THE STEPHEN GROUP

NEBRASKA

DEPT. OF HEALTH AND HUMAN SERVICES

Child Welfare Transformation

RFP Number 113287 O3

Technical Proposal

Date: September 27, 2022

PREPARED BY:

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THE STEPHEN GROUP

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DHHS
301 Centennial Mall S 5th Floor
Lincoln, NE 68508

September 26, 2022

Re: Child Welfare Transformation
RFP Number 113287 O3

The Stephen Group, LLC (TSG) is pleased to offer this proposal in response to the Nebraska Department of Health and Human Services' (DHHS) RFP seeking a partner to lead a workgroup in the development of new practice and finance models for Nebraska's child welfare system.

TSG is uniquely positioned to partner with DHHS to lead this workgroup. Within the past five years, TSG has partnered with DHHS on three targeted child welfare assessment projects that will inform this comprehensive, statewide child welfare transformation. This work assessing structured decision making, treatment family care and foster care rates, and provider management in the Eastern Service Area provides TSG extensive knowledge of Nebraska's current system and familiarity with nearly all the stakeholders who will contribute to this project.

And beyond Nebraska, TSG's team possesses unparalleled experience assessing child welfare systems and operations, designing effective strategies for child welfare transformation, engaging diverse stakeholders to build consensus for change, and assisting states in achieving meaningful improvement in outcomes. TSG's consultants have provided child welfare assessment and/or implementation services in Texas, Florida, Arkansas, and Mississippi. Several of them also have led transformational change initiatives as secretaries, commissioners, or directors of state child welfare systems. And TSG has worked closely with the Annie E. Casey Foundation on its work to identify, develop, and advance cutting edge prevention strategies.

TSG also recognizes that child welfare systems do operate in isolation, that child well-being depends upon a number of state systems, and that effective transformational change in child welfare must leverage and align with these other systems. Accordingly, the team of expert TSG Senior Consultants assembled for this project also brings an incredible depth of expertise across the health and human services sector, and these individuals have designed and led innovative change initiatives in Medicaid, economic assistance, behavioral health, and judicial systems that improve outcomes for children and families involved or at risk of involvement with child welfare systems. TSG will bring this same full system of care approach to this project.

TSG looks forward to partnering with DHHS once again.

Sincerely,

John Stephen
Managing Partner
The Stephen Group, LLC
814 Elm Street, Suite 309
Manchester, NH 03101
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1. Corporate Overview

1.a. Contractor Identification and Information

The Stephen Group, LLC (TSG) is a New Hampshire Limited Liability Corporation formed in 2011. The firm's principal office is 814 Elm Street Suite 309 Manchester, New Hampshire 03101. TSG has not changed its name or form of organization.

1.b. Financial Statements

TSG is a privately held company solely owned by Founder and Managing Partner John Stephen, a former Secretary of Health and Human Services for the State of New Hampshire. Since 2011, TSG has provided expert consulting services for state and local governments, as well as private for-profit and non-profit corporations, that range from cutting edge and reform-oriented child welfare and healthcare policy to technical assistance across state social services programs.

The TSG team of 17 Senior Consultants—including multiple former directors, secretaries, and commissioners of state child welfare, behavioral health, economic assistance, and Medicaid programs—uses its vast experience and knowledge at the highest levels of state government and the private sector to assist states in process improvement, program development, management, informatics, strategic planning, management training, and health and social services reform. Our core competencies involve child welfare practice, policy, and operational re-design, government efficiency and reform, project management, financial and analytical services, other health and human services reform, organizational redesign and regulatory reform, and offering innovative private sector solutions to government.

Our partners and clients include entities ranging from multi-billion-dollar corporations and large states, such as Texas, down to smaller non-profits. We focus on and bring expertise in all aspects of health and human services, delivering multi-disciplinary solutions that leverage our additional expertise in information technology, workforce development, and legal/judicial systems.

TSG uses the accounting firm Baker Newman and Noyes, which is located at 650 Elm Street Manchester, New Hampshire 03101 for its financial accounting and reporting. Senior Partner and TSG Accountant Tom Musgrave stands ready to attest to the financial stability and strength of TSG and can be reached at (603) 626-2200 or TMusgrave@bnncpa.com.

TSG has used TD Bank for its banking services since it incorporated in 2011. Hennessy Aquino, Assistant Manager can be contacted at 603-695-3481 or hennessy.aquino@td.com as TSG's banking reference.

1.c. Change of Ownership

TSG does not anticipate any change in ownership or control of the company during the twelve (12) months following the proposal date.

1.d. Office Location

TSG's primary place of business and sole office location is 814 Elm Street Suite 309 Manchester, New Hampshire 03101. If awarded a contract based on this proposal, TSG intends to deliver services through a combination of onsite activities with Department of Health and Human Services (DHHS) and remote work.

1.e. Relationships with the State

TSG is set apart from other prospective vendors because it has successfully completed three prior targeted child welfare assessment projects for DHHS within the past five years. These projects equip TSG with a deep working knowledge of Nebraska's child welfare system as well

as familiarity with key stakeholder groups, many of whom it has partnered with in past projects. This experience uniquely positions TSG to move forward quickly and effectively with this project.

1.e.1. Treatment Family Care and Foster Care Rate Analysis

Between June of 2020 and July of 2021, TSG evaluated three recommendations from the Foster Care Reimbursement Rate Committee (FCRRC) regarding adding a fourth level of reimbursement for high needs children, adopting the Nebraska Caregiver Responsibility tool, and adopting the Treatment Family Care service definition and rate setting structure. In evaluating these recommendations, TSG interviewed numerous DHHS staff, providers, FCRRC members, and other stakeholders. TSG also conducted a detailed literature review, a state-by-state best practice survey, and a Nebraska data analysis, which all culminated in a report to DHHS detailing findings and actionable recommendations. A copy of that report is provided as Appendix A to this proposal. TSG also reviewed and analyzed Medicaid data for high needs children, particularly related to medical, behavioral health, and pharmacy claims. This analysis provided insight into important Medicaid utilization, access, and network capacity issues for DHHS.

TSG's prior Treatment Family Care and Foster Care Rate Analysis enhances its ability to lead the workgroup designing Nebraska's new practice and finance models in several ways. For instance, TSG's rate assessment included a deep-dive into Nebraska's Title IV-E claiming and revenue optimization for child placement, which can serve as the foundation for a full assessment of Nebraska's child welfare financing model. Similarly, TSG's review of Medicaid, behavioral health, and pharmacy claims data could support the development of a full system of care approach in Nebraska's child welfare transformation.

A copy of the report for this project is included as Appendix A to this proposal. TSG's DHHS contract manager for this project was Nanette Simmons.

1.e.2. Eastern Services Area Review

Between October of 2018 and September of 2019, TSG performed an assessment of DHHS' provider contracts and management in the Eastern Service Area (ESA) and evaluated the existing service delivery system in the ESA. Here, TSG utilized a comprehensive approach including:

- Review of prior audits, studies, and reports on the Nebraska child welfare system and the outsourced services in the ESA.
- Review of the existing contracts, extensions, and amendments.
- Review of other state best practices in child welfare contracting.
- Review of financial, operational, and performance data from DHHS and PromiseShip.
- Interviews with DHHS and PromiseShip leaders and staff.
- Focus groups, process mapping, and analysis of the case transition process with DHHS and PromiseShip administrative, supervisory, and frontline caseworker staff from Douglas and Sarpy Counties.
- Interviews with key stakeholders including the State's Inspector General, judges, county attorneys, state and county CASA officials, guardians ad litem, the Foster Care Review Board, the Nebraska Family Support Network, and Project Harmony.
- Meetings with child welfare providers including facilitating a group call with providers operating in state-run and outsourced regions and individual provider interviews with the Nebraska Children's Home Society, Capstone BH Services, and Cedars.

After completing the review, TSG produced a comprehensive report for DCFS that included detailed findings and recommendations. Some of the recommendations included:

- Enhancements to the contract to include performance-based elements including financial incentives and remedies that drive progress.
- A new process of contract oversight and management.
- A new form of collaboration between DHHS and the next ESA contractor.
- The engagement of other DHHS divisions in the ESA model to ensure that the state and contractor maximizes existing resources.
- A vision for a different community engagement model.

A copy of the final report for this project is included as Appendix B to this proposal.

As with the Treatment Foster Care project, this experience also positions TSG well to lead the workgroup designing Nebraska's new practice and finance models. In its ESA assessment, TSG engaged and conducted structured interviews with nearly every stakeholder group DHHS has identified as a potential partner in this RFP. This project also included another deep dive into Nebraska's claiming and financial model supporting the contracted services as will be necessary to consider in designing the new finance model and how it can support desired practice. And as part of this project, TSG also designed DHHS current contract management tools and processes, which will be necessary to implement desired changes in practice for contracted services.

TSG's DHHS contract manager for this project was Lori Harder.

1.e.3. Structured Decision-Making (SDM) Assessment

In September of 2018, TSG performed a targeted assessment of SDM-related concerns and impact as well as field experience with the SDM instruments. As part of this project, TSG also examined related topics including the needs of children and youth removed from their homes, specifically those that need behavioral health or substance use disorder services. TSG assessed access to these services through linkages with the Division of Developmental Disabilities, Division of Medicaid, and MCOs serving child welfare-eligible children and youth through Nebraska's Heritage Health Medicaid managed care plans. Finally, TSG reviewed whether the SDM tools were sufficient to assess the risk of suicide as well as potential improvements to the process used by the hotline related to reports received pursuant to the Comprehensive Addiction and Recovery Act (CARA).

A copy of the final report for this project is provided as Appendix C.

This assessment provides TSG detailed knowledge of DHHS' intake and assessment processes and tools. It also provided TSG an opportunity to engage DHHS frontline staff, which will be a key task in gathering the information necessary to design a new practice model.

TSG's DHHS contract manager for this project was Lori Harder.

1.f. Bidder's Employee Relations to State

TSG does not have any employee relations to the State of Nebraska.

1.g. Contract Performance

TSG has never had any contract terminated for default, nor has it had any contract terminated for convenience, non-performance, non-allocation of funds, or for any other reason. Each of TSG's numerous contracts with public and private clients has been completed on time and within budget.

1.h. Summary of Bidder's Corporate Experience

No other vendor can match the breadth, scope, and relevance of experience that the TSG team brings to the table. This team has a rich history of both consulting and management for state

projects having successfully delivered child welfare system or child-welfare related assessment and transformation services in Florida, Texas, Nebraska, Arkansas, and Mississippi. Only TSG senior consultants have conducted comprehensive assessments for the two largest state-administered child welfare agencies in the country: Texas (2014 & 2017) and Florida (2011). And only TSG has led the Annie E. Casey Foundation's work to develop its Child and Family Well-being Strategy Group's mission identifying and expanding emerging best practices in prevention, integration of child and family serving systems, and Family First Prevention Services Act (FFPSA) implementation.

TSG maintains a dedicated government and business intelligence consulting team with years of experience working in and out of government, which provides comprehensive analytic services and strategic direction to public sector clients. TSG's team includes subject matter experts who have deep experience offering state government solutions in the key aspects of child welfare, Medicaid including specialty child welfare managed care programs, economic assistance, and behavioral health programs. We help state governments address a number of complex issues and make rigorous fact-based decisions. Then, where appropriate, we help them take action to achieve superior outcomes.

TSG never has had a contracted terminated early for any reason, always has delivered on time and within budget, and—most importantly—consistently produces actionable and effective results that improve child and family well-being.

1.h.1. Staff Experience

TSG's past projects have included tasks similar to every aspect of the services sought by this RFP. The summary matrix (Table 1), provided below, outlines that alignment:

Table 1: Summary Matrix	Nebraska Treatment Family Care and Rate Analysis	Nebraska ESA Assessment	Nebraska SDM Assessment	Texas DFPS Transformation	FL DCF Transformation	Ark. Health Care Leg. Task Force	Mississippi CPS Hotline Assess	Annie E Casey Foundation
Operations Improvement	◆	◆	◆	◆	◆	◆	◆	◆
Business Process Improvement	◆	◆	◆	◆	◆	◆	◆	◆
Best Practices Research	◆	◆	◆	◆	◆	◆	◆	◆
Policy Review and Analysis	◆	◆	◆	◆	◆	◆	◆	
Stakeholder Engagement		◆		◆	◆	◆		
Federal Funding Analysis/FFPSA		◆		◆		◆	◆	
Organizational Assessment				◆	◆	◆	◆	◆
Workflow Analysis		◆	◆	◆	◆		◆	◆
Technology Assessment		◆		◆	◆	◆	◆	◆
Child Welfare Operations Assessment		◆		◆	◆		◆	◆
Protective Investigations			◆	◆	◆		◆	
Workforce Development				◆	◆			
Public-Private Partnerships						◆		◆

Table 1: Summary Matrix	Nebraska Treatment Family Care and Rate Analysis	Nebraska ESA Assessment	Nebraska SDM Assessment	Texas DFPS Transformation	FL DCF Transformation	Ark. Health Care Leg. Task Force	Mississippi CPS Hotline Assess	Annie E Casey Foundation
Performance Based Contracting		◆		◆	◆	◆		
Training		◆	◆	◆	◆		◆	
Title IV-E Claiming	◆			◆				
Finance		◆		◆	◆	◆		
Foster Care Rate Analysis	◆							
Inter-Agency Collaboration		◆		◆	◆			
Theory of Change Development		◆		◆	◆			

Three of these projects exemplify the breadth and depth of TSG's work designing and leading transformational change in child welfare systems.

1.h.2. Child Welfare Transformational Change Project Experience

Narrative Description 1: Operational Assessment of the Texas Department of Family and Protective Services (DFPS) Child Protective Services (CPS)

Between February and July of 2014, TSG performed an operational assessment of the Texas Department of Family and Protective Services (DFPS) Child Protective Services (CPS) program. During the assessment task of the initial phase of the project, TSG visited each of the state's 12 regions, documented major workflow processes using six sigma business process mapping methodology, conducted a statewide survey and regional focus groups, reviewed data, and met with key internal and external stakeholders. We analyzed personnel and hiring practices, the use of technology in decision making, and a host of practices pursuant to the Texas CPS Practice Model.

Child Welfare Brown Paper Process Mapping Session – Texas CPS

Based on this assessment, TSG identified over 160 recommendations for improvement across all areas of program operations including: recruitment and hiring, training, case safety decision making, policy development, organizational changes, continuous quality improvement and data-driven management, and communications. The TSG recommendations formed the basis for the 2014 CPS Transformation Project that ensued.

Following completion of the assessment, DFPS launched the CPS Transformation initiative to improve safety, permanency, and well-being outcomes for children and families served by CPS. DFPS then extended the contract with TSG for technical consulting assistance during the next

year and made successive amendments to the contract to extend the time periods for such assistance as CPS rolled out to implementation almost all the TSG recommendations.

From July 2014 through December 2016, TSG assisted DFPS in implementing the Transformation Plan and numerous change related initiatives, including providing technical assistance and subject-matter expertise to teams of DFPS/CPS staff (known as Transformation Teams) and project management support, as well as assistance in drafting RFPs and designing pilot programs.

Specifically, TSG provided leadership and support to the Transformation Teams as they defined solutions for statewide implementation, with focus on recruitment and hiring, training, implementation of new structured decision-making tools and the practice model, and a shift to performance-based contracting in residential foster care. TSG also provided leadership to two teams of frontline staff who identified process and practice improvements to increase the speed of service provision (such as in kinship families), improve the case transfer process between stages of service, and decrease siloing of staff. Major accomplishments include:

- Implementation of national best practice structured decision-making safety and risk assessment tools for investigators.
- Redesign of the training model for new caseworkers and implementation of a new CPS Professional Development Program statewide.
- Design of a performance-based demonstration project for residential foster care providers including development of performance measures and a data-driven methodology to identify high-risk case.
- Implementation of the process and practice changes identified by frontline staff in 11 out of 12 regions (note: CPS state office staff supported one region). TSG provided customized support to CPS regional directors including assistance with project management, change management, communication, and data analysis/evaluation.

TSG provided ongoing project management support during Transformation, including establishing an alignment committee in the initial stage of transformation to keep the Transformation Teams organized and informed about all ongoing efforts, tracking progress of completed milestones, identifying issues and risks for escalation, providing weekly reports to client leadership, and developing communications materials related to Transformation for internal and external use.

In addition to these roles, DFPS also requested that TSG perform ad hoc assessments of high priority areas including organizational and staffing issues, how the child welfare system meets the needs of high needs foster children, and service provision in the family based safety services stage of service.

"The Stephen Group reviewed CPS exit interviews from an entire year as part of an overall agency review. That report was remarkably insightful"[1]

A summary of this project is provided in Table 2 below.

[1] http://www.mysanantonio.com/opinion/editorials/article/Let-public-see-CPS-exit-interviews-5976244.php

Table 2: Operational Assessment of the Texas Department of Family and Protective Services (DFPS) Child Protective Services (CPS)	
Time Period	February 2014-December 2016
Scheduled/Actual Completion Dates	The original contract term was for a one-year period from 2/1/14 to 1/31/15 and allowed for an initial payment for completion of Phase one – the assessment and delivery of recommendations and an improvement plan. DFPS reserved the right to continue the contract at a negotiated amount for implementation support subsequent to the acceptance and delivery of the assessment, recommendations and improvement plan. Upon review of the recommendations and improvement plan, DFPS amended the original contract to add additional funds so TSG could act as its consultant in providing the technical and consulting services it needed to implement the TSG recommendations and plan. There were a series of amendments up to December 2016 when TSG completed its assignment under the original contract. See above – all assignments and deliverables for every contract and amendment were delivered on time and on agreed budget.
Responsibilities	End-to-end assessment of statewide child protection services, recommendations for improvement, development of improvement plan, and assistance with implementation.
Client	Texas Department of Family and Protective Services (DFPS) Child Protective Services (CPS)
Client Contact Information	Brock Boudreau, Deputy Commissioner Department of Family and Protective Services brock.boudreau@dfps.state.tx.us 830-387-1138
Role	Primary Contractor

More than any other project, TSG's work in Texas mirrors the deliverables requested under this RFP. In Texas, our team assessed all aspects of the child welfare system of care, led teams of state staff and leaders as we would do workgroup here, engaged diverse stakeholders from across the state, and developed new practice and training models for the State.

Narrative Description 2: Arkansas Legislative Health Care Task Force

TSG was chosen to provide members of the Arkansas General Assembly and The Arkansas Health Care Reform Task Force detailed and accurate information concerning the current state of healthcare programs in Arkansas, as well as recommendations for alternatives to the current programs and options for modernizing Medicaid programs serving the foster care, indigent, aged, and disabled populations. TSG's findings in Arkansas were nationally recognized by the Kaiser Family Foundation and were adopted by the Arkansas Governor and Department of Human Services. These efforts were important in securing a Section 1115 Medicaid Waiver, and also led to the passage of legislation implementing many of the recommendations, including an estimated $800 million in savings over a 5-year period. The project had been one of deep analytical analysis and program evaluation, including a comprehensive review of high utilizers, including foster care children, and the development of an improvement plan regarding future state related to contract consolidation, administrative efficiencies, cost analysis and state and federal match allocation, department re-organization, best practices in children's health, long-term care, developmental disabilities, and behavioral health as well as an examination of the roles of other agencies in the

state that impact the patient populations, which have all led to the recent Department of Human Services and Medicaid transformation plan.

"People say we ought to run government more like a business," said [Sen. James] Hendren, who also is president of a plastics company. "Well, when you have a tough decision to make in business on a subject you don't know, you hire the best analyst you can to look at all the facts. That's what we did."[2]

A summary of this project is provided in Table 3 below.

Table 3: Arkansas Legislative Health Care Task Force	
Time Period	May 2015-December 2016
Scheduled/Actual Completion Dates	The project was completed within the original prescribed timeline. Monthly status reports were provided to the Legislative committee were developed on time each month. The preliminary and final reports on findings were delivered on time per the contract terms. The final recommendation report also was delivered on time as required by the contract.
Responsibilities	Assessment and recommendation related to state healthcare services and Medicaid programs, including focus on services affecting children in foster care.
Client	Arkansas General Assembly: The Arkansas Health Care Reform Task Force
Client Contact Information	Marty Garrity, Director, Bureau of Legislative Research Office garritym@blr.arkansas.gov 501-537-9114
Role	Primary

As with TSG's work in Arkansas, understanding Medicaid utilization by foster children is key to developing a comprehensive child welfare system of care and building the best financing model for Nebraska's child welfare system.

Narrative Description 3: Annie E. Casey Foundation

TSG has provided consulting services for the Annie E. Casey Foundation Center for Systems Innovation (CSI) to provide recommendations for a new focus on efforts to assist state systems and communities with child welfare and juvenile justice reform, including focusing on creating assets for youth advancement and independence, as well as ways to strengthen focus on cultural diversity in child welfare and juvenile justice operations. In this consulting role, TSG has assisted CSI leadership with the creation of a new infrastructure integrating its child welfare work into one cross-functional team — the Family Well-Being Strategy Group (FWSG). The work of FWSG is focused on family well-being along three prongs: Child welfare system reform; Older youth strategies, including the Jim Casey Youth Opportunities Initiative; and Prevention to address intersectional issues across the spectrum of child welfare. TSG work on this project has included project management with ongoing communication including bi-weekly status reports; engagement of staff through meetings, focus groups, and interviews; interim and final reports; presentations to project leadership, foundation leadership, and foundation staff; a roadmap for implementation; and ongoing implementation support. TSG also has assisted with its work to assess state FFPSA implementation activities and provided an intensive look into innovative ways states are

[2] http://www.arkansasonline.com/news/2016/apr/17/health-plan-opponents-won-t-budge-they-/?f=news-arkansas-nwa

leveraging Medicaid-funded behavioral health services to prevent family separation and involvement with child welfare and juvenile justice systems.

A summary of this project is provided in Table 4 below.

Table 4: Annie E. Casey Foundation	
Time Period	2018-Present
Scheduled/Actual Completion Dates	All tasks have been completed in time and budget as requested by the Foundation. The Foundation has continued to assign new tasks to TSG.
Responsibilities	Comprehensive consulting services supporting the Foundation's internal changes and support for state child and family serving systems.
Client	The Annie E. Casey Foundation
Client Contact Information	Sandra Gasca-Gonzalez, Vice President, Center for Systems Innovation sgasca-gonzalez@aecf.org (202) 815-6650
Role	Primary

TSG's work with the Annie E. Casey Foundation places it at the forefront of innovation in prevention strategies and FFPSA implementation, both of which should inform Nebraska's new practice and finance models.

1.h.3. Additional Project Experience

2017 Texas Department of Family and Protective Services (DFPS) Comprehensive Professional Services to Child Protective Services (CPS) Program

In 2017, Texas DFPS sought additional services arising out of the prior TSG CPS Operational Assessment and the implementation of The Sunset Advisory Commission's recommendations, which DFPS branded as the "CPS Transformation." TSG was selected as the vendor for this component of the Transformation as well and provided the following services:

- Briefing and training for DFPS staff (including on-boarding new staff), the Office of the Governor, legislative staff, and other necessary stakeholders on the assessment, findings, and recommendations previously generated by TSG for DFPS.
- Continued support for implementation of DFPS programs, projects, and initiatives resulting from TSG's assessment.
- Assistance to DFPS executive staff and other DFPS personnel in preparing for and engaging in interactions with individuals external to DFPS including, but not limited to, the Office of the Governor, legislators, and agency stakeholders.

Florida Department of Children and Families: Organizational Assessment

In 2011, TSG Managing Director, John Stephen and Senior Consultant, John Cooper were instrumental in completing another end-to-end child welfare assessment and transformation project with the Florida Department of Children and Families (DCF). There, Mr. Stephen and Mr. Cooper developed the State's future strategic vision for child welfare services. Support was provided to the DCF Program Management Office that oversaw the development of a $200 million multi-year transformation of Florida CPS. In this role, Mr. Stephen and Mr. Cooper defined the

strategic objectives of the program, facilitated the work of 10 client teams and two contractor organizations, and developed the business case for the Governor and Florida Legislature to approve the implementation of a new decision model, a new call center, and staff reorganization statewide. They also ran or provided substantial leadership for three statewide client transformation teams, including over 75 client personnel. A key portion of the project was setting up the foundation for change management. To that end, Mr. Stephen and Mr. Cooper mobilized a series of focus groups to engage a broad range of agency personnel in designing and planning the solutions, worked with the Agency in planning outreach efforts to courts and other stakeholders that were appointed to a statewide Transformation Advisory Committee, and assisted the Secretary in providing reports and routine updates to the statewide Advisory Committee on the statewide Child Welfare Transformation efforts.

The transformation project served to improve the technology, human services, and training in the Florida child welfare system, and ultimately produced a business case for $100 million of technology improvements to support the transformation as well as the maintenance and operations to support the state's SACWIS system.

Mississippi CPS Hotline Assessment

In June of 2018, TSG completed a review and assessment of the Mississippi Child Protection Services (MDCPS) child abuse hotline and provided recommendations to MDCPS to strengthen controls and operations. TSG also provided training to MDCPS staff on to prepare for FFPSA implementation activities**.**

1.i. Summary of Bidder's Proposed Personnel/Management Approach

TSG has convened an expert team of child welfare and business process professionals who have the skills and experience necessary to deliver the workgroup leadership, assessment, recommendations, and change implementation DHHS needs to improve the well-being of Nebraska children and families. TSG's consultants have more than a century's worth of combined experience conducting similar assessments for state child welfare agencies, leading state child welfare and human services agencies through major transformation, and providing services in business process improvement, process improvement implementation planning, and project improvement implementation.

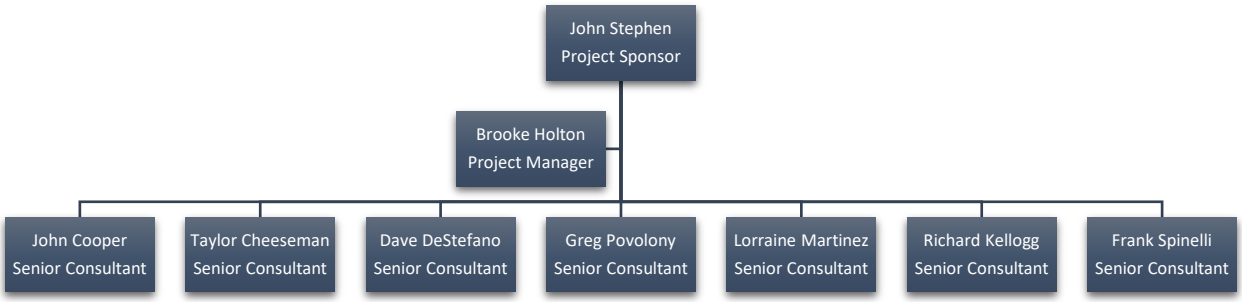
TSG's team for this project will consist of a Project Sponsor, Project Manager, and a seven Senior Consultants with diverse expertise related to various project components. The Project Sponsor, TSG Founder and Managing Partner John Stephen, will be responsible for the overall successful delivery of services and ensuring TSG meets DHHS expectation for this project. The Project Manager, Brooke Holton, will be responsible for coordinating work among the TSG team, ensuring tasks and deliverables are completed on time, and maintaining communications with the DHHS throughout the project. And the seven Senior Consultants will provide the on-the-ground and remote assessment and recommendations in partnership with the DHHS workgroup.

Table 5: Project Personnel Roles identifies each member of the team's roles and responsibilities.

Project Personnel Roles	
John Stephen, Project Sponsor	John will maintain overall responsibility for the project's success and ensure that DHHS expectations are met. John directly oversees the work of all TSG Senior Consultants.
Brooke Holton, Project Manager	Brooke will coordinate work among the TSG team, ensure tasks and deliverables are completed on time, and maintain communications with the DHHS throughout the project.

Project Personnel Roles	
Taylor Cheeseman, Senior Consultant	Taylor will serve as the lead consultant for the review of DHHS' policy and practice, engagement with stakeholders, and the alignment of DHHS' practice with legal/judicial systems. Taylor also will provide support across all aspects of the project.
John Cooper, Senior Consultant	John will serve as the lead consultant for review and recommendations related to DHHS' policy and practice review that involve child welfare field practice. John also will provide support related to aspects of the project involving prevention, quality improvement and provider management.
Dave DeStefano, Senior Consultant	Dave will serve as the lead consultant for review and recommendations related to DHHS' preventative and CPS in-home services, areas of accountability as well the development of best practice claiming and finance models. Dave also will provide support to aspects of the project dealing with field practice, technology, and data.
Greg Povolny, Senior Consultant	Greg will serve as the lead consultant for review and recommendations related to DHHS' use of technology and data.
Lorraine Martinez, Senior Consultant	Lorraine will serve as the lead consultant for system of care alignment with MCO services and public health programs. Lorraine also will support TSG's reviews of DHHS' policy and practice.
Richard Kellogg, Senior Consultant	Richard will serve as co-lead for aspects of the project dealing with alignment with Medicaid funded services and behavioral health programs. Richard also will provide support TSG's reviews of DHHS' policy, practice, and finance.
Frank Spinelli, Senior Consultant	Frank will serve as co-lead for aspect of the project dealing with alignment with Medicaid funded services. Frank also will support TSG's reviews of DHHS' finance model.

Figure 1 below provides the organizational structure TSG will utilize for this project:



1.i.1. Project Personnel Resumes and References

John Stephen, JD

Education: JD, Detroit College of Law, Michigan State University; BA, Whittemore School of Business and Economics, University of New Hampshire

Experience and Employment History: John Stephen is the founder and managing partner of The Stephen Group, a government consulting firm, focusing on assisting state agencies and non-

profits to bring efficiency and quality to a range of health and human service areas, including child welfare, juvenile justice, Medicaid, behavioral health, developmental disability, and long-term care services. In addition to his experience consulting with government agencies and non-profits, John has the benefit of heading two large state agencies through a period of major change.

John is a former Commissioner of Health and Human Services in New Hampshire from 2003 to 2007. In that capacity, John led the state Department of Health and Human Services through a major re-organization effort that combined the divisions of behavioral health, long term care, and developmental disabilities into a single integrated Division of Community Based Care Services, as well as legal, HR, and other support functions. John also developed and implemented a nationally recognized healthcare reform program that focused Medicaid on prevention, wellness, and rebalancing long-term care. John initiated disease management and care coordination programs that transitioned New Hampshire Medicaid away from treating the sick to keeping people healthy. Through John's efforts, Medicaid long term care home and community placements increased 23%, replacing more expensive nursing home placements, which dropped 11%. Moreover, John also integrated many services and programs for child welfare and juvenile justice and during each of the four years John was Commissioner, New Hampshire ranked first nationally in the Kids Count survey. During that same period, the enrollment of low income, uninsured children into the State's Medicaid and CHIP program increased by 7500. John also oversaw the state's welfare program, Special Nutritional Assistance Program (SNAP) and Temporary Aid to Needy Families (TANF) program.

As a consultant for TSG, John has been involved in a number of large-scale successful state and child welfare system improvement projects.

In 2018, John was part of a TSG team that conducted an assessment for Nebraska Department of Health and Human Services, Division of Children and Families (DCF), use of the National Council on Crime and Delinquency's Structured Decision Making (SDM) model, and to recommend improvement strategies, including linkages with the Division of Developmental Disabilities, Division of Medicaid and Managed Care Organizations serving child welfare-eligible children and youth in Nebraska. The TSG assessment identified key immediate issues, barriers, and opportunities for improvement.

John also was part of the TSG Nebraska team that conducted a comprehensive assessment of the Eastern Service Area in Nebraska. The study evaluated the existing service delivery system and recommended a future state model. During that project, John conducted extensive meetings with Nebraska DHHS staff, providers, stakeholders, courts, prosecutors, and families in identifying the current state and strategies for improvement should the state continue to outsource case management and out-of-home services. John also assisted the Division in drafting a new contract monitoring tool that will be used in the future to ensure vendor accountability. TSG's comprehensive report was delivered to the state in May of 2019, on time and on budget, and has been used in developing the new Eastern Service Area Contract Management and Oversight Plan.

From 2014 – 2017, John led a TSG team that first conducted an end-to-end assessment of the Department of Families and Protective Services (DFPS) Child Protective Services (CPS) organization, process, and technology in the State of Texas. This assessment concentrated on all aspects of child welfare, including protective services, family based services and foster care. John and his team developed a comprehensive analysis of internal operations, organizational design and continuous quality improvement. John also helped develop recommendations and presented findings to leadership and to the Texas Legislature. After the initial assessment report and recommendations were received, DFPS asked John and the TSG team to assist with implementation of the TSG recommendations during the phase referred to by DFPS as the Child

Protective Services Transformation. During this phase, John and his staff led regional teams to facilitate over 20 significant initiatives to improve field operations, briefings and trainings for DFPS and CPS leadership, and technical assistance with pilot initiatives geared towards improved performance in residential foster care, performance-based contracting, responses to addressing care of high needs foster care population, and development of evidence based approaches to family based in home diversion services.

In addition, John completed another successful Child Welfare transformation project in 2011 for the State of Florida, Department of Children and Families, where he assisted the Secretary in developing the state's future strategic vision. The transformation project served to improve the technology, human services and training in the Florida Child Welfare system. John assisted the State of Florida's child welfare agency with creating the vision for redesign, and in developing the business case for $100 million of technology improvements to support the Child Welfare Transformation as well as the maintenance and operations to support the state's SACWIS system. John also worked with the Agency in planning outreach efforts to courts and other stakeholders that were appointed to a statewide Transformation Advisory Committee and assisted the Secretary in providing reports and routine updates to the statewide Advisory Committee on the statewide Child Welfare Transformation efforts.

In 2018, John also worked along-side TSG consultants John Cooper and Dave DeStefano, as TSG was asked by the State of Mississippi Child Protection Services to provide its senior leadership with training related to the new Families First Prevention Services Act, as well as assessing the current state of the Mississippi Child Welfare Abuse Hotline and making recommendations for improvement.

John has also been offering child welfare and early childhood and family preservation system improvement consulting services to Annie E. Casey Foundation, Medicaid Managed Care organizations, and the United Arab Emirates.

Prior to his tenure as NH Commissioner of Health and Human Services, John also served as Assistant Commissioner of the Department of Safety, where he was appointed as the state's first Homeland Security Coordinator. Before that John was a NH Assistant Attorney General where he prosecuted homicide crimes, and prior to that John served as an assistant county attorney where he specialized in the prosecution of child sexual abuse and vehicular homicide cases. John is also a respected author and has either written or co-authored eight books on various law enforcement and legal matters.

References

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Brooke Holton, MS

Education: MS Organizational Leadership, Southern New Hampshire University; Graduate Certificate - Human Resource Management, Institute for Nonprofit Management and Leadership, Boston University School of Management; BA, Human Services, Paralegal Studies, Franklin Pierce University

Experience and Employment History: The Stephen Group (10/2017 to present). As a Senior Consultant, Brooke builds and leverages high quality relationships with clients. She works with cross functional teams to deliver exceptional results on multiple engagements across the county. Brooke manages TSG's projects and client relationships. Her work includes large scale projects such as Mississippi DHS, Nebraska DCFS, New Hampshire DOE as well as the Annie E. Casey Foundation.

Highlights of her consulting work include:

- Project management, analysis and restructuring of programs in state agencies in multiple states
- Project management, analysis and restructuring of staffing and engagement models in a national foundation
- Project management, analysis, strategic planning and organizational development of a national technology company
- Market entry/development, stakeholder engagement, RFP response development, network building and implementation in a number of states for a national Medicaid managed care organization

St. Joseph Community Services (5/2007 - 10/2017) As Vice President of Operations, managed organizational strategies, operations, programming, finance, contracts, development, external relationships and partnerships for a nonprofit whose multiple programs were delivered by 500 volunteers and 80 employees in 24 locations. Notable accomplishments include:

- Restructured the Program, Development and Finance departments to strengthen long-term sustainability, including the elimination of deficit spending and the development of $1M reserve.
- Grew revenue by 14% through restructuring programs for efficiency, restructuring the development department and the negotiation of contracts.
- Standardized systems and production, and improved data collection and technology which resulted in expense reduction and improved efficiencies.
- Achieved highest accreditation level: the only program with this recognition in NH and, at the time, the first of its kind in New England.
- Increased volunteer outreach efforts which resulted in 20% increase in participation.
- Focused on staff training and development to support all accomplishments noted above.

Merrimack County Superior Court (re: Home Insurance Company) (11/2004 to 5/2007) As Liquidation Clerk, managed disputed claims process arising from the liquidation of the company $3.6 billion in creditor claims and $1.6 billion in assets. Established workflow processes; created

a docketing database system; innovated and updated filings website for the liquidation case. Managed all aspects of courtroom hearings to include scheduling, liaison with remote technical staff for website and courtroom technology. Instructed litigants in the use of courtroom technologies; provided technical support to judge and staff.

Town of Salem (2003 - 2004) As Human Resources Director, provided human resource management for municipality with more than 200 employees. Reduced experience relative to workers compensation. Sought out collaborative relations with unions. Facilitated and assisted negotiating collective bargaining positions and agreements. Managed hiring processes for all departments. Conducted investigations. Provided consultation to Town Manager, Select Board, Department heads on a variety of issues.

State of NH (1987 – 2003) Held various positions that included managing stakeholder engagement and constituency outreach meetings statewide for rollout of new federal grant program; evaluating short and long-term policy changes and program implementation; criteria for equitable allocation of funds; managed in depth inventory of equipment; established a prosecution unit; management/delegation of work; selection, training and retention of clerical staff; legal research and writing. analyzing statistical data; reports to administration; evaluating policies; creating grant proposals. Disseminated relevant information to troopers responding to both routine and critical incidents. Instructed and certified local, county and state personnel. Developed and implemented training programs.

References

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John Cooper, BS

Education: BS Criminology, Florida State University; United States Army Military Police School, Ft. McClellan, Alabama; University of South Florida, PDC, Child Protective Investigations; Florida Department of Law Enforcement, Crimes Against Children; Department of Children and Families – Executive Leadership Program; Total Quality Management – QIC Story Green Belt; Project Management, Balanced Scorecard, & Six Sigma DMAIC Black Belt training.

Experience and Employment History: John Cooper is a Senior Consultant with TSG. John has an extensive senior leadership background in the administration of a large state human services organization, as well as private sector leadership and management. Mr. Cooper has over 27 years of experience in human services; 20+ in state government and 6 years in the private sector.

Mr. Cooper held several leadership positions for more than 20 years within the Florida Department of Children and Families. He completed his tenure with the department serving as the Assistant Secretary. In this capacity, he was responsible for a $1.7 billion budget and oversight of more than 6,000 staff across multiple program areas including: ACCESS (TANF, food stamps, Medicaid eligibility), Child Protective Investigations, Contracted Child Protective Services, Adult Protective Services, Refugee Services, Substance Abuse and Mental Health Services, Child Care Licensing, and was the primary operational interface for Florida's unique statewide outsourced Community-based Care model.

From 2004 – 2006, as a District Administrator in Florida, John oversaw the transition of the largest child welfare outsourcing contracting effort in the country. The oversight included procurement, contract development, contract readiness, contract execution, and contract monitoring.

From 2006 – 2009, John was the Florida statewide project leader for a national demonstration project with the Quality Improvement Center for the Privatization of Child Welfare on performance-based contracting.

