the Department or that they were not being employed effectively.

Aftercare services are not provided to any DHHS families. Several of those interviewed reported that aftercare services assist in getting court-involved cases closed in a timely manner and some argued that aftercare services prevent re-entry. Currently, NFC provides one year of aftercare services. According to staff at DHHS the initial Request for Proposal (RFP) for lead agencies did not require the provision of aftercare services, but NFC staff chose to include those services in their proposal and they were subsequently written into the contract with NFC. Because of this, aftercare is provided in the ESA under NFC, but not elsewhere in the State.

Placement Resources

Currently, when a child is in need of an out-of-home placement, information on the child is sent to all contracted placement providers in the area. The information reportedly comes via fax or e-mail and is often limited. Service providers stated that after the "information blast" from the State, the child is placed on a "first come first served" basis, meaning that the first agency to respond and accept the child gets the placement. This pressure felt among providers to place children and get paid results in rushed placements with limited information. According to providers, if they call the Department staff for more information on the child in order to make a good placement, it is often too late and the child is placed with another agency. Similarly, if an agency calls with a more appropriate placement, the initial placement decision will not be reversed. This same method of "first come first served" for placing children is also employed by NFC in the ESA.

Along the same lines, placement resources in the form of foster homes are scarce. This is particularly true for children with high needs and for teenage children. Although each service area's recruitment plan addresses this issue, staff unanimously report that placements for older youth are extremely difficult to find. Staff also report that recruitment of foster homes is very competitive. Because there is no set rate paid to foster parents, those agencies that pay the most are able to recruit the most families. This leaves smaller agencies who cannot afford to pay more with fewer families and at risk of shutting down.

Similarly, according to adoption workers, the payment to adoptive homes is often lower than the amount paid to most foster homes because of the competitiveness of foster home rates. This discrepancy between the foster care rate and the adoption rate

[16] Nebraska Health and Human Services Manual. Manual Letter # 68-98. Revised November 10, 1998 (390 NAC-1-001).

creates a disincentive to adopt versus keeping the child in foster care. These two issues leave some children in less than desirable placements such as shelters for extended periods of time and prevent children in foster homes from achieving permanency.

Outcome Measurement

As mentioned in the Administrative Standards section, there are no outcome measures for providers. The contracts are currently not performance based and do not require providers to meet any outcomes in order to keep the contract or be paid in full for services provided. Providers from across the State recently attended a results based accountability workshop and many providers report this was the first step to introducing the new results based contracts that are forthcoming. Staff at the central office have confirmed that the State is moving to results based contracts in July 2013. Although providers at this point have been told this change is coming, a few are skeptical, stating that the Department has talked about changing the structure of the contracts for years, but never has. Service providers would like to have outcomes from the State and the data to drive those outcomes. Currently they have no access to NFocus and are limited in tracking outcomes with clients they serve, especially after their services have ceased.

Many providers also report that they should have access to NFocus for numerous reasons. In addition to outcome tracking, service providers would like to be able to get more information on the children and families they are serving (particularly when making placements as discussed above) and to help with reconciling billing issues. While the Department reports that confidentiality is a barrier to sharing NFocus data with the providers, other states have been able to solve the technical and confidentiality issues involved.

Client Rights

The State lacks a formal grievance process for the families it serves. Although there are formal processes for foster and prospective adoptive parents to file grievances, a similar policy is not in place for families. This means there is no formal check or balance to ensure that services are in fact family-centered. Grievances may be handled through the courts for court involved cases or they will simply be handled up the chain of command (i.e., worker, supervisor, administrator, Service Area Administrator). With no formal system in place, it is likely that clients are not informed of their right to complain.

Summary

Applying the standards for network management agencies, DHHS has the capacity to oversee the network of child welfare agencies. As with NFC, this has not translated into outcomes meeting national standards. With some improvements the Department would be in a position to serve families more effectively. The primary areas needing improvements are contracts, quality assurance and outcome monitoring, service delivery, placements and client rights. Each is summarized below.

Table 16 Administrative Standards	
Area Needing Improvement	Description
Contracts	The Department needs a way to verify that the services contracted providers bill for were actually provided. Similarly the Department should either not rely solely on NFocus for payment to placement providers or take steps to ensure that NFocus data are accurate and timely. Contracts need outcome measures built in to ensure that the services provided are achieving positive outcomes for families and are worth the Department funds expended.
Quality Assurance and Outcome Monitoring	The Department should continue to build upon its quality assurance initiatives and incorporate some into the service provider contracts.

Table 17 **Practice Standards**	
Area Needing Improvement	Description
Service Delivery	Although many staff report using the least intrusive services with families, the Department should ensure that all caseworkers employ this approach to decrease the number of children in care.
Placements	The system for placing children needs to be restructured to provide more information and time for child placing agencies. This will likely result in better matching of children and available placements and fewer future disruptions. Foster home and adoption subsidy rates should be examined so they do not provide families with a disincentive to adopt.
Client Rights	The Department should formalize a process for families to file grievances and make that process known to all families.

COORDINATION AND DUPLICATION OF EFFORTS

Although case management services have been privatized in the Eastern Service Area, the Department maintains custody of the children who enter care. Because of this and the statutory prohibition against the Department delegating certain decisions, Child and Family Outcome Monitors (CFOMs) were created by the Department to monitor NFC's decisions for children in state custody. Although CFOM's are DHHS employees some – called co-located CFOMs – work out of the NFC office in the ESA while others – court CFOMs – attend court all day.

According to staff, each co-located CFOM oversees 400 to 500 cases at a time, yet they have no substantive contact with any of the children or families; their only client contact is when they physically move children from one placement to another. CFOM's must approve case documentation such as court reports and must approve all major

decisions related to the case. This includes medical consent, placement decisions and case closures.

Essentially, although NFC FPSs do all of the actual casework, DHHS staff must approve that work and have the authority to deny key decisions made by the FPS. According to some staff the co-located CFOMs working with the FPSs has created a lot of back and forth with casework procedures. One example is recommendations made in court reports. Interviewees reported that when the CFOM disagrees with a recommendation, it is sent back to the FPS for revisions. This back and forth takes up time and slows case decisions from being made timely. When these disagreements occur and the FPS and CFOM cannot come to an agreement, the issue is brought to the supervisor and the issue is passed up the chains of command at DHHS and NFC until there is a resolution. To some extent, much of this issue seems to have been resolved. According to staff at NFC, the frequency of these disagreements has decreased over time, or they are at least being resolved more quickly.

There are six court CFOMs who attend court all day on behalf of DHHS. Initially, the court CFOM position was created to ensure that NFC staff show up to court, ensure that the court report is submitted on time and for the CFOM to serve as the legal guardian in the case. While these responsibilities appeared to be worthwhile initially, NFC now has a court liaison that ensures the FPS is in court and checks the timeliness of court reports. In addition, the Department attorney is present. Staff reported that the court CFOMs are often unfamiliar with the case, often do not read the court report and are rarely, if ever, called upon by the judge for a statement or recommendation. In essence, court CFOM's report that they do very little in terms of contributing to the case. Their role is one of quality assurance.

The contract between DHHS and NFC provides NFC responsibility for case management and specific outcomes related to safety and permanency, but not with the necessary authority to control the number of cases it receives, manages or closes. Only DHHS and the court can authorize placements, and they are not required to follow NFC's recommendations for services or placement. This creates a situation in which NFC bears financial responsibility over the life of the case, without maintaining control over key decisions that have significant financial impact. For example, one of the Nebraska Performance Accountability Measures is "71 percent of all children placed in out-of-home care will be reunified within 12 months." NFC may recommend a high level of services to prepare the family for reunification, but DHHS may deny that level of service resulting in the child remaining in foster care beyond 12 months.

The analysis of the residential placements required by the RFP is not directly connected to the issue of privatization, and it requires examination of data from outside the child welfare system. Beyond a description of the children placed into residential care and a description of the placements themselves, the analysis was intended to identify those services which could help prevent the need for residential services and, among that group, those which were unavailable in the community.