John has achieved an impressive inventory of awards and commendations for his exceptional leadership, innovation, and productivity. Most recently, he was bestowed with his greatest honor, a 2016 Congressional Angels of Adoption recipient. In 2015, he was recognized as the Florida Child Welfare leader of the year. Throughout his career, he has served on multiple state and local boards and councils related to human services.

John has worked in the human services public and private sector for over 27 years as caseworker, supervisor, administrator, statewide director, and CEO of a large nonprofit human services organization. He has provided coaching and consultation services throughout Florida and other states in differential response, engagement, permanency, family-centered practice, leadership, performance-based contracting, and organizational change management. His administrative leadership, advocacy, and commitment to protect children and elderly by strengthening families and promoting collaborative community-based interventions are the foundation of his practice.

Mr. Cooper brings a unique combination of leadership, operational effectiveness, and community engagement and assumed the role of President and Chief Executive Officer of Kids Central Inc after leaving Florida DCFS. As the CEO of Kids Central John was responsible for the oversight of child welfare services in a five-county area including direct service delivery, network management, contract management, systems improvement, quality assurance, finance and budget, operations, data analysis, and policy development. One of John's most important initiatives at Kids Central was leading Kids Central in successfully engaging, recruiting, and improving relationships with hundreds of foster families in Central Florida. In addition, by partnering with an innovative marketing firm to create a Strategic Marketing Plan to recruit foster parents, Kids Central has increased annual recruitment by more than 300%. His team has successfully led multiple system of care initiatives using root cause analysis Lean Six Sigma process improvement techniques to increase foster home capacity, reduce licensing cycle time, and improve permanency for children.

John was a member of TSG Nebraska ESA Assessment team in 2018. Mr. Cooper's role in that assessment was to review the existing contract and identify best practices in contracting going forward to include the design and development of a new performance-based contract. John also provided subject matter expertise to the TSG team on the ground.

Mr. Cooper was also a member of TSG team that conducted a comprehensive top to bottom operational review of the Texas Department of Children and Families, Child Protection Services Operation in 2014 where he focused on assessing personnel hiring, recruitment and retention, as well as professional training and supervision. John also developed as part of that project a survey

tool for the state to identify the best background for child welfare case managers who stay for longer periods of time.

In addition to the Operational Assessment, Mr. Cooper also continued his work as a member of the TSG team during implementation of the Texas CPS Operational Assessment project after TSG issued findings and recommendations for improvement. In this role, Mr. Cooper assisted in developing an outsource model and RFP in the El Paso Texas region for family-based safety services that exists today and is producing good outcomes.

References

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Taylor Cheeseman, JD

Education: JD, Mississippi College School of Law; Certificate, Advanced Applied Leadership Studies, Millsaps College; BA, Public Management, Millsaps College.

Experience and Employment History: Taylor Cheeseman is a Senior Consultant with TSG. Taylor brings a unique perspective to child welfare transformation having held multiple executive leadership positions within a state child welfare agency, tried cases adjudicating allegations of child maltreatment in juvenile courts, and worked with a state judiciary on major child welfare reform initiatives.

During his stints as Chief of Staff, Deputy Commissioner for Strategy & Policy/General Counsel, and Interim Commissioner with the Mississippi Department of Child Protection Services, Taylor actively oversaw every aspect of the state child welfare agency's work, leading major transformation projects related to judicial practice, procedure, and alignment with Agency efforts; workforce development; primary prevention and targeted community-based services; stakeholder engagement and empowerment; and information technology. Examples of this work include:

Judicial Engagement: Taylor spearheaded a successful and innovative initiative centered around judicial engagement to prevent family separation. This multi-pronged partnership between MDCPS, the Mississippi Supreme Court, the Court Improvement Project, and juvenile court judges across Mississippi utilized federally required reasonable efforts findings as a catalyst for (1) focusing judges on family preservation and (2) reinforcing quality family

preservation practices through judicial oversight of investigator and case manager efforts. To move reasonable efforts findings from a compliance checkbox to a meaningful partnership between courts and MDCPS to prevent removal, the initiative combined court docket management system enhancements, data-sharing, and shared oversight processes to ensure courts made in-depth reasonable efforts findings with intensive training for judges, attorneys, and court staff on trauma-informed practice through a condensed version of the practice model training for MDCPS case managers. Prior to this initiative, Mississippi's foster care population had peaked at an all-time high. But through this collaborative effort Mississippi safely reduced its foster care population by a third in only two and a half years without corresponding increases in recurrence of maltreatment or reentry into foster care, an achievement out of line with national trends and which then Associate Commissioner of the Children's Bureau, Jerry Milner, dubbed "the Mississippi Miracle."

Workforce Development: Taylor developed and implemented a multi-approach comprehensive organizational health assessment utilizing web-based surveys, focus groups, individual conversations, and data across multiple strata of the Agency organizational structure focusing on organizational culture and values, supervisory practices, professional development, resource availability, and staff well-being . This assessment successfully exposed opportunities for improvement across these domains, including regionalized geographic variation. For instance, the assessment identified a misalignment between the expectations placed on frontline staff to engage clients with a supportive, strengths-focused approach and the behaviors modeled by frontline staff's supervisors in their supervisory practices. Similarly, the assessment identified a number of root cause factors within the Agency's control driving deficits in workforce well-being , burnout, secondary traumatic stress, and ultimately staff turnover. These observations then served as the source of foundational strategies with Mississippi's Round 3 Child and Family Services Review Program Improvement Plan.

Primary Prevention and Community-Based Services: In partnership with Casey Family Programs, Taylor led an innovative assessment of geolocated maltreatment and removal data at the neighborhood level to assess trends in Hinds County, Mississippi, providing opportunities to partner with community leaders and organizations to develop targeted primary prevention strategies tailored to the community's needs.

Information Technology: Taylor served as part of the MDCPS team that developed its RFP for the development and implementation of a CCWIS data system.

As a consultant, Taylor has worked as part of the TSG team supporting the work of the Annie E. Casey Foundation's Child Well-being Strategy Group, assessing ways states have leveraged Medicaid-funded behavioral health services as primary prevention strategies upstream of child welfare and juvenile justice systems. Taylor also has advised Casey Family Programs on next steps in community-based prevention work in Mississippi.

Prior to the Department of Child Protection Services, Taylor served as a Senior Law Clerk with the Mississippi Supreme Court. Taylor also served as an attorney in juvenile dependency and delinquency cases in Mississippi youth courts.

References

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David DeStefano, MA

Education: MA, Public Policy, New England College; BA, Psychology, Purdue University

Experience and Employment History: David DeStefano is a Senior Consultant at TSG, where he leads many of the child welfare projects in the area of quality, continuous improvement, change management and system assessment. Dave has extensive experience providing consultation on various issues impacting the implementation of child welfare and other health and human service programs. His range of experience includes assessment of statewide child welfare services and outcomes; process and workflow analysis; assessment of statewide quality management systems; development of public/private partnerships, performance based contracting; program evaluation; development of software and database applications; maximization of federal revenues; federal compliance with program standards; external evaluation and reporting; rate setting; project management; work process analysis; and the development and implementation of program policies and procedures. Six Sigma certified, he is experienced with the use of multiple process improvement tools and strategies.

State of Nebraska: As part of the TSG Nebraska team that conducted a comprehensive assessment of the Eastern Service Area in Nebraska, Mr. DeStefano evaluated components of existing service delivery system and developed recommendations for a future state model. The project included extensive meetings with Nebraska DCF staff, providers, stakeholders, courts, prosecutors, and families in identifying the current state and strategies for improvement should the state continue to outsource case management and out-of-home services. Mr. DeStefano is also presently assisting the state with the development of strategies related to the implementation of the Family First Prevention Services Act (FFPSA) including the Title IV-E Prevention State Plan, identification of evidence-based services to include in the Prevention Plan, identification of options for evidence-based kinship navigator services, and strategies related to implementation of criteria related to Qualified Residential Treatment Providers (QRTPs).

Seminole Tribe Child Welfare Assessment: Comprehensive assessment of all aspects of the Seminole Tribe child welfare system including policy, practice, assessments, documentation, scope and access to services, financial management, competencies, interaction with Florida DCF and Child Protective investigators, and outcomes. The analysis generated a set of recommendations related to agency structure, management, practice and provision of prevention services to tribal members in the context of cultural

Child Welfare Practice Assessments (Georgia, Arizona, Indiana, Iowa, Pennsylvania): Comprehensive assessments of State child welfare programmatic policies and procedures including interviews of key stakeholders regarding the effectiveness of intake, eligibility

determination and service provision. Assessed findings in relation to recognized best practice and developed recommendations for presentation to a state steering committee.

Florida Coalition for Children and Families Child Welfare Financial Model: Collaborated with nineteen agency members on the development of a proposed statewide funding model for child welfare using normed and validated cost averages, service volume, utilization data, and projections of client needs.

Child Welfare Strategy and System of Care Development: As the Chief of Strategy to Kids Central, a private Florida-based not-for-profit Community Based Care Child Welfare Lead Agency, Mr. DeStefano is responsible for evaluating organizational direction and effectiveness, developing recommendations for system improvement, overseeing implementation of performance improvement initiatives, monitoring outcomes, strategic planning (using a Balanced Scorecard format), and project planning and management.

State of Indiana Provider of Development and Implementation Services Project: As Project Director, Mr. DeStefano oversaw the implementation of this four-year, $21 million project. The project provided consulting, development and implementation services related to programmatic cost allocation, provision of foster care and adoption related consulting, review and validation of changes to the State's SACWIS (ICWIS), establishment and validation of Title IV-E eligibility, residential foster care licensing, and preparation for Title IV-E federal eligibility audit development of federal reimbursement rates, and SSI application processes. He was responsible for managing 35 staff working on multiple initiatives.

Administration for Children and Families (ACF) Federal Grant Evaluations: Mr. DeStefano serves as either an external evaluator or co-principle Investigator for multiple federal demonstration projects as well as a National Resource Center and a Federal Quality Improvement Center. In these roles he was responsible for design, implementation and management of both the process and outcome analysis and cost analysis.

South Carolina Alternative Response Network of Care: Designed policies and procedures for, a regional lead agency responsible for implementing a community-based alternative response system of care for children and families at risk of involvement with the child welfare system

Child Welfare System of Care Design and Proposal Development: Acted as a primary coordinator and author for multiple private agency responses to become lead agencies in areas of Florida, Texas and other jurisdictions.

State of Indiana Title IV-E Rate Setting Rule and Procedure Analysis: Under contract to a number of private non-profit organizations, Mr. DeStefano completed an analysis and developed recommendations pertaining proposed State residential foster care rate setting rules. The analysis was used as the basis for public comments submitted by the non-profit agencies to the State Department of Children's Services.

Department of Justice – National Council of Juvenile and Family Court Judges: Co-facilitated strategic session for the State of Nebraska Juvenile Court Association designed to assess and prioritize concerns of the judicial sector in relation to child welfare privatization efforts underway in the State.

Title IV-E Foster Care Cost Analysis and Rate Setting (Indiana, Missouri, Texas): Established state-level rate setting models and cost allocation models related to Title IV-E reimbursement for residential care and child placing agencies.

References

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Greg Povolny, BS

Education: BS, Marist College

Experience and Employment History: Greg is a Senior Consultant with TSG specializing in technology solutions. He is the founder of Mindshare Technology, a company that has deployed and currently supports the first and only operationalized, child-welfare focused, predictive models for daily use. Greg's concentration in the industry always has been laser-focused on providing improved quality of life, and the technology he created for Mindshare is a testament to that commitment.

Greg has worked on a number of TSG state projects. For instance, he worked with the TSG team that recently completed the Nebraska Therapeutic Foster Care Assessment. As part of that project, Greg worked to integrate data sets for foster care children under the Child Welfare State Information System with Medicaid, Behavioral Health, and pharmacy claims under the Medicaid program. Nebraska is a state with Medicaid Managed Care and TSG's analysis, led by Greg's efforts, identified important gaps in behavioral health utilization, including low utilization for some of the highest need children in the state, and higher than normal usage of pharmaceutical drugs. This information was used by the State in its coordination and meetings with MCOs to ensure system improvements.

Greg also worked with TSG in developing and designing an electronic survey collaboration tool, which validates that critical child safety and well-being issues are being addressed by child welfare professionals during foster home or in-home service visits. This tool provides data and alerts for child welfare staff; measures foster parent, kin, or caregiver satisfaction; and helps agencies respond to case manager performance using foster parent, kin, or caregiver feedback. The Guardian Tool has been used in Nebraska, Mississippi, Florida, and Texas.

Among other high impact large scale projects, Greg was charged with the responsibility to design and architect a secure biodefense emergency operations and communication system for the Pennsylvania National Guard and University of Pittsburgh Medical Center. The effort required collaboration across state and local government agencies, community partners, and volunteers. Reporting to Colonel Xavier Stewart, federally recognized Colonel, State Brigadier General Ret. R1 CBRN, Military Police, Military Intelligence, Chemical and Medical Service Corps Officer, Greg and the Mindshare team were responsible for a massive data interoperability and integration effort to attain maximum visibility across emergency operations.

Greg has more than 30 years of professional experience that started at IBM in 1998 where his focus then, as it is now, was using technology to help measurably improve outcomes and the well-being of the communities being served. After leaving IBM and co-founding his first company, Greg continued to innovate using applied data science and as a result has been granted several patents (Publication number WO2000069141 A3). The granted patents are based on Greg s innovations for a new and effective approach to data interoperability and transfer.

Greg's focus for the last twelve years has been leading Mindshare to become an internationally recognized leader in developing and implementing capability to positively impact the many aspects of child well-being. Greg passionately believes in developing solutions that help provide long term benefits for children, families and the community. He has established a reputation as an innovative thinker, leader and strong advocate for those efforts that best support and nurture children across multiple geographies and cultures.

References

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Lorraine Martinez, MS

Education: BA Psychology, Southwest Texas State University; MS Organizational Leadership, Quinnipiac University

Experience and Employment History: Lorraine Martinez is a Senior Consultant with TSG where she leverages years of experience in top management in child welfare, foster care, and Medicaid managed care. For the past 25 years, Lorraine has worked directly with the foster care community. She first began her calling protecting abused and neglected children working as a Child Protective Specialist in the units of investigations, intensive family preservation, and legal conservatorship. She continued her social work commitment employed as a Child Placing Agency group home case manager and CPA Administrator with social duties serving as Court Appointed Special Advocate (CASA) volunteer and Child Welfare Board President.

From May 2007 to 2020, Ms. Martinez brought her experience and knowledge of child welfare and foster care to Medicaid services where she was hired by Centene Corporation's Superior HealthPlan providing executive level and primary leadership to two Medicaid Managed Healthcare Programs for foster care children in Texas and Florida. In this role, she has supervised the inception and integration of new policies and procedures, work processes, financial reporting, and data systems supporting child welfare specific metrics for both the Texas legacy child welfare system and the community-based care model for Texas and Florida. She has also served in the Program Policy and Government Relations sector for Superior supporting the implementation of the STAR Kids Program and the carve in of the Medically Dependent Children's Program into STAR Health. Ms. Martinez also served as a foster care subject matter expert to support Centene's national complex healthcare business for various child welfare state programs.

Most recently, Ms. Martinez successfully served as Superior HealthPlan's Executive Director for the Texas STAR Health Program, establishing herself as a subject matter expert and respected leader for optimizing statewide clinical and non-clinical operations. She led the successful implementation of many new initiatives while optimizing operational performance to ensure the fulfillment of organizational, state, and contractual agreements. Her key achievements include:

3 Business Day Medical Exam: Led an interagency legislative mandate, which helped over 70% of children to receive medical care within three days of entering the Texas foster care system statewide. Endorsed the gathering of health care utilization data to support Superior offering financial incentives to primary care providers to accommodate the timely and accurate billing of the 3 in 30 examinations required. Operationalized statewide assistance for STAR Health Members to access and receive medications upon entry to foster care even though their STAR Health Medicaid eligibility had not yet been activated.

Child and Adolescent Needs and Strengths Welfare Assessment: Led Superior's implementation efforts of the interagency legislative mandate to provide a comprehensive behavioral health assessment, resulting in the Texas CANS 2.0 (Child Adolescent Needs and Strengths Assessment). Endorsed the gathering of healthcare utilization data and rate setting discussions for provider payment through Medicaid, supported the development of the CANS algorithm that generates the recommendation of health care services to be prioritized, led the state implementation of CANS 2.0 data to be displayed in Health Passport and provided guidance to legacy and community-based care child welfare placement providers as needed.

a2A Program: Created and developed Superior's transitioning youth program named a2A (adolescent to Adult) empowering youth to take charge of their health prior to leaving foster care. The program encourages healthy habits and offers financial rewards until the age of 21 if STAR Health Members receive timely preventive health screenings and examinations.

Turning Point (A Psychiatric Hospital Diversion Program for Children and Youth in Foster Care): Analyzed Superior's behavioral health inpatient admissions, placement day utilization and days accessed beyond medical necessity to endorse the expansion of Superior's Turning Point Program. Initially offered in Dallas/Fort Worth, Superior expanded Turning Point Services into Houston, San Antonio, and Abilene areas offering emergency assessment and crisis intervention 24 hours a day, 7 days a week.

Texas Trauma-Informed Child Welfare System Blueprint: The Blueprint is the result of an extensive interagency collaboration and commitment to building a trauma-informed child welfare system in Texas. Facilitated by the Texas Children's Commission, Ms. Martinez contributed her child welfare experience and health care background to support the development of short-term and long-term goals that would successfully partner child welfare stakeholders to deliver trauma-informed practices.

Florida's Child Welfare Specialty Plan: Led the implementation of Florida's first Medicaid managed health care program specialized for children and youth placed in foster care. Florida's child welfare system operates in a Community Based Care model which requires the statewide health plan to innovate and offer health care solutions locally.

STAR Health General Health Screening Process: Analyzed non-compliance data and labor hours dedicated to completing general health screenings for new STAR Health Members entering foster care. Revamped staffing model and operational processes to streamline outreach efforts increasing compliance to over 97%.

Health Passport: Supported the enhancement of Health Passport technological upgrades, a web-based application used to deliver relevant healthcare information, thereby allowing a better understanding of a patient's medical history and health interactions.

Kinship Program: Operationalized a dedicated team of staff to support Kinship Caregivers by enabling them to better understand how to access Medicaid services timely and effectively.

STAR Health Training Curriculum: Designed and launched a foster care training curriculum for internal staff and Child Protective Services caseworkers statewide.

ASPIRE (Achieving Success through Proactive, Innovative and Rewarding Experiences): Acted as the Committee Chair for an employee-led initiative to promote change within Superior's corporate culture for staff empowerment to demonstrate core values of passionate customer service, innovation, integrity and accountability.

High Profile Management Experience: Provided daily executive leadership to a high profile and specialized health care program for children and youth placed in foster care. Demonstrated collaborative partnerships with the Department of Protective and Regulatory Services and Health and Human Services Commission leadership. There was daily focus to minimize potential negative impact from regulatory problems by executing in-depth analysis and executing strategic mitigation plans.

Unique Experience: Ms. Martinez the only individual in the nation who has directed two specialized managed health care contracts for state child welfare programs, including having front line experience serving the foster care community. She has experience implementing specialized programs that are trauma informed both in the legacy state child welfare system and the Community Based Care model for Florida and Texas.

Ms. Martinez has a real passion for finding collaborative solutions to ensure the success of programs supporting high-risk children and families. She currently serves on the Texas CASA Board of Directors and supports the Texas CASA Public Policy Committee and Texas CASA Program Services & Operation Standards Committee. She served on the Statewide Collaborative on Trauma-Informed Care as an Organizational Leadership Committee Member and is a Former Child Protective Services Child Death Citizen Review Committee Member.

References

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Richard Kellogg, M.Ed., CAS

Education: CAS The World of Health Economics, Harvard University; CAS Administrative Psychiatry, Dartmouth University; M. Ed. Organization Development, University of Vermont; BA: History, Political Science, Economics, University of Vermont

Experience and Employment History: Richard Kellogg is a Senior Consultant at TSG and brings years of experience in HHS administration, programming, and consulting at the state, community, and private sector levels. Richard has served as Commissioner, Deputy Commissioner, and Director of HHS agencies in four states. Richard served as CEO for two multi-county mental health, developmental disabilities, and substance abuse services provider organizations in Virginia and as a provider/CSB statewide member of the DMAS Medicaid Executive Committee that created the rules and rates for the initiation of mental health rehabilitation option services, the 1915 (c) HCBS waiver for people with developmental disabilities, and child welfare wraparound services related to the Comprehensive Services Act.

The Stephen Group (02/2011 to present). Richard has provided expert level consulting services for all areas of HHS. Richard has led aspects of consulting transformation projects in South Carolina, Maine, Texas, Arkansas, and Mississippi, as well as Medicaid MCO and behavioral health plan market development including government, provider, and stakeholder relationship building in New Hampshire, Ohio, New York, and Texas.

- **Texas.** Richard served as lead team expert for child safety and risk assessment, planning and implementation of Structured Decision Making, and IT related integration aspects for Medicaid eligibility for a comprehensive agency transformation consultation for the Texas HHSC, Division of Child Protective Services/DFPS. A function of this work included a comprehensive assessment of the state's carved out Medicaid managed care contract under STAR Health, HHSC's Medicaid Managed Care solution for foster care children/adolescents, which integrated medical/pharmacy, EPSDT, and litigated requirements for mental health/substance abuse services. Richard provided expert consultation to the DFPS Commissioner and Assistant Commissioner during their re-procurement and negotiations with the chosen state vendor and offered areas of performance management that were added to ensure appropriate outcomes to enhance child well-being. These changes have led to many improvements in behavioral health utilization for children in foster care.
- **Nebraska.** Richard served as Senior Consultant for TSG on three projects for the Division of Children and Family Services: 1) assessment and recommendations on ESA; 2) assessment of the use of SDM risk assessment tools within the Case Management System and recommendations for improvement; 3) assessment and recommendations of a legislatively proposed Therapeutic Foster Care treatment modality and related changes to community based Medicaid services for the Foster Care population.

- **Mississippi.** Richard worked with the TSG team on restructuring the Temporary Aid to Needy Families (TANF) community-based contracts from one of tracking outputs to a performance/outcome-based contract under the Department of Human Services innovative gen+ program, child support, and A-87 enrollment/eligibility.
- **Arkansas.** Richard served as senior consultant to the Joint Legislative Task Force (5/15-12/16) responsible for developing comprehensive Medicaid program reform options including organization structure of DHS related to Medicaid policy, purchasing strategy options, budget projections (Managed Care, MFSS, PCMH), BH Medicaid Evidence-Based Practices, and BH Health Homes as well as integration strategies. In addition, Richard supported the analytical work on the Arkansas private option for ACA Medicaid expansion that was continued during a Legislative Special Session in 2016 and re-approved by CMS.

Washington Department of Social and Health Services (01/2006 to 1/2011). Richard served in the position of Director of Integrated Health Services, a DSHS-wide leadership position that served as the Secretary's policy advisor on all aspects of Medicaid, managed care, and national health reform impacting a $13 billion-dollar budget, structural transition of the Single State Medicaid Agency designation, and a member of the Governor's Sub Cabinet on National Health Reform.

Prior to this role, Richard served as the Director of Medicaid Mental Health Systems and was a senior member of the Washington State Medicaid Executive Leadership team focused on comprehensive Medicaid policy, managed care, operations.

New Hampshire Department of Health and Human Services (07/2004 to 01/2006). Richard served as New Hampshire Department of Health and Human Services Director of Community Based Services. In that capacity, Richard was responsible for the Bureaus of Behavioral Health, Developmental Disabilities, and Long-Term Care Services. Under the Commissioner's leadership and Richard's efforts, New Hampshire was able to successfully rebalance the LTC system to a community first choice culture and option, assist in the reorganization of contracting and procurement services for community-based mental health and developmental disability agencies, and developed a new integrated service delivery system. Richard was also Acting Medicaid Business Director when New Hampshire moved ahead on disease management and effective cost containment strategies.

Tennessee Department of Finance and Administration (04/2001 to 10/2003). While serving as Deputy Commissioner of the Department of Finance and Administration in Tennessee, Richard "brought about significant progress in helping the division address the multitude of challenges" it faced from three DOJ/CRIPA lawsuits and a CMS moratorium on the state's HCBS waiver for the developmentally disabled. Under Richard's leadership, DMRS worked with the TennCare Bureau, the Attorney General's Office, and the Commissioner's Office to craft a joint mediation strategy for the three (federal) lawsuits and removal of the CMS moratorium.

Virginia Department of Mental Health, Developmental Disabilities, and Substance Abuse Services (12/1994 to 01/2002). As Deputy Commissioner and Commissioner of Virginia's Department of Mental Health, Developmental Disabilities and Substance Abuse Services, Richard served as the designated liaison with the state's single state Medicaid Agency (DMAS), partnered with DMAS on the DHHS Secretary's Executive Committee, and was responsible for all Department contracts.

As Commissioner in Virginia, Richard provided "expert level" leadership and knowledge as Virginia resolved four DOJ/CRIPA lawsuits that had lingered over 12 years while instituting 500 targeted state hospital discharges, permanently closing the beds, increasing state to patient

ratios in the state hospitals, expanding community housing options, “hard wiring” discharge partnership between the state hospitals and community services boards, and successfully operationalizing 17 fidelity PACT teams across the commonwealth distributed by an Olmstead-based utilization method.

On December 1, 2001, Governor James S. Gilmore III characterized Richard’s expertise as “possessing national level knowledge in the financing methods of public and private healthcare with a concentration in behavioral health. His knowledge of treatment and program methods is that of a national expert.”

In addition, Richard served as Chairman of the State Executive Council of the Comprehensive Services Act, Commonwealth of Virginia. The Act mandated special education, foster care, and juvenile justice funding into a statewide-managed “pool" in a wrap-around system. The CSA funding pool included all Medicaid related funding including EPSDT and special services for foster care children/adolescents including FFS mental health services.

References

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Frank A. Spinelli, MA

Education: Graduate Certificate, Health Care Financing and Administration - University of Rhode Island**,** Master of Arts, Psychology – Rhode Island College, Bachelor of Science, Education – Rhode Island College

Experience and Employment History: Frank Spinelli is a former Medicaid director with a proven record of innovative, and successful leadership of healthcare programs in the public and private sector. He is an independent health care consultant specializing in organizational restructuring, managed care, contract and vendor management, long-term care transformation, care management, Medicaid, delivery system transformation and value-based purchasing. He has over thirty years of experience working in a variety of leadership roles for Rhode Island Medicaid and fourteen years in the private sector as a senior executive for Xerox’s Government Healthcare and as a consultant.

Senior Consultant (01/2017 – Present) Providing consultation services in the healthcare industry with a focus on organizational management, policy/ program development, valued based purchasing, quality improvement, operational excellence, business process improvement, Medicaid, care management and long-term services and supports. Developed an organizational restructure for the Arkansas Medicaid program to redesign the oversight and management of its managed care programs and vendors; worked on transitioning Medicaid eligibility and related contractual responsibilities from one state agency to another for the state of Mississippi; a former member of the CMS Pre-Admission and Screening (PASRR) Technical Advisory Group which provides technical assistance to states on the administration of the PASRR program including oversight of PASRR vendors; provided Medicaid and long-term services and support subject matter expertise to state governments, private sector companies and health plans; help managed care programs design delivery systems to address the needs of special populations and LTSS members, evaluate health care company acquisitions for private equity firms and provide subject matter expertise to companies submitting requests for proposals. Also consulted with the Deloitte on its New York LTC managed care rate setting contract.

Xerox Government Healthcare (10/2010 -1/2017) Vice President: Developed the Long -Term Care line of business and oversaw the merger of the Long-Term Care and Care Management businesses. Business Leader responsible for the development and implementation of market strategy, new pursuits, solutions and portfolio development, business development and service delivery for Xerox's long-term services and supports and care management services. Also, responsible for strategic planning, innovation, budget analysis, recommending and implementing changes to business processes. Responsible for the oversight and management of vendors providing IT support, staffing, prior authorizations of diagnostic testing, pregnancy related services and self-directed care services

Xerox (12/2008 – 9/2010) Client Executive/Consultant: Provided executive level consultation concerning MMIS, pharmacy benefit management programs, payment method and fee schedule changes, cost containment, business improvement, health information exchanges, long term services, and Medicaid / healthcare reform policy. Managed multiple contractors providing support to the New Hampshire and DC MMIS design and implementation. Also, developed the first MMIS Enterprise Provider Relations Unit.

RI Medicaid (8/2007 -10/2008) Medicaid Director: Directed the Division of Healthcare, Quality and Purchasing with policy development and fiscal oversight for programs servicing 185,000 beneficiaries and managed a $1.95 billion Medicaid budget. Coordinated services between Medicaid, Title XX, TANF, SSI, GPA, Child Support, Vocational Rehabilitation, Early Intervention, Veterans Affairs, Food Stamps, Child Care, and other state agency programs. Authored, designed and implemented a number of Medicaid 1115 and HCBS waivers. Other duties included budget preparation; legislative liaison; rate setting; provider relations: constituent affairs; personnel; strategic planning; representing the department at legislative hearings, public functions, stakeholder meetings and governor's briefings; and acted as the Director when absent.

RI Medicaid (1/2007 – 8/2007) Associate Director: Directed the Center for Medicaid Operations and Pharmacy Management and managed the Medicaid Management Information System and its multiple vendors, Medicaid eligibility systems, provider relations and enrollment, rate setting and sat on State Health Information Exchange steering committee.

Center for Adult Health for RI (1/1997 -2/2007) Administrator: Managed the department's acute, behavioral, pharmacy, and oral health programs, long term care services, beneficiary services, provider enrollment and relations and programs supporting persons with disabilities and the elderly. One of the leaders who reorganized the RI Department of Human Services and the Medicaid program into population centers.

References

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1.j. Subcontractors

TSG does not intend to utilize subcontractors for the services outlined in this proposal. All services included in this proposal will be provided by TSG Senior Consultants

2. TECHNICAL APPROACH

2.a. Understanding of Project Requirements

This RFP represents an ambitious aim to fundamentally transform the system of care supporting Nebraska children and families. Towards that end, DHHS is looking for a vendor that can facilitate a workgroup made up of individuals chosen by DHHS leadership that will work with the vendor to develop new practice and finance models for the proposed child welfare system transformation in Nebraska. During the project, and in collaboration with the workgroup, the vendor will facilitate engagement strategies with a number of key system stakeholders, to include, at a minimum, judges from separate juvenile courts, private child welfare providers, individuals with lived experience in the child welfare system, the Nebraska Children's Commission, the Inspector General of Nebraska Child Welfare, the Foster Care Review Office, child advocacy centers, law enforcement, county attorneys, and all Nebraska DHHS divisions.[3] These strategies will consist of individual structured interviews, focus groups, or other methods of qualitative data collection for the purpose of consultation, evaluation, and input related to the design and implementation of the recommended practice and finance models.

It is our understanding that the State is looking for a vendor that can facilitate, coordinate, and manage such a process, conduct detailed interviews, assess the current state child welfare system, review other state models, analyze available quantitative and qualitative data, provide monthly status reports to DHHS leadership, accept continuous input and direction from the workgroup and DHHS leaders, and include information obtained from the key stakeholders in developing any findings and recommendations related to the a new child welfare system of care in Nebraska. The overall process will be one of collaboration and partnership from all entities involved as Nebraska moves to practice and finance models that are truly transformative with improved outcomes for all of Nebraska's children and families involved with the child welfare system.

A baseline for the recommended new child welfare practice and finance models in Nebraska will include, at a minimum, the following:

a. Development of a statewide mission and vision,
b. Development of values and practice priorities,
c. Development of statewide program goals,
d. Development of a practice model for case management and service delivery,
e. Development of a finance model,
f. Development of engagement strategies to support community involvement in child welfare system transformation,
g. Development of strategies that strengthen relationships across the court system, probation, executive branch agencies, the State Department of Education, and community partners,

[3] Throughout this proposal, "key stakeholders" includes, but is not limited to, judges from separate juvenile courts, private child welfare providers, individuals with lived experience in the child welfare system, the Nebraska Children's Commission, the Inspector General of Nebraska Child Welfare, the Foster Care Review Office, child advocacy centers, law enforcement, county attorneys, and all Nebraska DHHS divisions. TSG will work with DHHS leadership and the workgroup to ensure that all relevant stakeholders have an opportunity to provide input throughout the project lifecycle.

h. Development of strategies that support integration of programs across child and family serving agencies,

i. Development of accountabilities across the entire child welfare system,

j. Evaluation of the State's Title IV-E claiming practices and identification of appropriate steps to optimize federal reimbursement for child welfare system expenditures,

k. Opportunities and financial mechanisms for providers to pilot innovative solutions to meet program goals, and

l. Development of a strategy for data collection and outcome monitoring.

By pursuing a new mission and vision for Nebraska's child welfare system and prioritizing collaboration across child and family serving systems and agencies, DHHS has taken the first steps towards a fundamental shift in service delivery that tangibly improves outcomes in holistic child and family well-being.

A project of such scope is an ambitious undertaking, and success will hinge on whether a consensus emerges among key stakeholders for supporting the implementation of new comprehensive practice and finance models, and whether those models include both cutting edge, national best practices and tailored nuances for Nebraska's unique strengths and needs. Accordingly, the vendor selected to lead this initiative in partnership with the workgroup must possess both the proven capacity to build consensus across stakeholder groups and deep expertise in best practices across child and family serving systems, including child welfare, behavioral health, Medicaid, economic assistance, legal/judicial systems, education, and public health.

2.a.1. Task 1: Strategic Visioning for Transformational Change

TSG believes that this task will involve engaging Nebraska child welfare key stakeholders to define and build consensus around a new vision for the future of Nebraska's child welfare system. TSG will work with the workgroup and the other key stakeholders to develop:

- a statewide mission and vision for the child welfare system in Nebraska,
- values and practice priorities for the child welfare system in Nebraska, and
- statewide program goals.

Every effective practice model rests on a foundational vision that guides decisions from the system to the case level and across stakeholder groups. With a clear, tangible, and shared vision, system leaders are equipped to invest resources, design systems, and measure progress throughout the transformational process. Without such a vision, system transformation may slip into competing or incongruent efforts that divide attention and resources and minimize the impact of any one intervention. Accordingly, TSG views this task as one of the most important in the entire project. Additionally, identifying the right vision, mission, values, priorities, and goals require input from diverse perspectives. Here, it will be particularly important that the key stakeholders groups help define the new Nebraska child welfare vision.

2.a.2. Task 2: Assessment of Child Welfare Practices

TSG believes this task includes a detailed assessment of the current Nebraska child welfare practice and finance models and the identification of gaps in practice and finance that could support the workgroup's focus on areas of improvement and best practice. Included in this task would be review and assessment of:

- the practice model for child welfare system case management and service delivery,

- the finance model for child welfare services,
- any changes to training necessary to implement the practice and finance models,
- engagement strategies to support community involvement in child welfare system transformation,
- strategies that strengthen relationships across the court system, probation, executive branch agencies, the State Department of Education, and community partners,
- strategies that support integration of programs across child and family serving agencies, and
- accountability systems and measures across the entire child welfare system.

Throughout this assessment, TSG will ensure that the State aligns effective practice and service delivery systems with best practices in Title IV-E claiming and the optimization of federal reimbursement for child welfare system expenditures as well as data collection, outcome monitoring, and continuous quality improvement practices.

2.a.3. Task 3: Assessment of Disproportionality in Current Practice and Outcomes

TSG believes this task is intended to assess and examine statewide, regional, and local data to identify areas of disproportionality and disparity in services and outcomes for minority populations involved with the child welfare system. A comprehensive approach to this task would encompass the identification and root-cause analysis of disparities across racial and enthic groups, tribal affiliation, sexual orientation and gender identities, socio-economic status, and between urban, suburban, and rural populations. Through a review of statewide policy and research of national best practices, TSG will help the workgroup formulate recommendations that ensure the new system focuses on ensuring equity in service delivery and outcomes.

Achieving this aim will require both systems and case level analysis, and the root-cause analysis will require an understanding of both concrete (i.e. resource investment decisions) and adaptive (i.e. cultural competence and implicit bias) factors affecting the equitable treatment of diverse individuals involved with the child welfare system. The voices of youth and families with lived experience will be central to this assessment, collaborating with individuals of diverse backgrounds and experience.

2.a.4. Task 4: Evaluation of Child Welfare Practice Models

A jurisdiction's child welfare practice model serves as the foundation for integrating practice, investment, and system design decisions toward the achievement of the jurisdiction's specific goals in outcomes for children and families. A comprehensive practice model includes a concrete vision for system improvement and success, clearly articulated values and principles underlying that vision, measurable outcome and performance measures, core intervention components designed to achieve those outcomes and performance measures, and investments in system structures and resources that support and enable those core intervention components.

There is no one-size-fits-all practice model appropriate to every jurisdiction. Instead, a practice model must be tailored to a particular jurisdiction if it is to achieve the jurisdiction's desired ends. However, in developing and designing a new and innovative child welfare practice and finance model, an evaluation of national best practices is important and could help the workgroup inform specific areas of change. Here, Nebraska intends to look to what is working across the country

and what could be developed in Nebraska to transform the current system into a world class system of care.

2.a.5. Task 5: Formalize Recommendations and Facilitate a Theory of Change Model

Even a clearly articulated vision, detailed assessment, and well-designed practice and finance models will not shift outcomes without a successful implementation process. Implementation, in turn, requires a clear theory of change that aligns understanding and efforts across key stakeholder groups. In this task, we will support the workgroup's effort to develop a theory of change tailored to Nebraska's strengths and needs and aligned with its vision for a transformed child welfare system. This will require the development of a detailed implementation plan that considers concrete and adaptive barriers to implementation, clearly identifies the fiscal and resource commitments required of the State and individual stakeholders for successful implementation, and plan for continued collaboration across key stakeholder groups throughout the implementation timetable.

To this end, TSG will work with DHHS leadership to finalize the practice and finance models and then assist the State in preparing for their implementation. TSG will work with the DHHS workgroup to facilitate the development of a theory of change and create a detailed implementation plan including, but not limited to, the rollout of training, technology, new contracts, new tools, policies, legislation, and other supports necessary for the new models.

2.a.6. Task 6: Identification of Training Needs

Any fundamental transformation of the system of care changes the required competencies of those operating within the system. In turn, the scope of a given transformation plan influences the modalities and content of training that is needed to achieve positive outcomes. Training needs associated with a given practice or finance model may affect all aspects of training for staff in many roles across stakeholder groups.

For this task, TSG will assist the workgroup in identifying all training-related implications of the proposed practice and finance models. We will work to ensure that DHHS and other key stakeholders adopt of comprehensive training plan for both new and experienced staff that supports the practice and finance model implementation. This plan will be rooted both in the specifics of Nebraska's chosen models and national practices in professional development.

2.b. Proposed Development Approach

TSG's development approach for this project will rest on two key principles.

First, this project is a collaborative effort. TSG does not intend to conduct an assessment in isolation. Instead, TSG will partner with the DHHS workgroup throughout the assessment process, and together we will conduct the research and activities that ultimately inform the new Nebraska practice and finance models. And TSG will help the workgroup engage the key stakeholders early and often throughout the project lifecycle, giving these stakeholders opportunities for input in each of the project tasks.

Second, TSG will work to balance the perspectives of national best practices and Nebraska's unique strengths and needs in guiding the workgroup's recommendations. TSG will not simply bring one-size-fits-all solutions but will leverage its unique expertise in national best practices while ensuring the workgroup's product provides what is best for Nebraska.

2.b.1. Task 1: Strategic Visioning for Transformational Change

Visioning will focus on establishing a statewide mission and vision for the Nebraska child welfare system, shared values and practice priorities across Nebraska child welfare stakeholders, and

statewide program goals that will serve as the measure of whether DHHS' desired transformational change takes root.

Because child welfare services and child and family well-being more broadly depend on a multi-disciplinary approach and multiple child and family serving systems, fundamental transformation that tangibly improves outcomes requires consensus across systems and stakeholder groups around the State's values, goals, and approach to service delivery. Accordingly, TSG's strategic visioning activities will focus on building this consensus by ensuring every key voice is heard in the development of the State's mission, vision, values, priorities, and goals.

TSG will facilitate strategic visioning for transformational change of the child welfare system to include:

a. Robust collaboration of system partners,
b. System accountability,
c. Change management methodologies, and
d. Key performance indicators for during period of change.

We will begin by meeting with DHHS leadership to understand their desires for the future of Nebraska's child welfare system and the outcomes of this project. In this meeting, TSG will conduct a facilitated discussion focused on identifying the strengths of Nebraska's current system, the pain and pressure points that have led to this project, the specific external stakeholders who will determine the success of this project, and any challenges or barriers to success that DHHS leadership expects to encounter. Here, DHHS leadership also will identify the key state staff and any outside agency stakeholders that DHHS will want as part of the project workgroup.

This information will then be used by TSG to plan an Initial Project Kickoff Meeting with the workgroup. This workgroup should consist of DHHS managers knowledgeable of all aspects of Nebraska's child welfare operations, including both programmatic and administrative staff. This team will work with TSG throughout the project and provide key guidance on all aspects of the project, including the development of a new practice and finance models.

The Initial Project Kickoff Meeting will serve as the first convening of the workgroup. The purpose of the meeting will be to (1) articulate DHHS' goals for the project, (2) outline of TSG's proposed project approach, including its approach for developing the strategic vision for transformational change, assessment, evaluation of disproportionality, evaluation of national best practice, training models, recommendations and theory of change, (3) provide the workgroup an initial opportunity for input on the development of the State's mission, vision, values, priorities, and goals, and (4) begin to lay the foundation for consensus for transformational change.

After this Initial Project Kickoff meeting, TSG will work with DHHS leadership and the workgroup to develop an Initial Community Vision Meeting. This will include a DHHS presentation to DHHS' identified key stakeholders on DHHS's goals for the project, a TSG presentation on the project process, and a scripted discussion that TSG will facilitate to collect high-level thoughts about the appropriate mission, vision, values, priorities, and goals for the State's child welfare system from individuals representing:

- Key DHHS managers from programs including child welfare, child care, economic assistance, Medicaid, and behavioral health,
- The judiciary including the Supreme Court, the Administrative Office of Courts, the Court Improvement Project, the Juvenile Services Division, and Juvenile and County Court judges,

- Leadership and managers from private service provider agencies,
- Key leadership and managers from the Department of Education,
- Members of the Nebraska Children's Commission,
- Leadership and staff from the Inspector General of Nebraska Child Welfare,
- Leadership and staff from the Foster Care Review Office,
- Leadership and staff from Nebraska child advocacy centers,
- Representatives of law enforcement agencies,
- County attorneys,
- Key legislators or legislative staff, and
- Representatives of the Office of the Governor.

Following this Initial Community Vision Meeting, TSG will begin to schedule focus groups and interviews with key individuals and stakeholder groups represented above to drill down on thoughts related to the appropriate mission, vision, values, priorities, and goals of the system transformation project. Priority focus groups will include youth with lived experience in the child welfare system, parents with lived experience in the child welfare system, and foster and adoptive parents. Additional focus groups and interviews will include representatives of the key stakeholder entities from the Initial Community Vision Meeting. TSG also will work with DHHS and the workgroup to develop a survey on the State's mission, vision, values, priorities, and goals to be administered electronically to DHHS staff, external stakeholders, and individuals with lived experience. We would expect the survey to go out right after the Initial Community Vision Meeting.

Following the completion of the interviews, focus groups, and surveys, TSG and the workgroup will prepare a written assessment of consensus points and divergent views in stakeholders' thoughts about the appropriate mission, vision, values, priorities, and goals for the State's child welfare system. TSG will then meet with the workgroup and DHHS leadership to review this summary and draft a proposed Nebraska Child Welfare Vision document with vision and mission statements, practice values and priorities, and system goals. TSG then will work with DHHS leadership to distribute this draft to the key stakeholders, solicit feedback, and adopt a final version.

2.b.2. Task 2: Assessment of Child Welfare Practices

The Assessment of Child Welfare Practices will serve as the core of this project as TSG leads the workgroup through an end-to-end assessment of Nebraska's current child welfare system of care

Workgroup Facilitation Leadership

To the lead the workgroup, TSG provides Nebraska DHHS an exemplary team of senior level consultants with executive policy making leadership experience in state child welfare systems at the Secretarial (NH/WA) and Commissioner (FL/MS) levels as well as past transformative consulting assessment and recommendation services including comprehensive policy and practice reviews for the Texas, Nebraska, Mississippi, and Florida child welfare systems. Our team also includes policy experts in key related fields affecting child welfare clients, including a former director of a Medicaid managed care plan specifically designed for child welfare service recipients (TX STAR Health); a former Commissioner of Behavioral Health with responsibility for wraparound integrated care (behavioral health, Medicaid, foster care, and special education) (VA); and leads for child welfare state litigation (WA/MS).

Key Components of Assessment

During this task, TSG and the workgroup will conduct a detailed assessment of current child welfare practices, functions, conditions, and partners, to include:

a. Policy
b. Statute
c. Nebraska best practices
d. National best practices
e. Quantitative data reports
f. Licensing of foster and resource homes
g. Prevention practices to support families at risk of entering the child welfare system to include following structures in Nebraska:
    I. Families First Prevention and Services Act (FFPSA) implementation;
    II. Thriving Families Safer Children in Nebraska; and
    III. Community Collaborative models
h. Child welfare field practices, to include:
    I. Child Protective Services (CPS),
    II. Preventative and CPS in-home services,
    III. Child fatality review and oversite,
    IV. Placement of children in out-of-home care,
    V. Support of relative foster homes
    VI. Work with older youth
    VII. Services to children and families to achieve reunification,
    VIII. Practices to achieve permanence including reunification, adoption and guardianship,
    IX. Provision of physical health, mental health, educational and development services for children in out-of-home care; and
    X. Mental health service array and gaps
    XI. Workforce and caseload recommendations to include training, educational requirements and staffing model recommendations.
i. Children and Family Services (CFS) organizational structure and capacity, to additionally include recommendations of enhancing prevention design within FFPSA implementation,
j. Training of child welfare staff and partner agency staff,
k. Technology needs to support practice,
    XII. Financing structure:
    XIII. Provider rates; and
    XIV. Title IV-E claiming
l. Organizational and systemic barriers to implementation of practice and finance models; and
m. Experience of partners with lived experience,
n. Systemic factors affecting child wellbeing and permanency,
o. Impacts of disproportionality on marginalized communities,
p. Mandated boards and commissions related to the oversight and review of child welfare, including the Children's Commission

Policy and Practice

The TSG/workgroup review of policy and practice will serve as the backbone of this project. TSG understands the critical importance and role of state child welfare policy, rules, and related practice models because of their direct impact on children, youth, and families. Policy and practice, as well as staff competency in their execution, directly determine the quality of a state child welfare system's services. Accordingly, Nebraska's efforts to achieve safety, permanency,

and well-being for children depend upon adopting and maintaining policy and practice requirements effectively tailored to these ends.

TSG is prepared to lead the workgroup through an end-to-end review of policy and practice requirements. Statutes, administrative rules, policy manuals, internal operating procedures, guidance documents, forms, training activities, and supervisory guidance all dictate policy and practice requirements for staff. So, an effective assessment of DHHS policy and practice will require in-depth consideration of each of these sources.

The TSG team will help the workgroup comprehensively assess DHHS policy as established in statutes, administrative rules, policy and practice manuals, internal operating procedures, guidance documents, forms, training activities, and supervisory guidance and how it is managed across DHHS. Through this process, TSG, in consultation with the workgroup, will:

- Review the current structure, format, and organization of DHHS policy as well as the processes for its creation, management, and implementation.
- Develop a policy and practice data metric crosswalk connecting policies to the identified outcomes they are meant to influence.
- Review all staff training structures, content, and processes.
- Assess the alignment of policy with practice in the field.
- Assess how policy and practice questions from the field are addressed and resolved and in what timeframes.
- Assess whether and how policy and practice questions result in adaptation.
- Assess whether there are positive or negative unintended consequences from current policy and practice.
- Assess how caseworkers understand and operationalize policy and practice in the field as well as any improvements or barriers they would like to see addressed going forward.
- Review how policy and practice is integrated into the DHHS' data management system and how well this technology meets the needs of supervisors, caseworkers, and support staff.

TSG will utilize a multi-prong approach for the policy and practice assessment. Each of the selected approaches will be used to (1) gain an understanding of the current policies and practices; (2) gather participant and stakeholder input identifying what is working, what is not working, what is missing, what can be eliminated, and what can be improved with current policy and practice; and (3) integrate our findings to inform our recommendations.

To complete this assessment, the workgroup will utilize the following assessment activities:

- In-person guided interviews and focus groups with internal leadership directly responsible for policy and practice, field supervisors, caseworkers, field support staff, and others identified as necessary during the assessment.
- Electronic surveys, focus groups, and individual guided interviews of external stakeholders.
- Comparisons of Nebraska policy and practice to three best practice states identified in partnership with DHHS.
- Data assessment including AFCARS, NCANDS, and other readily available sources of management data.

- Case reviews.
- Observation of DHHS operations.

TSG and the workgroup will use this information to recommend practical approaches for improving DHHS' responsibilities and accountability for policy and practice that drives the system.

Technology and Data Integration

Measurably improving outcomes for children and families clearly resides in the overall makeup and coordination of skilled staff, case practice, and accountability. Moreover, the use of technology as a decision support mechanism further aligns with efforts to improve outcomes. Outcomes are impacted by productivity, focus, quality, expediency of actions, proactive interventions, visibility to risk, and awareness of gaps and needs. Use of technology should cover this spectrum and be considered at all levels of staff within an agency. Technology systems should operate within a master data management strategy where information is consolidated and not siloed across departments. Information should be managed consistently, and the source of record should not be compromised by duplicative efforts to manage such data. Contributing agencies should be considered part of the user base and connected to agency systems for batch and transactional information processing. As such, the agency must have a data sharing strategy that offers contributing agencies and business associates an approach to participate for the purposes of enhancing the system of care.

As with its quality assurance system, DHHS' technology and data management practices will be pivotal in its efforts to implement the new practice and finance models. The TSG assessment here will also consider whether the right tools and practices are in place to support its practice and finance model recommendations.

TSG senior consultants have experience working on statewide child welfare systems in many jurisdictions, including Texas, Nebraska, Florida, New Hampshire, Ohio, Connecticut and within the UAE (Abu Dhabi Early Childhood Authority). Often, use of technology has been resisted by those who conduct casework, perceiving such technology primarily as instruments of management and accountability instead of a genuine asset to facilitate decision making and to improve services to families. (Gillingham & Humphreys, 2010). We have seen this situation in nearly every state we have worked. Yet when data and technology are well thought out, properly deployed, and used consistently, we have also witnessed measurably improved outcomes across safety, permanency, and well-being . The scope of our work plan will address a broad range of data and technological pitfalls and the approach employed will focus on specific recommendations that will improve productivity across staff as well as establish the most appropriate use of technology combined with case practice to measurably improving outcomes.

TSG's approach will include a comprehensive review of existing use of technology, areas where technology components or improper use of technology may be impeding outcomes, how short and mid-term plans will address current issues and identification of where gaps may remain. Assessment activities include in-person focus groups, stakeholder surveys, review of existing data sources, review of existing inputs (intake forms, assessment forms, etc), review of existing and future data exchange(s), review of mobility, assessment of caseworker tools and productivity gaps, use of business intelligence tools, use of analytics, review of overall operationalization and daily use of data, and review of business process automation.

An extensive analysis will include an overview of the various business processes that are in place for all applicable phases of service delivery. This includes the processes and information exchange involved in incoming reports; investigation; prevention services, referrals, utilization management, outcome tracking; placement; managing and maintaining case plan(s);

permanency; foster parent licensing and re-licensing; tracking of foster parent preferences, capacity, and communications; and methods for emergency management communications.

Focus groups will also be conducted, in coordination with the Workgroup, to identify business processes, data sources, data systems, and system interfaces. Surveys will be constructed, and a combination of survey data and/or focus groups will identify user experiences, productivities (gained or lost), desired capabilities that do not yet exist, use of paper, use of Excel, Word or other programs.

Assessment Topics will include the following:

- Business processes and alignment w/ technology and associated automation
- Use of paper
- Use of spreadsheets to track data
- Ancillary systems (outside of SACWIS)
- Programming interfaces and data sharing between partners and contributing agencies
- Electronic signatures
- Mobile apps
- Mobility integration with backend systems (SACWIS) and interfaces to support them
- Knowledge base
- Master data management strategy and operation
- Reporting; source of records, data marts, data warehouse, data lake
- Support for web services, API's (where, how broad)
- Data sharing, bi-directional
- Single audit pane and 360-degree views
- Data quality data quality plan
- Data sharing agreements
- Productivity tools for front line
- Foster parent participation in technology
- Document library
- Interface with document library
- Master document index
- Master client index
- Documentation of data, platforms, configuration, administration, backup, recovery, disaster management.
- Situational awareness and communications in emergency
- GIS services
- Alerting, notification (automation, what, who, when)
- System performance, bottlenecks, why, when
- IT continuity and communications plan
- System capacity
- Training (end user, system admin)
- Personnel redundancy (IT)

From the findings discovered, we will identify gaps and provide considerations for the Workgroup to consider related to possible new technology, in particular, for frontline staff. To that end we will focus on high priority functions not limited to the following:

- A system that provides readily accessible, detailed, and easy to read reports that contain accurate and timely information. Such reports should be interactive and specific for the target user (for example, different reports for case workers, supervisors, court staff, legal, etc).
- A system that can accurately and readily identify the location of children in foster care. This includes a complete journey of the child's previous placements, reasons for change, current placements, incidents at each placement (child specific, provider specific, etc) and the child to provider match score at each setting.
- A system that tracks timeliness of documentation requirements such as placement changes, face to face visitations, medical/dental check-ups, and more. An automated alerting system must notify user groups of upcoming [critical] activities, escalations of late activities and notifications that include status of key milestones.
- A system that considers variations in business processes across regions (such as quality assurance processes and protocols). Business processes may differ across regions, perhaps certain activities or forms that involve different workflows or approval processes. The system should easily accommodate with configuration changes of modular components.
- A system that includes CQI that supports a comprehensive feedback loop (for example, frontline staff and provider collaboration). A complete feedback loop must include bi-directional, electronic communications (within the system) and span all parties involved.
- A system that provides frontline staff access to relevant data reports and information at any time from any location and from any device. Furthermore, the frontline staff must have the capability to submit documentation is real-time (including but not limited to completing forms, obtain electronic signatures, upload photographs, and upload documents). Workers must also have immediate access to supervisors and/or emergency personnel.
- A system that provides access for foster parents. This includes an unsolicited, bi-directional flow of information where the agency can reach foster parents and foster parents can reach agency staff. Foster parent access must support the ability to submit or communicate concerns, needs, status, documents, and have access to emergency personnel.
- A system that can present insights of foster home limitations, including lack of foster homes in geo-graphical areas. The system must address diligent recruitment of foster and adoptive parents. The system must have the capacity to present geo-spatial views showing areas that have gaps with an understanding of what is required to address such gaps.
- A system that provides the capability to match available placements to the needs of the child. The match criteria must be more than rudimentary and must consider the characteristics of the child with the capabilities, capacity and successes of the foster home.
- A system that supports secure and auditable teleconference and video capabilities from the field and to/between any/all support staff. Teleconference and video calls have been

on the rise, largely due to COVID but its value is now more indispensable than ever. Teleconferencing/Video must NOT be out of band and managed by a siloed 3rd party. The system must include the ability to schedule and track such conferences, the host and the participants.

TSG will deliver a series of assessment findings to the Workgroup, seek input and guidance and identify areas of significance that will help support the development of recommendations on achieving a technology platform that is based on standards, is interlocked with case practice, supports contributing agencies and downstream providers, provides economies of scale, maximizes productivity and positively impacts outcomes.

Legal/Judicial Systems & Practices

One of the unique characteristics of child welfare systems is the overlap and integration of work and responsibility between the executive and judicial branches of government. While state child welfare agencies hold responsibility for delivering services to children and families, juvenile courts make key decisions determining if children have experienced maltreatment, when family separation is a necessary, how and when children exit foster care, and whether the child welfare agency has made appropriate and necessary efforts to prevent removal or achieve permanency. In this respect, courts themselves are a component in a state's system of care.

Involvement with the legal/judicial system also can serve as an overwhelming and challenging experience for parents. Already in a state of crisis and having had their children removed, parents often encounter a punitive legal process disinterested in understanding what they need to move to stability and well-being. Accordingly, moving a state child welfare system to a supportive, family-centered practice often requires changes not only to child welfare practice, but also the legal/judicial system.

Given the authority judges wield over child welfare cases, meaningful child welfare transformation requires judicial engagement, collaboration, and alignment of efforts. Court expectations for reasonable efforts findings affect workload and often create geographic variation in workforce needs based on varying judicial expectations from locality to locality. The relationships between investigators and case managers and judges and attorneys as well as the overall environment within the courtroom affect staff experiences, the duration of their tenure with the agency, and ultimately the agency's workforce needs. And changes to policy and practice expectations for frontline staff without corresponding alignment in judicial expectations, or incongruence between agency and judicial priorities, place staff in an untenable position with competing demands on their work. TSG proposes a four-focus assessment related to judicial systems and practices.

First, TSG will assess the current priorities, expectations, and perspectives of judicial leaders, judicial staff, and attorneys. Judges and attorneys possess a unique perspective into the work of investigators and case managers, often seeing gaps in practice exposed through the judicial process, and this assessment will serve to reinforce the workgroup's assessment of policy and practice while simultaneously allowing TSG to determine whether DHHS and Nebraska's legal/judicial community share common values, priorities, and goals.

Second, TSG will conduct an in-depth review of reasonable efforts findings in DHHS cases. Because these findings are a prerequisite for Title IV-E eligibility, ensuring that courts consistently make reasonable efforts findings is an important element of stewarding DHHS' financial resources. But, more importantly, reasonable efforts findings are intended to serve as a source of accountability for ensuring quality casework. Meaningful reasonable findings—those that probe whether DHHS made all efforts that were reasonable under the specific facts and circumstances—can serve as an effective mechanism for reinforcing practice expectations. If

leverage properly, this may serve as an important resource to the workgroup in designing the implementation plan for the State's new practice model.

Third, TSG will review legal/judicial education related to juvenile court proceedings. Effective reasonable efforts findings depend on an in-depth knowledge of social work practice and the resources available to DHHS case managers. Similarly, decisions regarding removal or permanency require knowledge of trauma and its effects on human development and well-being and protective factors. Oftentimes, legal/judicial education omits these key aspects of practice.

Finally, TSG will review Nebraska statutes and court rules governing practice and procedure in juvenile courts to ensure they align with present DHHS goals and priorities. Courts, as highly regulated and structured systems, often operate with outdated legal structures that continue to determine the outcome cases despite changes in priorities and practice. Aligning these structures with other transformative efforts is necessary for comprehensive reform.

The TSG team brings proven experience integrating transformative child welfare strategies with legal/judicial systems. In addition to our experience leading state child welfare agencies, TSG's team includes two attorneys, one of whom led a partnership between the Mississippi Department of Child Protection Services, the Mississippi Supreme Court, the Mississippi Court Improvement Project, and juvenile court judges across Mississippi.

In TSG's assessment approach for legal/judicial practice and expectation alignment, TSG will work with DHHS staff to gather:

- Data on case numbers and types by local court jurisdiction.
- Aggregate data on Title IV-E ineligibility related to judicial contrary to the welfare and reasonable efforts findings, including local jurisdiction-level data.
- A sample of court orders from local jurisdiction across the state.
- Copies of all DHHS policy and training related to courtroom appearances or presentation, preparation for participation in judicial proceedings, and interactions with attorneys and courts.
- All Nebraska courts rules, states, and standing orders governing the conduct of child welfare cases in Nebraska courts.
- Any existing training materials for Nebraska judges, attorneys, and court staff provided by DHHS related to child welfare cases.
- The Nebraska Court Improvement Project (CIP) state plan.

TSG will review these materials in preparation for engagement with legal/judicial stakeholders. Based on this review, TSG will work with the workgroup to identify key focal points for that engagement and develop a comprehensive legal/judicial engagement plan. As part of this planning process, TSG will work with the workgroup to identify key legal/judicial stakeholders, including:

- State CIP staff.
- State judicial leaders in the appellate courts or state administrative office of courts.
- Juvenile and county court judges.
- Attorneys frequently practicing in juvenile courts representing the state, children, and parents.

- Guardians ad litem, Court Appointed Special Advocates (CASAs), or other non-attorney courtroom advocates.
- Nebraska law school faculty or staff who do work related to juvenile court practice.
- Providers of legal services for indigent individuals.
- Nebraska Bar Association representatives who work on access to justice initiatives.

Following the identification of key legal/judicial stakeholders, TSG will employ a multi-prong approach for engaging these stakeholders and collecting their feedback, including:

- One-on-one meetings and interviews.
- Focus groups.
- Online surveys.
- Presentations/trainings.

As these engagement process continues, TSG will continuously debrief with the DHHS Project workgroup and adjust its approach if necessary. We will also update the workgroup on findings regularly.

After the conclusion of these engagement efforts, TSG will analyze all the information it has reviewed and collected and synthesize its findings for the Workgroup and DHHS and, as appropriate and approved by DHHS leadership, with the legal/judicial stakeholders who participated in the assessment.

Medicaid, Managed Care, and Behavioral Health Systems Alignment

State child welfare systems often fail to fully leverage Medicaid-funded services as a source of specialized care and additional capacity for meeting the needs of child welfare service recipients. Leveraging these resources is important component in an effective system primary prevention, secondary, and tertiary prevention as well as a key tool to meet the needs of children in out-of-home care. TSG has proven experience working with state child welfare systems to ensure they utilize Medicaid-funded services and managed care organization capacity to meet the needs of their clients.

Child welfare service recipients often experience acute medical, behavioral, and pharmacological needs. The child welfare agency cannot meet these needs on its own, but often bears the most direct responsibility for doing so. Many challenges child welfare agencies experience in preventing family separation, maintaining placement stability, and achieving permanency sit downstream of their inability to effectively connect children and parents to the medical, behavioral, and pharmacological services that will ensure their well-being.

This portion of the assessment would involve walking through the current interactions of the child welfare agency and Medicaid services available through the Medicaid Managed Care Organizations (MCOs) to ensure that medical, behavioral health and social determinants of health needs are met. The assessment would consider the degree of coordination between frontline child welfare state and managed care organizations and how and when child welfare staff access client's Medicaid information, coordinate services with MCOs and how the child welfare staff maximizes the available, and sometimes required, network resources of the MCO. It also would identify any overduplication of staff efforts, administrative burden, and opportunities to streamline processes.

TSG's assessment approach for Medicaid/Managed Care Organization Alignment and Utilization will include review of the Nebraska Medicaid state plan, managed care organization contracts,

and other Medicaid policy documents related to care for child welfare service recipients to understand the current landscape of Medicaid funded supports through the MCO system in the state. It also will involve a review of child welfare policies related to managing healthcare services. TSG will work with DHHS staff to identify key stakeholders with a firsthand understanding of current partnership between Medicaid MCOs and child welfare programs, including:

- State child welfare staff responsible for medical and therapeutic services.
- State Medicaid staff responsible for children's services and targeted child welfare programs.
- State staff responsible for behavioral health services.
- Representatives of managed care organizations.

TSG and the workgroup will assess managed care organization staff interaction with DHHS child welfare case workers in a multidisciplinary manner in the community and MCO efforts in assisting the State and providers in building capacity for FFPSA Clearinghouse Evidence Based Prevention Programs, especially "well supported" programs that are billed to Medicaid.

Following the identification of key stakeholders, TSG will employ a multi-prong approach for engaging these stakeholders and collecting their feedback, including:

- One-on-one meetings and interviews.
- Focus groups.
- Online surveys.
- Presentations/trainings.

TSG also will work with DHHS to collect the Medicaid claims data for service rendered to child welfare service recipients. This may require engagement with state Medicaid officials and manage care organizations. TSG will analyze this data to identify patterns or gaps in utilization. Specific attention will be paid to placement in inpatient treatment, outpatient service utilizations, access to wraparound supports and targeted case management, and frequency of care.

From this assessment, TSG will report its findings to the workgroup and work with the workgroup to identify potential opportunities for collaboration with Medicaid Manage Care providers that could fill gaps in care and/or support the coordination of medical services for children in the newly recommended system design. We will then use this analysis to identify any gaps and, along with the national best practice findings, align these findings with the practice model recommendations so that the transformation encompasses the important area of promoting child well-being. In fact, this is a great opportunity for Nebraska to adopt a world class system of integration and multi-disciplinary action with key components of the state's Medicaid, behavioral health and social determinants of health practices.

TSG's work with the Annie E. Casey Foundation has involved a focus on ways states leverage Medicaid-funded behavioral health services to prevent children and families' involvement with the child welfare system. TSG will bring that experience to the Workgroup and together will assess whether changes in DHHS's behavioral service delivery models could help improve the functioning of Nebraska's new future child welfare system.

Financing

Building the best possible system of care and implementing the ideal practice model depend upon making the best use of DHHS' fiscal resources. Accordingly, TSG's effort with the workgroup to assess Nebraska child welfare financing will focus on optimizing the resources available to DHHS

for the implementation of its new practice model. To do so, TSG will have to comprehensively assess all sources of fiscal support for Nebraska child welfare services as well as funding for other child and family serving systems that may enhance DHHS' ability to achieve quality outcomes.

TSG is uniquely positioned to assist DHHS with the development of its new child welfare finance model. TSG's prior Nebraska projects on assessment Treatment Family Care and the Eastern Service Array both included assessment of Nebraska's Title IV-E claiming. And the Treatment Family Care assessment also included an in-depth review of Medicaid utilization for services to Nebraska child welfare service recipients. This experience, coupled with financial assessments in other states, will inform TSG approach with the Nebraska workgroup to reviews its statewide finance model.

In this portion of the review, TSG will comprehensively assess DHHS' use of federal child welfare funding sources, including Title IV-E claiming, Title IV-E eligibility, the Promoting Safe and Stable Families grant, the Community Based Child Prevention Services Grant, and Title IV-B Child Welfare Services funding. Regarding Title IV-E, TSG will lead the workgroup through an effort to:

- Review the state's public assistance cost allocation plan,
- Review eligibility determination processes,
- Review data on reasons for Title IV-E ineligibility and assess opportunities to increase the State's penetration rate,
- Assess state fund expenditures for uncaptured match for Title IV-E claims, and
- Review FFPSA implementation and potential for expanded prevention services funding.

Beyond child welfare funding sources, TSG also will review opportunities to expand and improve services to child welfare services recipients through utilization of Medicaid, TANF, SSBG, and other social services programs.

As TSG develops its proposed practice model recommendations with the workgroup, it also will assess the expected fiscal impact of these changes and work with DHHS to develop a realistic budget for the new practice model. Part of this assessment include analysis of per child and family costs across service types and potential efficiencies that may be achieved through alternative models. TSG has performed a similar assessment as a subcontractor on a project for the Colorado Department of Human Services.

TSG will lead the workgroup through an assessment of current requirements, identified problems and operational stress points, and potential solutions.

2.b.3. Task 3: Assessment of Current Practice on Disproportionality

Child welfare systems often produce disproportionately adverse outcomes and effects for minority children and families. And these disparities exist across racial and ethnic groups, tribal affiliation, sexual orientation and gender identity, socio-economic status, and urban, suburban, and rural communities. State child welfare agencies in the last decade have acknowledged this problem, but few have developed systemic solutions that have proven successful.

Nebraska is not an exception to these trends. For instance, as depicted in the charts below, the African American disparity gap is larger in Nebraska when compared to other states, and the American Indian disparity gap is large when compared to other races[4].

Figure 2: 2020 Nebraska Foster Care Caseload by Race

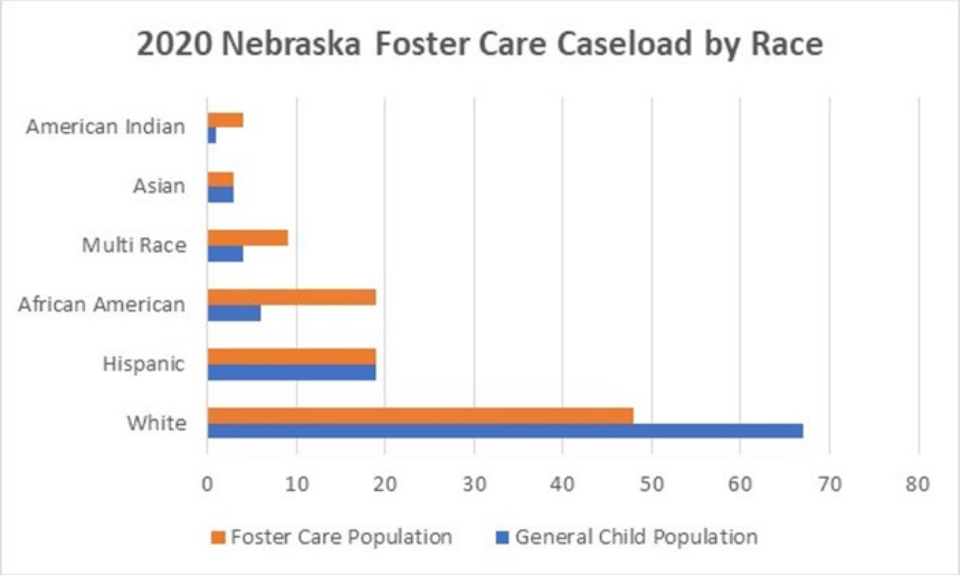
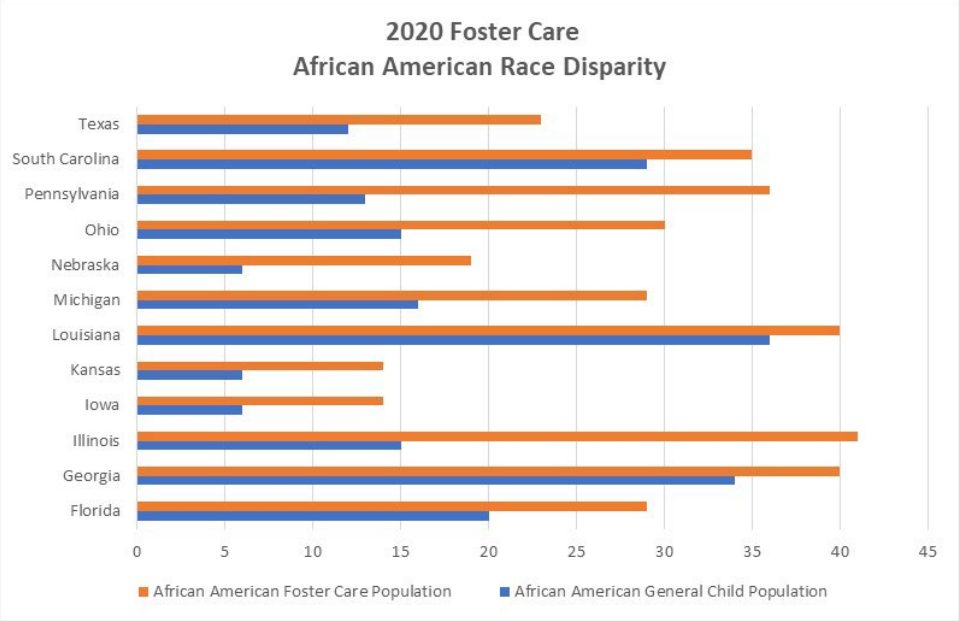


Figure 3: 2020 Foster Care African American Race Disparity



Our approach to pursue equity in the practice and finance models will begin with engaging DHHS and the workgroup to collectively examine statewide, regional, and local data to identify

[4] https://www.childtrends.org/

areas of disproportionality and disparity. In addition, TSG will review and summarize national research, examine statewide policy, and research national best practices.

TSG will use a cross-functional approach and focus on the intersection of foster care and other systems to avoid a one dimensional analysis. TSG and the workgroup will work with a broad array of stakeholders and community thought leaders throughout the state in a series of focus groups to collect information and possible solutions. The focus groups will involve collaborating with system leaders, communities, and engaging minority young people and families to learn directly from them about what works. TSG also will work with the workgroup to identify practices within DHHS that can strengthen cultural competence and reduce implicit bias.

Prevention services will also be looked at as they can strengthen families and decrease the number of children entering care, regardless of race, ethnicity, or other minority status. The implementation of evidence-based prevention practices should be prioritized in Nebraska to augment the framework of the FFPSA and align with strategies to improve equity.

2.b.4. Task 4: Evaluation of Child Welfare Practice Models

A jurisdiction's child welfare practice model serves as the foundation for integrating practice, investment, and system design decisions toward the achievement of the jurisdiction's specific goals in outcomes for children and families. A comprehensive practice model includes a concrete vision for system improvement and success, clearly articulated values and principles underlying that vision, measurable outcome and performance measures, core intervention components designed to achieve those outcomes and performance measures, and investments in system structures and resources that support and enable those core intervention components.

There is no one-size-fits-all practice model appropriate to every jurisdiction. Instead, a practice model must be tailored to a particular jurisdiction if it is to achieve the jurisdiction's desired ends. Many considerations influence what the right child welfare practice model design encompasses for a particular state. Some key considerations include, but are not limited to:

- Goals and desired areas of improvement in outcomes and performance measures.
- Population demographics and trends within social determinants of health for the population.
- The geographic distribution of populations and system resources.
- Resource availability and constraints.
- The strength of the workforce and talent pool within relevant professional disciplines.
- The strength and specialties of the private service provider community.
- The feasibility of cross-sector and interagency collaboration.
- Relationships between key stakeholders.
- Public trust in existing structures.
- Openness to change.

TSG's approach to evaluating child welfare practice models across the country will take into consideration all the key considerations above and together with DHHS leadership and the workgroup will:

- Agree on a set of frameworks, policies, practices, metrics, and other considerations on which to benchmark Nebraska with other states
- Conduct a review and study of the different systems of care that have produced good outcomes and agree on a few state systems or aspects of integration and other components that are important to Nebraska and align with gaps found during the assessment
- Conduct analysis of the specific state system, including background on evolution, stakeholder involvement from the design, development and implementation, system and provider integration throughout, delivery of practice model, alignment with other government agencies and departments, provider support, management and performance-based models, involvement of community-based organization and non-profits, etc.
- Provide listing to the workgroup of components of system, including practices and policies and obtain agreement on ones to advance to recommendations
- Develop a summary report of each system reviewed and analyzed and the importance to providing the outcomes Nebraska is looking for in its future child welfare system

TSG will bring to this part of the project the necessary national child welfare experience from projects in large states with metropolitan and rural areas, and small states with largely rural areas, like Nebraska. These experiences will assist DHHS in developing the right child welfare practice model to meet Nebraska's needs, bringing experience as both state leaders and consultants for jurisdiction utilizing a variety of practice models and service delivery structures in diverse jurisdictions.

For example, when Nebraska was tasked by DCFS to assist in developing a future Treatment Foster Care Model, TSG conducted a comprehensive review of other state best practices and included in the report its analysis in terms of applicability to Nebraska DCFS's desired state, and a report that included detailed information of the requirements of the Texas, Washington, Michigan, Georgia, and Florida models of Medicaid reimbursed Therapeutic Foster Care. These models could then be used to launch a successful framework for implementation in Nebraska.

TSG also has direct experience recently in evaluating best practice state child welfare service delivery and practice models for one of its projects with Annie E. Casey Foundation's Center for Systems Innovation, The TSG team provided an in-depth assessment of national best practices in state integrated systems of care that blended mental and behavioral health supports with child welfare systems. During that assessment, the TSG team provided an in-depth analysis and overview of the background, model, and outcomes of New Jersey's Children's System of Care, OhioRise, the Indiana Children's Mental Health Initiative, and two other models in Florida and Texas. Each of those state child welfare programs provided innovative systems of care with unique characteristics and their respected scopes extended a statewide system of child behavioral health services, concrete resources, and social supports for a state's entire population of children to a specific intensive in-home clinical services model.

Thus, TSG will not only bring this type of approach to this best practice evaluation task but will also rely on its own national experience to help guide DHHS leadership and the workgroup to the

specific recommendations that best fit the objectives of Nebraska DHHS in developing its own future system of care.

2.b.5. Task 5: Formalize Recommendations and Facilitate a Theory of Change Model

Our recommendations will focus on ensuring DHHS (1) minimizes the occurrence of child maltreatment through the effective use of community-based services, (2) delivers effective support services that safely prevent removal, (3) timely reunifies every family whose child can safely return home, (4) identifies a permanent family for every child who cannot be reunified, and (5) provides appropriate services to children in out-of-home care.

To accomplish this objective, TSG will facilitate the development of a theory of change to establish how early and intermediate accomplishments will set the stage to achieve long-range results. We will engage key stakeholders to clearly articulate assumptions about the process through which change will occur and specify the ways in which all the required early and intermediate outcomes related to achieving the desired long-term change will be brought about and documented as they occur. Through this facilitation, stakeholders will be led through a series of exercised designed to clearly identify what will change, how the change will occur, the time period for change, what resources will be brought to the table, and what outcomes are expected as a result of the change. An example a programmatic theory of change developed by TSG is depicted below.