The descriptive information on the children in residential care can all be drawn from NFocus. Information on the placements, including the durations and costs of placements, comes from both NFocus and the Medicaid databases. The research team received ten years worth of NFocus information, six years of Medicaid claims data for state wards and five years of Medicaid authorizations. The most important information of all for this project, however, involves information about denials of Medicaid services and information about approvals for Medicaid services which were never delivered.

The denials are important both because the RFP included several questions about them and because they provide the only realistic means of identifying what services might have prevented placements. Unfortunately, the three years of data DHHS was able to provide included only denials of residential placements themselves, rather than other types of services, and not even all of those. Those data provide no means by which to identify any cases denied non-residential placements who later entered residential placements, and therefore no means of comparing their outcomes to those of cases which were approved for those same non-residential services.

Similarly, the structure of the Medicaid data on approvals and claims is such that no services can be identified which were approved but not provided. The research team had intended to use these data to show either that some services were frequently not available or that there were no services which Medicaid would approve which were systematically unavailable. With the data actually provided to the research team, neither of those is possible.

Most of what follows in this section, therefore, represents a descriptive analysis of Nebraska's residential placements. Nevertheless, even a description of these placements provides some insight into other components of the child welfare system which need improvement.

THE YOUTH

During the three State Fiscal Years 2010 through 2012, 1,898 children were in at least one residential placement at some time. The frequency with which these placements

are made, however, has been in a slow decline since 2007, with steeper declines the last two years, as shown in Table 18.

Table 18
Number of New Residential Placements by State Fiscal Year

Placement Year	Children
SFY 2003	1,180
SFY 2004	1,270
SFY 2005	1,232
SFY 2006	1,220
SFY 2007	1,135
SFY 2008	1,060
SFY 2009	1,258
SFY 2010	1,056
SFY 2011	910
SFY 2012	694

The nearly 1900 children who were in residential placements over the past three years experienced a total of 3,103 placements during that period. Despite the fact that the average number of placements is 1.6, nearly two-thirds of these children were in only one setting. Table 19 shows the distribution. No child had more than 12 residential settings during this time period.

Table 19
Number of Residential Placements per Child
SFY 2010 – SFY 2012

Number of Residential Placements	Number of Children	Percent of Children
1	1,204	63.4%
2	414	21.8%
3	156	8.2%
4	68	3.6%
5	30	1.6%
6+	26	1.4%
Total	**1,898**	**100.0%**

While the available data do not provide a reason for all children's placements into residential settings, they do reveal why children are removed from their homes in the first place. Among the children who experienced at least one residential setting during the three-year period, 1490 or 79 percent were removed, at least in part, for child behavior reasons, including child drug or alcohol issues. Neglect of the child was a distant second with 315 children and children's disabilities accounted for only 100 cases.

For those in Medicaid reimbursed settings, data are available as to the diagnoses which established the medical necessity for the residential care setting. Table 20 shows the frequencies for the three most common diagnoses for youth in Medicaid settings. Each child can have more than one diagnoses, and only those diagnoses which comprise at least two percent of the population are shown.

Table 20
Most Common Diagnoses for Youth in Medicaid Residential Settings

Diagnosis	Number	Percent
Opposition Defiant Disorder	376	14.6%
Episodic Mood Disorder NOS	320	12.4%
Cannabis Dependency-Unspecified	252	9.8%
Posttraumatic Stress Syndrome	150	5.8%
Attention Deficit with Hyperactivity	109	4.2%
Other Conduct Disorder	98	3.8%
Bipolar Disorder NOS	81	3.1%
Conduct Disorder Adolescent Onset	75	2.9%
Alcohol Dependency NEC/NOS-Unspecified	66	2.6%
Depressive Disorder	63	2.4%

Not surprisingly, roughly two-thirds of the 3,103 placements originated in the Eastern and Southeast Service Areas. Table 21 shows the distribution across all service areas.

Table 21
Residential Placements by Originating Service Area

Service Area	Placements
Central	298
Eastern	1,249
Northern	434
South East	813
Western	290
Unknown	19
Total	**3,103**

NFocus also indicates which lead agency is responsible for the residential placement, but these data are clearly not usable. While the Eastern Service Area originated 1,249 residential placements in this period, the three lead agencies which were responsible for a majority of the ESA cases throughout the three-year period are shown in NFocus as responsible for only 416 residential placements. This is clearly an underestimate, with much of the data never entered.

As shown in Table 22, the vast majority of the children in residential placements are teenagers and none of them is under the age of six.

Table 22 Age of Children at First Admission to Residential Placement during SFY 2010 – SFY 2012		
Age	Number of Children	Percent of Children
0 – 5	0	0.0%
6 – 9	43	2.3%
10 – 12	174	9.2%
13 – 15	703	37.0%
16 – 19	978	51.5%
Total	**1,898**	**100.0%**

Nearly three-fourths (72 percent) of the youth in residential settings are white, while 17 percent are black and six percent American Indian. For another five percent race was listed as "other." Many of these may be part of the ten percent of the residential population which is Hispanic, although that is supposed to be entered as an entirely separate piece of information, just as in the census.

Gender also plays a role in residential placement. Sixty-nine percent of all the youth placed into residential care during this three-year span were male. Overall, the "typical" youth in residential care is a white teenage boy who is in DHHS wardship due to behavior issues.

THE PLACEMENTS

The term "residential placements" encompasses a relatively wide variety of settings. Moreover, while such placements are recorded both in NFocus and in the Medicaid database, those two systems use different names for the same setting and the way the data are entered do not always match a single type of NFocus setting to the same type of Medicaid setting, or vice versa. For instance, NFocus identifies one type of residential setting as "enhanced treatment group home." Among the youth placed in residential settings over the past three years, those enhanced treatment group homes have been recorded in the Medicaid database as "psychiatric residential treatment facility," "residential rehabilitation," "residential treatment center," "therapeutic group home" and "treatment foster care." The variation works in the opposite direction, as well. What Medicaid records as "psychiatric residential treatment facility" is found in NFocus as "enhanced treatment group home," "group home treatment," "psychiatric residential treatment facility" and "residential treatment facility."

These inconsistencies make it difficult to decipher "levels of care." The best that can be done is to show the distribution of placement types which appear in each of the two

systems. Tables 23 and 24 do that. Table 24 shows fewer placements because not all residential placements are paid by Medicaid.

Table 23
Residential Placement Types
as Recorded in NFocus
SFY 2010 – SFY 2012

Setting Type	Placements	Percent
Enhanced Treatment Group Home	440	14.2%
Group Home Treatment	684	22.0%
Institution for Mental Disease	1	0.0%
Mental Health Facility	240	7.7%
Psychiatric Residential Treatment Facility	419	13.5%
Residential Treatment Facility	1,144	36.9%
Therapeutic Group Home	175	5.6%
Total	**3,103**	**100.0%**

Table 24
Residential Placement Types
as Recorded by Medicaid
SFY 2010 – SFY 2012

Setting Type	Placements	Percent
Psychiatric Residential Treatment Facility	299	11.6%
Residential Rehabilitation	1	0.0%
Residential Treatment Center	431	16.7%
Substance Abuse Treatment Center	6	0.2%
Therapeutic Group Home	1,792	69.4%
Treatment Foster Care	54	2.1%
Total	**2,583**	**100.0%**

Residential placements of Nebraska wards are typically rather short. While this is not overly unusual when compared to what the research team has observed in other states, the fact that the mode, i.e., the most frequent value, is less than one month is quite

extraordinary. In fact, as shown in Table 25, nearly 19 percent of all residential placements during this three-year period ended less than one month after they began and nearly five percent ended within three days. Almost certainly, many of these children could have been accommodated in a less restrictive setting.