Figure 4 Theory of Change

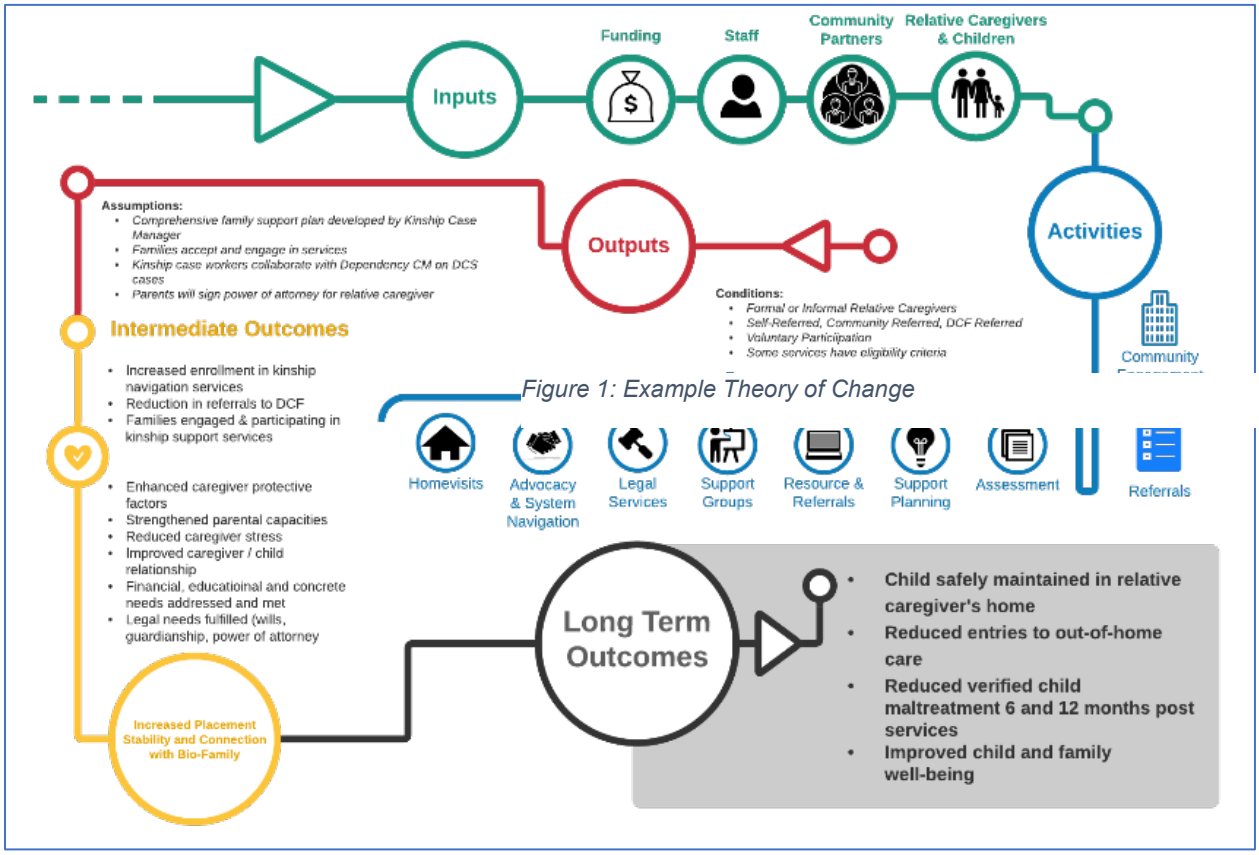


Figure 1: Example Theory of Change

Formalize recommendations and facilitate a theory of change model for implementation of child welfare practice model and finance model to include:

a. Leadership needed from three branches of government, identifying support needed to both implement finance and practice models; and create strategies and processes for shared accountability;
b. Strategies for phased implementation of practice model;
c. Strategies for phased implementation of finance model:
d. Engagement and partnership with Tribal partners;
e. External partnerships to promote improved outcomes for children and families;
f. Partnerships and shared strategies across all State agencies;
g. Workforce strategies for training, workloads, salaries and retention;
h. Strategies to improve Nebraska's child fatality review process to review child fatalities with a suspicion of child abuse and neglect designed to develop learning and prevention strategies.

It is critical to align strategy with the people that are going to implement the operations process. Child welfare agencies will not execute unless the right people, individually and collectively focus on the right details.

Improving quality outcomes for children and families is directly aligned with an agency's ability to build a high-quality, professional, and stable workforce with manageable caseloads. Child protective services (CPS) workers help children and families in complex environments that demand a skilled and professional workforce. The work requires a specialized set of intellectual and behavioral skills with appropriate and effective training.

Child protective services workers provide a unique and essential service to support the children and families served by the Nebraska Department of Health and Human Services. The role is a complex and challenging job that requires significant mental and emotional demands (Kothari et al., 2021; Annie E. Casey Foundation, 2003). As a result, the field has seen significant levels of turnover for more than three decades (Lipien et al., 2020). More specifically, national estimates indicate case manager turnover exceeds 30% (Casey Family Programs, 2017).

High CPS turnover disrupts continuity and stability of service for the families they serve, but also creates instability in the workplace through increased workload and the depletion of skilled workers. Child welfare leaders know high attrition amongst the CPS workforce has a direct effect on the quality of services and a negative impact on service outcomes. Improving the recruitment and retention of skilled workers is of critical importance to ensure the continuity of quality services and maintaining reasonable stability in the workforce and workload. In a 2008 report, the Child Welfare League of America suggested that,

"No issue has a greater effect on the child welfare system's capacity to serve at-risk and vulnerable children and families than a shortage of competent and stable workforce."TSG's approach to help Nebraska improve their workforce stability will analyze the factors most determinantal to child protective services workers recruitment and retention. TSG will offer a multi-faceted methodology as a means of not only identifying key associated factors, but also a comprehensive approach to validation. TSG will deploy in-person focus groups, stakeholder surveys, agency data analysis, national literature review, national CPS salary comparison, Nebraska CPS salary comparison with similar professions, caseload analysis, and comparison to the existing and revised CWLA caseload standards.

Throughout the process of developing the Theory of Change and project implementation plan, TSG and the DHHS workgroup will circulate drafts for consideration by the workgroup, DHHS leadership and the key external stakeholders. The focus of this consultation will be to ensure that

key stakeholders (1) understand the theory of change and implementation plan, (2) agree that it that it represents the best path forward for child welfare transformation in Nebraska, and (3) are committed to their obligations within the implementation plan.

2.b.6. Task 6: Identification of Training Needs

TSG and the workgroup will collaborate to develop a comprehensive training plan and any corresponding Request for Proposal (RFP) language that ensures Nebraska's professional development activities align with the needs of the new practice and finance models. As part of this task, TSG will lead the workgroup through an assessment of DHHS' current training modalities, activities, and curricula for conformity with the workgroup's recommendations for the new models. We also will support the workgroup with research into national best practices in training for child welfare staff.

The training needs and changes identified by this assessment will not be limited to those for frontline staff or DHHS employees. Within DHHS, we will ensure the workgroup develops training resources for all staff whose work impacts the practice and finance models. And outside DHHS, TSG will work with the workgroup to identify training needs for all key stakeholders (e.g. DHHS legal, Guardian Ad Litem (GAL), judges, law enforcement, county attorneys, providers, Court Appointed Special Advocate (CASA), etc.) to support the recommended practice model.

This assessment will require close collaboration with the key stakeholders themselves, but also entities involved in their training. This may include institutions of higher education, credentialing or certifying entities, professional associations, and trade associations. It also may require engagement with the state Legislature to create, remove, or modify statutory credentialing requirements.

2.b.7. Summary

No vendor can match TSG's senior-level systems design and leadership experience across all these domains. The entirety of TSG's work is dedicated to ensuring that child and family serving systems improve their client's well-being. Our work is outcomes focused every step of the way and committed to rigorous assessment of the efficacy of state interventions. We also prioritize stakeholder input, ensuring that all those affected by a proposed solution—youth, parents, staff throughout an organization, community partners and service providers, courts, and legal advocates—have a meaningful opportunity to inform its development.

Throughout the assessment approach, TSG and the workgroup will co-facilitate engagement strategies with DHHS' identified key external stakeholders. They will be provided repeated opportunities throughout the project lifecycle for consultation, evaluation, and input of every work product produced by the workgroup.

These values underlie TSG's success executing similar projects in the past, and TSG believes no other vendor can match the breadth and depth of its relevant experience. TSG senior consultants have conducted comprehensive or targeted child welfare related assessments in Nebraska, Texas, Florida, Mississippi, and Arkansas. These assessments have included end-to-end assessments in Texas and Florida, the two largest state-administered child welfare systems in the country. They also have included targeted focus on treatment foster care (Nebraska), structured decision making (Nebraska), provider management (Nebraska), intake and assessment (Mississippi), and medical services for foster children (Arkansas). Additionally, TSG is the only vendor who has co-led the efforts of the Annie E. Casey Foundation's Center for Systems Innovation's work to develop a Family Well-being Strategy Group focused on identifying best practices in primary and secondary prevention and FFPSA implementation.

TSG's successful work delivering transformative solutions for child welfare systems comes from the unique expertise of our team. Unlike larger firms who may delegate work to junior associates with little experience, all of TSG's services are provided by Senior Consultants with deep expertise in the project focus areas. And in addition to its consulting services, TSG's team has extensive experience working in and leading state child welfare systems from frontline investigative and case management functions up to cabinet-level secretaries and commissioners, giving us first-hand understanding of the challenges and pressures DHHS faces and focusing our consulting on realistic solutions.

2.c. Technical Considerations

2.c.1. Project Communications

Transparency is an essential requirement in any project. TSG is committed to including stakeholders and sharing information from the beginning. A clear concise communication plan helps to ensure this transparency. The communication process provides a structured approach to creating and delivering information, defining audiences, and establishing delivery methods. The process ensures accurate and consistent communication conveyed timely, to the right audience, and via the most appropriate means. Having an established communication framework ensures relevant, accurate, and consistent information is always provided to appropriate stakeholders.

Throughout the project's lifecycle, TSG will utilize multiple mechanisms to maintain open and active communications with DHHS that keep DHHS leadership and staff up to date on the project and allow TSG to constantly refine its approach to meet DHHS' expectations for each deliverable. First and foremost, TSG's Monthly Progress Reports will provide detailed information on the completion of assessment activities and the development of TSG's recommendations.

Our communications will include the following best practices in communication to ensure effective communication:

- Project Status Reporting — Comprehensive reports are used in regular status meetings.
- Action Plans — The creation and execution of action plans are recommended whenever realized project risks or outstanding project issues indicate intervention is needed.
- Risk and Issue Management — Each risk and issue are assigned to an individual for monitoring and planning and are reported on and evaluated in regular status meetings.
- Quality Management — All deliverables are reviewed for technical and business correctness, as well as adherence to standards.
- Change Management — TSG follows proper change review process by identifying and agreeing to procedures to adjust the scope and communicate any changes.

TSG also will share drafts of deliverables as necessary and solicit feedback from DHHS leaders and staff throughout their development.

2.c.2. Project Management

As demonstrated throughout this proposal, TSG's team of consultants has proven experience managing large-scale projects in both consulting and state leadership capacities, including the management of child welfare assessment and transformation projects for the two largest state administered child welfare systems in the country: Texas and Florida. And unlike other prospective vendors, all of TSG's work on this project, including project management, will be conducted by the Senior Consultants TSG has identified. The Project Sponsor, Project Manager, and Senior Consultants all will provide hands project management services.

TSG overall approach to project management for this assessment will focus on open and constant communication and an aggressive timetable that allows for adjustment in the back-half of the project. By dedicating a Senior Consultant as the lead for each assessment topic area, TSG will be prepared to engage in assessment activities for each topic simultaneously. This will ensure time remains later in the project for any additional assessment activities that emerge as necessary during the project's lifecycle.

2.c.3. Needs from DHHS

The size and scope of this project requires an aggressive assessment timetable. As such, TSG will need a DHHS workgroup who can dedicate time to this project. The members of this group must be accessible for meetings and document review throughout the project lifecycle. TSG does not intend to conduct assessment activities in isolation. Rather, based on the requirements of this RFP, the workgroup will be engaged in the assessment process alongside TSG. Similarly, TSG will need access to DHHS staff and external stakeholder for focus groups, interviews, surveys, and operations observation throughout the project.

Beyond the commitment of staff time, TSG will need access to all DHHS policy, procedures, training materials, internal operating procedures, and other documentation establishing practice expectations. It also will need timely access to DHHS data including, but not limited to, AFCARS, NCANDS, management reports, data dashboards, and case reviews.

2.d. Project Work Plan

TSG's Project Work Plan will be finalized with DHHS leadership during contract negotiations and the weeks immediately following the contract start date, but the timeline provided below identifies TSG's expected timeframes for the project.

The visioning process will run from the contract start date (currently expected December 1, 2022) until March of 2023. During this phase, TSG will work with DHHS to ensure that every relevant key stakeholder group in Nebraska's child welfare system has an opportunity to contribute to the new statewide mission and vision, values and practice priorities, and program goals. This portion of the Project Work Plan is pivotal as stakeholder consensus around a shared conceptional framework for change and commitment to the implementation of strategies for achieving that change may be the single greatest determinant of success.

Accordingly, TSG intends to utilize multiple methods for collecting feedback and building consensus during this phase, including:

- A preliminary meeting with DHHS leadership.
- An Initial Kickoff Meeting with the workgroup.
- An Initial Community Vision Meeting with the key stakeholders.
- Focus groups, individual interviews, electronic surveys with the key stakeholders and DHHS staff.

Following these activities and by late February, TSG and the workgroup will have worked with DHHS leadership to draft Nebraska Child Welfare Vision, which will then be circulated for feedback from the key stakeholder groups. And before the end of March, the Vision will be finalized. Table 8: Visioning Timeline provided below identifies TSG's expected timeframes for these activities:

Table 6: Visioning Timeline

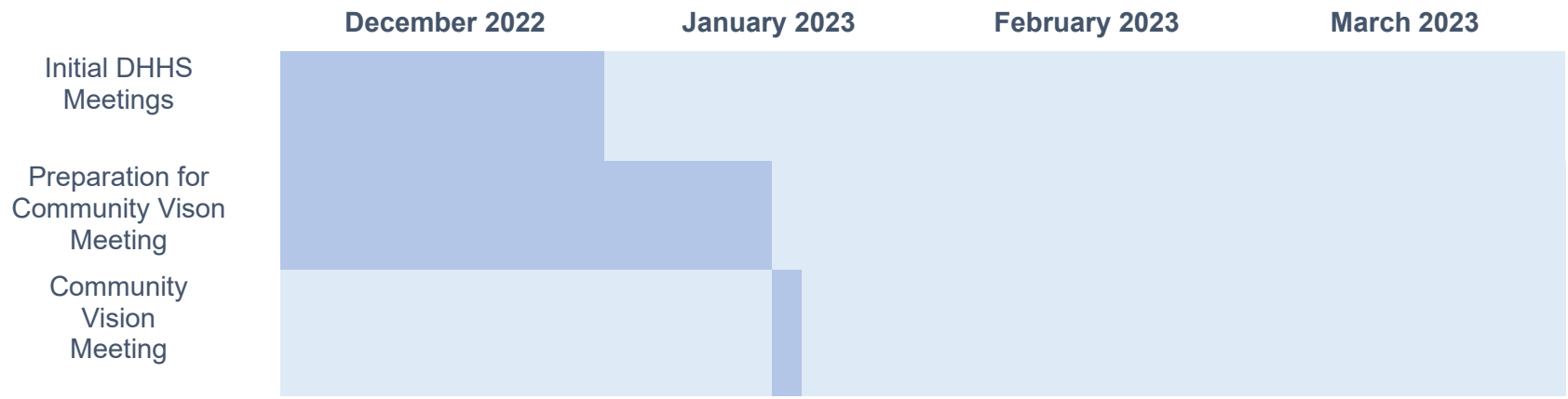
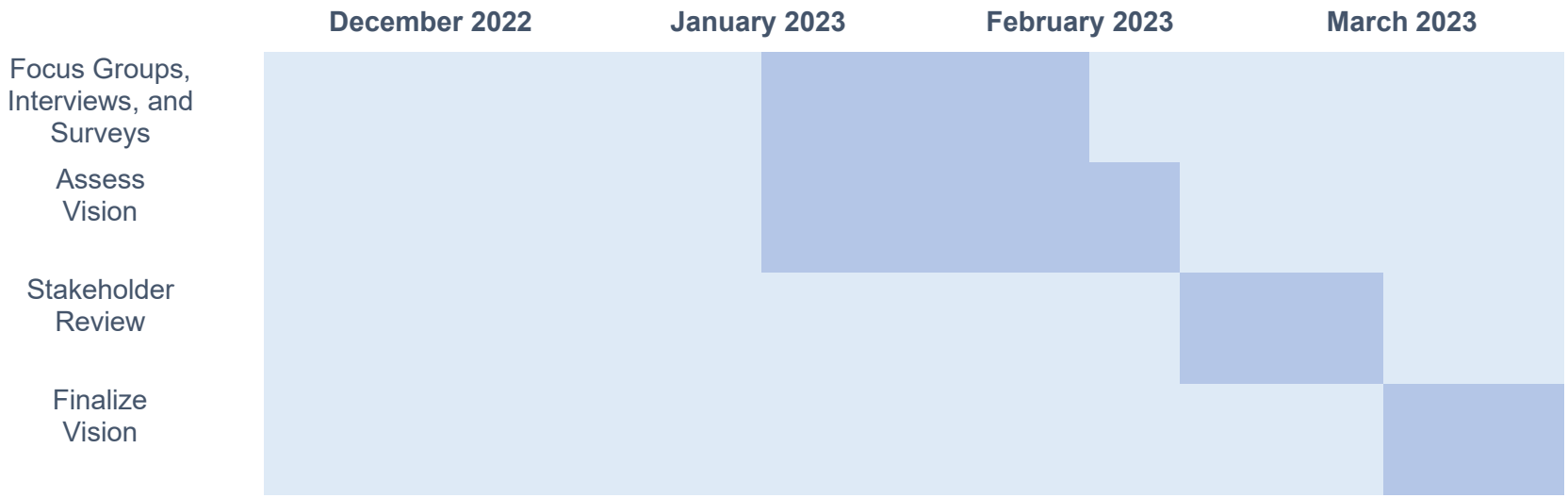


Table 6: Visioning Timeline

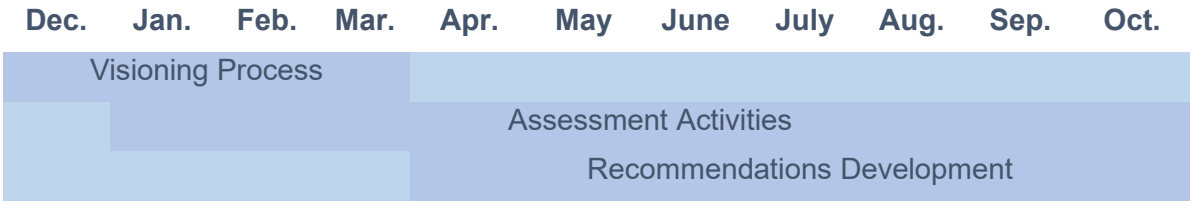


During the visioning process, TSG intends to utilize a combination of onsite and remote work. TSG will be onsite with DHHS, at a minimum, for the Initial Kickoff Meeting, Initial Community Vision Meeting, Visioning Focus Groups and Interviews, and the TSG/DHHS joint finalization of the Nebraska Child Welfare Vision. This will complete Task 1: Strategic Visioning for Transformational Change.

The assessment process will begin on or about January 1st and will run until November 1, 2023. During this time, TSG will lead the workgroup through its end-to-end assessment of Nebraska's child welfare system of care and develop recommendations for new child welfare practice and finance models. This will include the focus groups, interviews, surveys, practice and operations observation, data and documentation review, and best practice and peer state comparisons described Proposed Development Approach above. Throughout this process, DHHS' key stakeholders and DHHS leadership will be provided opportunities to review and provide feedback on the workgroup's assessment. The assessment will culminate in the delivery of the TSG/workgroup recommendations for new practice and finance models as well as training requirements and RFP language by November 1, 2023.

Because the Child Welfare Vision will establish the vision and mission, values and practice priorities, and program goals for the future of Nebraska's child welfare system, the precise Project Work Plan and timelines for assessment will depend upon the Child Welfare Vision created as TSG and workgroup will refine and adapt their approach to meet the State's needs and goals. Accordingly, the tentative Table 9: Assessment and Recommendations Timeline provided below is subject to change depending upon the needs of the State.

Table 7: Assessment and Recommendations Timeline



This portion of the project timeline will include completion of Tasks 2 through 6.

After November 1, 2023, TSG's focus will shift to implementation planning with the workgroup. TSG will work with DHHS to finalize the new Nebraska child welfare practice and finance models and plan for their implementation. TSG will provide support as needed to DHHS leadership and staff as they review the workgroup's recommendations and finalize the practice and finance models they wish to adopt. Then, once these decisions have been made, TSG will work with DHHS to develop a detailed implementation plan. The specific timeline in this phase will depend upon the practice and finance models adopted by DHHS.

2.e. Deliverables and Due Dates

TSG acknowledges the following deliverables and anticipates their delivery on the following dates consistent with the RFP and proposed Project Work Plan.

Table 8: Deliverables and Due Dates

Project Phase	Deliverable	Due Date
Visioning	First Monthly Report/Final Recommendation of Timelines	January 10, 2023
	Monthly Report	February 10, 2023
	Monthly Report	March 10, 2023
Assessment and Recommendations	Monthly Report	April 10, 2023
	Monthly Report	May 10, 2023
	Monthly Report	June 10, 2023
	Monthly Report	July 10, 2023
	Monthly Report	August 10, 2023
	Monthly Report	September 10, 2023
	Monthly Report	October 10, 2023
Implementation Recommendations	Training Assessment	November 1, 2023
	Final Report of Implementation Recommendations	January 31, 2024

3. APPENDICES

3.a. Nebraska Treatment Family Care and Rate Analysis Report

Sent as an attachment with this document.

3.b. Nebraska Eastern Services Area Assessment Report

Sent as an attachment with this document.

3.c. Nebraska Standardized Decision Making Assessment Report

Sent as an attachment with this document.

II. TERMS AND CONDITIONS

Contractors should complete Sections II through VI as part of their proposal. Contractor is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The contractor should also provide an explanation of why the contractor rejected the clause or rejected the clause and provided alternate language. By signing the solicitation, contractor is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and contractor fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this solicitation. The State of Nebraska reserves the right to reject proposals that attempt to substitute the contractor's commercial contracts and/or documents for this solicitation.

The contractors should submit with their proposal any license, user agreement, service level agreement, or similar documents that the contractor wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the contractor's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JMS			

The contract resulting from this solicitation shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the solicitation;
3. Questions and Answers;
4. Contractor's proposal (Solicitation and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JKS			

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally, electronically or mailed. All notices, requests, or communications shall be deemed effective upon receipt.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

C. NOTICE (POC)

The State reserves the right to appoint a Buyer's Representative to manage [or assist the Buyer in managing] the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the Contractor will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Statutory)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK

The contractor shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
JKS			

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties.

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

G. CHANGE ORDERS OR SUBSTITUTIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

*****Contractor will not substitute any item that has been awarded without prior written approval of DHHS*****

H. VENDOR PERFORMANCE REPORT(S)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State may document any instance(s) of products or services delivered or performed which exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications. The State Purchasing Bureau may contact the Vendor regarding any such report. Vendor performance report(s) will become a part of the permanent record of the Vendor.

I. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The State may recover from the Contractor as damages the difference between the costs of covering the breach. Notwithstanding any clause to the contrary, the State may also recover the contract price together with any incidental or consequential damages defined in UCC Section 2-715, but less expenses saved in consequence of Contractor's breach.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

K. NON-WAIVER OF BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. INDEMNIFICATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

1. GENERAL

The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this solicitation.

3. PERSONNEL

The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. **SELF-INSURANCE**
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. ATTORNEY'S FEES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. ASSIGNMENT, SALE, OR MERGER

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS OF THE STATE OR ANOTHER STATE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Contractor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. FORCE MAJEURE

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. CONFIDENTIALITY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

S. OFFICE OF PUBLIC COUNSEL (Statutory)

If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract.

T. LONG-TERM CARE OMBUDSMAN (Statutory)

Contractor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

U. EARLY TERMINATION

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar day's written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable; and,
   i. In the event funding is no longer available.

V. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;

5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the contractor's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. EMPLOYEE WORK ELIGIBILITY STATUS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/bidopps.html
2. The completed United States Attestation Form should be submitted with the solicitation response.
3. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this solicitation.

D. COOPERATION WITH OTHER CONTRACTORS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. PERMITS, REGULATIONS, LAWS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

F. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

G. INSURANCE REQUIREMENTS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within five (5) years of termination or expiration of the contract, the contractor shall obtain an extended discovery

or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and five (5) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**

   The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**

   The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

   The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory**. **The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$300,000 each occurrence
Contractual	Included
XCU Liability (Explosion, Collapse, and Underground Damage)	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
USL&H Endorsement	Statutory
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$3,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

3. EVIDENCE OF COVERAGE

The Contractor shall furnish the DHHS Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work. The awarded contractor will receive a notification from DHHS requesting the COI, once the Intent to Award is posted.

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. **DEVIATIONS**

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

H. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If Contractor breaches the contract or anticipates breaching the contract the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, and may include a request for a waiver of the breach if so desired. The State may, at its discretion, temporarily or permanently waive the breach. By granting a temporary waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

I. ANTITRUST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

J. CONFLICT OF INTEREST

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

K. ADVERTISING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

L. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)

Contractor shall review the Nebraska Technology Access Standards, found at https://das.nebraska.gov/materiel/docs/pdf/Technology%20Access%20Clause%2020210608%20FINAL.pdf and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

M. DISASTER RECOVERY/BACK UP PLAN

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

N. DRUG POLICY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

O. WARRANTY

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Despite any clause to the contrary, the Contractor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry

standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Contractor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to Customer, or if Contractor is unable to perform the services as warranted, Contractor shall reimburse Customer the fees paid to Contractor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

P. LOBBYING

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

1. No federal or state funds paid under this RFP shall be paid for any lobbying costs as set forth herein.
2. Lobbying Prohibited by 31 U.S.C. § 1352 and 45 CFR §§ 93 et seq, and Required Disclosures.
   a. Contractor certifies that no federal or state appropriated funds shall be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this award for: (a) the awarding of any federal agreement; (b) the making of any federal grant; (c) the entering into of any cooperative agreement; and (d) the extension, continuation, renewal, amendment, or modification of any federal agreement, grant, loan, or cooperative agreement.
   b. If any funds, other than federal appropriated funds, have been paid or will be paid to any person for influencing or attempting to influence: an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with Contractor, Contractor shall complete and submit Federal Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. Lobbying Activities Prohibited under Federal Appropriations Bills.
   a. No paid under this RFP shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation of the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any state or local government itself.
   b. No funds paid under this RFP shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than normal and recognized executive legislative relationships or participation by an agency or officer of an State, local or tribal government in policymaking and administrative processes within the executive branch of that government.
   c. The prohibitions in the two sections immediately above shall include any activity to advocate or promote any proposed, pending or future federal, state or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale of marketing, including but not limited to the advocacy or promotion of gun control.
4. Lobbying Costs Unallowable Under the Cost Principles. In addition to the above, no funds shall be paid for executive lobbying costs as set forth in 45 CFR § 75.450(b). If Contractor is a nonprofit organization or an Institute of Higher Education, other costs of lobbying are also unallowable as set forth in 45 CFR § 75.450(c).

Q. AMERICAN WITH DISABILITIES ACT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor shall comply with all applicable provisions of the Americans with Disabilities Act of 1990 (42 U.S.C. 12131–12134), as amended by the ADA Amendments Act of 2008 (ADA Amendments Act) (Pub.L. 110–325, 122 Stat. 3553 (2008)), which prohibits discrimination on the basis of disability by public entities.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

Neb. Rev. Stat. §81-2403 states "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency" Standard term is to pay after deliverables and that any alteration of that standard term should be carefully considered and used only when absolutely necessary to accommodate certain critical exceptions, i.e. insurance premiums, etc. that must be paid in advance.)

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. The Contractor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. Contractor must submit monthly Invoices to Contract Manager, which will be provided upon contract execution. The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT (Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2403). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. LATE PAYMENT (Statutory)

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Statutory)

The State's obligation to pay amounts due on the Contract for a fiscal year following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Statutory)

The State shall have the right to audit the Contractor's performance of this contract upon a thirty (30) days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. §84-304 et seq.) The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

A. BUSINESS REQUIREMENTS

For the purpose of garnering insights, the project plan should include focus groups, site visits and other methods of qualitative data collection. Project plan should include recommendations for system assessment timelines, responsible partners, methods of engagement and completion tracking.

B. PROJECT OVERVIEW

1. Facilitate a workgroup that will develop a practice and finance model for child welfare system transformation in Nebraska; with consultation, evaluation and input from key stakeholders (judges from separate juvenile courts, private child welfare providers, individuals with lived experience in the child welfare system, the Nebraska Children's Commission, the Inspector General of Nebraska Child Welfare, the Foster Care Review Office, child advocacy centers, law enforcement, county attorneys and all Nebraska DHHS divisions). The practice and finance model shall include, but not be limited to:
    a. Development of a statewide mission and vision for the child welfare system in Nebraska;
    b. Development of values and practice priorities for the child welfare system in Nebraska;
    c. Development of statewide program goals;
    d. Development of a practice model for child welfare system case management and service delivery;
    e. Development of a finance model for child welfare services;
    f. Development of engagement strategies to support community involvement in child welfare system transformation;
    g. Development of strategies that strengthen relationships across the court system, probation, executive branch agencies, the State Department of Education, and community partners;
    h. Development of strategies that support integration of programs across child and family serving agencies;
    i. Development of accountabilities across the entire child welfare system;
    j. Evaluation of the State's Title IV-E claiming practices and identification of appropriate steps to optimize federal reimbursement for child welfare system expenditures;
    k. Opportunities and financial mechanisms for providers to pilot innovative solutions to meet program goals; and
    l. Development of a strategy for data collection and outcome monitoring.

C. SCOPE OF WORK

1. Facilitate strategic visioning for transformational change of the child welfare system to include:
    a. Robust collaboration of system partners;
    b. System accountability;
    c. Change management methodologies;
    d. Key performance indicators for during period of change.
2. Produce a project plan to facilitate an assessment of current child welfare practices, functions, conditions and partners to include:
    a. Policy
    b. Statute
    c. Nebraska best practices
    d. National best practices
    e. Quantitative data reports
    f. Licensing of foster and resource homes
    g. Prevention practices to support families at risk of entering the child welfare system to include following structures in Nebraska:
        i. Families First Prevention and Services Act (FFPSA) implementation;
        ii. Thriving Families Safer Children in Nebraska; and
        iii. Community Collaborative models
    h. Child welfare field practices, to include:
        i. Child Protective Services (CPS),
        ii. Preventative and CPS in-home services,
        iii. Child fatality review and oversite,
        iv. Placement of children in out-of-home care,
        v. Support of relative foster homes
        vi. Work with older youth

vii. Services to children and families to achieve reunification,
viii. Practices to achieve permanence including reunification, adoption and guardianship,
ix. Provision of physical health, mental health, educational and development services for children in out-of-home care; and
x. Mental health service array and gaps
xi. Workforce and caseload recommendations to include training, educational requirements and staffing model recommendations.

i. Children and Family Services (CFS) organizational structure and capacity, to additionally include recommendations of enhancing prevention design within FFPSA implementation,
j. Training of child welfare staff and partner agency staff,
k. Technology needs to support practice,
l. Financing structure:
   i. Provider rates; and
   ii. Title IV-E claiming
m. Organizational and systemic barriers to implementation of practice and finance models; and
n. Experience of partners with lived experience,
o. Systemic factors affecting child wellbeing and permanency,
p. Impacts of disproportionality on marginalized communities,
q. Mandated boards and commissions related to the oversight and review of child welfare, including the Children's Commission.

3. Provide assessment of impact of current practice on disproportionality for minority children and recommendations to ensure access and belonging.
4. Provide research and evaluation of multiple child welfare practice models; assess Nebraska's capacity to implement each.
5. Formalize recommendations and facilitate a theory of change model for implementation of child welfare practice model and finance model to include:
   a. Leadership needed from three branches of government, identifying support needed to both implement finance and practice models; and create strategies and processes for shared accountability;
   b. Strategies for phased implementation of practice model; and
   c. Strategies for phased implementation of finance model.
   d. Engagement and partnership with Tribal partners;
   e. External partnerships to promote improved outcomes for children and families;
   f. Partnerships and shared strategies across all State agencies;
   g. Workforce strategies for training, workloads, salaries and retention;
   h. Strategies to improve Nebraska's child fatality review process to review child fatalities with a suspicion of child abuse and neglect designed to develop learning and prevention strategies.
6. Identify training needs for child welfare staff to support recommended practice model and evaluate training Request for Proposal (RFP) language to ensure all aspects and identified needs are included.

D. Include a recommendation for transition of current training model and training RFP for child welfare training as current vendor contract ends in 2023.

1. Identify training needs for all stakeholders (e.g. DHHS legal, Guardian Ad Litem (GAL), judges, law enforcement, county attorneys, providers, Court Appointed Special Advocate (CASA), etc.) to support recommended practice model and develop a project plan for deployment.
2. Assess workforce needs and structure of Central Office team (Programs, Finance, Quality Assurance and Policy) to support practice and finance model recommendations.
3. Evaluate workforce needs for Protection and Safety field staff based on the current statutory caseload standards versus emerging workload standards being researched by Child Welfare League of America (CWLA), and present recommendations for any needed changes to statutory standards.
4. Produce monthly status reports on behalf of the workgroup to be presented to the strategic leadership group.
5. Within thirty (30) calendar days of the end of the contract, a final report outlining the proposed practice and finance model for Nebraska is due; the report should also detail the information collected from the evaluation, assessment, and recommendations developed in conjunction with the workgroup and any data analysis which may have been completed. Final report will include recommended implementation timeline for all recommendations and theory of change steps.

E. DELIVERABLES

1. Monthly status report of activities, meetings, data analysis and deliverables met are due by the 10th of each month, commencing January, 2023. The first report, due January 10, 2023, must include a final recommendation of the timelines for the duration of the contract to be mutually agreed upon with DHHS.

2. Final report outlining recommendations for practice and finance model for Nebraska's child welfare systems, as well as summary of all activities, evaluations, and data analysis which aided in the final recommendations will be due on or before November 1, 2023.
3. Recommendations for training that will be needed in order to implement practice and finance model by CFS for new worker and in-service training, as well as stake-holder training.
4. Within thirty (30) calendar days of the end of the contract, a final report outlining the proposed practice and finance model for Nebraska is due; the report should also detail the information collected from the evaluation, assessment, and recommendations developed in conjunction with the workgroup and any data analysis which may have been completed. Final report will include recommended implementation timeline for all recommendations and theory of change steps. Workforce needs and structure of central office to support finance and model recommendations, workforce and caseload recommendations, and strategies to improve Nebraska's child fatality review process designed to develop learning and prevention strategies.

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by contractors in preparing the Technical and Cost Proposal. Contractors should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. **CONTRACTOR IDENTIFICATION AND INFORMATION**
The contractor should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the contractor is incorporated or otherwise organized to do business, year in which the contractor first organized to do business and whether the name and form of organization has changed since first organized.

b. **FINANCIAL STATEMENTS**
The contractor should provide financial statements applicable to the firm. If publicly held, the contractor should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the contractor's financial or banking organization.

If the contractor is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The contractor must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. **CHANGE OF OWNERSHIP**
If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the contractor should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded contractor(s) will require notification to the State.

d. **OFFICE LOCATION**
The contractor's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

e. **RELATIONSHIPS WITH THE STATE**
The contractor should describe any dealings with the State over the previous five (5) years. If the organization, its predecessor, or any Party named in the contractor's proposal response has contracted with the State, the contractor should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. **CONTRACTOR'S EMPLOYEE RELATIONS TO STATE**
If any Party named in the contractor's proposal response is or was an employee of the State within the past twelve (12) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the contractor or is a Subcontractor to the contractor, as of the due date for proposal submission, identify all such persons by name, position held with the contractor, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the contractor may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. **CONTRACT PERFORMANCE**

If the contractor or any proposed Subcontractor has had a contract terminated for default during the past five (5) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the contractor's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the contractor or litigated and such litigation determined the contractor to be in default.

It is mandatory that the contractor submit full details of all termination for default experienced during the past five (5) years, including the other Party's name, address, and telephone number. The response to this section must present the contractor's position on the matter. The State will evaluate the facts and will score the contractor's proposal accordingly. If no such termination for default has been experienced by the contractor in the past five (5) years, so declare.

If at any time during the past five (5) years, the contractor has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. **SUMMARY OF CONTRACTOR'S CORPORATE EXPERIENCE**

The contractor should provide a summary matrix listing the contractor's previous projects similar to this solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the contractor during its evaluation of the proposal.

The contractor should address the following:

iv. Provide narrative descriptions to highlight the similarities between the contractor's experience and this solicitation. These descriptions should include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a contractor performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

v. Contractor and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as Subcontractor projects.

vi. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, Subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. **SUMMARY OF CONTRACTOR'S PROPOSED PERSONNEL/MANAGEMENT APPROACH**

The contractor should present a detailed description of its proposed approach to the management of the project.

The contractor should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of

the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The contractor should provide resumes for all personnel proposed by the contractor to work on the project. The State will consider the resumes as a key indicator of the contractor's understanding of the skill mixes required to carry out the requirements of the solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. **SUBCONTRACTORS**

If the contractor intends to Subcontract any part of its performance hereunder, the contractor should provide:

vii. name, address, and telephone number of the Subcontractor(s);
viii. specific tasks for each Subcontractor(s);
ix. percentage of performance hours intended for each Subcontract; and
x. total percentage of Subcontractor(s) performance hours.

2. TECHNICAL APPROACH

The technical approach section of the Technical Proposal should consist of the following subsections:

a. Understanding of the project requirements;
b. Proposed development approach;
c. Technical considerations;
d. Detailed project work plan; and
e. Deliverables and due dates.

Form A
Contractor Proposal Point of Contact
Request for Proposal Number 113287 O3

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the contractor's name and address, and the specific person(s) who are responsible for preparation of the contractor's response.

Preparation of Response Contact Information	
Contractor Name:	The Stephen Group
Contractor Address:	814 Elm Street, Suite 309 Manchester, NH 03101
Contact Person & Title:	John A. Stephen, Managing Partner
E-mail Address:	jstephen@stephengroupinc.com
Telephone Number (Office):	603-419-9592
Telephone Number (Cellular):	603-419-9592
Fax Number:	

Each contractor should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the contractor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Contractor Name:	Same as above
Contractor Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

CONTRACTOR MUST COMPLETE THE FOLLOWING

By signing this Request for Proposal for Contractual Services form, the contractor guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that contractor maintains a drug free work place.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN.

FIRM:	The Stephen Group
COMPLETE ADDRESS:	814 Elm Street, Suite 309 Manchester NH 03101
TELEPHONE NUMBER:	603-419-9592
FAX NUMBER:	
DATE:	9/21/22
SIGNATURE:	John A Stephen 9/21/22
TYPED NAME & TITLE OF SIGNER:	John A. Stephen, Managing Partner

Cost Proposal
Child Welfare Strategy Consultant
Request for Proposal Number 113287 O3

Bidder Name: The Stephen Group

Bidder must bid the Unit of Measure (UOM) pricing. Do not provide the extended cost. The State will calculate the extended cost by multiplying the quantity by the price bid for each line item.

Description	Quantity	UOM	Initial Contract Term Cost Date of Award – fifteen months
First Monthly Report incl timeline	1	EA	$25,000
Monthly Reports (Quantity Estimated)	9	EA	$5,000
Final Report and Timeline	1	YR*	$250,000
Training Plan and Training for Stakeholders	1	YR*	$100,000

*For the contract term, the quantity for Year (YR) is from Date of Award through fifteen months.