Table 25
Duration of Residential Placements
(in months)
SFY 2010 – SFY 2012

Months	Placements	Percent
<1	584	18.8%
1	298	9.6%
2	322	10.3%
3	472	15.2%
4	416	13.4%
5	252	8.1%
6	204	6.6%
7	115	3.7%
8	115	3.7%
9	74	2.4%
10	67	2.2%
11	44	1.4%
12	39	1.3%
13+	101	3.3%
Total	**3,103**	**100.0%**

The data do not provide any information about the extraordinary number of very short term residential placements, but at least two possibilities are suggested by other parts of this report. The first is that children are placed in residential settings due not to need but to the dearth of available foster homes, especially for teenagers. If this is the case, residential settings are being used as emergency shelters. The second possibility is that the "first come first served" method of deciding with which provider to place a child, which is utilized by both NFC and DHHS, may result in placement levels higher than necessary if those residential providers respond more quickly than others. If either of these explanations, or perhaps both, explains any significant portion of the short duration residential placements, the State is bearing unnecessary costs. Fixing the problem, however, will involve focusing not on residential services but on foster homes and the process for matching children to service providers.[17]

[17] In its response to this issue in the draft report, DHHS argued that "by and large" the issue was one of workers inputting the wrong placement types into NFocus, then closing the incorrectly coded setting and re-entering it with the correct code. Detailed examination of these cases indicated that is true of the very short term placements (56 percent of the placements of three days or less were of this type), but it is not

The costs of residential care can be measured both by the individual placement and by child. The average cost of a single residential placement, as recorded by Medicaid, was $27,930.[18] There was, however, a wide variation around that average, with a low of zero dollars and a high of $157,500. The median cost, i.e., the point at which 50 percent of the placements cost less and 50 percent cost more, was $23,100, slightly below the arithmetic average.

Because some children experience more than one residential setting, per child costs are clearly higher than per placement costs. Again, the lowest per child cost was zero, but the highest was $352,100, more than double the highest per placement cost. The average cost per child was $42,920, slightly more than 50 percent higher than the per placement cost. The same is true of the median costs: $34,530 per child against $23,100 per placement. All of this makes sense because the average number of placements per child was 1.6.

Aside from the doubling of the maximum figure, probably the most interesting comparison between the per placement cost and the per child cost relates to the lower end of the spectrum. As shown in Table 25, whereas 25 percent of the placements cost $6,331 or less, the 25 percent mark for children is well more than double that amount: $14,990. Because length of stay and cost are clearly connected, e.g., the median length of stay, which is just over three months, generates the median cost per placement of $23,100. What this suggests is that youth who stay in residential settings very short periods of time probably do so more than once. In most human service systems, many of the costs are concentrated on relatively few clients. If, as suggested above, many of the very short term residential placements are not due to the youth's actual need for residential care but to features of the current operation of the child welfare system, repeated short term residential placements identify a group of youth whom the system has particular difficulty serving.

YOUTHS' PLACEMENTS AFTER MEDICAID DENIALS

Although DHHS reported that it was not including in the denial data any cases in which residential care was later approved, there were 37 youth who later showed up in the claims data as having been in Medicaid reimbursed residential care. Six of those entered residential settings within one month of the denial. Another 22 went to residential care between one and six months after the denial, and another seven between six months and one year. The remaining two entered residential care 16 months and two years after the denial, respectively.

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true of the majority of settings lasting less than one month. Among these the incorrect data appear to represent 18 percent of the cases or about three percent of all placement settings in the last three years.

[18] The Medicaid data showed some residential placements associated with negative payments. These were ignored in these analyses. Moreover, the costs not paid by Medicaid but recorded in the NFocus system were not provided to the research team, so all cost residential information relates to Medicaid.

Overall, the Medicaid denial data provided to the research team included 1,114 denials of residential care for an unduplicated count of 872 youth. Among these, 363 were placed in non-Medicaid residential settings subsequent to the Medicaid denial, including all of the 37 who later entered Medicaid settings. Table 26 shows that about one-third of these youth entered their residential placements within one month of the Medicaid denial and that more than 60 percent did so within three months. With more than 40 percent of the youth denied Medicaid reimbursed residential placement ending up in residential care anyway, and most of those doing so very shortly after the denial, the denial of Medicaid reimbursement for residential placements appears to have limited impact on what happens to the youth, although it is having a clear impact on the relative proportions of state and federal funds used to pay for the care. Judges decide where children go, but they do not decide who pays for their care.

Table 26
Youth Entering Non-Medicaid Residential Placements after Medicaid Denial by Time between Denial and Placement SFY 2010 – SFY 2012

Time	Children	Percent
7 Days or Less	30	8.3%
8 – 30 Days	87	24.0%
31 – 90 Days	103	28.4%
91 Days – Six Months	62	17.1%
Six Months to One Year	51	14.0%
One to Two Years	25	6.9%
Over 2 Years	5	1.4%
Total	**363**	**100.0%**

Out-of-State Placements

NFocus shows, during the three years covered by the analysis of residential care, 58 youth placed into residential care who were also designated as subject to the Interstate Compact on the Placement of Children (ICPC). These are the youth placed out-of-state. The vast majority of them (42) were in only one setting out-of-state, and another 12 were served in two such settings. Two youth experienced three settings, and the remaining two were in four and seven out-of-state settings, respectively.

Fifty-one of the 58 youth had been in at least one in-state setting prior to their placements out-of-state, with 26 of them having been in in-state residential care. That means that the out-of-state setting was the first residential placement for more than half of the youth. Seventeen of the 58 had received in-home services prior to their placement out-of-state.

Medicaid does not appear to play a large role in decision-making about out-of-state placements. Among the 58 youth placed out-of-state, seven had been previously denied a Medicaid residential setting. Four of those were among the 26 youth with an in-state residential placement prior to going out-of-state (with two of these being paid by Medicaid), while three were among the 32 for whom the out-of-state setting was the first residential placement.

SUMMARY

Most of the information regarding youth in residential settings and regarding the settings themselves is not surprising. The youth themselves are typically older youth with behavioral issues, and most of the placements are not in large institutions but in therapeutic group homes. In addition, most of the youth denied residential placement under Medicaid do not show up in any residential settings later, and out-of-state placements appear to be made only after in-state options have been tried.

The one surprising fact turned up in this analysis has to do with the short duration of many of the residential placements. While DHHS responded to this finding with an argument about the quality of the data, closer examination of the placements lasting less than one month indicated that the data generally reflected the actual experiences of the children. After correcting for bad data, nearly one in six residential placements lasts less than one month. This suggests that these settings are being used as emergency shelters in some cases and that may be a function of the dearth of foster homes for teenagers and youth with behavioral problems. If the State is to reduce its placements in residential care, it will need to find develop additional foster homes which can deal with these youth.

STRENGTHS

The major strengths of Nebraska's privatized child welfare system are the durability and stamina of the private sector and the fact that both NFC and DHHS have the capacity to act as network management entities. While the privatization experiment has cost the State some of its private service provider resources, including some who never even attempted to be lead agencies, those who remain have demonstrated the ability to withstand the impact of large changes in opposite directions, along with repeated changes in their revenues. That NFC has been able to enlist a broad network of accredited service providers is a tribute to the private sector.

At the same time, it has to be recognized that privatization is not the only way Nebraska's child welfare system can serve children and families. DHHS has shown itself equally able to act as a network management entity, taking over the responsibility for all case management cases in SESA this past March and even gaining praise from several of the private agencies for improving the relationships between them and the case managers. In addition, DHHS has begun to improve its accountability mechanisms and to increase its capture of federal funding for the system. Its structures appear to be in better shape than they were when the experiment began.

AREAS NEEDING IMPROVEMENT

Despite these strengths, outcomes for children and families have not improved to a significant degree. In part, this is due to the upheaval in the system, but in part it is also a function of components of the system which are not functioning effectively and of overlaps and duplications.

Stability

When privatization began, an official from DHHS sought advice from the National Quality Improvement Center on the Privatization of Child Welfare Services, announcing that Nebraska planned to implement its privatization effort within the next three months. The Center's reply was simple: Don't try to do it that quickly.

The result of ignoring that advice and trying to complete all of the planning and preparation in a very short period of time has been an extraordinary level of upheaval over the past three years. Many service providers have struggled to keep up with the changes, focusing as much or more on survival as on service effectiveness and improvement. Some in fact did not survive. The major area needing improvement in relation to network management is simply stability. That implies that the Eastern

Service Area should remain privatized under NFC and none of the rest of the State's child welfare system should be privatized for the foreseeable future. If the system is to serve children and families more effectively, i.e., if children and families are to experience the benefits of a true "reform" as opposed to either a "privatization" or a "de-privatization," both the public and the private sector have to be given time to adjust to new roles, to develop new tools and capacities and to work together in new ways. None of those things can happen while major shifts in responsibility are occurring. This is a time for consolidation and incremental improvement.

Resources and Costs

A second component of the system needing improvement has to do with the balance between resources and costs. Without conducting an extensive examination of NFC expenditures, and probably of DHHS expenditures on child welfare, as well, it is not possible to determine whether the rates paid are too low, as NFC contends, or NFC's costs are too high, as DHHS argued in response to the first draft of this report. Either way, multiple voices are warning that without a re-balancing of costs and revenues, NFC is not likely to remain a viable entity.

NFC Resources

The issue of resources needs to be considered from several perspectives. The most obvious has to do with the rates paid to NFC. When the State chose to begin the privatization effort, it also chose to increase administrative costs, because that is the inevitable consequence of dividing up responsibility for managing any system among two or more entities. In states where child welfare is operated at the county level, the additional costs of replicating the state administrative structure in every county are more than offset by county contributions to revenue. In a privatized system the same additional costs are incurred, but there is no reasonable expectation that the private sector will pick up some of the costs of what is fundamentally a public function. The implication is that the State has to cover the legitimate costs of NFC's operations, if it is to continue with privatization.

While NFC and DHHS strongly disagree with one another about whether the problem lies in the revenues or in the costs, there are two standard means of setting rates which have not been fully utilized. One method involves examining NFC's actual expenditures, defining ahead of time which expenditures are allowable and which are not, and then establishing the rates at a level which would fully compensate NFC for those costs. Current rates represent NFC's costs, without a definition of what is allowable and without a close examination of what those costs are, for some of the components of the rate, but the rate for direct services in out-of-home cases is based on a weighted average of NFC's and KVC's costs. This was probably reasonable at the time the costs were collected; it became less so when KVC was no longer a lead agency, and that was the case when the new rates began.

The second method involves modeling the rates. This is particularly relevant to the non-administrative costs, i.e., essentially the costs of case management. Because NFC is required to maintain specific caseload sizes, the most appropriate means of determining an appropriate rate would be to calculate it on the costs of a staffing pattern adequate to meet the caseload size standards. Basing it on NFC's actual expenditures when it is not meeting that standard guarantees either that NFC will run a deficit or that it will not meet the standards.

Changes in the rates may or may not require a statutory change. The statute requires that the Department pay no more than the prevailing rate or the rate at which the Department itself could deliver the service. With only one lead agency one may conclude either that that agency's costs represent the prevailing rate or that there is no prevailing rate. If the latter interpretation is made and no private concern is able to deliver the services at a cost equal to or lower than the State's cost, the statute effectively prohibits purchase of that service. For the sake of stability in the system, either the first interpretation should be used or the statute should be changed.

There are also other reasons for changing the statute. First, neither DHHS nor NFC has control over the costs. The current out-of-home rate is based on assumptions about the distribution of children among various levels of care, e.g., kinship homes, foster homes, residential facilities. Quite often, however, where children go is a decision made by judges, not by social workers, either public or private. If the judges in the Eastern Service Area are more (or less) likely to place children in residential settings than are judges elsewhere in the State, it makes little sense to assume that NFC's legitimate costs will be equal to DHHS' costs, especially since those can now only be calculated from other parts of the state.

Second, the statute does not permit DHHS to reward NFC for positive results. The State agency reports that it intends to move towards results based contracts for its purchased services during the coming year. The precise shape of that system is not yet clear, at least to anyone outside DHHS, but it will almost necessarily allow some agencies to be paid beyond their costs when their results are sufficiently positive. Not to allow that would mean that any payment variations based on results would be punitive, ultimately driving many service providers out of business. If the statute limiting payment to costs equal to those of the state applies to all purchased services, as it appears to, results based contracting will necessarily be punitive, and that is not useful.

However the cost/revenue issue is resolved, two principles should guide the construction of the NFC rates. The first is that the system should support DHHS goals. This might be done by developing in-home rates that are higher relative to in-home costs than out-of-home rates are relative to out-of-home costs. This would likely encourage more in-home cases than out-of-home cases. It could also be done by building rewards for positive outcomes into the payment structure. However it might be done, supporting DHHS' goals needs to be the key component of the rate calculation.

The second principle is that NFC must be compensated based on rates sufficient to cover its allowable and required costs. As noted, this could involve either higher rates or lower expenditures by NFC, but the history of the other lead agencies and the doubt KPMG auditors expressed about the long-term viability of NFC make this principle critical if the Eastern Service Area is not to face the possibility of another major change in the next few years. This is not, however, something that DHHS can necessarily do by itself. The Nebraska Legislature is also a key player here. As indicated at the outset of this report, previous studies have warned that privatization does not lead to lower costs immediately. This system is still in transition and transitions always imply costs beyond the normal. Those transitional costs need to be included both in the legislative appropriations and in the rates provided to NFC.

State Resources

If the result of examining NFC's allowable costs results in a decision that NFC should receive higher reimbursements, DHHS' resources should increase, as well. The typical ways for this to happen are to increase state appropriations and to increase federal reimbursement. Putting state appropriations aside, DHHS already has some efforts underway to increase federal reimbursement: trying to raise its Title IV-E penetration rate and preparing an application for a Title IV-E waiver which would provide additional flexibility as to how those funds are spent. In addition, the State has received advice from national experts on other ways to increase revenues.

In relation to privatization issues, two paths should be explored further. One is to make federal Title IV-E training funds available for training private agency workers. Currently, training of workers at both NFC and the service provider agencies, whether contracted with NFC or with DHHS, is delivered by the agencies themselves and there is no federal reimbursement available. For that funding to become available, training would have to be provided by DHHS or its contractor; under the Grants to Educational Institutions component of Title IV-E and because of its existing relationship it would make some sense to use a public university through a contract with DHHS. In essence, that would mean expanding the current contract with the University of Nebraska to include training private agency staff, and it would have the added advantage of providing consistent training to all workers, whether public or private. Just as importantly, it would reduce the costs the private agencies now incur by providing their own training.

Originally, NFC case managers were trained by the University. According to NFC, both DHHS and NFC agreed that NFC would conduct training in-house as of April 2012. NFC had expressed dissatisfaction with the CCFL training provided under DHHS's contract with the University and with what it perceived as unresponsiveness to requests for improvements. Those issues may need to be resolved if the training is to return to the University, but capturing additional IV-E training funds for the training would reduce the financial burden on both NFC and the State.

The second path is for DHHS to determine the extent to which it is claiming Title IV-E administrative costs for foster care "candidates." These are children who are still in their

homes but who are receiving services to prevent placement. From a federal perspective there are three ways to justify candidacy and the State needs only *one* for any given child to qualify:

- A case plan which clearly indicates that absent preventive services, foster care is the planned arrangement for the child;
- An eligibility determination form which has been completed to establish the child's eligibility under Title IV-E:
    - This should include evidence that the child is in serious risk of removal;
    - Evidence of AFDC eligibility in and of itself is insufficient to establish candidacy;
- Evidence of court proceedings that relate to the removal of the child from the home; this could be in the form of a petition to the court, a court order or transcript of court proceedings.

Administrative costs include caseworker expenses, whether provided directly by the public agency or through contractors. Because Nebraska has many court ordered cases where children are still in the home, both conditions one and three above should affect a lot of children and therefore a significant proportion of the costs. If the State claims administrative costs for candidates, both NFC case manager costs and DHHS case manager costs in other parts of the State, a large portion of the costs could be eligible for Title IV-E administrative claims (50 percent rate). Making sure this source is fully utilized can help bolster what is now considered the in-home rate without additional cost to the State, while also increasing the total amount of federal dollars available for child welfare services throughout the State.