THE STEPHEN GROUP

NEBRASKA TREATMENT FAMILY CARE AND FOSTER CARE RATE ANALYSIS

JUNE 2021

THE STEPHEN GROUP

Nebraska Treatment Family Care and Foster Care Rate Analysis

1. Table of Contents

2. Executive Summary

The Nebraska Department of Health and Human Services, Division of Children and Family Services (DCFS) engaged The Stephen Group (TSG) to evaluate three recommendations by the Foster Care Reimbursement Rate Committee (FCRRC) regarding adding a fourth level of reimbursement for high needs children, adopting the Nebraska Caregiver Responsibility tool and adopting the Treatment Family Care service definition and rate setting structure.

In evaluating these recommendations, TSG interviewed numerous DCFS staff, providers, FCRRC members and other stakeholders. TSG also reviewed historical and real-time data, Nebraska regulations and recent reports and analyzed best practices in other states and survey results.

After completing these evaluations, the following report offers these analyses of the FCRRS recommendations.

2.1. Adding a Fourth Level of Reimbursement for High-Needs Children

DCFS should consider establishing a level of care between the existing Intensive and recommended Specialized tiers. We found that fewer than 10%, or roughly 200 children, meet the criteria of high needs. Additionally, existing children receiving services through Letters of Agreement (LOA) were doing so at a level below the rates proposed by the FCRRC.

We found that the LOA process is ad hoc, and crisis driven, which has unnecessarily driven up costs. DCFS also has no standardized process to identify when to use a LOA or what the specific expectations are for care for children receiving service at this level.

Given all the aspects within the existing LOA structure that would lead to higher costs for the state, and that LOA costs are still below the proposed Specialized tier, a new tier, slightly below the existing LOA average, with clearly defined expectations of care and a standard process, would achieve the goals of better care for high needs children, fewer LOAs, removing barriers to permanency while reducing state costs.

Moreover, in adding an additional level of care, DCFS should work carefully to ensure all criteria are clearly established to ensure compliance to receive federal reimbursement. This consideration should drive the development of the methodology for creating this level of care.

2.2. Adopting Nebraska Caregiver Responsibility (NCR) tool

The NCR would benefit by conducting a normative scoring process to assure the instrument is valid for the purpose of assigning levels of care. Currently, the tool delineates level of effort on the part of the parent, without addressing the clinical needs of the child and treatment plans and available coverage options for parental education and use are not currently attached to the NCR. Harmonizing these two components would lead to better outcomes for children.

TSG strongly recommends that an independent standardized Evidence-Based assessment process and instrument for behavioral health needs and services covered by Medicaid be implemented. This approach would offer standardized assessments that would inform decision-making over the arc of a child's engagement with DCFS and would identify progression (or regression).

Additionally, there should be regular audits to ensure fidelity to the NCR for staff and supervisors. This would support consistent application of the tool and help support identifying the appropriate level of care for children.

2.3. Adopting Treatment Family Care Service Definition and Rate Setting Structure

The FCRRC's recommendation to adopt a Treatment Family Care model is sound. However, there are improvements that DCFS should integrate into the adoption of Treatment Family Care. This should start by identifying and implementing best practices from states that have seen success in implementing similar models. This report includes a number of best practice models nationally for DCFS to consider during this process.

Utilizing best practices in adopting Treatment Family Care would provide additional service definition criteria, clear expectations of providers and foster parents, enhanced training and accountability, education and outreach on covered Medicaid benefits, enhancement to the Medicaid service delivery system, cross agency data integration, continued division collaboration, and a continued focus on removal of barriers to permanency.

2.4. Additional Findings Recommended for Further Review

1) TSG found that existing maintenance per diems are established based on a rational approach and sound methodology and appear to be reasonable in nature. Also, administrative support rates fall within an expected range.
2) Nebraska is not claiming Title IV-E reimbursement for many expenditures related to LOAs. Such expenditures should be considered reimbursable if a child is placed in a child welfare licensed placement and is determined to be categorically eligible under Title IV-E requirements.
3) The Eastern Service Area serves statistically fewer youth at the Essential Level of Care and a higher number of children and youth at the Intensive Level of Care. While there may be many reasons for this, the discrepancy (24% at the highest levels of care versus 10% for the rest of the state) warrants additional investigation.
4) DCFS has done an extraordinary job over the past few years in significantly decreasing DD out-of-home foster care placements, reducing that number by over 35%.

5) TSG observed that there appears to be a fundamental lack of understanding of the Medicaid Managed Care system in the child welfare community and how to access the benefits and providers the MCOs provide.
6) TSG heard from providers that a covered Medicaid in-home behavioral health service and benefit for high needs children that was adopted by the FCRRC and made as part of their array of essential Treatment Family Care Medicaid Services – Community Treatment Aide – is often not available in Nebraska, even though this Medicaid benefit is required to be part of the Medicaid Managed Care Organization's service network. A review of Medicaid claims data for a four year period, from 2017 to 2020, identified that 51 foster care children out of 7,599 total foster care children with Medicaid claims during this time period, or .67% had claims for Community Treatment Aide (CTA).
7) In analyzing the intersection of DCFS, DMLTC, DPH, DBH and DDD, TSG found that each one of these agencies has its own eligibility system, assessment tools, and funding mechanisms and that there is no integrated case record that could be provided to a multi-disciplinary team responsible for their care with accurate, consistent, actionable information that can be utilized proactively in the placement and treatment process.
8) TSG found DCFS is competing with other Nebraska government entities for beds in the homes of community-based providers, which can allow bidding wars between multiple state agencies, driving up the cost of care.
9) The use of antipsychotics and antidepressants in the child welfare population is not based on a standardized prescription practices model.

3. Scope

The Nebraska Department of Health and Human Services (DHHS) Division of Children and Family Services (DCFS) contracted with The Stephen Group (TSG) to evaluate specific recommendations made by The Foster Care Reimbursement Rate Committee (FCRRC) of the Nebraska Children's Commission (Commission) to the Commission and the Health and Human Services Committee of the Legislature on June 22, 2020.

TSG evaluated the following FCRRC recommendations:

- The development and implementation of a fourth tier of reimbursement for specialized caregiving for children who have exceptional medical, behavioral, or developmental needs which necessitate extenuating caregiving responsibilities.
- The FCRRC recommended DHHS, Saint Francis and Tribal Courts adopt and implement the use of the revised Nebraska Caregiver Responsibility (NCR) Tool. The FCRRC's Nebraska Caregiver Responsibility assessment tool modifications reflected the uniqueness of the specialized level of responsibility and the needs of children and their caregivers achieving permanency through adoption or legal guardianship.
- The FCRRC recommended DHHS Divisions of Medicaid and Long-Term Care and Children and Family Services adopt the recommended Treatment Family Care service definition and rate structure contained in the Report.

In evaluating these three FCRRC recommendations, TSG focused its evaluation on the following questions:

1. Are the FCRRC's recommendations the best strategies and process for Nebraska to meet the needs of the target population(s) to lead to better outcomes and increased permanency?
2. Do the FCRRC's recommendations take into consideration the most important implementation factors facing Nebraska and is the current "Single Agreement" process the most efficient and cost-effective method to build a system of care and wrap-around for the target population(s)? If not, have other states come up with more effective models to achieve improved outcomes at reasonable costs?
3. Are there lessons learned or gaps identified that other states have taken into consideration in rolling out similar models to achieve design, implementation, and outcomes success; and,
4. Are there improvements that can be made to the recommended structure, model, rates, tools, and service definition and process that could improve outcomes, including outcomes related to essential Medicaid services that are a critical part of the new Treatment Family Care overlay.

4. Methodology

As part of this project, TSG conducted a detailed literature review, stakeholder engagement, state-by-state best practice survey, and Nebraska-specific data analysis, culminating in a report to DCFS detailing significant objective findings and realistic actionable recommendations.

TSG was also able to review and analyze Medicaid data for high needs children, particularly related to Medical, Behavioral Health and Pharmacy claims. This analysis also provided insight into important Medicaid utilization, access, and network capacity issues that will be important for both DCFS and the Division of Medicaid and Long-Term Care (DDMLTC) to consider in adopting or further modifying the FCRRC recommendations going forward.

TSG worked with DCFS to collect available documentation and data including from DHHS sister agencies and stakeholders interviewed. In addition, TSG conducted independent research specific to Nebraska's current health and human services landscape and identified applicable child welfare best practices from TSG's national expertise. TSG utilized the following tactics in drafting this final report:

1. Review of FCRRC Decision-Making Criteria and Information
    - Interviewed FCRRC members;
    - Reviewed FCRRC reports and meeting minutes dating back to 2014;
    - Analyzed survey results.
2. Nebraska Regulatory Analysis
    - Reviewed LB 541 including history, related FCRRC legislation, and amendments;
    - Reviewed DHHS agency regulations, including: DCFS, Medicaid State Plans, Medicaid Managed Care Organization contracts, DD, and BH.A
3. Literature Review
    - Reviewed more than 100 Nebraska-specific reports, many provided by DCFS.
4. Data Review
    - Reviewed DCFS level-of-care, placement, and Letters of Agreement (LOA) data.
    - Reviewed and analyzed Medicaid claims data for foster care children and youth
5. Stakeholder Engagement
    - Regular cadence of project meetings with DCFS;
    - Conducted 13 structured interviews, including: FCRRC members; DHHS Agency Staff (DCFS, DBH, DD, DMLTC); Probation and Court Improvement Project Administrator; child welfare providers (KVC, Omni, St. Francis Ministries); and associations (Child Saving Institute, Nebraska Foster and Adoptive Parent Association)

6. Multi-State Best Practices Research and Analysis

- Reviewed criteria including Title IV-E agency practices, foster care levels of care and rates, Medicaid system opportunities specific to children in foster care and multi-system youth including Managed Care Organization (MCO) contracts.
- Incorporated findings from Child Trends and other national state by state foster care rate reviews.
- Incorporated findings from Florida, Georgia, Kentucky, Texas, Ohio, Michigan, and Washington, related to their Therapeutic Foster Care models.

5. Assessment Findings

5.1. Findings Related to the Recommended Specialized (4th Tier) Level of Care

5.1.1. Title IV-E Maintenance and Administrative Support Rates: Federal Requirements

When implementing any Title IV-E rate setting system, a structured payment process for Child Placing Agencies must be carefully established as it will be eventually used to claim federal reimbursement. As a result, there are multiple factors that must be considered when developing the methodology. This section briefly describes some key points related to Title IV-E, the federal funding source for foster care maintenance and administrative costs.

Research completed in the development of this report found that every rate setting system reviewed cited federal guidance around cost standards and indicated their approach to rate setting was firmly grounded in these standards. To meet federal requirements, cost must be considered "reasonable" in nature. A "reasonable" cost is identified within *OMB Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.* Within the confines of OMB guidance, costs must be:

- allowable,
- reasonable, as defined above, but;
- must also be appropriately "allocated" to all benefiting programs or services; and
- be net of any applicable credits.

Federal documents offer the following guidance surrounding the allocation of costs to program or service and applicability of credits:

"Allocable costs.

a. A cost is allocable to a particular cost objective, such as a grant, contract, project, service, or other activity, in accordance with the relative benefits received. A cost is allocable to a Federal award if it is treated consistently with other costs incurred for the same purpose in like circumstances and if it:
    1) Is incurred specifically for the award.

2) Benefits both the award and other work and can be distributed in reasonable proportion to the benefits received, or
3) Is necessary to the overall operation of the organization, although a direct relationship to any particular cost objective cannot be shown.

b. Any cost allocable to a particular award or other cost objective under these principles may not be shifted to other Federal awards to overcome funding deficiencies, or to avoid restrictions imposed by law or by the terms of the award."

"Applicable credits.

a. The term "applicable credits" refers to those receipts, or reduction of expenditures, which operate to offset or reduce expense items that are allocable to awards as direct or indirect costs. Typical examples of such transactions are purchase discounts, rebates or allowances, recoveries or indemnities on losses, insurance refunds, and adjustments of overpayments or erroneous charges. To the extent that such credits accruing or received by the organization relate to allowable cost, they shall be credited to the Federal Government either as a cost reduction or cash refund, as appropriate.
b. In some instances, the amounts received from the Federal Government to finance organizational activities or service operations should be treated as applicable credits. Specifically, the concept of netting such credit items against related expenditures should be applied by the organization in determining the rates or amounts to be charged to Federal awards for services rendered whenever the facilities or other resources used in providing such services have been financed directly, in whole or in part, by Federal funds.

Title IV-E Administrative (Support) Payment

Federally Allowable administrative costs under title IV-E are defined in 45 CFR 1356.60(c)(2) as those "*costs necessary for the administration*[1] *of the foster care program:*

1. *Referral to services;*
2. *Preparation for and participation in judicial determinations; Placement of the child;*
3. *Development of the case plan;*
4. *Case reviews;*
5. *Case management and supervision;*
6. *Recruitment and licensing of foster homes and institutions;*
7. *Rate setting;*
8. *Proportionate share of related agency overhead;*
9. *Costs related to data collection and reporting.*"

[1] "Administration" in this context must be differentiated from "administrative costs" and is federally defined as those activities required to "execute the state Title IV-E Plan

Administrative Payments related to the cost of social services, including counseling and therapy, may not be part of the Foster Care Maintenance or Administrative Payment.

Social Services Payment

Allowable administrative costs do not include the cost of social services provided to the child, the child's family or foster family that provides counseling or treatment to ameliorate or remedy personal problems, behaviors, or home conditions. "Social services" are not allowable as maintenance payments under any circumstances, regardless of what type of person provides them. Examples of unallowable "social services" are: counseling and therapy to help with a child's adjustment at the institution; counseling and therapy to help a child resolve the problem(s) for which he or she was placed; counseling and therapy with the child and his or her biological family to resolve the difficulties that led to the need for placement; counseling and therapy to plan for the return of the child to the community; and psychological or educational testing, evaluation, and assessment.[2]

The Social Services portion of cost is subject to an allocation of staff and agency administration costs. In many jurisdictions this is determined through an annual time study. As with all items of care and for costs of administration and operation, the critical factor is the activity being performed and not the title or position of the performer.

Maintenance Payment

Though maintenance payments (payment to the foster parent for daily care and supervision of the child) are paid separately, it is important to have a complete understanding of what these costs include. In any rate setting methodology established for CPAs, those costs related to foster care maintenance must be separated from the “administrative payment” made to the CPA. The term “foster care maintenance payments” means payments to cover the cost of:

1. Food,
2. Clothing,
3. Shelter,
4. Daily supervision,
5. School supplies,
6. A child’s personal incidentals,
7. Liability insurance with respect to a child,
8. Reasonable travel to the child’s home for visitation, and
9. Reasonable travel for the child to remain in the school in which the child is enrolled at the time of placement. [3]

[2] Federal Administration for Children and Families; Children’s Bureau Child Welfare Policy Manual
[3] Social Security Act Sec. 475 (4)(A), [42 U.S.C. 675]

As stated in the legislative history of P.L. 96-272, "*payments for the costs of providing care to foster children are not intended to include reimbursement in the nature of a salary for the exercise by the foster family parent of ordinary parental duties*."[4] Therefore, basic maintenance payments to foster parents are intended to reimburse foster parents for the cost of those items listed above (food, clothing, shelter, personal incidentals, travel, and school supplies.)

Although Congress did not intend that salaries be paid under title IV-E to foster parents for ordinary parental duties, "daily supervision" is one of the items included in the definition of "foster care maintenance payments" in section 475(4) of the Social Security Act.[5] Since foster care maintenance payments are not salaries, foster parents must often work outside the home and a foster family parent who is working while a foster child is not in school will have to arrange for some form of alternate care, such as day care, for the daily supervision of the child. As a result, daily supervision" in family foster care may include the cost of childcare. Therefore, according to the Code of Federal Regulations (CFR 1355.20), daily supervision includes the cost of licensed childcare[6] when:

- Work responsibilities preclude foster parents from being at home when the child for whom they have care and responsibility in foster care is not in school, and
- The foster parent is required to participate, without the child, in activities associated with parenting a child in foster care that are beyond the scope of ordinary parental duties, such as attendance at administrative or judicial reviews, case conferences, or foster parent training.

Further, certain categories of children, including those with physical or emotional disabilities, may require more day-to-day supervision and attention than those without such conditions. Therefore, a supplement to the basic maintenance payment for a particular child is justified when the child has greater than usual needs for the items included in the definition, as determined by the State agency.[7]

5.1.2. Child Placing Agencies: Rate-Setting Models in Other States

Models for other states were reviewed to determine whether there were features or functionality which should be considered when developing a payment structure for administrative rates paid to child placing agencies. Methodologies were reviewed for ease of

[4] p. 5, House of Representatives, Report No. 96-900, April 23, 1980.
[5] Federal Administration for Children and Families; Children's Bureau Child Welfare Policy Manual
[6] The State of Nebraska pays the cost of childcare independently of the foster care per diem rate when the foster parent meets eligibility critiera.
[7] Federal Administration for Children and Families; Children's Bureau Child Welfare Policy Manual: https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp_pf.jsp?id=8

use, application of cost limits / determination of reasonable costs, whether the issue of "profit" is addressed, and audit requirements. In some cases, reports were designed to simply capture costs – the methodology to establish rates in these cases was not always clear or transparent to the provider. Other reports clearly captured costs and included a methodology to allocate costs into activity areas related to child placing agencies.

In reviewing rate models and approaches, TSG looked to materials and information from:

- California,
- Ohio,
- Wisconsin,
- Michigan,
- Indiana,
- New York,
- Kentucky,
- Illinois, and
- North Carolina.

Information regarding the processes and components used to establish provider rates in these states is included in Appendix A.

Considerations and Barriers in Reviewed Rate Setting Systems

Several factors were identified as playing a role in the validity of rates established when implementing a cost-based reimbursement system:

- **Rates sufficient to cover the cost of service:** In many instances, rate processes reviewed have not historically covered the full cost of service. In some cases, such as California, this is because rates were not updated or adjusted frequently enough. In other cases, such as Indiana, such an occurrence may be a byproduct of the rate setting process as retroactive costs and service units are used to establish prospective rates.
- **Frequency:** Frequency across methodologies varied, not only in terms of reporting intervals, but also in terms of establishing rates. In some states, cost reports are submitted annually but not used to establish rates with any regularity.
- **Cost adjustments and rate modifications:** Rates set using historical costs or applied to a multi-year period should be adjusted for changes to the cost of providing services or Cost of Living (COLA). A COLA should be based on available data and applied to cost or rates in a manner that aligns them with the time period the rate will be paid. If the rate covers multiple years, applying a COLA at regular intervals is acceptable and reasonable.

- **Variability in rates from period to period**: When rebasing payment rates on actual costs and utilization frequently, a variance in payment rates between time periods may result in excessive variability in payment. This may have a negative impact on the provision of quality services and create animosity between the paying agency and CPA. Some state associations recommend that three-year average be applied for the census calculation in each cost report, with the exception of cost reports for new programs and for those providers who have justification to request an administrative review based on the provider's unique circumstances.
- **Determination reasonable costs**: The definition of reasonable costs is federally established and gives considerable discretion to the paying agency within guidelines set by the federal government. Decisions regarding the establishment of reasonable costs are policy decisions and are not a function of the cost report itself. "Reasonable costs" are typically defined as, those a prudent person would incur in a similar circumstance. Given this, different rate methodologies have established various upper-end caps or limits to ensure cost is reasonable in nature. Caps vary across the methodology from almost non-existent, to fairly restrictive. Caps are most typically applied to:
    - Agency administration including executive leadership, finance and accounting, human resources, information technology, and overhead.
    - Fringe benefits (limited to a percent of reported salaries),
    - Indirect costs (definitions of indirect costs vary considerably),
    - Staffing-ratios may be considered in rate-setting methodologies. The application of such caps may be prudent in some situations but must be carefully constructed in order to not negatively impact case supervision, recruitment and other client-based activities provided by the CPA.

5.1.3. Nebraska's Current System of Rates to Include Recommended 4th Tier

Nebraska's foster care Title IV-E Maintenance and Administrative rates are established by a statewide committee representing stakeholders, foster parents, advocates, and providers. In developing their approach to setting rates, the committee looked to surrounding states to identify best practices and establish a comparative baseline. Given variances between states in provider contractual expectations, established age-ranges for children, and disparity in service criteria, the committee did not determine that any one state offered a valid, reliable standard against which the methodology could be directly compared. Based on their research, internal discussion, and concurrence among members, the committee has established a reasonable approach to establishing both administrative support and maintenance rates for three primary levels of care funded by the state and the recommended "Specialized" level of care.

Nebraska Foster Care Maintenance and Administrative Rates

Current foster care maintenance and administrative support rates are rates for the coming two years (July through June) are depicted in the chart, below. Rates will increase by two percent (2%) in July 2021 and July 2022. Current year rates are used for each of the analyses presented in the following sections.

		7/1/20 - 6/30/21	7/1/21 - 6/30/22	7/1/22 - 6/30/23
Foster Care Maintenance				
Essential	Age 0 - 5 years	$20.81	$21.23	$21.65
	Age 6 - 11 years	$23.93	$24.41	$24.90
	Age 12 - 18 years	$26.01	$26.53	$27.06
Enhanced	Age 0 - 5 years	$28.61	$29.18	$29.76
	Age 6 - 11 years	$31.73	$32.36	$33.01
	Age 12 - 18 years	$33.81	$34.49	$35.18
Intensive	Age 0 - 5 years	$36.41	$37.14	$37.88
	Age 6 - 11 years	$39.54	$40.33	$41.14
	Age 12 - 18 years	$41.62	$42.45	$43.30
Agency Supported Foster Care				
Essential Level		$22.64	$23.09	$23.55
Enhanced Level		$29.30	$29.89	$30.49
Intensive Level		$40.33	$41.14	$41.96

Title IV-E Maintenance Rates

Maintenance rates were based on USDA expenditure data with increases added at each level of care to compensate for the foster parent's need to provide additional supervision and care of the child. A fourth level, Specialized, was recommended by the committee in the past year. This rate was added to match rates paid by the private provider in the Eastern Service Area (ESA) and the Department of Juvenile Justice. Maintenance rates established by the committee are depicted in the following table:

Age	Essential	Enhanced	Intensive	Specialized (New Level)
0-5	*$22.26*	*$29.76*	*$37.26*	*$77.75*
6-11	*$26.06*	*$34.56*	*$42.06*	*$82.55*
12-18	*$28.73*	*$36.23*	*$44.73*	*$84.22*

While Nebraska's rates are not equivalent to those established by other states due to variances in level of care service definitions and variances in age ranges, the overall range (low to high) of

rates calculated by the committee appear to be reasonable in nature when compared to other jurisdictions.

For example, the state of Indiana's rates are based on a study of foster parent expenditures completed by Ball State University[8]. The University determined that both common sources, USDA Expenditure Data and the M.A.R.C. (MARC) Study, used to calculate foster per diem payments present certain limitations which can lead to misrepresentations in the calculation of the per diem. As a result, the university determined their approach, "*represents the most comprehensive analysis of costs associated with foster child care to date. The approach is designed to capture true incremental costs of foster care that are allowable under Title IV-E of the Social Security Act, with particular attention to disaggregation of individual cost elements. This permits varied uses of the data in the administration and management of foster care and related services".* Since completion of the study in 2011, rates have been adjusted regularly by the State to account for inflation and the increased cost of living. Presently, foster parent per diems paid by the State of Indiana are as follows:

Age	Foster Care	Foster Care with Services	Therapeutic Foster Care	Therapeutic Plus
0-4	*$21.59*	*$29.36*	*$41.50*	*$65.25*
5-13	*$23.44*	*$31.17*	*$43.31*	*$67.06*
14-18	*$27.05*	*$34.72*	*$46.86*	*$70.61*

In addition, current rates in Ohio and Texas are in the following ranges:

- Texas: $27.07 to $92.43 / day
- Ohio[9]: $34.45 – $73.69 / day

In addition, TSG compared Nebraska's rates to national averages to assess the reasonability of rates established by the committee. In doing so, TSG reviewed multiple sources and ultimately relied on *Basic Foster Care Rates* from a 2012 report published by ChildTrends examining national foster care rates. As their report was published in 2012, TSG adjusted their calculations through the application of a 2% annual COLA. The following table provides an adjusted average of nationally "Basic" foster care per diems calculated by ChildTrends by age of child. Rates at higher levels of care are based on the variance between Nebraska's existing levels of care. Please note, the following levels of care may not directly coincide with Nebraska's established levels. As such, they are simply intended to be a comparative analysis against which Nebraska's current rates may be assessed for reasonability.

[8] 2001, Ball State University, Foster Care Cost Survey of Indiana, https://www.in.gov/dcs/files/SurveyMethodReport081611.pdf
[9] Ohio rates based on average per diem payments made by Child Placing Agencies, as reported to ODJFS at assessed levels of care.

	Basic	*Mild Therapeutic*	*Therapeutic*	*Therapeutic +*
Age 0-2	*$26.54*	*$39.05*	*$69.81*	*$125.96*
Age 3-5	*$27.28*	*$39.33*	*$70.10*	*$126.24*
Age 6-8	*$29.97*	*$42.02*	*$72.79*	*$128.93*
Age 9-11	*$31.05*	*$43.10*	*$73.86*	*$130.01*
Age 12-14	*$32.60*	*$44.66*	*$75.42*	*$131.56*
Age 15-17	*$33.15*	*$45.20*	*$75.96*	*$132.11*

On average, ChildTrend's report determined that states paid an average of 70% to 76% of the expected per diem. Applying this factor to the calculated rates generates the following estimates.

	Basic	*Mild Therapeutic*	*Therapeutic*	*Therapeutic +*
Age 0-2	$20.52	$32.57	$63.33	$119.48
Age 3-5	$20.73	$32.79	$63.55	$119.69
Age 6-8	$21.88	$33.93	$64.69	$120.84
Age 9-11	$21.73	$33.78	$64.55	$120.69
Age 12-14	$23.80	$35.85	$66.61	$122.76
Age 15-17	$24.20	$36.25	$67.01	$123.16

Given this research, TSG finds there is no single best practice identified against which Nebraska's Title IV-E Maintenance per diems can be assessed. Instead, we compared the calculated rates to ranges across multiple states. In this, we find rates calculated by Nebraska's Rate Committee to be reasonable and within expected ranges for each level of care. We recommend the Committee continue their work and monitor these rates on a regular basis to ensure they appropriately reimburse foster parents for their level of effort and commitment to children placed in their care.

Title IV-E Administrative Support Rates

Administrative support rates are based on required staffing levels within three primary categories, case management, supervision, and recruitment/licensing. Staffing ratios and average salaries for each position have established for each level of care and are used to calculate a daily direct staff cost. To this cost, fringe benefits, overhead and a Cost-of-Living Adjustment (COLA) have been added to arrive at the daily administrative payment rate. As shown in the following table, rates for each of the primary levels of care have been established based on agreed upon staffing ratios and salaries. Given an approximate distribution of children by Level of Care (LOC) (based on the NCR Tool) over an extended period of time, the average administrative rate paid by the state is $30.08.

Level	Rate	Approximate % @ LOC	Weighted Rate
Essential	*$26.92*	*60.26%*	*$16.22*
Enhanced	*$32.16*	*28.44%*	*$9.15*
Intensive	*$41.73*	*11.30%*	*$4.72*
Specialized	*$78.95*	*N/A*	*N/A*
Blended Daily Rate	-	***100%***	***$30.08***

As with Nebraska's Title IV-E Maintenance Rates, the comparison of administrative support rates paid by Nebraska to child placing agencies proves difficult due to variances in service definitions, contractual expectations, and established levels of care. With this in mind, TSG looked to several states (Indiana, Minnesota, and Ohio) to determine whether Nebraska's rates appear reasonable in relation to service expectations established by the state.

These states were selected because cost data is collected annually from each contracted provider and administrative reimbursement rates are established based on the allowability of these expenditures under Title IV-E.

The limitations of this approach are based in variances to the contractual expectations placed on the child placing agencies and the acuity of children placed through these agencies. For instance, Indiana primarily uses child placing agencies to work with foster parents and children of higher need and acuity. The state internally recruits, licenses, and manages a significant number of foster homes to care for children at a "basic" level of care who don't require high levels supervision, behavioral supports, or therapeutic treatment. The State of Ohio permits child placing agencies to define individual levels of care for their programs, which leads to significant variability across the state. Within the context of these limitations, TSG sees the value in completing a comparative analysis to these states as their payments represent the actual cost of care provided by organizations in each state.

- **Indiana**: Indiana's rate methodology establishes a single administrative payment per provider regardless of the child's level of care. Across the thirty (30) providers operating in the state, these rates range from, $32.20 per day to $118.85 per day. Statewide, the administrative payment averages $55.02 per day of care. Again, this rate is likely higher than it would be if the private agencies handled all foster placements meeting the state's basic level of care. The state does not publish identifying data indicating whether individual providers care for youth of certain acuity or diagnosis. Therefore, a direct comparison to Nebraska's rates is not possible. Rather, this comparison is meant to assess whether Nebraska's rates appear to be reasonable and fall within an expected range of rates.

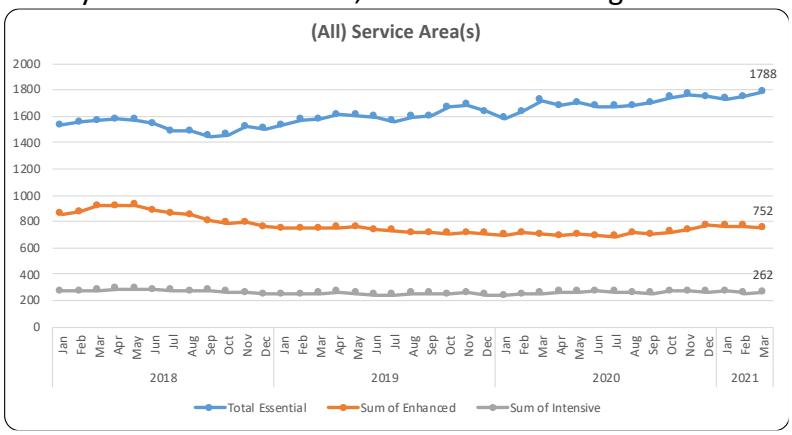
- **Ohio**: In reviewing Ohio's rates, TSG assessed levels of care identified by each agency and associated each with one of five presumed levels of intervention and child acuity. The average payments at each level were then blended using the percent of children typically placed at each level. Through this approximation, we calculated administrative support rates ranging from $35 per day at a basic level to $98 per day at the highest level of care. The calculated, blended administrative rate, for the state is approximately $39 per day.
- **Minnesota**: Though more difficult to assess due to the way statewide data was provided, 2020 rates paid to child placing agencies in the State of Minnesota ranged between the upper $20 to the mid $30 for basic levels of care and as high as mid $80 for therapeutic levels of care.

Based on our review of Title IV-E requirements, FCRRC's recommended rates at all levels of care, and a comparative analysis to cost-based rates calculated in other states, we find that rates established by the committee appear to be within the range expected for such services. In general, we find administrative support rates to be calculated on a rational methodology and to be generally reasonable in nature.

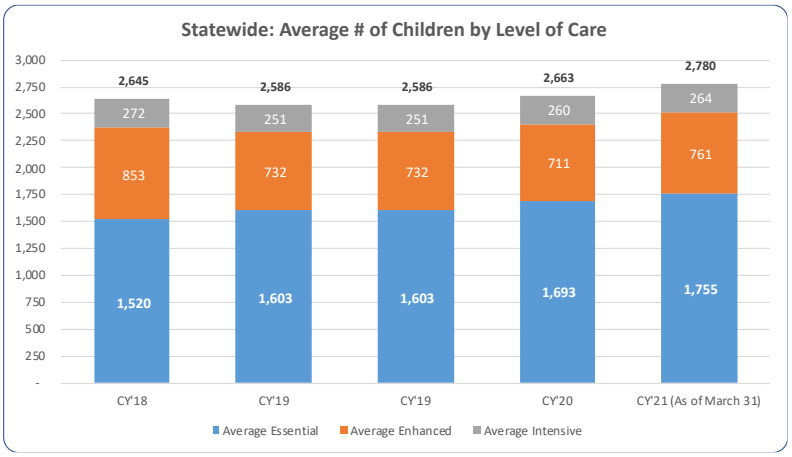
Finally, during TSG's interviews with child placing agency providers, several noted the need to "supplement" state payments with external funds in order to meet expenses associated with the operation of their child placing activities. It is recommended that the Rate Setting Committee continue to work diligently within its membership to continually assess staff ratios, direct expenditures, and administrative overhead percentages used to establish rates and determine whether they adequately reflect time and efforts associated with each Level of Care and compensate providers for the cost of services provided.

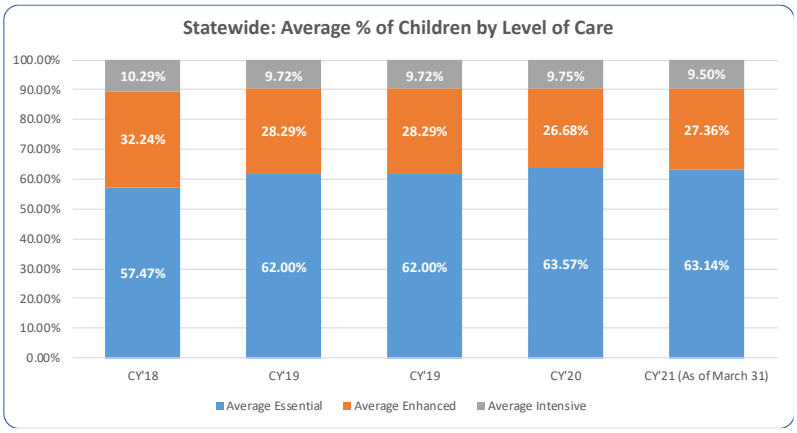
5.2. Findings Related to Data Analysis of High Needs Children and Youth in Foster Care

In any given month during the current calendar year across Nebraska, there are an average of 2,780 children and youth residing in the three (3) established levels of foster care. The distribution of children and youth across the three (3) levels of foster care has not changed substantively. At a statewide level, the percent of children determined to fall within each level of care has remained relatively stable over the past five (5) calendar years and no single level appears to be impacted disproportionately by the recent increase in volume.



As depicted in the following table, a comparison of the number and percent of youth in each level of care by Service Area illustrates a statistical dissimilarity of Level of Care determinations across the state using the Nebraska Caregiver Responsibility (NCR) Tool. (*The Chi-Squared statistic is 175.169. The p-value is 0.000. The result is significant at p < .05*)





While the Central and Southeast areas are statistically similar to each other as well as to the statewide average (*The Chi-Squared statistic is 1.493. The p-value is 0.837587. The result is not significant at p < .05*), we find that the Eastern Service Area serves fewer youth at the Essential Level of Care and a higher number of children and youth at the Intensive Level of Care. This variance is statistically significant when compared to the Statewide average (*The Chi-Squared statistic is 48,054. The p-value is 0.000. The result is significant at p < .05*)

	Average # Foster Youth Served Per Month (January – March 2021)	Essential	Enhanced	Intensive
Central	301	61.53%	29.93%	8.54%
Eastern	1,130	51.49%	34.24%	14.27%
Northern	563	77.75%	19.41%	2.84%
Southeast	484	62.88%	26.86%	10.26%
Western	302	81.55%	14.70%	3.76%
Statewide	2,780	63.14%	27.36%	9.50%

While there may be programmatic, geographic, or demographic reasons leading to these results, the variance is significant enough to warrant additional investigation and research surrounding the validity, consistency of use, and interrater reliability of the NCR.

5.3. Findings Related to Letters of Agreement for Specialized Rates

Specialized Letters of Agreement (LOAs) are sometimes used by DCFS, St. Francis and Probation where special agreements on rates are negotiated beyond the existing three original levels of care that require more exceptional, or specialized caregiving needs of children outside of the NCR and where there are a limited number of providers and foster caregivers to care for the children. As noted by the FCRRC in its June 22, 2020 Report, DHHS is in some cases "accessing a caregiver and network through the Enhanced Family Home model used by the DHHS Division of Developmental Disabilities" where "[t]he reimbursements range varies extensively."

Many of homes are unlicensed under child welfare and, as such are not reimbursable under Title IV-E. This results in significant fiscal loss to the state which would be mitigated through the use of DCFS licensed placements.

5.3.1. DCFS

DCFS staff and leadership acknowledged to TSG they do not have a standardized process outlining when the agency should enter into an LOA, including threshold criteria regarding children that would trigger consideration of an LOA's necessity. Thus, LOAs do not correspond to a given level of care. They are just what it takes to incentivize the agency and foster parent to take on the challenge of caring for children who require extensive, intensive supervision due to medical, behavioral, mental health diagnosis or other complex need. DCFS has previously tried to implement contracts with criteria such as SMI diagnosis, I/DD diagnosis, exceptionally aggressive or sexually acting out behavior, or exceptional medical needs, specific expectations of the caregiver, desired outcomes, or contract and quality monitoring. However, providers balked at the inclusion of such criteria and DCFS staff reported the current contract template was negotiated as a result. To its credit, DCFS leadership is currently working closely with its field staff and reviewing LOAs as well as a revised contracts to include criteria as described here.

As it currently stands, the template's only requirements of foster parents are to provide:

- Structured care and supervision;
- Basic needs;
- Family visits;
- Youth-specific plan of care to meet behavioral health and educational and vocational goals;
- Monthly written youth progress reports to DCFS worker.

The template's only requirements of DCFS and Probation regarding oversight and monitoring are to:

- Develop plan of care;
- Monitor plan of care through regular team meetings; and,

- Withhold payment if reports are not provided.

5.3.2. St. Francis

St. Francis currently uses a standardized form and process identifying criteria for specialized placement. St. Francis reported to TSG that they require specialized training through Omni Behavioral Services of their foster care parents for high-needs children. St. Francis reported five percent of the 1700 children in their care are placed above the Professional Foster Care rate. They indicate their goal for children at this rate is short term and often used for children discharging from or waiting for a congregate care placement. However, they also reported to TSG that they focus on "permanency from day one with these higher-level placements." The St. Francis service agreement indicates foster care homes must be licensed, but they acknowledged to TSG they do utilize non-licensed homes through the DD system when necessary.

5.3.3. Probation

Probation leadership indicated a very small percentage of children or youth on probation that are also in Foster Care are served through LOAs. They tend to utilize the DD Enhanced Family Homes when they need a higher level of care due to either the children's cognitive functioning or if they have been removed from other placements due to behavior. Probation negotiates these rates separately with each provider based on DD rate structure as posted and based on the specific needs of the child. Probation visits these single agreement homes on a monthly basis and describes their monitoring as continuous but not formalized. Probation reported to TSG they have success reducing the rate with providers as the child improves. Probation is currently working to formalize their workflows and processes.