State revenues can also be enhanced by reducing costs. The most important cost reduction strategy the State could undertake is simply to reduce the number of children in care where the State is incurring both caseworker *and* placement costs. As was reported repeatedly during the interviews for this project, Nebraska places proportionately more children than any other state in the country but one. Other states have found ways to keep children safe without removing them from their homes and incurring the costs implied by that action. There is no reason Nebraska cannot do the same thing, but it will require an approach that values families far more than the current system does. However much administrators, supervisors and caseworkers in both the public and private sectors believe they are delivering services in a family-centered way, the fact is that the mini-CFSR reviews show that fewer than 40 percent of the families even receive adequate visits from caseworkers. Becoming more family-centered will not be simple. The State's use of the prosecutorial model in its court procedures involving child welfare cases risks putting more emphasis on what parents did wrong than on what families need. Becoming family-centered will require an approach that views the job of casework as making families better capable of protecting their own children rather than one of replacing those families with the child welfare system.

Accountability Mechanisms

While DHHS is making a major push to enhance its outcome measurement and accountability systems, this remains an area where improvement is needed and where significant levels of duplication exist. Nearly all of DHHS' data-driven measures are either drawn directly from federal indicators or represent process more than outcome. A great deal of emphasis is placed on the frequency of processes such as Family Team Meetings and caseworker contacts, with less attention paid to their quality or their outcome. The frequency of those processes is important, but the processes are not client outcomes. More focus is needed on the extent to which positive outcomes are actually achieved, i.e., the extent to which children and families are actually better off after receiving services from the child welfare system.

Where DHHS does focus on outcomes, it has simply adopted the federal measures. As indicated earlier, however, some of these include components which are not useful for guiding casework. There are, for example, measures which penalize states for reunifying children if they have been in care more than one year and for getting adoptions finalized after the children have been in care more than two years. Measuring either NFC or DHHS service areas on those kinds of standards works against the goal of reducing the number of children in care and against achieving permanency for children. Even though DHHS must address these measures for federal purposes, for purposes of its accountability mechanisms for both service areas and for NFC it needs to examine its own goals and make its performance measures consistent with those goals.

That includes adding a measure which is not currently used by the federal government: the placement rate, defined either as the proportion of children in Nebraska who are place in foster care on a given day or as the proportion of children coming into care during a year. The current effort to reduce the number of children in care by eight percent this year is a start, but it needs to be converted into a goal statement which can be permanent and it needs to be translated into guidance to supervisors and caseworkers as to what that means for individual cases. Ideally, it would also be accompanied, at least in the privatized part of the system, by positive rewards for making progress.

DHHS' accountability structure for NFC needs to change, however, in an even more radical way and this will require statutory change. Aside from measuring NFC's achievement of the process standards and its achievement of the federal standards, DHHS exercises accountability through the Child and Family Outcome Monitors, the DHHS workers who rarely interact with the client but approve key decisions made by the case manager. This means that the case manager does not have the real decision-making authority. In effect, not only is NFC told what outcomes it should achieve; it is also told how to achieve them. While even NFC reports that initial problems with second-guessing by the CFOMs have largely been resolved, their role represents an area of overlap and duplication which is simply not necessary. Eliminating it would reduce DHHS costs.

This is not the situation in all privatized systems. In a case study[19] conducted of seven jurisdictions that have privatized child welfare, six of the seven private agencies were given the authority to make independent decisions about placements. Moreover, in some of the jurisdictions private case managers can decide, subject to court approval, to send the child home from care. If some kind of review mechanism were maintained in Nebraska, it could be performed on a sampling basis.

The major point here is that in a privatized system it is not merely the private agencies who must play a different role; the Legislature and DHHS must do so, as well. Instead of acting as super-case managers, DHHS staff need to focus on using data to measure the extent to which the privatized system is achieving DHHS' goals. Stated differently, DHHS' oversight of NFC needs to be similar to its oversight of its service areas. For that, the Legislature will need to pass a bill permitting DHHS to delegate these critical case management decisions.

Foster Homes

A major area in which the system is not functioning adequately involves the availability of foster homes. Foster home recruitment has long been privatized in Nebraska, with individual private service providers responsible for finding, training and supporting foster parents. Within each service area, each individual agency providing foster care services is responsible for recruiting its own resources. Multiple providers in both service areas reported that recruitment is extremely competitive. The agencies that can pay the most or provide the most alternative incentives (e.g., restaurant gift certificates) are able to recruit the most families. This creates a turf war and puts smaller agencies, who cannot afford to pay families as much, at a disadvantage.

While there may be some advantages to the competition for foster homes, the problem of too few foster homes, especially for teenagers and youth with behavior issues, is a statewide problem. As discussed in the chapter on residential care, it appears that the lack of foster homes for older youth and those with behavior problems may be resulting in residential facilities being utilized as emergency shelters. This is problematic from both programmatic and fiscal standpoints. According to information received by the research team DHHS has recently assigned workers to recruit and support foster parents. The agency's recognition of the issue and its proactive stance are positive signs. If those efforts do not solve the problem, however, it should look for ways in which to support the private efforts underway to address the same problem.

[19] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (2008). Child welfare Privatization Initiatives – Assessing Their Implications for the Child Welfare Field and for Federal Child Welfare Programs. *Topical Paper #3: Evolving Roles of Public and Private Agencies in Privatized Child Welfare Systems.*

Child Placements

One component of the system which is not functioning properly may not be a direct result of privatization but is common to DHHS and NFC involves selecting placements for children. Currently when NFC or SESA has a child who is in need of a placement, information on the child is sent to child placing agencies and the first agency to respond will place the child. The problems with this system are two-fold. First, the information provided is often limited and not nearly detailed enough for an agency to make an appropriate match. Second, staff from the agencies report that they do not have time to reach out to NFC or SESA for additional information because by the time they get the information, the child is placed with another agency. The lack of information and rush on the part of providers to place the child undoubtedly leads to future placement disruptions.

For emergency placements there may be few alternatives to the current system. For non-emergency placements, however, both NFC and DHHS need a system for measuring the degree of fit between the child's needs and the available homes. This should include taking account of the foster parent preferences, the composition of the family and the training and skills each set of foster parents has. Better matches will mean fewer disruptions and fewer disruptions will lead to fewer children with behavior issues.

Information Sharing

Information gathering represents an area needing improvement and an area of duplication. Throughout the interviews conducted for this study, the research team heard complaints about DHHS' tracking system, NFocus. According to these reports, the data in NFocus are not accurate and even when they are accurate, they are not timely. Moreover, service providers have no access to the data either for input or for output, although billing relies on those data, especially where the contracts are with DHHS directly.

It is not within the purview of this project to make a judgment on NFocus' quality, and that is being done by another consulting group, in any event. What does seem clear, however, is that DHHS' system is too isolated from the service delivery system, and that, if there are issues of quality with the data, at least part of those are due to NFC's perceived need to have its own system and therefore to do double data-entry. NFC has its own management information system, in part for billing purposes, and it is planning on introducing a more comprehensive system within the next few months. For both the individual service providers and NFC, entering data into that system is necessarily a higher priority than getting complete and accurate data into NFocus.

To improve the data available in NFocus, DHHS and NFC need to develop a means by which NFC can upload data into NFocus from its own system. This reduces its own efforts and the associated costs and it makes the data in the two systems consistent

with one another. Among other things, that should reduce the reconciliations needed for billing, reducing everyone's efforts.

In addition to the upload capability, which is highly feasible, each of the agencies should receive periodic, e.g., monthly, extracts from the other's system. Having access to each other's data will permit any faulty data to be recognized and corrected more easily. In addition, the complaints that many NFocus reports cannot be accessed in a timely way should disappear, because NFC would have the ability to generate its own reports from that system. Transparency in both directions should end the disputes about data, either dispelling misperceptions or providing a mechanism for correcting bad data.

ADMINISTRATIVE STANDARDS

I. Organization and Compliance
II. Network Service Providers
III. Staffing and Training
    a. Staff Qualifications
    b. Background Checks
    c. Staff Requirements
IV. Management Information
V. Reporting
VI. Quality Assurance
VII. Short and Long-term Planning

PRACTICE STANDARDS

I. Intake
II. Service Delivery
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    c. Service Coordination
    d. Court Requirements
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III. Placements and Placement Resources
IV. Outcome Measurements
V. Client Rights

Note: In the following tables,

"Network Management" refers to staff at NFC, DHHS central office and any other organization to which either of these has delegated any network management functions.
"Service Provider Management" refers to the management of the DHHS Southeast Service Area, the management of the agencies contracted with NFC and any agencies contracted with DHHS to provide services in the Southeast Service Area.
"Service Provider Staff" refers to both supervisors and caseworkers (or other direct service delivery staff) at any of the agencies contracting with NFC or contracting with DHHS to provide services to the Southeast Service Area, as well as DHHS supervisors and caseworkers in the Southeast Service Area.

ADMINISTRATIVE STANDARDS

I. Organization and Compliance

Standard	Source	Interviewees/Data Collection Activity
The contracted organization operates through a centralized entity or structure (e.g., Lead Agency) that provides for the integration and coordination of services of participating entities or community partners.	COA[20]	Document Review
The Lead Agency establishes lines of authority, accountability and supervision of personnel.	AAAHC[21]	Network Management Document Review
The Lead Agency and its network service providers (i.e., the organization) agree to unannounced compliance checks.	NFC Contract	Document Review (reports of checks)
The organization agrees to be subject to and comply with the Office of Public Counsel (Ombudsman).	NFC Contract	Document Review
The organization agrees to be subject to and comply with state law regarding the Foster Care Review Board.	NFC Contract	Interviews
The organization submits a schedule of rates for services provided under the contract.	NFC Contract	Document Review (schedule of rates)

[20] Council on Accreditation (2008). *Network Administration.* Retrieved on August 13, 2012 from http://www.coastandards.org/standards.php?navView=private&core_id=1212.
[21] Accreditation Association of Ambulatory Health Care (2012). *Accreditation Handbook for Managed Care Organizations.* Skokie, IL.

Standard	Source	Interviewees/Data Collection Activity
The organization adjusts rates only with written approval of DHHS.	NFC Contract	NFC
The organization ensures continuation of services in the event of a disaster that causes the organization and its communication lines to be non-functional.	ASO RFP	Document Review
The Lead Agency furnishes DHHS with a certificate of insurance coverage complying with the requirements.	NFC Contract	Document Review
The Lead Agency demonstrates sufficient financial resources to carry out the terms of its contract.		Document Review

II. Network Service Providers

Standard	Source	Interviewees/Data Collection Activity
The network recruits and contracts with community partners based on anticipated and identified needs of the service population, including needs related to geographic location and cultural and linguistic diversity.	COA	Network Management
The network is responsible for all network service provider actions and ensures providers do not subcontract to others unless the subcontractor is also a lead contractor with DHHS for service coordination and case management.	NFC Contract	Network Management
The Lead Agency's application process for network service providers is consistent with applicable legal requirements and includes procedures for: • making decisions to accept or reject applicants, • appealing application decisions, and • terminating the relationship.	COA	Network Management Document Review

Standard	Source	Interviewees/Data Collection Activity
The process of becoming a network service provider includes: • a written application, • verification of staff licensure or qualifications to provide services, and • an on-site review of the compliance with the organization's protocols and requirements.	COA	Network Management Service Provider Management Document Review
The application process for becoming a network service provider emphasizes the continuity of care for the clients served.	COA	Document Review
The Lead Agency establishes an organizational structure, specifying the functional relationships among the various components of the organization, including the services that will be provided by the community partners or network service providers.	AAAHC COA	Network Management Document Review
The Lead Agency provides all network service providers with the necessary information to operate effectively including a developed policies and procedures manual and uniform management protocols to ensure efficiency, high quality services and adherence to policies and procedures.	AAAHC COA	Network Management Service Provider Management Document Review
An effective communication system is set up so that the Lead Agency and its network service providers are able to communicate information including expectations of all parties and resolving conflicts. Communication will also assist in ensuring a linkage between quality assurance and improvement activities.	COA AAAHC	Network Management Service Provider Management

Standard	Source	Interviewees/Data Collection Activity
A formal grievance system is in place for the Lead Agency and its network service providers, including: • denial or termination of privileges, • decisions not to contract with providers, • organization's referral process, and • issues with claims or payments.	COA	Network Management Service Provider Management

III. Staffing and Training

Standard	Source	Interviewees/Data Collection Activity
Staff Qualifications		
Staff, including supervisors, carrying out service coordination and case management functions have a minimum of a Bachelor's Degree. This education must be verified.	NFC Contract	Network Management Service Provider Management
The organization ensures that direct service providers meet minimum education/certification requirements outlined by any evidence based or promising practice.	NFC Contract	Network Management Service Provider Management
The organization makes all attempts to hire culturally competent staff based on community demographics.	NFC Contract	Network Management Service Provider Management

Standard	Source	Interviewees/Data Collection Activity
Background Checks		
The Lead Agency and its entities complete background checks on all employees, interns and volunteers, if they may have contact with children, youth and families. Background checks consist of: • Sexual Offender Registry, • Child and Adult Abuse and Neglect Central Registry, • state repository of driving records, • references, • drug test and • internet search.	NFC Contract	Network Management Service Provider Management
The organization completes additional checks for people who have been employed or resided in Nebraska for less than five years including: • criminal history check for each state in which the individual resided or worked and • criminal background checks in the cities, counties, and states if the individual's previous state of residences does not maintain the above registries.	NFC Contract	Network Management Service Provider Management
The Lead Agency completes these checks on existing employees within 30 days of contract execution.	NFC Contract	Document Review
Training Requirements		
All staff must be appropriately trained, qualified and supervised.	AAAHC	Network Management Service Provider Management
To improve professional competence and skill, as well as the quality of performance of staff, the organization provides convenient access to reliable, up-to-date information and trainings on relevant topics.	AAAHC	Network Management Service Provider Management Document Review

Standard	Source	Interviewees/Data Collection Activity
The organization ensures all staff involved in placements or home studies are trained in MEPA requirements.	NFC Contract	Network Management Service Provider Management
The organization ensures all staff involved in placements or home studies are trained in ICWA requirements.	NFC Contract	Network Management Service Provider Management
The organization provides Service Coordinator/Case Manager training as approved by DHHS, at no additional cost to DHHS.	NFC Contract	Network Management Service Provider Management
The organization provides training in the service area on evidence based, promising practice and family driven care concepts. Families and youth are included in the planning and delivery of this training.	NFC Contract	Network Management Service Provider Management
The organization updates training materials for provider manuals as deemed necessary by DHHS.	ASO RFP	Network Management Service Provider Management

IV. Management Information

Standard	Source	Interviewees/Data Collection Activity
The organization operates in compliance with DHHS computer systems, DHHS IT policies and all applicable state and federal physical, administrative, and electronic safeguard publications.	ASO RFP NFC Contract	IT Management Document Review
The organization develops a system for managing information that collects, integrates, analyzes and reports data as necessary to meet the needs of the DHHS.	COA AAAHC	IT Management Document Review (actual reports)
The system has the ability to create backup copies of software and to restore and use those backup copies for the basic protection against system problems and data loss. This requirement refers to all application system files, data files, and database data files.	ASO RFP	IT Management Document Review

Standard	Source	Interviewees/Data Collection Activity
The organization identifies and implements a system recovery plan that ensures component failures do not disrupt services. The plan is completed, implemented, and tested prior to system implementation.	ASO RFP	IT Management Document Review
The organization complies with all applicable federal and state data retention and archival rules, regulations, and requirements for all program information, data, and correspondence and with the Financial Data Protection and Consumer Notification of Data Security Breach Act.	ASO RFP NFC Contract	Document Review
Only contractor owned and supported computers are permitted to access, process or store DHHS information or access DHHS computer systems.	NFC Contract	Document Review
All information is encrypted using DHHS approved technology.	NFC Contract	Document Review
The organization describes security safeguards, integrates the safeguards into the application and demonstrates how these safeguards address DHHS security.	ASO RFP	Document Review
A technology coordinator is appointed to serve as primary contact with DHHS on IT issues.	NFC Contract	IT Management
Internet connections must be provided to staff.	NFC Contract	IT Management
The organization ensures that remote office and home office work sites are permitted, provided they comply with the above requirements, including encryption and data security.	NFC Contract	IT Management
The organization uses a secure email system when emailing private and confidential information.	NFC Contract	IT Management