5.3.4. Accountability

During interviews with DCFS, private agency, and Probation staff, TSG learned the LOA process has morphed into a crises-driven system where placement providers have driven up rates by bidding agencies against one another, threatening to or terminating placements when their rate demands are not met, and resisting licensing requirements that would bring in federal funding to improve the overall child welfare system. According to stakeholders, the contracts require no specialized training of foster parents, no meaningful outcomes related to permanency, and no quality measures beyond security and supervision. While the contracts require regular monitoring by DCFS caseworkers and regular reporting by foster parents to receive payment, stakeholders said that neither of these take place in a standardized manner. Stakeholders reported there is a significant difference between the LOA contracts being utilized by DCFS as was confirmed by our review of several of these documents as provided by DCFS.

5.4. Findings on Data Analysis Related to Letters of Agreement Process

The statewide placement of children and youth becomes disproportionally greater when additional child specific LOAs and a Professional Levels of Care are included in the comparison. Using twelve months of placement data, the following table includes youth at the three (3) standard levels of care as well as additional youth placed at a Professional level care in the Eastern Service Area (ESA) and through Letters of Agreement (LOAs) statewide.

	ESA	Remainder of State	Statewide
Essential	41%	68%	58%
Enhanced	35%	22%	27%
Intensive	15%	6%	9%
Professional	4%	0%	1%
Special (LOA)	5%	4%	4%

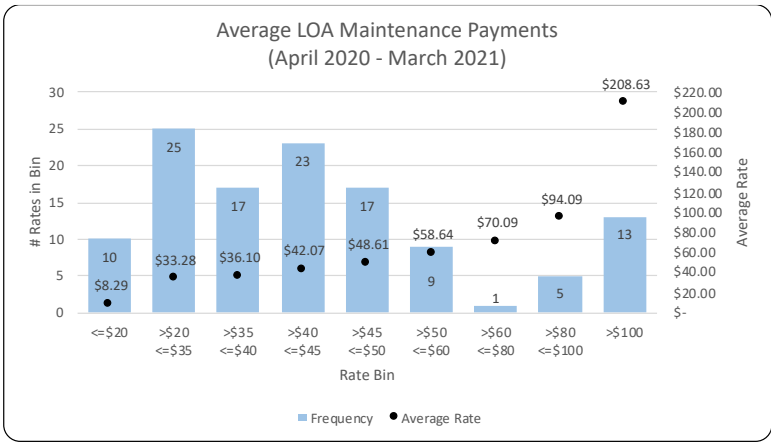
The ESA clearly serves a far-greater number of children at the highest levels of care (24%) when compared to the remainder of the state (10%). Again, while there may be valid reasons for such a variance, this finding reflects the need to standardize the means (tool, training, and ongoing validation) for determining appropriate levels of care for youth placed out-of-home.

In reviewing LOAs established for regions of the state outside the ESA TSG determined:

- There were: 120 new, amended, or renewed LOAs between April 2020 and March 2021.
- Children placed through these LOAs averaged 13.72 years of age.
- 8,643 days of care covered by these LOAs during the twelve (12) month period reviewed.
- Maintenance and Agency Support (Administrative) payments for this period totaled $810,061.

Maintenance rates paid in addition to the Intensive LOC rate for this period ranged from $7.80 to $209.20/ day. Of these payments:

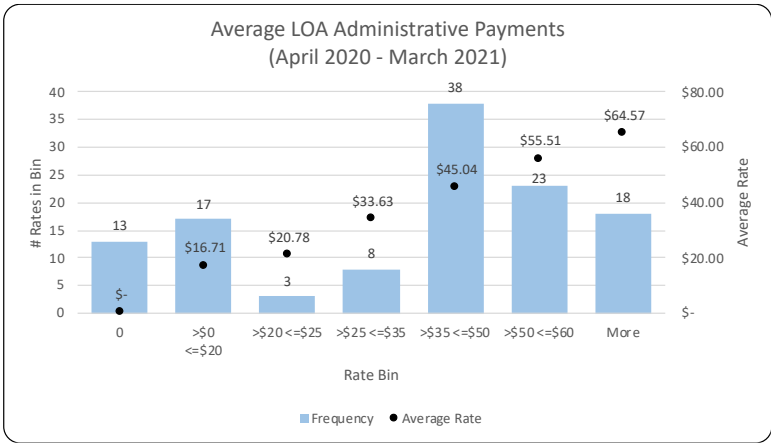
- 92 of 120 (77%) of LOA maintenance rates were less than or equal to $50/day, of these:
    - 29% (35 LOAs) were less than or equal to $35 / day in additional per diem,
    - An additional 14% (17 LOAs) were between $35 and $40 per day,



- And 33% (40) fell between $40 and $50 per day

LOAs with maintenance rates less than or equal to $50 day support 4,158 of 8,643 days of care of care (48%).

Of the remaining LOAs, those with additional maintenance costs of more than $50 per day are primarily associated with three (3) contracted agencies in the southeast service area.



Additionally, agency support (Administrative) payments fall proportionately within ranges similar to the excess maintenance payments. Of the administrative support rates paid through the LOAs during the twelve (12) months reviewed:

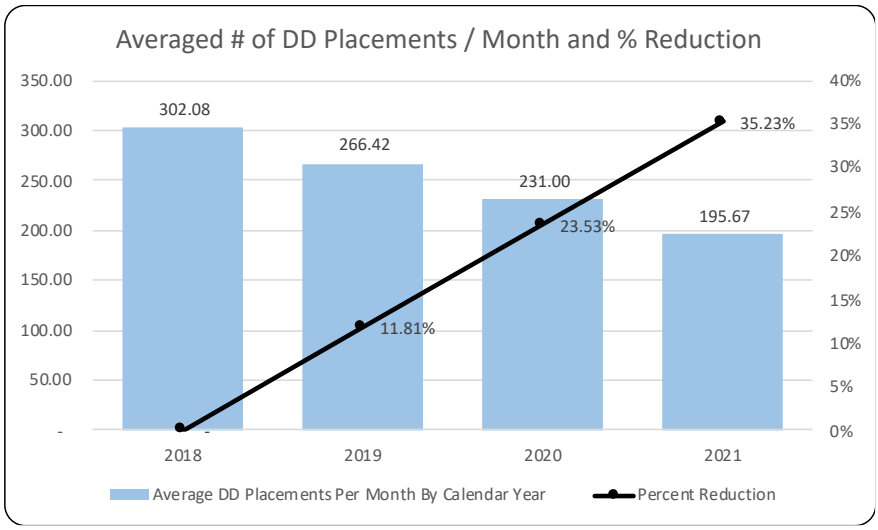
- The average payment above the Intensive level per diem was $39.74 per day
- 34% (41) of the administrative payments were less than $35 per day
- An additional 32% (38) fell between $35 and $50 per day

5.4.1. LOA Data Analyzed Supports Consideration of an Additional Level of Care

DCFS should consider establishing a LOC between the existing Intensive and recommended Specialized tiers. As reflected in the LOA data analyzed, payments for a significant percentage of existing LOAs fall below the proposed Specialized ("Professional") Maintenance and Support Rates. This finding supports the recommendation that a tiered rate (LOC) between the existing Intensive LOC and proposed Specialized (LOC) is reasonable as caregivers are currently willing to accept a rate below the proposed $80 tier. The addition of both an interim LOC and implementation of the proposed Specialized LOC will support improved permanency outcomes as adoption subsidy payments will be able to be made at these higher levels in accordance with state policy.

5.5. Findings Related to Developmental Disability Out-Of-Home Foster Care Placements

In reviewing the data related to the LOAs for specialized placements at DCFS, it must be noted that DCFS has done an extraordinary job over the past few years in significantly decreasing DD out-of-home foster care placements. Over the last four years there has been a:



- 35.23% decrease in the number of DD Children placed in out-of-home settings
- 11% decrease to the percent of DD placed in Agency Supported Homes
- 23% increase to the percent of DD children in approved relative foster homes
- Near elimination of the use of Youth Rehabilitation Treatment Center Placements

5.6. Findings Related to Nebraska Caregiver Responsibility Tool

In its recommendations, the FCRRC made modifications to the Nebraska Caregiver Responsibility (NCR) Tool that reflected the uniqueness of the specialized level of responsibility for new higher level 4th tier rate and the needs of children and their caregivers achieving permanency through adoption or legal guardianship. More specifically, the FCRRC recommended:

- Implement the use of the NCR at DHHS, Saint Francis and in Tribal Courts.
- Develop revised training curriculum for the most recent version of the NCR for case managers and supervisors.
- Assimilate components of the NCR Specialized Level of Care with service definitions and vouchers for Juvenile Probation.
- Utilize the NCR Specialized Level of Care to minimize letters of agreement and reduce permanency barriers.

TSG believes these are sound recommendations and realizes that the NCR Tool is unique to the State of Nebraska and has been developed after a very through stakeholder process identifying all necessary and significant aspects of the foster care caregiver responsibility. TSG's evaluation, however, found aspects of the process and use of the NCR that could be improved.

5.6.1. NCR Does Not Focus on the Child's Clinical Treatment Needs

The NCR determines the Foster Care Maintenance Rate for caregivers of foster children. Each level describes the intensity of care that the caregiver will provide the foster child. The variance in expectations for each level is detailed in the NCR Tool (See Appendix B attached to the June 2020 FCRRC Recommendations report). The first level (LOR1) is considered essential for all placements and the minimum expectation of all caregivers, LOR2 is a higher level of care, and LOR3 is the highest level of care. Each level includes the responsibilities of the previous level along with other duties. Payment increases as the caregiver responsibility increases. Payment level decreases when caregiver responsibility decreases. Thus, the NCR Tool is intended to tease out the caregiver's level of effort and determine the level of care based on the amount of supervision / interaction the foster parent provides and there may not be a correlating diagnosis associated with a level of care.

Nebraska, however, is unique in that the level of care is based on the amount of care, supervision, coordination, transportation, and interaction a foster parent is required to provide rather than on a diagnosis or assessment of the child. Thus, the NCR does not take into consideration the treatment plan identified clinical needs of a child placed at a more intense level of care. Any information about the trauma related, behavioral health, developmental disabilities, substance abuse disorder, medical/pharmacy needs of the child/youth are external to the NCR document and not specifically detailed in the NCR document.

Moreover, in reviewing the NCR, the domains have a definition of what is expected of the foster parent(s) for each domain at each current level of care. What is missing is what is the child/youths presenting strengths, needs, preferences, and current treatment plan(s), if any. Effective outcomes related to the comprehensive treatment needs and funding coverage for children/youth with the highest-level needs do not appear to be attached to the NCR for the parents' education and use. "Treatment plan" is mentioned three times in the NCR, but it simply says parents need to follow the treatment plan. "Treatment plan" and Medicaid are not mentioned in the instructions on completing the NCR. So, if the case worker does not have detailed information about the child's treatment plan(s) foster parents are agreeing to the NCR levels without this critical information.

In addition, the lack of an independent standardized child/youth Evidence Based assessment process and instrument for Behavioral Health (such as the CANS, CAFAS, ANSA -over 18) services, which are covered Medicaid benefits through Managed Care Organizations, results in the loss of comparable standardized assessments and data that, over time, could have a direct impact on the level of need for Medicaid paid Treatment Family Care Services, DCFS levels of care, and also result in the loss of tracking child/youth progress and regression through individual case and aggregate data.

When the FCRRC made their original recommendations in 2014, the CANS behavioral health assessment tool was recommended to be completed along with the NCR. The decision was

made at the time by DCFS that, instead of completing a CANS assessment along with the NCR, they would utilize the Family Strengths and Needs Assessment (FSNA). However, the FSNA is not a treatment plan and not all children coming into care will have a treatment plan, especially since the first NCR is to be completed within 30 days of placement and DCFS may not have a lot of information about the child at the time. Children or youth who have been in DCFS placement for quite some time should have treatment plans. We believe DCFS should revisit this issue with the Foster Care Rate Reimbursement Committee.

5.6.2. No Assessment Fidelity Surrounding NCR Use

While the approach in using the NCR seems innovative, unique and the result of significant work by stakeholders, the NCR Tool has not been research informed, normed, validated, or evidence-based like the CANS Assessment has. Moreover, we have heard from DCFS Leadership that the Tool is also used inconsistently in the field, staff are not all trained to use the tool in the same manner with the same understanding of the criteria at each level.

Moreover, DCFS policy requires additional documentation in a narrative on the NCR under the section "Outline of Caregiver Responsibilities" for the additional care that the foster parent has committed to provide the supports a Level 2 and Level 3 ranking in each level of responsibility. The rule states that the documentation must describe the specific activities that the foster parent(s) will engage in that meet the definition of Level 2 or Level 3***, including the intensity and frequency of those activities***. DCFS Administration has found that when there are these levels with use of the NCR, documentation is often not being provided, nor is it being requested by CFS Specialists or Supervisors. DCFS Administration, therefore, should ensure that DCFS case workers and supervisors are adhering to this policy and should consider audits as part of its quality control process and also provide on-going training for case workers and supervisors on just what the expectations are related to proper documentation prior to committing to a higher level of care, including the recommendations of the FCRRC.

5.6.3. NCR Continuous Monitoring

The NCR also requires a process statewide for continuingly monitoring the levels of care at a 6-month interval with proper documentation of such a review to ensure the child is not being placed at a higher level of care and to assist with permanency planning. The policy was changed a few years ago to once every 12 months after DCFS staff complained that they were having to complete the NCR too often. DCFS Administration recently changed the policy back to a 6-month review. We believe DCFS Administration is correct to require, at the minimum, a 6-month review of the NCR, especially where a new higher rate tier is implemented, to ensure rate accountability and provide the best opportunity for timely moving the child or youth to a lower level of care as part of the permanency planning process.

5.7. Findings Related to Child Placing Agency Level of Effort and Contract Expectations

Contracts between the Department and child placing agencies (CPAs) should clearly set forth expectations related to regular visitation with the child. Such expectations should be based on acuity of need and the child's determined level of care. Presently, though payment rates at each established level of care are based on progressively lower staff to child ratios, no such expectations are contractually established. While such expectations vary in other states, our review of contracts indicates that such requirements are common.

- **Ohio**: As a county-managed child welfare system, individual jurisdictions in the state independently develops separate contracts with CPAs. While each contract varies, several do contain specific language related to the frequency of visits with the child or youth. Typically, this is the only aspect of care specified by the level of child acuity.
- **Indiana**: The State has clearly established expectations for visitation by level of care. Presently, child placing agencies are required to:
    - Maintenance Payments Only (Basic Level of Care): If the Contractor is receiving a maintenance payment with no Enhanced Supervision payment, the Contractor shall ensure one visit with the Child at the foster home monthly and weekly telephone contact with the foster parent(s).
    - Enhanced Supervision: If the Contractor is receiving an Enhanced Supervision
    - payment, the Contractor shall ensure the following minimum:
        - Enhanced Supervision category Foster Care with Services: visits at least every other week with the Child and with the foster parents, with at least every other one being in the foster home;
        - Enhanced Supervision Therapeutic: at least weekly visits with the Child and with the foster parents, with at least every other one being in the foster home;
        - Enhanced Supervision Therapeutic Plus: visits at least twice a week with the Child, with at least every other one being in the foster home, and a weekly visit with the foster parent(s).
- **Michigan**: The State of Michigan has some of the most comprehensive child placing agency contracts reviewed as part of this project. State contracts include visitation and related quality requirements. (See Appendix B) CPA expectations for enhanced foster care (EFC) are contractually defined as follows:
    - Level 3: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth several times per week unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays severe impairment, which may include

causing property damage in the school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist multiple times per week, participating in wraparound services and therapy with youth, using de-escalation techniques, responding to emergencies at school, and implementing crisis safety plan when needed.

  - Level 2: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth more than weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays moderate impairment, which may include persistent non-compliant or irresponsible behaviors, sexually inappropriate or delinquent behavior, angry outbursts, or frequent mood disruption. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist each weekly, using positive behavior supports, transporting the youth to needed treatment, and incorporating treatment plan components in the home.
  - Level 1: Caregiver engages in additional case services provided through EFC, as well as additional clinical services provided to the youth at least weekly unless another frequency is recommended by the EFC Clinical Case Manager. A child assessed at this level displays mild impairment, which may include occasional disobedience, argumentative or annoying interaction with caregiver, problems at school or in relationships, or emotional distress. Examples of a caregiver's interventions could include: engaging with the EFC Case Manager and behavioral specialist weekly, attending Family Team Meetings at a higher frequency, exercising good control when provoked, providing consistency and predictable behavior towards the youth, and setting realistic expectations for the youth.

- **Pennsylvania**: Child placing agency expectations are established through county-specific contracts. An example of these requirements is included in Appendix C and include a description of:
  - Children qualifying by level of care,
  - Visitation requirements, and
  - Child therapeutic, medical, and behavioral health services requirements.

5.8. Findings Related to Treatment Family Care Recommendation

Therapeutic Foster Care, or Treatment Family Care (TFC), as identified by the FCRCC in its recommendations, is an "intensive, treatment-focused form of foster care provided in a family-based setting by trained caregivers, with the addition of case management and behavioral health services and clinically based supervision" and it is " designed to serve children who have

behavioral or emotional disorders or medical conditions that cannot be adequately addressed in a traditional foster home" and who might otherwise be placed into higher cost residential settings.[10] Although TFC programs can vary, most state programs incorporate elements of evidence-based models that have been thoroughly assessed and have demonstrated improved outcomes. [11]

TFC is currently used as an effective alternative to higher cost placements, including congregate care, in a number of states and evidence has shown that children in these foster care placements, with properly trained foster parents, are more likely to receive an array of comprehensive wraparound and behavioral health services than children placed in more restrictive settings.[12] Also, studies have found that models of TFC are associated with decreased drug use over time, reduced rates of post-treatment felony charges, greater reductions in depressive symptoms, as compared to congregate care models, and lead to more cost-effective care than congregate care.[13]

The FCRRC identified the Treatment Family Care model as a wraparound in home treatment service in a foster or family home providing specialized caregiving to a child with behavioral health needs who is at risk of, or stepping down from, out of home congregate treatment placement. It uses blended funding to support the caregivers and prevent placement disruption. The rate structure identified in the recommendation include Medicaid wraparound in home services, Agency Supported foster care providing specialized support to foster parent caregivers. The following rate components were taken into consideration by the FCRRC:

- Medicaid wraparound services previously known as "Community Based Alternative to Residential" treatment which are now unbundled were used to develop the service components using the current Medicaid rates. This includes weekly in home Community Treatment Aide (CTA) hours, individual therapy sessions, family therapy, an Initial Diagnostic Interview (IDI) and clinical consultations.
- Therapist and clinical supervisor salary considerations for licensed child placing agencies providing the service.
- Respite to be arranged, trained, and coordinated by the licensed child placing agencies providing the service up to 4 days per month.

[10] Office of Assistant Secretary for Planning and Evaluation & Office of Human Services Policy, U.S. DHHS, Patterns of Treatment/Therapeutic Foster Care and Congregate Care Placements in Three States, Research Brief, August 2019.
[11] Office of the Assistant Secretary for Planning and Education [ASPE], U.S. Department of Health and Human Services [HHS], 2018; Bishop-Fitzpatrick et al., 2014; Harold et al., 2013; Rhoades et al., 2013.
[12] Office of Assistant Secretary for Planning and Evaluation & Office of Human Services Policy, U.S. DHHS, Patterns of Treatment/Therapeutic Foster Care and Congregate Care Placements in Three States, Research Brief, August 2019.
[13] Id.

The FCRRC Recommendations Report of 6/22/2020 included the TFC service package designed to provide integrated community based rehabilitative services for children/youth with high needs in a more organized approach to coordinated care than presently exists in Nebraska. We understand that the model is based on a modified approach to a High-Fidelity Wrap Around approach to foster care children and youth with high needs for behavioral health and co-occurring conditions. The service model is defined as follows: [14]

> TFC is an all-inclusive rehabilitative model of care that provides intensive care for youth provided by trained and supported treatment parents. TFC must be a community based behavioral health program under the clinical direction of a psychiatrist, psychologist, or LIMHP. TFC is a Medicaid eligible, highly supportive, and individualized approach serving youth ages 20 and younger who have a history of trauma in addition to complex mental health or substance use disorders that are causing functional impairment. Children and youth with co-occurring developmental or intellectual disabilities and/or who are medically fragile are included. The youth have a history of psychiatric residential or inpatient treatment, or have been unsuccessful in remaining at home with outpatient services, and are clinically identified as requiring out of home treatment at the TFC level. This level of care will address the symptoms that affect the-daily functioning of the youth and prevent further regression. This service requires intensive involvement and frequent contact between members of the treatment team. It is intended to provide a high degree

Treatment Family Care Medicaid Services include[15]:

- Initial diagnostic interview
- Certified Treatment Aide
- Individual Therapy Session (child)
- Family Therapy Sessions
- Clinical Consultation

All current Medicaid covered benefits are available through the Heritage Health Managed Care program in Nebraska. The specific units recommended include:

    - 6 hrs of CTA @ 11.98 per 15 minute increment (Medicaid Rate)
  - 6 hrs x 4 to equal an hour = 24 (15 minute sessions per week)
  - 24 x $11.98 = $287.52 per week
    - 2 Individual therapy sessions per week (60 min. session with LMHP)
  - 2x $112.08 (Medicaid Rate) = $224.16 • 2 Family sessions per week (potentially one with foster family and one with birth family)
  - 2 x$90.42 (Medicaid Rate) = $180.84

[14] Microsoft Word - FCRRC 2020 Legislative Report DRAFT 06.12.2020 (nebraska.gov), p.84
[15] Ibid, p. 15

    - 1 IDI (Initial Diagnostic Interview – 1x)
  - $125.52 (Medicaid Rate)/4 months = $31.35 (Anticipated 4 months ALOS)
    - Clinical Consultation ($42.31-$87.25/hr Medicaid rate)
  - 2 hrs/month @ $87.25 = $174.50/4.5 wks = $38.77

The FCRRC recommendations for this grouping of services include a recommended bundled day rate of $108.95 and a weekly rate of $762.64. Currently the MCOs do not pay bundled rates. The FCRRC recommended that DMLTC adopt the service definitions and rate structure of the recommended Treatment Family Care model.

FCRCC's recommendation leading to the implementation of a Treatment Family Care model is sound. The committee reports looking to national standards, including those established by the Family Focused Treatment Association (FFTA), in recommending the new Intensive level of care. The definition of Medicaid wraparound services to be provided through the model is consistent with similar therapeutic foster care models in other states, and the provision of these services as a therapeutic overlay, for children at any level of foster care will promote placement stability and lead to better outcomes for children in care. Most importantly, the TFC model will promote and enhance permanency outcomes for children with acute needs and behaviors.

The proposed rate of $108.95 per day is based on therapeutic components and interventions provided at current Medicaid rates (Medicaid overlay to current LOCs). Florida's rate, for example, is $87.30 – 135.80 per day based on acuity of child and paid in addition to base (maintenance) rates. This is paid through Medicaid waiver with care and supervision paid by child welfare and claimed to Title IV-E as appropriate. TSG finds the service expectations, therapeutic overlay, and rate recommended by the committee to be reasonable.

Beyond the provision of training and an enhanced payment to foster parents, the addition of therapeutic services, and provision wraparound supports, it is critical that a child or youth's unique conditions or individual circumstances leading to the need for treatment are critically assessed. This requires the use of a comprehensive, normed, and valid assessment tool which is administered with a measurable degree of fidelity. Further, the assessment must result in the development of a planned approach to treatment which identifies the skills and responses necessary to equip the youth and their families with the ability to deal effectively with the conditions leading to the need for treatment. To this end, the department should ensure the expansion of foster care to a therapeutic model is based on a solid foundation of child and family assessment, individualized treatment planning, outcome monitoring, and continuous improvement at the case-specific level.

The FCRRC did not comment on or recommend which behavioral health assessment instrument should be used to determine strengths, needs, and service intensity of the child/youth for

Treatment Family Care services which, by contract, reverts to MCO requirements for behavioral health assessment. The current Heritage Health MCO contracts specify ten instances when "assessments" are required, however there are no provisions for the use of a specific behavioral health assessment instrument, such as the CANS and CAFAS, in the document.[16] The FCRRC recommendations report of 7/22/2020 does not include recommendations concerning behavioral health assessment processes. The responsibilities of the TFC provider treatment "team" and "licensed clinician" are detailed in the FCRRC recommendations. However, treatment team members are not delineated nor is a process and timeline of communication with DCFS and the family mentioned.[17]

In addition to the wraparound Medicaid benefits included in the FCRRC's definitions, there are also an array of additional behavioral health benefits that are currently part of Heritage Health and must be available through MCOs to DCFS children with high complex behavioral health needs who under 20 years of age statewide. They include:

- Crisis stabilization services (includes treatment crisis intervention).
- Inpatient psychiatric hospital (acute and sub-acute).
- Psychiatric residential treatment facility (age 19 and under).

Outpatient assessment and treatment:

- Partial hospitalization.
- Day treatment.
- Intensive outpatient.
- Medication management. FCRRC
- Outpatient therapy (individual, family, or group).
- Injectable psychotropic medications.
- Substance use disorder treatment.
- Psychological evaluation and testing.
- Initial diagnostic interviews.
- Sex offender risk assessment.
- Community treatment aide (CTA) services[18].
- Hospital observation room services (up to 23 hours and 59 minutes in duration).
- Parent child interaction therapy.
- Child-parent psychotherapy.
- Multi-systemic therapy.
- Functional family therapy.

16 71165(o4)awd.pdf (nebraska.gov)
17 Microsoft Word - FCRRC 2020 Legislative Report DRAFT 06.12.2020 (nebraska.gov), p. 84
[18] TSG was informed during interviews with stakeholders that this service is unavailable due to a lack of MCO contracted providers.

- Peer support.

Rehabilitation services

- Day treatment/intensive outpatient.
- CTA services.
- Therapeutic group home

Therapeutic Group Home (ThGH) is described as the delivery of an array of clinical, treatment and related services, including psychiatric supports, integration with community resources and skill-building taught within the context of a home-like setting. ThGH treatment shall focus on reducing the severity of the behavioral health issues that were identified as the reasons for admission. Most often, targeted behaviors relate directly to the client's ability to function successfully in the home and school environment (e.g. compliance with reasonable behavioral expectations, safe behavior and appropriate responses to social cues and conflicts).

All of these benefits are already factored into the MCO monthly per member per month capitated payment. Any benefits that are covered services would have inherit utilization in the base data that would be then included in the development of capitation rates (current and future) – unless an explicit program change is introduced expanding or restricting service, at which point an adjustment for the program change would be made in developing the capitation rates.

Respite serves are provided to all eligible Nebraskans through the Lifespan Respite program which is a program not managed by Medicaid although the program does extend to Medicaid patients. It is also a service available to children and caregivers through the A & D program

5.8.1. MCO Supports in Place

Currently, MCOs in Nebraska report that they have the following supports in place for foster children under their contracts:

- Care Management and/or Clinical Coordinator assigned to all Foster Children.
- Meet with DCFS and Juvenile Probation monthly to staff foster care cases and discuss option for services and placements.
- Make outreach calls to the foster parents of new children and youth in the Foster Care program to offer care management.
- Provides phone outreach to foster parents of all children and youth discharged from the emergency room or hospital with a primary diagnosis of mental illness or substance abuse disorder to follow up on the change in condition and assess for additional needs or services.
- Provides a texting education program to children and youth identified as having gaps in child or adolescent well visits or immunizations.

- Clinical Coordinators also participate in treatment team meetings with Behavioral Health providers, Psychiatric Residential Treatment Facilities or other Residential Treatment providers, Probation and Caseworkers upon request
- Completes phone outreach for children and youth newly prescribed an antipsychotic medication
- Per contract each MCO has a psychotropic drug oversight program that reviews antipsychotic usage and prescribing patterns. Antipsychotics require prior authorization for children and youth and often reviewed by a licensed child and adolescent psychiatrist.
- Pharmacies have medication checks in place for medications prescribed to foster children including antidepressants, antipsychotics, and antianxiety.

5.8.2. Assessments for High Needs Children

Foster children are designated for the MCOs by a special indicator. MCOs have supports around foster children. Each MCO has specific criteria to identify complex needs along with working directly with DCFS, Juvenile Services, and providers to identify high needs children and youth. Comprehensive medical and behavioral health assessments are a covered benefit under Medicaid.

5.8.3. Behavioral Health Medicaid capacity in the rural areas of the state

DMLTC works with providers that have concerns regarding rates. As a rural state there are areas with provider capacity needs for all patients. DMLTC has worked to support the use of telehealth to support the care needs.

5.8.4. Medicaid process of accountability with MCOs

- Monthly and annual reviews of contract requirements.
- DMLTC discusses with the MCOs any concerns raised from providers, patients, families, advocates, or Division partners regarding service needs.

5.8.5. Knowledge of the above Medicaid Benefits

DMLTC maintains a provider website that includes the service definition of all covered behavioral health benefits available to all Medicaid covered children and youth. The MCO's coordinate care for children and youth. The provider relations department, within each MCO, has information on the services that are available to children and youth.
TSG observed through multiple stakeholder interviews including an interview with DMLTC staff that there appears to be a fundamental lack of understanding of the Medicaid Managed Care system in the child welfare community and how to access the benefits and providers the MCOs are to provide. Specifically, there seems to be a general lack of knowledge among the

interviewed stakeholders regarding: the federal regulations that restrict what the Medicaid system can and cannot pay for (absent federal approval of a Medicaid State Plan amendment, waiver, or Performance Improvement Project); the limitations in the Medicaid electronic encounter and claims systems that requires specific information to process a claim; and the MCOs' prior authorization requirements, network adequacy requirements, and grievance and appeal processes.

5.8.6. Access to Medicaid Behavioral Health Services

If there are limited supply of behavioral health services in an area or none exits, per contract, the MCOs are required to ensure an adequate provider network to meet patient needs regarding a specific needed service. Where there are issues where no provider is available after a need is identified, either through DCFS or family or provider, the MCO, is required to work to identify providers that could be added to the provider network to meet the patient needs.

5.9. Therapeutic/Treatment Foster Care Best Practices

Before adopting the FCRCC's recommendations regarding the new TFC model, there are some improvements DCFS and DMLTC should consider based on our state best practice review that could involve additional service definition criteria, covered benefits, the assessment process, data system integration, continued division collaboration, increased regulatory flexibility and clear expectations of providers and foster parents, including training and accountability for outcomes, and removal of barriers to permanency. Key improvements will be identified further in our recommendations section of this Report. We also will highlight here some of the common program themes and practices observed in our state-by-state best practice review (Texas, Michigan, Georgia, Florida, Kentucky, Ohio, and Washington) which are summarized in more detail in the Appendix D to this Report.

5.9.1. TFC Common Themes and Best Practices

The following are some of the common themes and practices we observed for successfully implemented TFC programs in states (see Appendix D for more details on our state best practice review):

- **Innovative, multi-disciplinary treatment services that are evidence-based and research-supported**;
- **An intensive level of service** in a **highly structured environment**;
- **A time-limited program that promotes the stabilization and preparation of children to transition into a less restrictive or permanent placement** successfully;
- **Incentivizing foster parents and child-placing agency** contractors to receive a higher reimbursement rate due to the additional requirements of comprehensive training, an increase in treatment plan reviews, and the ongoing support required following the

discharge of a child from a residential setting or upgrade in level of care due to placement instability and/or mental health, medical or other behaviors;

- **Cross-agency and cross-system collaboration**. For example, in the State of Washington, the following is a required element:
    - Cooperative and collaborative planning between the Division of Children Youth and Family (child welfare agency) and the Health Care Authority (state Medicaid agency), including active stakeholder participation (Foster Parents, Transition Youth, Managed Care Organizations, and Providers) successfully developed the fidelity wraparound WISe program model that provides the necessary Behavioral Health Rehabilitation EBP services that a child/youth needing the Therapeutic/Treatment Foster Care level of care is assessed to need as well as support of the Therapeutic/Treatment Foster parents.
- **A Standard practice for Agency case workers** to follow to initiate this level of foster care;
- **An Operations Manual for Agency staff and providers** that contain an overview of the program and specific operations criteria related to:
    - types of youth served
    - determination of eligibility
    - treatment planning
    - initial assessment process and ongoing assessments
    - case progress notetaking
    - Level changes
    - Description of caregiver partnership, including trauma informed approach
    - Caregiver expectations
    - Training expectations
    - Provider expectations, including staffing requirements
    - Rates

See Appendix E for an example of the Enhanced Family Care Operations Manual that is used in Michigan by the Western Michigan Partnership for Children

- **A requirement for Behavioral Health Specialists to be available** to the Child Placing or provider agency for consult and review of behavioral health services, including medications and duration of service;
- **An embedded philosophy of caregiver partnership** with provider and Agency;
- **Continuous monitoring requirements** for Agency to ensure appropriate level of care and duration to include alignment with permanency planning. Level of care reviews every 90 to 120 days. (Michigan 90 days; Texas every a review every quarter)

- **A clinical assessment tool required** to be used in determining TFC level, that includes connection to treatment planning for child to utilize a valid and tested clinical Assessment instrument either before or within 30 days of placement into TFC
    - In most instances, the completion of the Child Adolescent Needs and Strengths (CANS). Washington requires at least a CANS screen, which consists of a subset of 26 questions, pulled from the Full CANS completed by a CANS-certified screener. Texas requires CANS to be completed within 30 days of entry into foster care. Michigan requires use of a Child and Adolescent Functional Assessment (CAFAS) Scale to be used as their instrument but allows for a 30 day provisional approval until the clinical assessment is submitted and confirmed to justify level of care.
- **Development of an individualized treatment plan** that consists of a structured, and goal-oriented schedule of services with measurable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. This treatment plan can be developed by the child placing agency, or an independent entity hired by the state, in collaboration with the DCFS case worker, foster parents, MCOs and other necessary members of a multi-disciplinary team.
    - Florida requires that individualized recipient treatment plans must directly address the primary diagnosis(es) that is(are) consistent with the assessment. The provider must document efforts to coordinate services for behavioral health diagnoses outside their expertise that, if treated, would assist meeting the recipient's goals.
- **History of active and supportive Legislative oversight** in partnership with the State child welfare Agency, Medicaid Agency, foster parents, youth in transition, child placing agencies and providers that has created on-going year to year dialogue and problem identification and improvement strategies;
- **Specific methods of accountability** for placement agency providers related to:
    - Access to services and service array
    - Reducing the acuity of need
    - Facilitating placements in less restrictive settings
    - Promoting permanency
    - Practice Model requirements, including staffing
    - Oversight
    - Cross-system collaboration
    - Documentation
    - Data warehouse
    - Performance measures and outcomes

Examples of accountability as follows:

In Texas, child placing agencies must meet the following requirements of service delivery accountability:

- a 24-hour on-call crisis person available to provide in-home crisis intervention and placement stabilization services, available to the child and family;
- a formal respite system, both routine and available upon request, when determined appropriate
- meet standardized caseload sizes to support high needs child or youth population
- Also, providers chosen must have a capacity growth plan with targeted milestones for both the number of Therapeutic foster family homes certified and the number of children served under each contract
- All foster homes and providers delivering this service are licensed by the rules of the state child licensing agency
- Requirement that at least one foster parent who does not work outside of the home and is highly trained to meet the specific needs of this child population;

In Florida, the following conditions must be met before the provider can enroll in Medicaid as a specialized therapeutic foster care services provider:

- The provider's primary clinicians, psychologists, psychiatrists, and foster parents delivering specialized therapeutic foster care services must meet specific education and training requirements.
- The provider must employ or contract with primary clinicians and foster care parents who provide the services. (The primary clinicians and foster care parents are not individually enrolled in Medicaid.)
- The provider has an approved pre-service and in-service training plan for staff providing specialized therapeutic foster care services.
- The foster home is properly licensed in accordance with state law.
- The foster parents have received basic training required of all licensed foster parents and meet all other licensing requirements.
- The provider has a financial agreement with the foster parents that reimburses the foster parents for their therapeutic intervention services.

  - The provider has policies and procedures that promote good therapeutic practice, ensure that therapeutic foster parents are the primary therapeutic agent, provide for appropriate treatment plans and documentation, and protect the rights of recipients and their families.
  - The provider has a program evaluation system to review the process and outcomes on at least an annual basis.
  - The provider has policies and procedures that address the legal school notification requirements.

In Michigan, provider expectations are all included in the Individualized Service Plan (ISP), which is required to be filled out 30 days of authorization of Therapeutic services to include specific additional caregiver responsibilities related to:

  - Increased supervision,
  - Behavior management,
  - Involvement in school
  - Participation in training that specifically pertains to the identified child(ren) placed in the home
  - Additional training needs of the caregiver

- Requirements for providers related to **storing of internal data and reporting out key TFC program performance measures**, such as:
  - Number of adoption placements
  - Number of children returning home
  - Number of children placed with a relative
  - Number of psychiatric admissions
  - Number of residential placements
  - Total discharges
  - Total successful discharges, with a contracted required success rate

  An example of one Texas TFC providers performance management dashboard is included in Appendix F.

- **Requirements for Child Placing Agencies and Foster Parents to be licensed** in accordance with state law and regulation and complete a set number of hours of preservice training specific to specialized therapeutic foster care.
  - In Florida, specialized therapeutic foster parent(s) serves as the primary agent in the delivery of therapeutic services to the recipient and are trained in interventions designed to meet the individual needs of the recipient. Specialized therapeutic foster parents must be available 24 hours per day to respond to

crises or to the need for special therapeutic interventions. Specialized therapeutic foster parents must receive ongoing in-service training from clinical staff to support, enhance, and improve their treatment skills and strengthen their abilities to work with specific children. In-service training should be provided as often as needed, but not less than 12 hours every six months for the highest level of care.

- **Specific Description of the Service**
  - States have specific descriptions of the type of service and service level either in statue or their policies so that providers and foster parents fully understand the type of service that is required for any child in this setting. For example, the Texas description of the specialized service level[19] includes the following:
    - 24-hour supervision to ensure the child's safety and sense of security, which includes close monitoring and increased limit setting;
    - Affection, reassurance, and involvement in therapeutic activities appropriate to the child's age and development to promote the child's well-being;
    - Contact, in a manner that is deemed in the best interest of the child, with family members and other persons significant to the child to maintain a sense of identity and culture; and
    - Therapeutic, habilitative, and medical intervention and guidance that is regularly scheduled and professionally designed and supervised to help the child attain functioning appropriate to the child's age and development.
- **Specific description of characteristics and behaviors that a child or youth exhibits** that identifies the need for this level of specialized services that usually consists of aggressive or potentially dangerous behavior, substance abuse dependency, Intellectually and Developmentally Disabled, a mental illness, or another condition that warrants a high level and specialized service. For example, Texas defines a child needing specialized services as one having severe problems in one or more areas of functioning, which may include:
  Unpredictable non-violent, anti-social acts;
    - Frequent or unpredictable physical aggression;
    - Being markedly withdrawn and isolated;
    - Major self-injurious actions to include recent suicide attempts; and
    - Difficulties that present a significant risk of harm to self or others.

[19] DFPS - Service Levels for Foster Care (state.tx.us)

A child who abuses alcohol, drugs, or other conscious-altering substances whose characteristics include one or more of the following:

- Severe impairment because of the substance abuse; and
- A primary diagnosis of substance abuse or dependency.

A child with intellectual or developmental disabilities whose characteristics include one or more of the following:

- Severely impaired conceptual, social, and practical adaptive skills to include daily living and self-care;
- severe impairment in communication, cognition, or expressions of affect;
- Lack of motivation or the inability to complete self-care activities or participate in social activities;
- Inability to respond appropriately to an emergency; and
- Multiple physical disabilities including sensory impairments.

A child with primary medical or habilitative needs whose characteristics include one or more of the following:

- Regular or frequent exacerbations or interventions in relation to the diagnosed medical condition;
- Severely limited daily living and self-care skills;
- Non-ambulatory or confined to a bed; and
- Constant access to on-site, medically skilled caregivers with demonstrated competencies in the interventions needed by children in their care.

Michigan – "A child assessed at this level displays severe impairment, which may include causing property damage in the school or home, destructive or aggressive behavior towards self or others, intense mood irregularity, and/or distorted thinking."

- **A direct connection with the state's Medicaid Managed Care Plan** for accessing Medicaid services thereby providing a seamless coordinated approach to meeting the Behavioral Health and general medical needs of children/youth in Foster Care.

5.10. Evidence Based Therapeutic Foster Care Best Practice Training Approaches

The cornerstone of effective foster care parent and clinical provider training is a curriculum based on understanding the trauma experienced by children in the child welfare system, the effects of that trauma on the child's behavior, and how to build a trauma-informed child welfare system. While a thorough discussion of trauma informed care is beyond the scope of this TSG project and report, well-accepted definitions familiar to Nebraska DHHS and DCFS through their work with KVC and the University of Nebraska Center for Children, Families, and the Law (CCFL) include:

Trauma is a life-threatening or extremely frightening experience — for the child or someone they care about — that overwhelms the child's capacity to cope.

Trauma-informed child welfare systems are characterized by a system-wide understanding of how to recognize and respond to the impact of traumatic stress, screening and assessment of children, data systems, workforce development, and evidence-based and evidence-informed treatments. Trauma-informed child welfare systems are distinct from other child welfare systems in that there is a system-wide and coordinated approach to recognizing and responding to trauma. [20]

TSG identified three evidence-based TFC national training approaches for agencies and providers implementing or developing TFC models and approaches that incorporate trauma-informed principles and are used by the various states in developing and sustaining successful TFC programs. Details about these programs are contained in Appendix G and they are summarized below:

5.10.1. Together Facing the Challenge

Together Facing the Challenge" (TFTC) is a training and consultation educational program focused on improving the skills of foster parents and their agency support staff to effectively parent children/youth with high needs for mental health and emotional services and supports. The program was developed by Maureen Murray, LCSW, of the Services Effectiveness research program of the Department of Psychiatry and Behavioral Sciences at the Duke School of Medicine. The TFTC foster parent training program is listed as an Evidence Based Practice by the California Evidence-Based Clearinghouse for Child Welfare. TFTC has been implemented in over 40 agencies in North and South Carolina and more than 60 agencies in over 20 states.

The model focuses specifically on the in-home intervention elements (and creating adequate skill levels to implement these strategies effectively) and on the important role of supervision and coaching in helping foster parents work effectively.

The model is based on eight core values:

- Relationships are Key
- Trauma Informed Practice
- Evidence Based Practice
- Educational Approach
- Intentional Promotion of Physical and Emotional Health
- Respect all aspects of the individual

20 Kelly Murphy, Kristin Anderson Moore, Zakia Redd, Karin Malm, Trauma-informed child welfare systems and children's well-being: A longitudinal evaluation of KVC's bridging the way home initiative, Children and Youth Services Review, Volume 75, 2017,Pages 23-34, ISSN 0190-7409,https://doi.org/10.1016/j.childyouth.2017.02.008.
(https://www.sciencedirect.com/science/article/pii/S0190740917301342)

- Transition to Adulthood
- Professional Growth

The TFTC implementation process is an organized educational experience that is clearly defined, time based, and hands on and leads to an agency certification process.

5.10.2. Pressley Ridge

Pressley Ridge was founded in Pittsburg in 1832 and was the first agency serving abandoned, neglected, and orphaned children west of the Alleghenies. Today Pressley Ridge provides a range of services and supports through 70 innovative programs to over 10,000 children and families annually in Pennsylvania, Ohio, West Virginia, Maryland, Delaware, North Carolina, and Virginia. The organization is headquartered in Pittsburg, is non-profit, and has an active Board of Directors.
The essential components of Pressley Ridge's Treatment Foster Care (PR-TFC) Pre-Service Curriculum includes:

- Lessons for prospective treatment foster parents for children with emotional and behavioral issues about the following areas:
- Roles and responsibilities of a treatment parent
- Safety and supervision of children in foster care
- Appropriate discipline of children
- Normal child developmental stages
- Effects of traumatic experiences on children's development
- Psychiatric diagnoses of children in foster care
- Separation and loss that children in foster care experience
- Effective Parenting competencies: social rewards, active listening, behavior management techniques, motivation systems, skill teaching
- Managing conflicts in parent-child relationships
- Managing crisis situations

5.10.3. Treatment Foster Care Oregon

The Treatment Foster Care Oregon (TFCO) program was developed as an alternative to institutional, residential, and group care placement for adjudicated teenagers with histories of chronic and severe criminal behavior. The two main goals of TFCO are to create opportunities for youth to successfully live in a family setting and to simultaneously help parents (or other long-term family resource) provide effective parenting. The rationale for TFCO is that adolescent adjustment can be enhanced by the extent to which parents are able to effectively supervise their teenager, follow through with consequences when necessary, and promote positive involvement in school and other normative activities.

Community foster families are recruited, trained, and closely supervised to provide TFCO-placed adolescents with treatment and intensive supervision at home, in school, and in the community; clear and consistent limits with follow-through on consequences; positive reinforcement for appropriate behavior; a relationship with a mentoring adult; separation from delinquent peers along with access to prosocial peers; and an environment that supports daily school attendance and homework completion.

TFCO utilizes a behavior modification program based on a three-level point system by which the youth are provided with structured daily feedback. As youth accumulate points, they are given more freedom from adult supervision. Youth are provided weekly meetings with an individual therapist who provides support and assists in teaching skills needed to relate successfully to adults and peers. Family therapy sessions help parents prepare for the youth's return home and help them become more effective at supervising, encouraging, supporting, and following through with consequences. Case managers closely supervise and support the youths and their foster families through daily phone calls.

Throughout the six- to nine-month placement in foster homes, there is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Aftercare services remain in place for as long as the parents want, but typically last about one year.

The certification application process involves a thorough evaluation of several components of an agencies TFCO program, including coding and evaluating treatment parent and clinical staff meetings, and a fee is charged for this process.

5.11. Medicaid Service Delivery Best Practice Models for High Needs Children

The following consists of some of the highlights of best practice Medicaid service delivery models we observed in states where Therapeutic Foster Care Medicaid services are paid through Medicaid Managed Care Plan(s), like Nebraska Heritage Health.

- **An independent agency that is doing assessments, treatment planning, responding to crisis prior to and during removals to foster care and working collaboratively with the Medicaid Managed Care companies to implement the Medicaid covered portions of the Treatment Plan (NJ System of Care).**
- **A statewide Medicaid Managed Care approach involving MCOs focusing exclusively on the comprehensive Medicaid services covering the entire foster care population**, such as single Managed Care Plan (TX., OK, KY, WV, FL., WA.).
- **Integration of physical and behavioral health** services
- **Critical and focused attention on behavioral health services**
- **Specialized service coordination**

- **Network and Access to Care requirements** that are continuously reviewed and monitored to ensure timely access to services
- Specialized language **requiring the Network to have providers who are specialized in treating victims of child abuse** and neglect and exploitation
- Specialized language **requiring the Network to have providers who specialize in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and other Evidence Based treatments**
- **Requirement for MCOs to encourage Providers to use Evidence Based Practices** and promising practices that are demonstrated through research to be effective with these traumas, such as TF-CBT, PCIT, CPP, and TBRI, and to address risk factors and stressors that influence future Abuse, Neglect, and Exploitation
- **Specific requirements that MCOs are to be responsive to inquiries and requests from the State child welfare agency**, including its staff, and caregivers
- **MCO case managers required to provide information** to state child welfare agency staff and caregivers upon request;
- **Requirement to provide intensive case management wraparound services**, including specific requirement that intensive case managers **complete training in the National Wraparound Implementation Center's Wraparound Practice model** and must incorporate wraparound process planning or other approved models in developing a plan that addresses the child's or youth's unmet needs across life domains.
- **Specific definition of Wraparound service requirement** that is connected to services for children and youth of high needs.
    - Washington Wraparound model described as follows:

    Wraparound with Intensive Services (WISe): "Wraparound with Intensive Services (WISe)" means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program serves children and youth under the age of 21 who are experiencing mental health symptoms that are causing severe disruption in behavior, and/or interfering with functioning in family, school, or with peers requiring: the involvement of the mental health system and other child serving systems and supports; intensive care collaboration; and ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.

- Requirements that the **case manager** meet with the child within few days of coming into service (7 days in Texas) and "**must take steps that are necessary to assist the child or youth in gaining access to the needed services and service providers**, including:

  - Creating a treatment plan based on standardized assessments that are then shared with caregivers and MCO case managers.
  - Making referrals to potential service providers.
  - Initiating contact with potential service providers.
  - Arranging, and if necessary, to facilitate linkage, accompanying the child or youth to initial meetings and non-routine appointments.
  - Arranging transportation to ensure the child or youth attendance.
  - Advocating with service providers.
  - Providing relevant information to service providers.
  - Monitoring the child's or youth's progress toward the goals set forth in the plan."

- Can **offer individualized services to members in high needs** based on Medical Necessity, Functional Necessity, cost-effectiveness, the wishes of the Member, Member's Legally Authorized Representative (L.A.R.), or Medical Consenter, as applicable, and the potential for improved health status of the Member.
  - Washington: The MCO does not have to receive HHSC approval for Case-by Case Services and does not have to provide such services to all MCO Members. MCO has the discretion to offer Case-by-case Services, which are not included in the Capitation Rate. The MCO must maintain documentation of each authorized Case-by-case Service provided to each Member
- Requirement to **contract with Providers with Telemedicine capabilities** to increase access to specialty care.
- **Waiver of Prior Authorization** for certain services.
  - Texas STAR Health: The MCO will not require a PA for all outpatient medication management services, and a PA will not be required for the first ten outpatient BH sessions, to include the initial evaluation.
- MCO must **recognize the intensive or ongoing need** for these services often present among the high needs children population, and **should not be unnecessarily burdensome** (Texas STAR Health)
- MCO **required to be part of "Team Based" philosophy** developing cross system care plan
- Requirement for a CANS Assessment, or similar tool, within 30 days of a child coming into care to be used in developing the treatment plan, and as part of the determination of level of care
- Requirement to **enter results of CANS Assessment in statewide child medical file accessible to state child welfare agency and providers**.

- Behavioral Health Assessment System (BHAS): "Behavioral Health Assessment System (BHAS)" means an online Child and Adolescent Needs and Strengths **(CANS)** data entry and reporting system that provides CANS data in real time to clinicians, supervisors, agency administrators, and AH-IFC administrators, as well as HCA staff, for quality improvement purposes. The reports in this system are explicitly designed to provide on-demand, multi-level feedback and are updated in real-time. (Wash.)

- **Care management responsibilities include moving the member to a less intensive Level of Care** Management as warranted by member improvement and stabilization.
- Provision **allowing MCO to pay for behavioral health services to high needs children not only in offices and clinics, but also in schools, homes, and other locations as appropriate**
- Requirement of **Electronic Health Record (EHR) of provider available to State child welfare department through MCO**

  The MCO must contractually require behavioral health providers to provide the following information for the Health Passport (Texas STAR Health EHR):

  1. primary and secondary (if present) diagnosis;
  2. assessment information;
  3. brief narrative summary of clinical visits/progress;
  4. scores on each outcome rating form(s);
  5. referrals to other Providers or community resources;
  6. evaluations of each Member's progress at intake, monthly or as significant changes are made in the treatment plan; and
  7. any other relevant care information.
- The requirement for the **assessment and treatment planning entity to have a Behavioral Health Services hotline**, answered by a live voice, staffed by trained personnel and available 24 hours per day, 7 days a week, toll-free throughout the state which addresses routine and crisis behavioral health calls.

- Requirement that **MCO offer clinical provider training programs in topics related to child welfare and trauma informed car**e;
  - An example is the Kentucky SKY Program: Aetna Clinical Providers Training Program Curriculum, which provides for provider training related to:
    - Review of Medical Consent, Information, and Timeliness. Medical consent requirements. Specific medical information required for court requests and judicial review of medical care. Required timelines for services and assessments

- Aging Out Process and support available through Aetna Family First Prevention Services Act and other federally mandated services and programs impacting Kentucky SKY enrollees
- Behavioral Health Resources. Screening for and identification of Behavioral Health disorders. Evidence-based Behavioral Health treatment interventions. Specific Behavioral Health and Physical Health needs of the Kentucky SKY populations
- Trauma-Informed Care
- Children Adolescent Needs & Strengths (CANS)
- Crisis Intervention Services
- High Fidelity Wraparound
- The impact of Adverse Childhood Experiences (ACEs)
- Neonatal Abstinence Syndrome
- Appropriate utilization of psychotropic medications
- Substance Exposed Infants
- Training for Youth Transitioning
- The Care Coordination Team
- Sex Trafficking 101
- Supporting LBGTQ Youth
- Performance Measures and Health Outcomes

5.12. Findings Related to State Agency Collaboration

Through extensive structured interviews with numerous DHHS leaders and staff, supplemented by interviews with private providers, TSG found that less than 10 percent of the children in DCFS' out-of-home care are considered children or youth with high needs, complex medical conditions and/or hard to place. At any one time, this group represents approximately 200 children. While a small percentage of the overall children and youth in out-of-home care, numerous stakeholders shared with TSG how the system of care in Nebraska struggles to address their needs. Within just DHHS, specific aspects of these children's custody and care is spread across DCFS (for placement) and licensing of foster parents, DMLTC (for Medicaid benefits), DPH (for licensing of the individuals and facilities caring for them), DBH (to assist with meeting their behavioral health needs), and DDD (to assist with I/DD waiver services and in some cases for placement even without an I/DD diagnosis).[21]

TSG found that each one of these agencies has its own eligibility system, assessment tools, and funding mechanisms and that there is no integrated case record that could be provided to a

[21] CFS licenses the foster parents but Public Health licenses the Child Placing Agencies; DD certifies the EFH.

multi-disciplinary team responsible for their care with accurate, consistent, actionable information that can be utilized proactively in the placement and treatment process.

TSG found, however, that new leadership at both DCFS and DMLTC has been meeting regularly to discuss a number of these intra-agency issues of importance and this provides an opportunity for continued close collaboration on a systemic, proactive level going forward for children in need of a crisis placement.

The most significant opportunities TSG found for improved DHHS agency collaboration pertaining to DCFS' hardest-to-place children and youth are:

- Data sharing including assessment tools and treatment history across agencies so as to minimize trauma and inform decision making;
- A need for meaningful, close, proactive collaboration that includes DHHS' private partners (i.e., MCOs for DMLTC , Child Placing Agencies/St. Francis for DCFS);

In addition to needed DHHS inter-agency coordination, TSG found DCFS is competing with other Nebraska government programs – including the Administrative Office of Probation – for beds in the homes of community-based providers. In the worst cases, these providers pit the agencies against one other, driving up the cost of placing a child through negotiated Letters of Agreement (LOAs) and demanding children be removed from their homes if the agency placing them asks for documentation of services provided, requires licensing, or encourages the provider to consider permanency at a lower payment rate.

TSG also found:

- DCFS children are not eligible for the professional partnership wraparound behavioral health services provided through the Regional Behavioral Health Authorities (RBHAs) because of their Medicaid eligibility;
- DPH licensing standards viewed as barriers for otherwise qualified placement providers (i.e., DD providers, relative and kinship providers)

5.13. Findings Related to Criteria and Definition of Children with High Needs

Stakeholders interviewed by TSG were unable to provide data regarding the specific categories that the approximately 10 percent of children at the highest levels of care fall into – medically fragile, I/DD, severe mental illness (SMI), part of a sibling group, etc. Probation staff did indicate that all DCFS children who are dual wards are placed at a level three or higher based on a risk assessment that presumes they are a risk in community placement. DCFS and private agency staff indicated that very few medically fragile children were in long-term out-of-home care. Collectively, stakeholders identified hard-to-place children as teenagers (the average age for a child in an LOA with DCFS is 14 years of age) who were post-termination of parental rights with

a significant history of behavioral health diagnoses and physical or sexual aggression leading to placement disruption.

There are multiple ways to define high needs children in the context of the child welfare system and the term means something different to different groups of program staff. Some identify this as the population with behavioral health diagnoses. Others take a broader approach to include those with behavioral health or physical health issues. To some, the population includes children and youth with more intensive or specialized authorized levels of care which dictate the amount of foster care payments. Others consider it a practical issue of placement and define high needs children as anyone with challenging diagnoses, behaviors, and other characteristics whose placements break down frequently and require new placements frequently. Another perspective is to define high needs children as those who drive foster care and health costs.

These children consume a large amount of human resources in DCFS and in the therapeutic and medical community. Depending on the definition one uses, the composition and size of the high needs population varies significantly. Coming to a common understanding of the definition of this population is important in the design of solutions to improve the provision of care.

In Texas, caseworkers capture a number of child characteristics in their SACWIS system and this information is helpful to begin the process of identifying children with high needs. While there are dozens of individual indicators, over time, child welfare agency management reporting created certain composite indicators that group together related characteristics to facilitate easier reporting. One indicator is also used in identifying eligibility for adoption assistance. These indicators include emotional, learning, medical, physical, and special needs. Some individual characteristics are included in multiple composite indicators (i.e., a child with bipolar disorder would have both the “emotional” and “special needs” indicators). The listing of individual characteristics mapped to the composite indicators is shown in Appendix H and, as DCFS moves forward on implementation of a new therapeutic system of care for high needs children and youth, we recommend that DCFS consider a similar process for caseworkers to capture child characteristics in the N-focus system.

5.14. Other Findings

- The State is currently identifying gaps in services for Families First Prevention Services Act Evidence Based Programs related to its PPFSA plan and has hired a contractor to assess gaps. There is no current focus on EBPs specifically designed for high complex need children. DCFS should add this as an item of focus with the FFPSA planning, since a number of these children will be reunified and continue to meet the FFPSA candidacy definition.

- The use of antipsychotics and antidepressants in the child welfare population is not based on a standardized prescription practices model. For example, antipsychotic prescription practices have been described as "overprescribed".. Drug utilization practice uses four or more antipsychotic scripts as the standard for drug utilization concern. Second opinions are not required for the use of two or more antipsychotic agents simultaneously as in several best practice states. Logically, the children/youth exhibiting the most difficult behaviors are likely to be prescribed multiple agents with MD/NP not having access to a standardized behavioral health assessment. This could have the effect of children prescribed multiple agents in LOA cases and prescription practice changes during the crisis continuum without continuity of care and safe age-related prescribing practices.

6. Recommendations

6.1. Recommended Rate Improvement

6.1.1. Data and Practice Supports the Addition of an Interim Rate Tier

In assessing the recommended Specialized level of care TSG compared the proposed Title IV-E Maintenance and Administrative payments to those paid through current Letters of Agreement (LOAs). We find that a significant portion of the rates paid through the LOAs fall below these proposed rates. This finding supports the need to establish a level of care above the current Intensive level but lower than the proposed Specialized level. We also find that:

- Many hard-to-place children in Nebraska foster care are being placed without the benefit of competition and performance based contracting, which is driving up costs unnecessarily. Moreover, some of the placements are with providers that are not licensed under the child care licensing requirements, which, if licensed under such regulations, would bring in federal funding to improve the overall child welfare system in the state.
- The Letters of Agreement system is a crises-driven system, and the contracts require no specialized training of foster parents, creating barriers related to permanency, and no quality measures beyond security and supervision. While the contracts require regular monitoring by DCFS caseworkers and regularly reporting by foster parents, we were informed neither of these activities take place in a standardized manner.
- CFS- at this time, does not have a standard process that outlines when to execute an LOA, what criteria must first be met, what specific expectations are for the care of the child, what the desired outcomes are and how the LOA will be monitored from a contract and quality oversight manner. DCFS leadership is currently working closely with the field and reviewing LOAs over a certain dollar amount.
- Providers indicate it is unclear what documentation related to the child's needs is being used in the resolution of crisis incidents that require an LOA.

- Nebraska is not claiming Title IV-E reimbursement for expenditures related to LOAs. Such expenditures should be considered reimbursable if a child is placed in a child welfare licensed placement and is determined to be categorically eligible under Title IV-E requirements.
- Finally, it has been determined that foster parents are not eligible for Adoption Assistance Subsidies as a level commensurate with current payment as a "professional foster parent" (in the ESA) or payments through an LOA.

Based on our review of Title IV-E Maintenance rates, Administrative Support Rates, and LOAs TSG finds:

- Existing maintenance per diems are established based on a rational approach and sound methodology,
- Maintenance per diems appear to be reasonable in nature
- Administrative support rates fall within an expected range.
- LOA payments are not being claimed to Title IV-E.
- Significant % of youth on a LOA fall below the proposed minimum (professional) maintenance rate – national research indicates small increases to per diems lead to enhanced placement stability and improvements to reported child behavior.

As a result, we recommend implementing the Special level of care proposed by the Rate Setting Committee and establishing an interim level of care between the current Intensive Level and the proposed Special Level.

Implementing these levels of care will serve to significantly reduce the number of LOAs executed in the state while supporting permanency options through higher adoption subsidies for children with more acute needs.

6.2. Recommended NCR Improvements

The Nebraska Caregiver Responsibility tool[22] was developed by the FCRRC and is defined as:

> "This tool is used by the Nebraska Department of Health and Human Services (NDHHS) to determine and modify the amount of financial assistance for eligible children. This tool is based on the Nebraska Caregiver Responsibility Tool that is used to determine foster care maintenance payments by NDHHS."

In reviewing the NCR and its use across the state, TSG finds:

- The NCR would benefit by conducting a normative scoring process to assure the instrument is valid for the purpose of assigning levels of care.

[22] Ibid, p. 44

- The NCR process would be considerably improved if the child/youth's medical, behavioral health, developmental/physical needs treatment plan process was included in a standardized manner, while conducting the NCR assessment process with the family/caregivers. Independent assessment information about the trauma related, behavioral health, developmental disabilities, SUD, medical/pharmacy needs of the child/youth provided through the MCOs are external to the NCR assessment process and are not specifically detailed in the NCR document. Aligning these efforts would achieve far better results.
- TSG strongly recommends that an independent standardized child/youth Evidence Based assessment process and instrument for Behavioral Health (such as the CANS, CAFAS, ANSA -over 18) needs and services covered by Medicaid and the MCOs be implemented in DCFS and/or MCO service delivery networks to provide a singular valid Behavioral Health assessment, determination of strengths, needs, level of intensity, and treatment plan by all entities involved with the child/youth. This approach will provide comparable standardized assessments and data that, over time, would have a direct impact on the level of need for Medicaid paid Treatment Family Care Services, DCFS levels of care, and valid data to assess child/youth progress and regression, support for step up or down decisions, and connections to pathways to permanency.
- DCFS should ensure that staff and supervisors are adhering to NCR policy, including receipt of documentation and should also conduct spot audits to assure continued adherence to an effective policy when determining the highest level of care.

6.3. Recommended Contract Improvements For Child Placing Agency Expectations

TSG recommends the state collaborate with the contracted Child Placing Agencies to develop service, worker / child visitation, performance, and outcome expectations by level of care and integrate these expectations into child placing agency contracts.

6.4. Recommended TFC Improvements:

There are a number of improvements DCFS should consider to the FCRRC recommendations regarding Treatment Family Care and its future program implementation. A number of those improvements have already been identified in state best practice review findings and are contained in this Report. Some of these improvements would involve additional service definition criteria, clear expectations of providers and foster parents, enhanced training and accountability, education and outreach on covered Medicaid benefits, enhancement to the Medicaid service delivery system, cross agency data integration, continued division collaboration, and a continued focus on removal of barriers to permanency.
Before implementing a TFC program in Nebraska, DCFS should:

- Consider the common themes and implementation factors identified in our state best practice section for:
  - Successful Therapeutic Foster Care model programs for providers and foster parents;
  - Evidence based training models for agencies and providers; and,
  - Medicaid service delivery models that assure the most effective approach and positive outcomes for high needs children and youth in foster care.
- Clearly identify to the provider, child placing agency, foster parent and stakeholder community all pertinent covered Medicaid benefits, including those recommended by the FCRCC to be included in the Wraparound benefit model, and those not included, but still covered under the Medicaid State Plan.
- Ensure that providers, child placing agencies, foster parents and stakeholders are educated about the role of the Managed Care Organizations in carrying out Medicaid covered benefits for high needs foster care children through their state contracts, especially concerning care coordination, case management, network adequacy and timely access.
- Consider the adoption of a TFC Operations Manual to guide Agency Staff and Providers of TFC services,– see Appendix E for examples from other states.
- Work with DMLTC to adopt a Treatment Family Care Medicaid Service Coverage and Limitations Handbook for providers – See Appendix I for examples. The Handbook should contain an overview of the therapeutic foster care program, specific qualifications of providers, enrollment standards and requirements, specific covered, limited and excluded services, the provider reimbursement fee schedule and descriptions and instructions on how and when to complete forms, letters, or other documentation.
- Work with DMLTC, as part of cross-agency data integration collaboration to improve data reporting and performance dashboards on Medicaid, pharmaceutical, and behavioral health claims for all foster care children, and use that data to inform program or policy changes;
- Implement a standard process for caseworkers to capture child characteristics in the N-focus system.
- Clearly identify, with process elements defined, the role of the licensed clinician responsible for the involvement and coordination of individual child/youth treatment teams.
- Clearly identify TFC licensed clinician responsibility to include DCFS and MCO on the treatment team
- Clearly identify the composition of individual child/youth treatment teams.

- Require a behavioral health functional assessment as part of the Initial Diagnostic Interview process. The Initial Diagnostic Interview "will identify TFC as the level of care needed"[23] and "the treatment team will develop the comprehensive treatment plan within 30 days of admission".[24] Basic service expectations of the IDI are detailed in Title 471, chapters 20 & 32. The Initial Diagnostic Interview requirements do not include requirements for a behavioral health functional assessment ("behavioral" is not mentioned in the IDI state plan service definition).
- Consider the use of a standardized behavioral health assessment instrument, such as the CANS or CAFAS, in the development of the comprehensive treatment plan (due within 30 days of IDI generated treatment plan) by licensed clinicians and, over time, be normed to be used as the tool used to identify the Treatment Family Care Services or other level of care for Behavioral Health services.
- Clarify the role of the TFC provider in real time crisis situations specific to the child, youth and family. This role is unclear and should be defined in terms of 24-hour coverage, reporting responsibilities to DCFS and the child/youth's MCO, and coordinated with crisis services.
- Ensure that a standardized training module be used by all TFC providers and that DCFS be included in determining the most effective training model to be used for this purpose. The TFC services model includes a 20-hour initial training on Behavioral Health to TFC involved parents but does not specify what training module will be used and whether TFC providers will use the same or different training materials and content.
- Work with DMLTS to ensure they review the TFC recommended bundled rate methodology so that the services are individualized. The TFC model recommends a bundled rate however this implies that all children/youth eligible for TFC will require the same level of care regardless of individual presenting problems, strengths and need for services.
- Meet with the FCRRC, and include DMLTS, for the purpose of reviewing, revising, and agreeing on the TFC rate paying methodology, use of a tiered standardized Behavioral Health assessment tool that will drive duration and levels of care and lead to step down, and role identification in real time child/youth/family crisis situations and their resolution.

For TFC to be successful, however, there will need to be an adequate supply of providers of targeted services. TSG consistently heard that there are significant gaps in the availability of MCO behavioral health providers, especially Certified Treatment Aides and Therapeutic Group

[23] Ibid, p. 84
[24] Ibid

Homes. We were unable to assess the degree, if any, of MCO network access issues. We recommend that DCFS, DMLTS, DBH, and the MCOs work together to develop a data-based method to address the question of behavioral health network adequacy.

7. Framework for successful implementation of Alternative Behavioral Health TFC

Therapeutic Foster Care is a level of care designed for the highest need children/youth with significant Behavioral Health and social functions needs that include proclivity to crisis driven events. Currently there is not a standardized CMS/Medicaid definition of Therapeutic Foster Care as noted in a June, 2019 MACPAC Report on Therapeutic Foster Care.[25] This report noted that:

- "Therapeutic foster care represents an important set of services, many of which are already coverable in Medicaid. Because the needs of this vulnerable population are varied, individualized assessments should determine which services are necessary and appropriate. A uniform definition could limit the ability of states and providers to tailor services to address these needs.
- Additional federal guidance could help states design or improve the coverage and provision of therapeutic foster care services. Such guidance could inform states of their options to cover therapeutic foster care services within the existing benefit design flexibility in Medicaid, as well as provide ways to coordinate effectively with other agencies serving the same high-need children and youth."[26]

A DHHS report on "State Practices in Treatment/Therapeutic Foster Care" listed the following standardized components of TFC[27]:

- Individualized Treatment Plan
- Treatment team planning meeting at least every 30 days
- Specialized training and credentialing of caregivers/staff
- Additional training for TFC Foster Care parents
- Access to Behavioral Health Services, including in-home
- 24/7 crisis support
- Structural activities to connect the child/youth to the community

The State Best Practices section of this report includes detailed information of the requirements of the Texas, Washington, Michigan, Georgia, and Florida models of Medicaid reimbursed

[25] Report to Congress on Medicaid and CHIP June 2019 (macpac.gov)
[26] Ibid, p. 2 of Chapter 4
[27] State Practices in Treatment/Therapeutic Foster Care (hhs.gov)

Therapeutic Foster Care. These models can be used to launch a successful framework for implementation in Nebraska.

7.1. Recommended Framework for Implementation of Therapeutic Foster Care Model in Nebraska

- DCFS, DMLTS, DBH, DDD, and the FCRRC should meet to discuss options for developing a Medicaid reimbursable model of Therapeutic Foster Care in Nebraska and make a decision on how to move forward on the FCRRC recommendation.
- A Project Work Team should be appointed by the parties to include a brief Mission Charter, Project Team members, a Project Work Plan, including timeline tasks and deliverables. In developing the Project Work Plan, we recommend that the agencies allow for significant time for legislative, rule or policy changes and review by stakeholders.
- Considerations, at a minimum, should include:
    - TFC Service Model Definition
    - Eligibility Criteria based on standardized Best Practice Assessment tools
    - Standardized behavioral health assessment process
    - Qualifications for TFC Program provider agencies
    - Role of TFC parent as a provider of Medicaid TFC services (licensing/training)
    - Determining the treatment planning and intensive case management process
    - Service Authorization process
    - Service Limits based on identified individual plan outcomes
    - Payment Model developed across Medicaid and IV E
    - Identified Roles of other state agencies
    - Communication and Implementation Strategy
    - How TFC will function relative to the existing Levels of Foster Care
    - Licensing/Certification requirements
    - Title IVE and Medicaid funding will be structured to assure Federal compliance requirements are met, maximize all sources of Federal funds, and decrease reliance on state only funds for current Letters of Agreements
    - Identified standardized quality and outcomes measures for the TFC service (Individualized Treatment Plan would include case specific outcomes)
    - Attention to Permanency integrated into TFC Treatment Plan
    - Draft Implementation plan with Tasks, Responsible Entities, and Timelines
    - Impact on state budget, if any, and participating state agencies/divisions

Nebraska Department of Children and Family Services

Assessment of Outsource Model in Nebraska's Eastern Service Area:

Findings and Recommendations

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Final Report

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1. EXECUTIVE SUMMARY

1.1. Background

Currently, the Eastern Service Area (ESA) region of Nebraska for the Department of Health and Human Services (DHHS), Division of Children and Family Services (DCFS), which comprises Douglas and Sarpy Counties, utilizes an outsourced vendor for the provision of children and family services. This vendor, a non-profit entity called PromiseShip (formerly Nebraska Families Collaborative), holds a contract through 2019.

DHHS contracted with The Stephen Group (TSG) to help it determine an appropriate path forward should it should continue forward with the outsource model, to ascertain if the model has been effective to date and how it could be made more effective if the state were to move forward with the outsource model. This assessment comes after numerous meetings with the state, the vendor and numerous stakeholders, as well as rigorous financial and performance analysis, and a review of past audits and assessments.

1.2. Why Outsource?

Nebraska is neither the only nor the first state to outsource children and family services. States have chosen this model, as it allows for flexibility to innovate new solutions that reduce costs and improve services, provides the ability to rapidly adapt to new circumstances and adjust to local considerations, and promotes greater community engagement to improve connectedness and deliver better outcomes.

Maintaining an effective outsource model, however, requires a shared vision and strong collaboration between the vendor and the state. This demands trust, strong communication, accountability and stability to ensure that the practice ultimately produces better results.

1.3. Key Findings

1.3.1. Cost and Outcomes

Fundamentally, the outsource vendor in the ESA has cost, performance and outcome measures similar to those of the other four insourced regions. While some regions performed better in some areas, the outsource vendor produced better in others.

There were no areas in terms of cost or outcomes in which the vendor was an outlier from overall state results. The areas in which outcomes are improving for the vendor match those areas where similar outcomes are improving on a statewide basis. For example, the ESA represents 43% of the state's case count and approximately 43% of the state's expenditure on children and family services.

Producing results mirroring insourced regions was not, however, the reason the state chose to utilize the outsource model – the goal was to develop innovation and best practice models that would lower costs, improve outcomes, or both. The lack of collaboration in the past between the vendor and DCFS has unfortunately hamstrung those efforts.

1.3.2. Vision

Through the years of the contract with the vendor, the lack of a shared vision for outsourcing generally, and between the vendor and the state specifically, has undermined the opportunity to capture the value of the outsource model. The lack of flexibility has also undermined the prospect of innovation that could improve service for children and families across Nebraska. The lack of stability has led to short-term thinking that undercuts a critical component of outsourcing.

The absence of a shared vision of outsource services has led to a breakdown in meaningful collaboration. This has resulted in missed learning opportunities for best practice development, unproductive competition and forcing each party to work to solve problems without the benefit of the experience and insight of the other party. Additionally, with staff and leadership changes at DCFS, it has led to evolving expectations and interpretations of the goals of the outsource model.

1.3.3. Contract Management

While the existing contract structurally contains provisions that would allow for viable management, TSG found a lack of structured and accountable oversight, an absence of performance focus and very few financial incentives that states use to maximize the value proposition of outsourcing. There are no meaningful incentives or consequences to drive performance and, the contract does not allow flexibility for innovation, thereby eliminating some of the best reasons for outsourcing.

Moreover, the ongoing short-term nature of extensions has confounded the vendor's ability to innovate, retain staff, invest in facilities or attempt long-term programming changes.

1.3.4. Data and Financial Reporting

For any partnership to work for an outsourcing model, there must be consistent, accurate and timely performance, outcome and financial data, so there is a shared understanding of how the vendor is delivering services. The ESA vendor relationship, however, has been marked by ongoing struggles between the vendor and DCFS to agree on financial and outcome data, an obstacle that exists to this day and makes understanding the effectiveness of the outsource model a challenge.

1.3.5. Stakeholder Support

Across the ESA, stakeholders were generally supportive of the outsource model, supporting the concept that it delivers strong community backing. There was also concern that moving back to an insourced model would put children and families through a difficult and unhelpful transition that could risk destabilizing existing programming.

1.3.6. Improving Collaboration

DCFS, PromiseShip and stakeholders all agreed that recent efforts between the state and vendor to improve collaboration were encouraging and are beginning to create an environment that will allow children and families to see the benefit of the outsource model.

1.4. Other Findings

1.4.1. Service Array

The ESA has a larger array of services than those offered in other regions. Some of these services are innovative and close the gap between children and families and providers. Despite these additional services, the outcomes for children are similar to those in other parts of the state, leading to the question as to whether they are truly adding additional value, or whether the contract is not allowing enough flexibility to allow the vendor to capture the maximum value from the programming.

1.4.2. Preparing for Family First Prevention Services Act (FFPSA)

DCFS is currently preparing for implementation of the federal Family First Prevention Services Act (FFPSA), which passed in February 2018, allowing states the opportunity to draw federal funding for qualified prevention services for children and parents. DCFS is aware of the impact that this legislation will have on the entire state and, in particular, is rightly concerned about the ability of the ESA vendor to assure that state-wide prevention programming is meeting the criteria necessary for obtaining these funds, mainly because of the provider capacity of the ESA.

Currently, the vendor has a small percentage of its funding (3.63%) used for prevention and only a small number of its interventions meet the current federal standards and are likely to be approved for federal reimbursement. FFPSA also places a heavy emphasis on placing children in licensed relative fosters, while today only 17% of kinship/relative foster homes are licensed. Thus, more work needs to be done to improve the readiness of the ESA, including the vendor for FFPSA implementation.

1.4.3. Case Management Differentiation

While the operations manual requires the vendor to follow all DHHS regulations for treatment of cases and requires that training content and decision-making must mirror state processes, the

vendor has implemented several innovations in training strategy, organization tools and technology to improve performance.

1.4.4. Case Transfer

Both the state and vendor identified case transfer as a place where problems can occur during "hand-offs." This is one area where the lack of collaboration has resulted in consternation by both parties, with DCFS expressing concerns about timely reporting of abuse and neglect after the transfer and about accessing services before the transfer and the vendor concerned about the state not completing the case transfer checklist ensuring that communications loops are closed during the transfer process.

TSG identified ambiguity regarding the decision to transfer an in-home case. This should be a protocol that is clearly established, especially with a vendor that has had so many years of experience working with the state. This is particularly true to ensure the case is transferred appropriately, given the increase in non-court/voluntary cases, which go to the vendor, and Alternative Response cases, which don't receive case management from the vendor.

1.4.5. Summary of Findings

With no clear vision, historically poor collaboration, confused and inadequate incentives and consequences, a lack of flexibility and analysis, as well as ongoing uncertainty about the outsource model, this creates a difficult environment for any vendor to be successful. If the state wants to succeed in maximizing the value proposition of outsourcing, substantial changes must happen to improve how the state works with vendors to achieve success.

1.5. Path Forward

Based on what the existing vendor has been able to achieve and despite the obstacles that have emerged in the current outsource model, TSG recommends that should Nebraska continue to use an outsource model in the ESA, DCFS should make some important changes in the manner in which it manages the vendor relationship, which could allow the state to realize the benefits of outsourcing more fully.

1.5.1. A Clear Vision

For an outsource model to work, there needs to a be a clear, shared vision that defines success, fosters collaboration and demands accountability from both the state and vendor. This vision should eliminate competition, promote innovation and substantially improve communication. The partnership should ensure that both parties are consistently working together to improve quality and efficiency of services.

This vision should lay out well-defined terms of how both parties will work to achieve the goals of the vision, including laying our clear-cut mechanisms for measuring and managing important

factors such as improving outcomes and reducing cost. It should also establish a process to encourage flexibility that would limit the number of areas of strict adherence and collaborate on other areas to deliver better results.