V. Reporting

Standard	Source	Interviewees/Data Collection Activity
The organization submits statements for direct services provided no later than 90 days following the end of the month in which services were provided, except in instances of payment for treatment services denied by Medicaid/Administrative Services Organization.	NFC Contract	NFC Document Review

VI. Quality Assurance

Standard	Source	Interviewees/Data Collection Activity
The organization conducts ongoing quality assurance and improvement activities in collaboration with DHHS Quality Assurance and Contract Monitoring staff.	NFC Contract	Network Management Document Review
The organization develops and implements a quality improvement program that is broad in scope to address clinical, administrative and cost-of-service performance issues, as well as client outcomes.	AAAHC	Network Management Document Review
The organization develops, implements and monitors program improvement plans based on the DHHS Quality Assurance and Contract Monitoring report results.	NFC Contract	Network Management Document Review
Formal case reviews occur quarterly.	COA	Service Provider Management Service Provider Staff Document Review
The organization identifies training needs based on case reviews and evaluations.	ASO RFP	Document Review

VII. Short and Long-term Planning

Standard	Source	Interviewees/Data Collection Activity
The organization's governing body meets at least annually and properly documents decisions and activities related to meeting contractual obligations, operation and performance.	AAAHC	Network Management
In developing and maintaining the initiative, the Lead Agency considers, as part of the annual review and annual planning: • the full range of services that are within the scope and the organization's capacity to meet those goals, • geographic access to services, including travel times to locations and proximity to public transportation, • the demographic makeup of organization service providers compared to the organization service of recipients, • access to specialty service providers, including culturally relevant providers, and • development of a plan that evaluates and identifies the type and number of service providers required to accomplish the organization's mission, goals and objectives.	COA	Network Management
The organization works with DHHS to meet provisions identified in the current Child and Family Services Review's Program Improvement Plan for Nebraska.	NFC Contract	Network Management

PRACTICE STANDARDS

I. Intake

Standard	Source	Interviewees/Data Collection Activity
The organization receives referrals through a single point of access system, which is available 24 hours a day, seven days a week.	COA NFC Contract	Network Management Service Provider Management Service Provider Staff DHHS CPS Staff (Omaha)
The organization accepts and serves all children, youth and families referred by DHHS regardless of diagnosis, court involvement, history, presenting problems, family composition or behaviors.	NFC Contract	Network Management Service Provider Management Service Provider Staff DHHS CPS Staff (Omaha)

II. Service Delivery

Standard	Source	Interviewees/Data Collection Activity
Case Management		
The organization provides service coordination and case management functions for treatment and non-treatment services for court involved and non-court involved children, youth and families.	NFC Contract	Service Provider Staff Document Review
The organization develops a sustainable reform model in which the Lead Agency is responsible for ongoing case management and service coordination functions as allowable by state statute and defined and agreed upon by both parties to be implemented.	NFC Contract	Network Management Service Provider Management
Progress of the above is monitored through an oversight committee comprised of DHHS, the Lead Agency and each of the network service providers.	NFC Contract	Network Management Service Provider Management

Standard	Source	Interviewees/Data Collection Activity
The case management process is the same for each entity of the organization and includes common criteria including case opening procedures, service delivery, re-assessment of appropriate levels of care and discharge planning.	COA	Network Management Document Review
All family members are involved in the case, when appropriate and needed, especially for children and youth in out of home care.	ASO RFP	Network Management Service Provider Staff COMPASS
The organization complies with DHHS's philosophy of using family-centered and evidenced based practices.	ASO RFP	Document Review
The organization increases the utilization of community based services to decrease residential services.	Magellan Contract[22]	Network Management Document Review NFocus
Access to Services		
The organization demonstrates a commitment to providing clients with access to provider organizations that best meet their needs and preferences, including providers who are responsive to the diverse cultural needs of clients and are able to connect clients with natural supports.	COA	Service Provider Staff
Families and children have the ability to easily move between programs, services and levels of care when necessary.	COA	Service Provider Staff NFocus
The least restrictive and most appropriate service that meets client needs and preferences is achieved through a flexible and responsive system.	COA	Service Provider Staff NFocus
The organization develops a mechanism and strategy for implementation of best, promising and evidenced based service practices.	COA	Network Management Service Provider Management Document Review

[22] State of Nebraska Service Contract Award, Contract Number 3352604. Magellan Health, 2008.

Standard	Source	Interviewees/Data Collection Activity
A complete continuum of non-treatment, non-Medicaid funded services, supports and placement resources is provided.	NFC Contract	Network Management Service Provider Management Service Provider Staff NFocus
The organization ensures appropriate and timely mental health, behavioral health and substance abuse treatment services are provided to adult family members, children and youth.	NFC Contract	Service Provider Staff
The organization follows all state and locally developed policies and protocols related to the authorization for the purchase of services.	NFC Contract	DHHS Management
The organization provides aftercare services.	NFC Contract	Service Provider Staff NFocus
The organization provides former state wards with ongoing support or access to ongoing support provided by any federal programs designed to serve this population.	NFC Contract	DHHS Management (to identify programs) Service Provider Staff NFocus
Service Coordination		
The organization provides all in-state and out-of-state transportation relating to services for children, youth and families. All DHHS policies regarding transportation must be followed.	NFC Contract	Service Provider Staff
The organization contacts DHHS to obtain consent for all treatment (medical, mental health or substance abuse).	NFC Contract	Service Provider Staff Document review
The organization coordinates all treatment and non-treatment services.	NFC Contract	Service Provider Staff
Court Requirements		
The organization complies with all court orders.	NFC Contract	Service Provider Staff

Standard	Source	Interviewees/Data Collection Activity
The organization ensures appropriate staff are able and prepared to attend court hearings and testify, if needed.	NFC Contract	Service Provider Staff
The organization ensures that all children and youth attend court, as required.	NFC Contract	Service Provider Staff
The organization follows the Professional Judgment Resolution Process in the event that the organization and DHHS disagree about recommendations to be made to the court.	NFC Contract	DHHS Eastern Service Area Management NFC Service Provider Management
Policy Requirements		
The organization complies with the MEPA, in making placements, arranging for placements, or doing home studies for foster or adoptive families.	NFC Contract	Service Provider Staff
The organization complies with the ICWA, in making placements, arranging for placements, or doing home studies for foster or adoptive families.	NFC Contract	Service Provider Staff NFocus
Reporting		
The organization provides documentation of protocol for reporting suspected abuse and neglect.	NFC Contract	DHHS Management (Service Area or Central) Service Provider Management
The organization immediately reports all critical incidents (e.g., running away) to DHHS (verbally).	NFC Contract	DHHS Service Area Management Service Provider Management
The organization provides a written report of critical incidents to DHHS within four hours.	NFC Contract	DHHS Management (Service Area or Central) Service Provider Management Document Review

III. Placements and Placement Resources

Standard	Source	Interviewees/Data Collection Activity
The organization ensures that all foster homes are licensed or approved by DHHS.	NFC Contract	DHHS Service Area Staff Service Provider Staff
The organization develops and implements a foster parent recruitment plan and report progress to DHHS quarterly.	NFC Contract	Document Review
The organization collaborates with DHHS to develop a statewide recruitment plan.	NFC Contract	DHHS Management Network Management
The organization obtains DHHS approval before placement of or use of respite care for a child/youth.	NFC Contract	DHHS Service Area Management Service Provider Staff

IV. Outcome Measurements

Standard	Source	Interviewees/Data Collection Activity
The organization develops specific strategies and targeted improvements to obtain timely permanency for children, and decrease the frequency and duration of out of home and congregate placements and increase the occurrence of children and families served in the family home.	NFC Contract	Network Management Service Provider Management NFocus
The organization reviews and revises program and financial outcomes, objectives and strategies that will fundamentally reform the child welfare/juvenile services system to more quickly achieve enhanced safety, permanency and well-being outcomes (quarterly).	NFC Contract	Network Management Service Provider Management Document Review
The organization identifies and explores outcomes, objectives and strategies for mutual efficiency, effectiveness and accountability that result in financial stability and improved service delivery on both a short and long term basis (monthly).	NFC Contract	Network Management Service Provider Management Document Review

Standard	Source	Interviewees/Data Collection Activity
The organization works towards developing a model for improved outcomes for Nebraska children and families utilizing national expertise.	NFC Contract	Network Management Service Provider Management Document Review

V. Client Rights

Standard	Source	Interviewees/Data Collection Activity
Clients are informed of their rights, treated with respect and provided appropriate privacy.	AAAHC	Document Review
Clients are provided complete information concerning their case.	AAAHC	Document Review
Clients are given the opportunity to participate in decisions involving their case.	AAAHC	Document Review
The organization maintains a clear written policy of how to lodge complaints, grievances and suggestions and provide it to all clients.	NFC Contract AAAHC	Document Review
Clients are provided with a choice of service providers for necessary services, when possible.	COA	Document Review
The organization obtains written consent of DHHS and the parent, if parental rights are intact, for use of a child's image of identifying information for posters, presentations, press releases and any other public forums.	NFC Contract	Document Review

Name	Title	Agency
Jodi Allen	Resource Development Administrator	DHHS
Mindy Alley	Financial Officer	DHHS
Mindy Anderson	IA Worker	DHHS
Trevor Baer	OJS Supervisor	DHHS
Doug Beran	Research, Planning and Evaluation Administrator	DHHS
Lindy Bryceson	Lincoln Service Area Director	DHHS
Nathan Busch	Protection and Safety Policy Chief	DHHS
Brenda Chase	IA Supervisor	DHHS
Camas Dias	DHHS Omaha Service Area Administrator	DHHS
Lexi English	CFS Specialist – Ongoing	DHHS
Janice George	IMFC Supervisor	DHHS
Sara Goscha	Special Projects Administrator for the Director	DHHS
Tony Green	ESA Administrator	DHHS
Jessica Hanner	Co-located CFOM	DHHS
Lesly Jameson	Resource Development Supervisor	DHHS
Sara Jelinek	CFS Administrator	DHHS
Chris Jones	Adoption Specialist	DHHS
Shelia Kadoi	Quality Assurance Administrator	DHHS
Meghan Koinzana	Supervisor of Ongoing Unit	DHHS
Doug Kreifels	IMFC/APS Supervisor	DHHS
Molly Krolikowski	CFS Specialist – OJS	DHHS
Vicki Maca	Deputy Director	DHHS
Ross Manhart	Resource Development Supervisor	DHHS
Pam Moriarity	IA Worker	DHHS
Tracy Morrison	Resource Development Worker	DHHS
Amanda Nawrocki	Hotline Administrator	DHHS
Linda Nelson	IMFC	DHHS

Name	Title	Agency
Terri Nutzman	Juvenile Services Administrator	DHHS
Jennifer Potterf	CPS Administrator	DHHS
Thomas Pristow	DCFS Director	DHHS
Jennifer Runge	CFS Administrator	DHHS
Kati Smit	CFS Specialist – Ongoing	DHHS
Sherri Splide	CFS Administrator	DHHS
Shannon Vanlingham	CFOM Supervisor	DHHS
Michelle Alexander	Records Coordinator	NFC
Monika Anderson	Legal Counsel	NFC
Emily Arent	Intake Specialist	NFC
Anita Bigger	Human Resources Manager	NFC
Angela Bredenkamp	PQI Director	NFC
Lynn Castrianno	Research and Analysis Manager	NFC
Stephanie Clark	Adoption/Permanency Consultant	NFC
Judy Dierkhising	Grant Development	NFC
Stacy Giebler	Accounting Director	NFC
Theresa Goley	FPS Director	NFC
Jackie Grieson	Utilization Management Supervisor	NFC
Judity Gutierrez	Cultural Liaison	NFC
Angi Heller	Court Liaison	NFC
Marianna Johnson	Network Manager	NFC
Paula Jones	Manager of Program Audit	NFC
Brenda Lee	Family Liaison	NFC
Dan Little	Human Capital Developer	NFC
Billi Lueders	Family Preservation Supervisor	NFC
Jennifer May	Aftercare Specialist	NFC
Melissa Misegadis	FPS Supervisor	NFC
Dave Newell	President and Chief Executive Officer	NFC
Clarissa Nielson	FPS	NFC
Mary Pinker	Utilization Management Supervisor	NFC
Sara Riffel	Aftercare Supervisor	NFC
James Ross	FPS	NFC
Donna Rozell	Chief Operating Officer	NFC
Jewell Sifferns	Director Foster Care and Quality	NFC
Christine White	FPS Director	NFC

Name	Title	Agency
Jennifer Richey	FPS	NFC
Laurel Hall	FPS	NFC
Matthew Allen	President	Community Based Services, LLC
Jodie Austin	Vice President of Support Services	KVC
Karen Authier	Executive Director	NE Children's Home Society
Lisa Batenhorst	Administrator of Foster Care, In-home Services and Parenting Program	Boys Town
Stephen Bauer	Program Director	Nebraska Family Support Network
Mikayla Beiermann	Foster Care Specialist	KVC
Lisa Blunt	Chief Operating Officer	Child Saving Institute
Luke Cerveny	Director Residential Services	Child Saving Institute
Susan Feyan	Clinical Director; NFC Board Mbr	OMNI Behavioral Health
Jeff Fusselman	Director of Finance	Boys Town
Jodi Gasper	Administrator of Contracts	Boys Town
Carrie Gobel	Therapist	Lutheran Family Services
Peg Harriott	President and CEO	Child Saving Institute
Chris Hess-Tevis	Chief Operating Officer	OMNI Behavioral Health
Dan Jackson	Executive Director	Nebraska Family Support Network
Hon. Douglas F. Johnson	Judge	Douglas County Juvenile Court
Nick Juliano	Director of Business Development	Boys Town
Morgan Kelly	Treasurer and General Counsel	OMNI Behavioral Health
Tasha Kelly	In-home staff	Child Saving Institute
Sarah Koley	In-home Family Consultant	Boys Town
Ramey McNamara	Shelter Counselor	Child Saving Institute
Michele Moline	Foster Care Program Director	Nebraska Children's Home Society
Teffany Murphy	Program Director, Children's Emergency Shelter and Tracking	Heartland Family Services
Ann O'Connor	Vice President/NFC Board Mbr	Heartland Family Services
Debbie Ordom	Administrator of Group Homes	Boys Town

Name	Title	Agency
Kendal Osbahr	Director of Foster Care Services	OMNI Behavioral Health
Javier Ovalle	Foster Care Specialist	KVC
Diana Owens (and staff)	President	Owens and Associates, Inc.
Bob Pick	Vice President Chairman of NFC Board	Boys Town
Judy Rasmussen	Executive Vice President Finance and Administration, Chief Financial Officer	Boys Town
Lori Reed	Foster Care Specialist	KVC
Amy Richardson	Vice President of Programs	Lutheran Family Services
Megan Riebe	Director of Outpatient Services	OMNI Behavioral Health
Brooke Rische	Adoption Staff	Child Saving Institute
Karla Robles	In Home Service Support	Child Saving Institute
Melissa Schaber	Foster Family Services Consultant	Boys Town
Mary Ann Slack	Shelter Coordinator	Heartland Family Services
Katie Stephenson-McLeese	Chief Operating Officer	Cedars
Lovely Taylor	Foster Care Specialist	KVC
Lana Temple-Plotz	Foster Care Family Services	Boys Town
Stephanie Tornquist	Intensive Family Preservation Worker	OMNI Behavioral Health
Jessyca Vandercoy	Senior Director of Permanency and Well-being	Lutheran Family Services
Lana Verbrigghe	Adoption Supervisor	Child Saving Institute
Andrea Von Rein	Lead Resource Development Caseworker	Nebraska Children's Home Society
Amie Wergin	Foster Care Specialist	OMNI Behavioral Health