1.5.2. Making any Outsourced Contract Performance-Based

Once the state and vendor have established a vision and standards for accountability, DCFS must work to ensure the vendor delivers what is agreed to and expected. This will set performance objectives, metrics for outcomes and costs and then solidifies these with financial incentives and penalties around the vendor's performance. The partners will then both have a strong interest in consistent, robust collaboration to hold each other accountable.

This contract must also include provisions that improve data sharing for financial and outcome data, so that DCFS can develop dashboards to measure performance in real time and share these with the vendor. The goal should be to ensure that both parties can identify problems and find solutions together quickly and with share understanding. This should transfer to the public as well, with these dashboards published on the DCFS website to offer transparency to the public.

1.5.3. Delivering Oversight that Works

Ensuring that accountability is daily priority begins with real oversight with the vendor. This starts with DCFS creating a Quality Assurance Team from resources across the Department, including agency leadership, finance, CQI staff and contract monitors that meets regularly (at least monthly) to share financial and performance data and discuss operational and strategic matters with the vendor.

This team must have sufficient resources and leadership commitment to maintain fidelity to the mission and will need to work to build a quality assurance tool to take the performance and financial dashboard to build a scorecard, so that the vendor can readily identify problems and improvement areas.

The goal of this effort is to change the nature of oversight from a compliance-based effort to a collaborative, performance-based approach that leads to continuously improving results.

1.5.4. If Outsourced, Include Case Supervision in New Contract

DCFS has already begun the process of identifying families that need services, but not ongoing case management. Utilizing full case management services is unnecessary and costly.

Should DCFS move forward in an outsourced environment, the agency should include in the new contract a second level of case oversight – case supervision – that can provide support for families who need direct services, but minimal case management. This would be supported by two rates to the vendor, which would reflect the level of service demands required. DCFS can

establish Utilization Management controls to ensure that families are getting the appropriate level of case involvement, while reducing overall costs to the state.

This new system would need to include important protocols for when a case would be elevated from case supervision to case management, and vice versa. Clearly, this would require strong coordination and collaboration with the vendor and an ongoing discussion about fine tuning the handoffs.

1.5.5. Building a Culture of Innovation

Nationally, the strength of the outsource model is its ability to adapt rapidly to utilize new technology, new training techniques and new interventions to deliver better outcomes and lower costs. Should DCFS continue with the outsource model, the next contract should loosen the rigid parameters that constrain this innovation and instead collaborate directly with the vendor to encourage this innovation and build a culture of exploring best practices to find solutions that enhance quality and efficiency.

The get there, the vendor and DCFS must discuss new service delivery models and agree in advance on how they should be implemented. This means including baseline standards in the contract and allowing change after the vendor submits an approved plan. This should also include incentives to the vendor to reward innovation, to ensure that it becomes a priority. In turn, DCFS can take the successful strategies, develop them into best practices and deploy them in other Service Areas.

1.5.6. Engaging Stakeholders

As the state moves to performance-based contracting, getting feedback from stakeholders will be essential to ensuring that one of the other major benefits of outsourcing – community engagement and connectedness – remains strong.

To do this, DCFS should begin meetings in the Eastern Service Area to discuss the new vision and renewed goals of the outsource model and take feedback to see how the program is functioning. This should be a consistent process that maintains after the contract is procured and develops into regular feedback process in collaboration with DCFS and the vendor.

1.5.7. Maximizing the Opportunity of FFPSA

DCFS must require any outsourced vendor to develop a comprehensive array of strong, evidence-based services that meet the approval criteria of FFPSA. This fidelity to the federal law must be an important metric connected to contract monitoring and performance management.

For services by the vendor that to meet existing standard of Evidence-Based Treatments under FFPSA, DCFS should work to identify if they meet the standards of innovation and performance,

and if so, should work with the FFPSA Clearinghouse to seek approval. For those that do not meet FFPSA standards and do not advance innovation and performance, DCFS should work with the vendor to transition into new models that are aligned with the federal law and the outsource vision, building a roadmap for these services and providing the resources for success.

DCFS and the vendor must also work with subcontractors to utilize FFPSA approved treatments when possible through provider agreements and offer training and operational resources to transition to these treatments.

Finally, DCFS and the vendor should collaborate with stakeholders to increase the licensing of relatives providing foster care. This could require a review of state licensing and policies, as well as active outreach and training, to move more of these foster families into FFPSA compliance, which will also benefit the children in care.

1.5.8. Improving Coordination with Medicaid

Ensuring coordinated health care will result in better outcomes and help children and families who are often in trying circumstances avoid confusion when passing through complex systems of care.

To deliver this improvement, the state should create an on-going Child Welfare Leadership Team from across DHHS (including DCFS, DM & LTC, DBH and DDD) to plan the services around children and families. This will require an integration of care for future managed care contracts that includes care coordination for high needs/high risk children and youth, a responsibility for manage care providers for finding accessible and timely services, development of behavioral health evidence-based practices and developing an electronic case record for children receiving DCFS services like the Texas Health Passport.

DHHS must work to improve data sharing between DM & LTC and DCFS to focus on meaningful outcomes. Presently, there are limitations that make it difficult to analyze data or create meaningful dashboards.

DCFS should also consider shortening the timeframe for a child getting a medical examination with two weeks of a removal down to 72-hours to ensure that child is getting appropriate care quickly.

2. SCOPE AND OBJECTIVES

The Nebraska Department of Health and Human Services (DHHS) Department of Children and Family Services (DCFS) contracted with The Stephen Group (TSG) to perform an assessment of the current outsourcing of in-and out-of-home case management and service delivery in the Easter Service Area (ESA), and to recommend an appropriate path forward, should DCFS continue to outsource the ESA region. DHHS has amended the contract of the current vendor, Nebraska Families Collaborative (PromiseShip), through December 31, 2019 to enable time for this assessment to occur so that TSG's analysis can inform its decision on the release a Request for Proposal (RFP) and any changes that need to be made.

TSG's primary charge is to conduct an insource vs. outsource feasibility study of the ESA. TSG is also tasked with:

- Evaluating the existing service delivery system for services in the ESA and recommend a future state model;
- Define the outsourced service delivery vision; and,
- Conduct impact analysis and provide recommendations for decision framework.

For the final item, TSG was directed to identify clear, actionable recommendations to assist the Department in improving the implementation of the next contract or in transitioning to the state-provision of case management in the ESA.

TSG's task is to determine whether the outsource model has been or can be successful with modifications made to its execution, or whether there is evidence that a vendor cannot be successful, and the state should assume responsibility for case management. This report is not meant to be a validation of whether the current vendor has been successful or not, but rather what the vendor's performance reveals about the success or failure of the outsource model itself.

In arriving at this recommendation, TSG will consider the following objectives:

- Has the vendor been able to achieve improved performance outcomes?
- Has the outsourced model been more cost-effective than state-provided care?
- Did the state achieve its vision in outsourcing case management?
- Did the contract/model allow for innovation in case management and the development of services?

3. REVIEW OF PAST AUDITS, STUDIES, AND REPORTS

TSG reviewed prior audits, studies, and reports on the Nebraska child welfare system and the outsource in the ESA. **Appendix A** summarizes TSG's complete review of these past audits, studies, and reports, including:

- State Auditor of Internal Accounts, 2018
- Letter to Senator Merv Riepe
- Letters to Patrick O'Donnell, Clerk of the Legislature
- Nebraska Child Welfare Blueprint Report March 2017
- OIG Annual Report, 2016-2017
- Hornby Zeller, 2014
- Digital Commons, University of Nebraska
- Hornby Zeller, 2012
- Platte Institute, 2012
- DHHS Report to the Legislature: Legislative Resolution 37 (2011): Review, Investigation and Assessment of Child Welfare Reform

In reviewing these reports, TSG did not find any reports that gave a favorable review concerning Nebraska's outsourcing of child protective services. The State Auditor found major fault with financial controls. The 2014 Hornby Zeller report is hopeful, but only if the State makes major changes to the method of managing the relationship. Digital Commons argued philosophically that privatization can never save money and goes on to demonstrate its going-in assumption.

These reports also indicate that outsourcing has not been especially effective for DCFS:

- The objectives of outsourcing were not clearly spelled out in advance, so it is difficult to say there have been achieved.
- Outcomes, though improved, are not especially better than the rest of the state.
- Cost controls are weak, though Hornby Zeller's 2014 report says costs are lower.

TSG noted a common thread through all the audits and reports: DCFS failed to create a functional outsourcing model. Objectives were not clear; contracts and organizational relationships were not structured correctly, and the relationship was not managed well. Even DCFS predicted that poorly implemented outsourcing would fail to address the situation better than "in-sourcing". Yet DCFS proceeded with weak outsourcing model and implementation.

These reports agree that that child protection outsourcing has not been "proven" or "disproven" by Nebraska's experience to date—rather that the administration of the outsourcing is inadequate. Prior to the TSG assessment, reports and audits could not determine whether it could have been effective or not or how it might be improved. Each of the reports call for the same thing: better management.

Across nearly a decade of reporting and audits, the message is clear. Privatization has been assessed as initially ill-conceived and poorly managed. None of the reports suggest that privatization has achieved significant improvement. Thus, the stage was set for TSG's assessment.

Rather than repeat the work of these past audits, TSG seeks to target its review to provide DCFS and policy makers with critical information at this juncture, including their need to know:

- What are reasonable objectives from privatization (outsourcing)?
- How best to arrange the relationship for high performance?
- What has been the performance to date?
- How best to respond: whether in- or out-source and how to improve performance in each scenario.
- How to create on-going management and reporting practices so that the benefits (and challenges) of privatized services are more transparent and adaptable.

4. METHODOLOGY

Upon completion of a thorough review of prior research and analysis on the Nebraska child welfare system and the outsourced ESA, TSG designed a comprehensive review to collect information using the following approaches:

- Review of the existing contract, extensions, and amendments in Nebraska
- Review of other state best practices in child welfare contracting
- Requests of multiple rounds of data, including from DCFS and PromiseShip
- Review and reconciliation of the financial data from DCFS and PromiseShip, which required additional meetings and data requests
- Review of operational and performance outcomes (for in- and out-of-home cases).
- Meetings with DCFS and PromiseShip:
    - DCFS state office contract management and continuous quality improvement staff
    - DCFS ESA regional staff
    - PromiseShip: Administrators, internal management across key functional areas, supervisors and FSR caseworkers
- Meeting with the DHHS Division of Behavioral Health.
- Focus groups, process mapping, and analysis of the case transition process with DCFS and PromiseShip administrative, supervisory, and frontline caseworker staff from Douglas and Sarpy Counties.
- Meetings with key stakeholders, including the following:
    - Inspector General
    - Judges (Sarpy and Douglas County)
    - Juvenile County Attorney and assistant county attorneys (Douglas County)
    - State Executive Leadership for CASA, as well as CASA leadership in Sarpy and Douglas counties
    - Guardians ad litem
    - Foster Care Review Board
    - Nebraska Family Support Network
    - Project Harmony
    - Conducted a provider call with providers operating in both State and ESA
    - Individual Service Providers: Nebraska Children's Home Society, Capstone BH Services, Cedars

5. ASSESSMENT OF CHILD WELFARE PERFORMANCE OUTCOMES

As noted in TSG's review of other Nebraska child welfare reports and assessments, in 2014, Hornby Zeller, found "…nearly three full years since the privatization of case management, it is clear that the outcomes achieved for families and children by NFC are no better than those produced by DHHS. Neither are they any worse."

Four years later, TSG performed a similar review in order to determine if there is compelling evidence to either continue to outsource or to in-source case management in the ESA. TSG finds that generally, outcomes have improved significantly statewide (including in state-run and PromiseShip Service Areas) over the last several years. There are some measures where ESA performs better and others where it performs worse than other Service Areas. However, the outcomes analysis does not suggest that the decision to outsource has been wildly successful or a failure for the state.

In analyzing this data, TSG took a two-pronged approach, which includes analyzing current performance in the ESA compared to historical performance and performance compared to other DCFS Service Areas.

In meetings with PromiseShip leadership as well as stakeholders in the ESA, TSG was cautioned to compare the performance of Nebraska regions due to unique factors of the ESA such as the population size, diversity and acuity, increased availability of placements and providers, and differences in the judicial system. While TSG agrees that these differences are substantial, because TSG is interested in assessing the question of whether DCFS should continue to outsource case management in the ESA, the ability of a vendor to improve performance as well as the performance of the other regions are both relevant.

TSG requested data on the level of care of the children in care (out-of-home cases) to put the performance differences and similarities in context. The following data are a snapshot from December 2016.

Table 1: Children in Out-of-Home Care, by Service Area, December 2018

Level Of Parenting	CENTRAL	EASTERN	NORTHERN	SOUTHEAST	WESTERN	TOTAL
Enhanced	82	450	119	156	69	876
Essential	153	685	209	240	238	1,525
Intensive	31	208	24	67	19	349
No NCR Completed	28	82	31	20	26	187
Grand Total	294	1,425	383	483	352	2,937

Source: DHHS, December 2018.
Notes: Excludes the YRTC youth and tribal youth. Intensive is highest acuity (shown lowest to highest).

Table 2: Share of Children by Level of Care, December 2018

	CENTRAL	EASTERN	NORTHERN	SOUTHEAST	WESTERN
Enhanced	9.4%	51.4%	13.6%	17.8%	7.9%
Essential	10.0%	44.9%	13.7%	15.7%	15.6%
Intensive	8.9%	59.6%	6.9%	19.2%	5.4%
No NCR Completed	15.0%	43.9%	16.6%	10.7%	13.9%
Grand Total	10.0%	48.5%	13.0%	16.4%	12.0%

Source: DHHS, December 2018.

This figure demonstrates that while the ESA has 48.5% of the state's population of children and youth in care, it has a slightly greater share of the state's children/youth with the Intensive level of care. Note: This is December 2018 data and captures the children in out-of-home placement. This differs from TSG's estimate that the ESA vendor has 43% of total cases.

Table 3: Case Mix by Service Area, December 2018

	CENTRAL	EASTERN	NORTHERN	SOUTHEAST	WESTERN	TOTAL
Enhanced	27.9%	31.6%	31.1%	32.3%	19.6%	29.8%
Essential	52.0%	48.1%	54.6%	49.7%	67.6%	51.9%
Intensive	10.5%	14.6%	6.3%	13.9%	5.4%	11.9%
No NCR Completed	9.5%	5.8%	8.1%	4.1%	7.4%	6.4%

Source: DHHS, December 2018.

This figure demonstrates the share of cases within each Service Area, and statewide, by level of care. The ESA is carrying the greatest share of the state's total of "Intensive" children (59.6% of

all "Intensive" children are in the ESA) and children with an "Intensive" level of care make up a greater share of the case mix in the ESA than and in other regions (14.6% compared to state average of 11.9%). While it is not possible to determine how this distribution affects each individual measure based on the data provided to TSG, this is important contextual information for evaluating the outcomes in the ESA, including permanency outcomes, as well as cost of care.

5.1. Child and Family Services Reviews (CFSR) Measures

The federal Administration for Children and Families Children's Bureau uses established measures to assess and compare the performance of state child welfare systems with key Title IV-B and IV-E requirements.[1] These measures focus on the out-of-home cases (children in the state's care).

5.1.1. Round II Measures

TSG reviewed performance of all of the Nebraska Service Areas for the following CFSR Round II measures to assess whether there are significant differences in performance:

- Absence of maltreatment recurrence (over 6-month, calculated over rolling 12 months)
- Absence of maltreatment in foster care
- Timeliness and permanency of reunification
- Timeliness of adoption
- Placement stability
- Permanency for children in foster care

Historically, all Nebraska Service Areas performed poorly on these measures (with the exception of the measure on permanency for children in foster care which the state has always been in compliance and is not included in the charts below)[2] but under the state and PromiseShip's leadership, achieved significant improvement between 2012 – 2016. The following five figures prepared by DHHS illustrate the historical improvement achieved statewide and in all Nebraska Service Areas. **Appendix B** provides more detailed data by Service Area.

[1] ACF, "Child and Family Services Review Technical Bulletin #7 Announcement of the next round of reviews, changes to the review process and information on the scheduling of reviews." March 2014. https://www.acf.hhs.gov/sites/default/files/cb/cfsr_tb7.pdf.
[2] Per Doug Beran email 12/12/18.

Figure 1: Absence of Maltreatment Recurrence

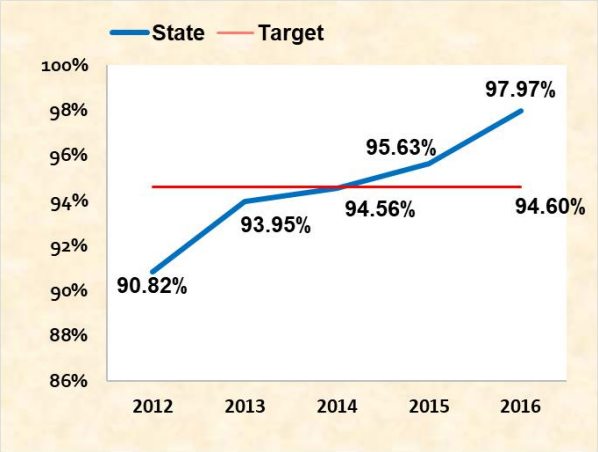


Figure 2: Timeliness of Adoption

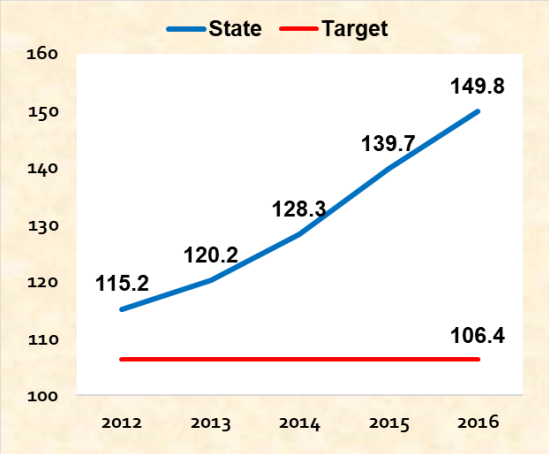


Figure 3: Absence of Maltreatment in Foster Care

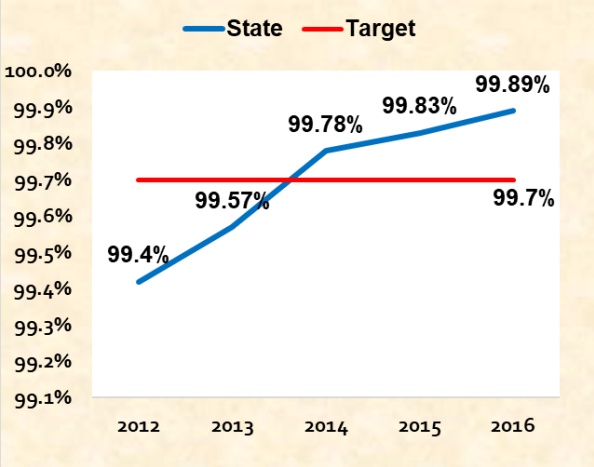


Figure 4: Placement Stability

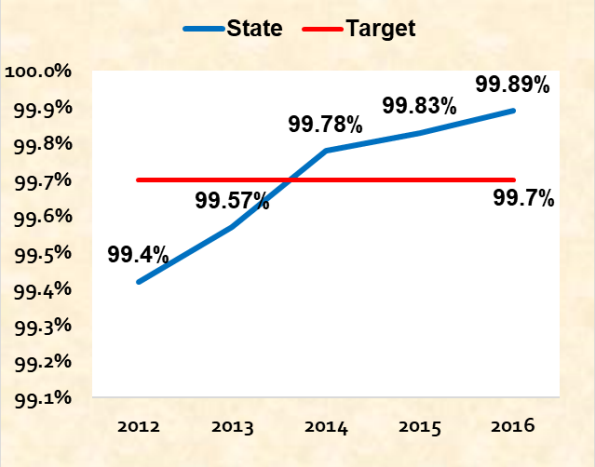
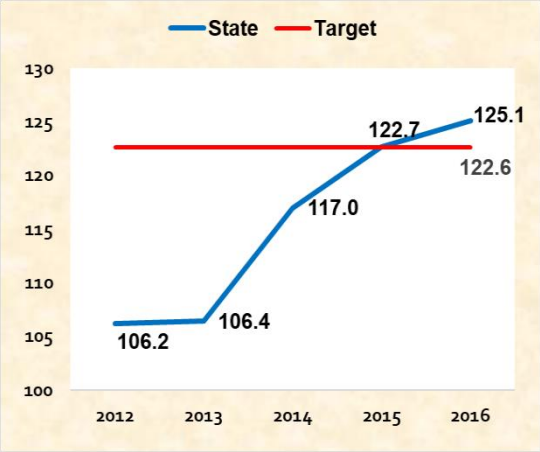


Figure 5: Timeliness and Permanency of Reunification

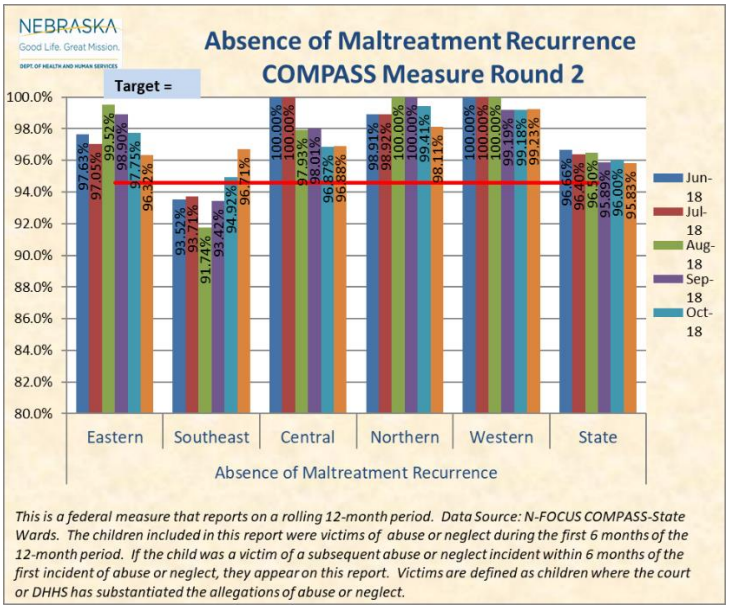


According to DHHS staff, performance has plateaued since 2016, with most Service Areas continuing to meet these measures on an ongoing basis, such that these measures are not ways to differentiate performance.

The following five charts, prepared by DHHS in December 2018, provide the state and each Service Area's performance over the past six months for these measures. Most of the Service Areas and the state are in compliance with all of the targets for this time period. Exceptions include:

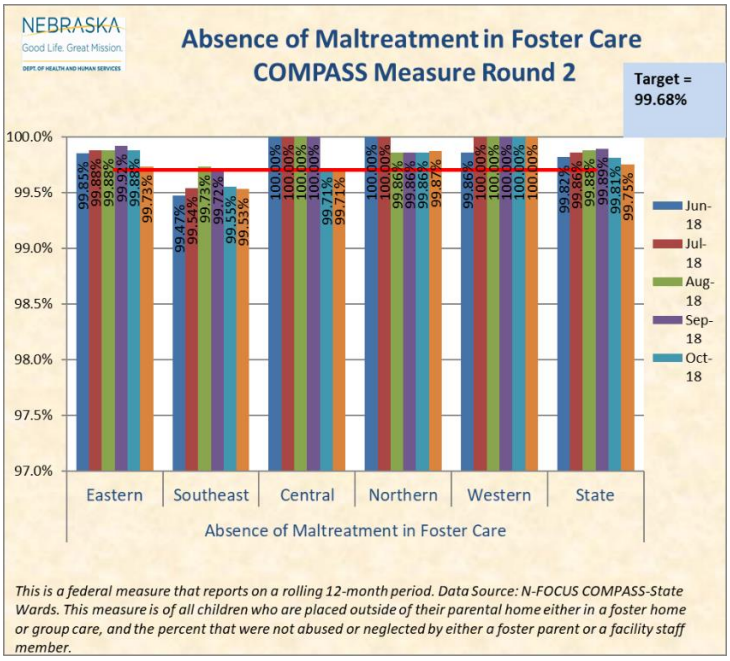
- For the Absence of Maltreatment Recurrence measure, the Southeast Service Area did not meet the target for several months over the past six months, but performance has improved to a passing level in the most recent month.
- For the Maltreatment in Foster Care measure, the Southeast Service Area has been out of compliance for four of the last six months and as of November 2018 was not passing.
- For the Timeliness and Permanency of Reunification measure, four Service Areas and the state overall did not have a passing score in November 2018 including the Eastern, Northern, Southeast, and Western Service Areas. The Eastern and Northern Service Areas did not reach the target for any of the last six months.

Figure 6: Absence of Maltreatment Recurrence, June – October 2018.



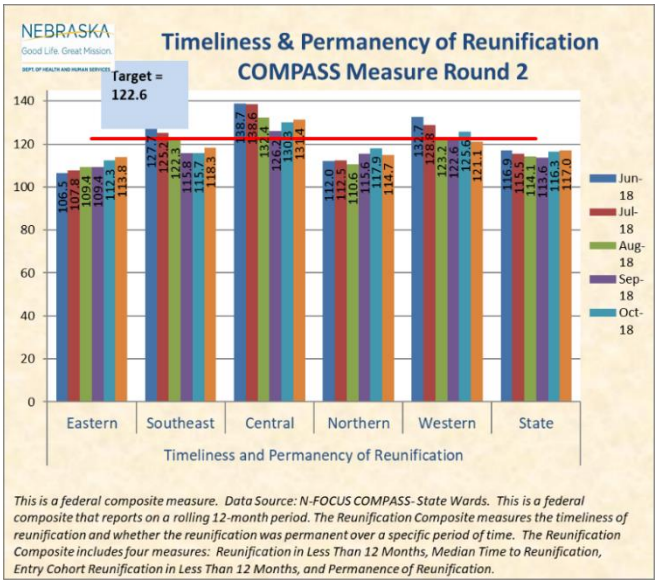
Source: DHHS, December 2018.

Figure 7: Absence of Maltreatment in Foster Care, June – October 2018.



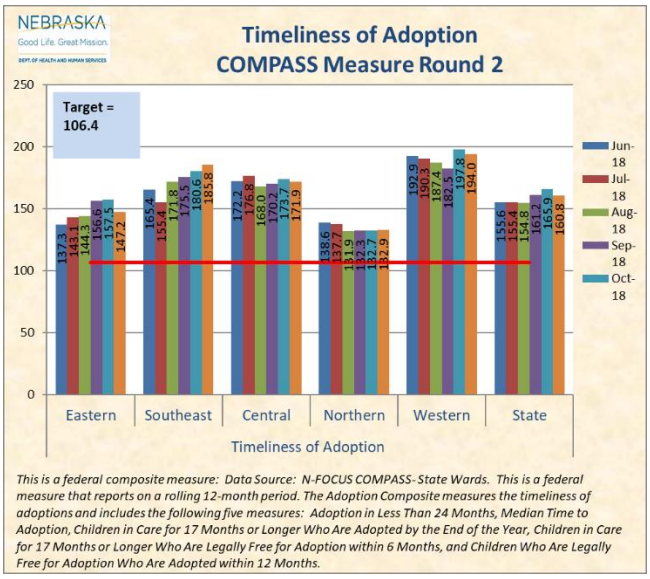
Source: DHHS, December 2018.

Figure 8: Timeliness and Permanency of Reunification, June – October 2018.



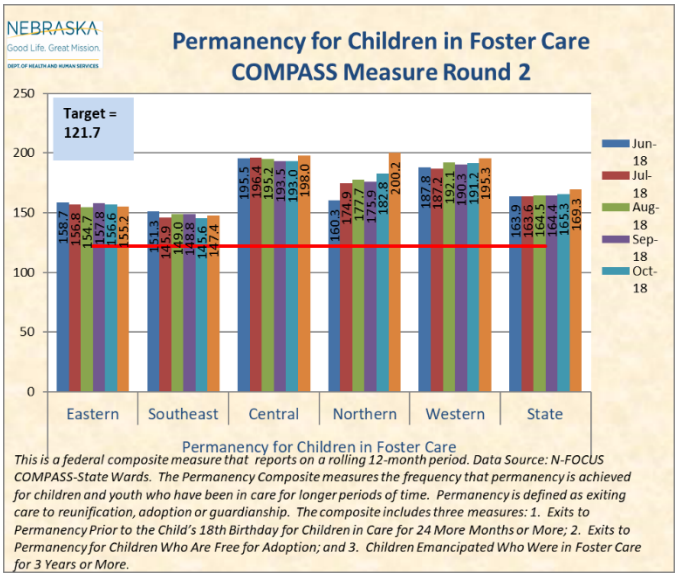
Source: DHHS, December 2018.

Figure 9: Timeliness of Adoption, June – October 2018.



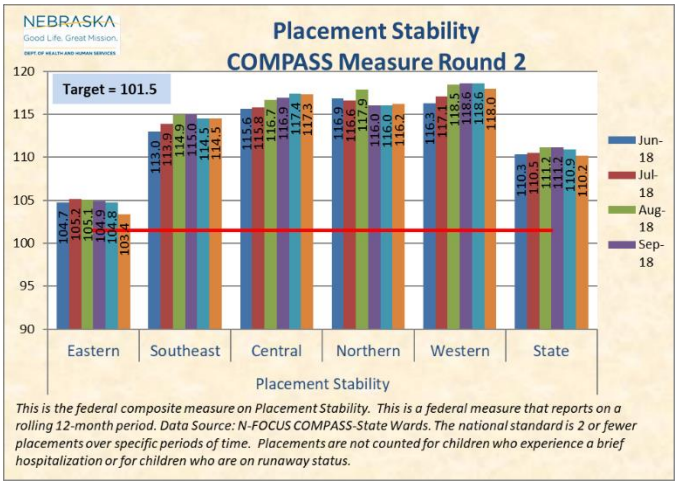
Source: DHHS, December 2018.

Figure 10: Permanency for Children in Foster Care, June – October 2018.



Source: DHHS, December 2018.

Figure 11: Placement Stability, June – October 2018.



Source: DHHS, December 2018.

Taken together, TSG concurs that performance on the Round II measures does not provide a means of differentiating between the Service Areas. All Nebraska Service Areas have made significant progress in improving performance on the Round II measures. The Eastern Service Area has a passing score on all of the measures but one, but that is a measure that four of the

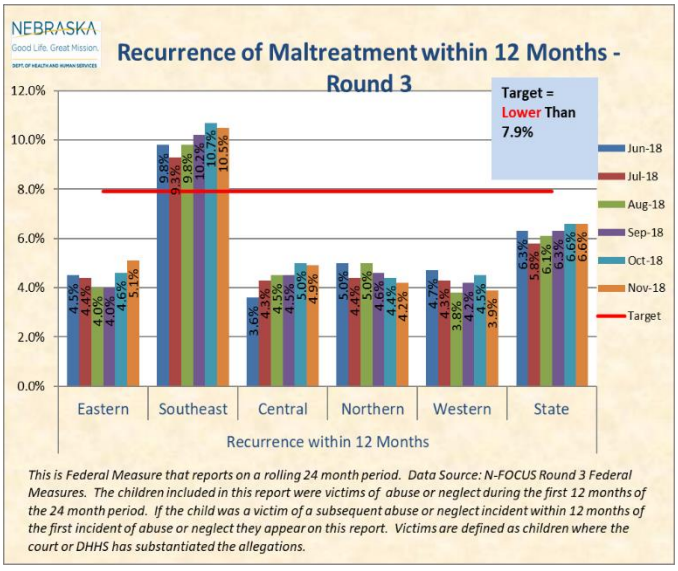
state's five Service Areas are struggling to meet, which suggests that there are system issues involved and not issues specific to the ESA.

5.2. Child And Family Services Reviews (CFSR) Round III Measures

These measures include some of the same general topics as are addressed in Round II, with some variations in the methodologies for calculating the measures:

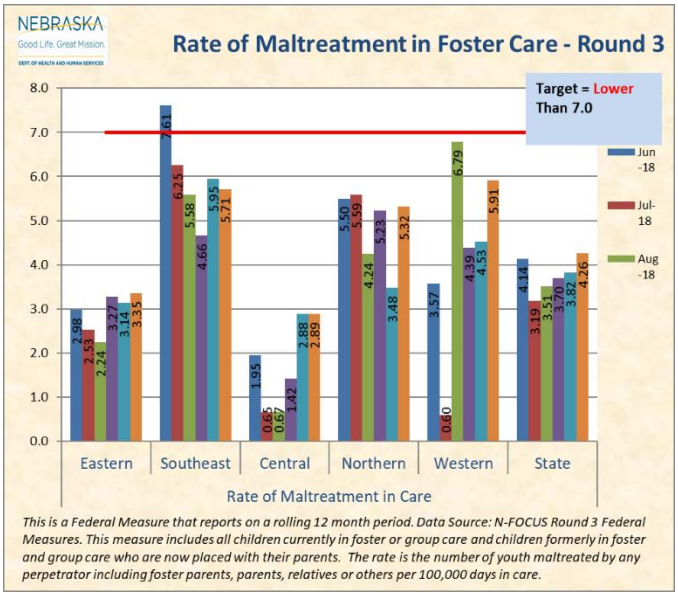
- Absence of maltreatment recurrence (over 12-month, calculated over rolling 24 months)
- Rate of maltreatment in foster care
- Placement stability rate
- Youth Entering Out-of-Home Care - Permanency in 12 Months
- Re-Entries into Care in < 12 Months of Discharge
- Youth in Care 12-23 Months - Permanency in 12 Months
- Youth in Care 24+ Months - Permanency in 12 Months

Figure 12: Recurrence of Maltreatment within 12 Months, June – October 2018.



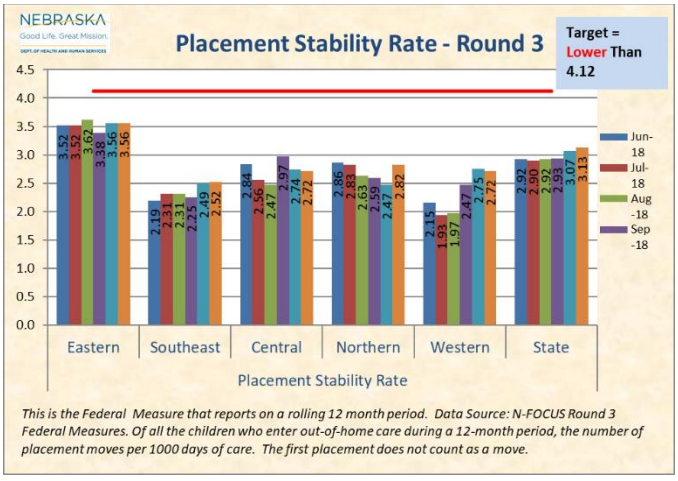
Source: DHHS, December 2018.

Figure 13: Rate of Maltreatment in Foster Care, June – October 2018.



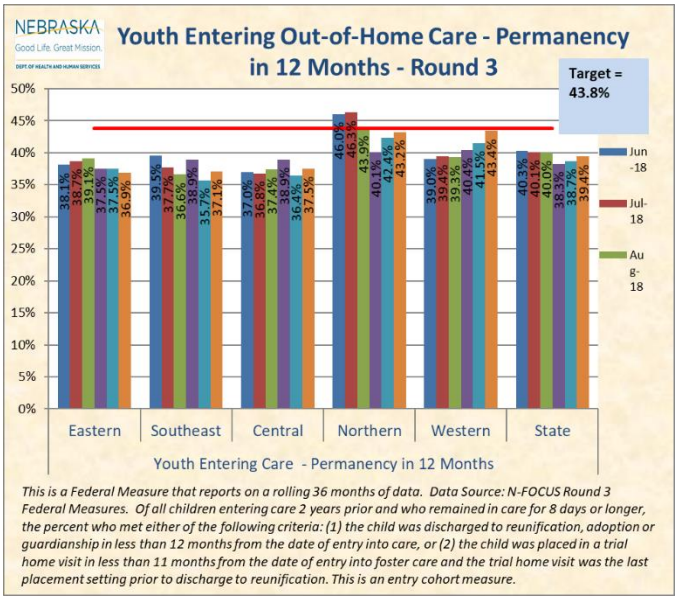
Source: DHHS, December 2018.

Figure 14: Placement Stability, June – October 2018.



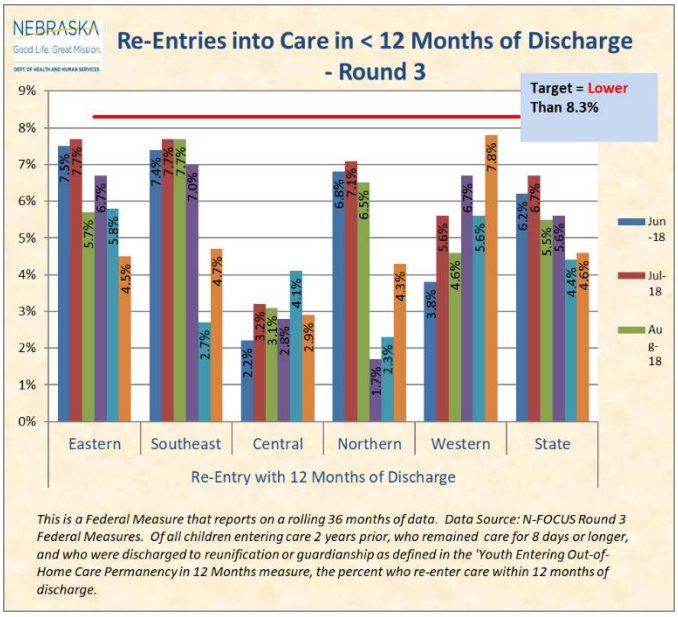
Source: DHHS, December 2018.

Figure 15: Youth Entering Out-of-Home Care, June – October 2018.



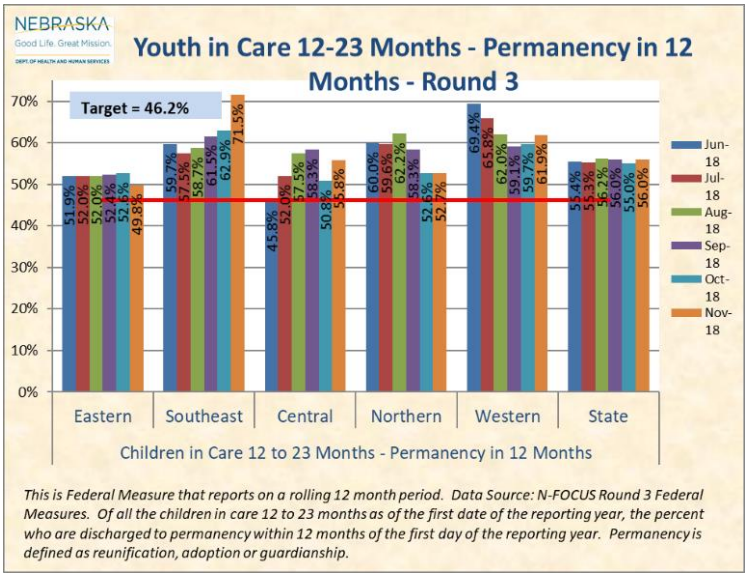
Source: DHHS, December 2018.

Figure 16: Re-Entries into Care Less than 12 Months of Discharge, June – October 2018.



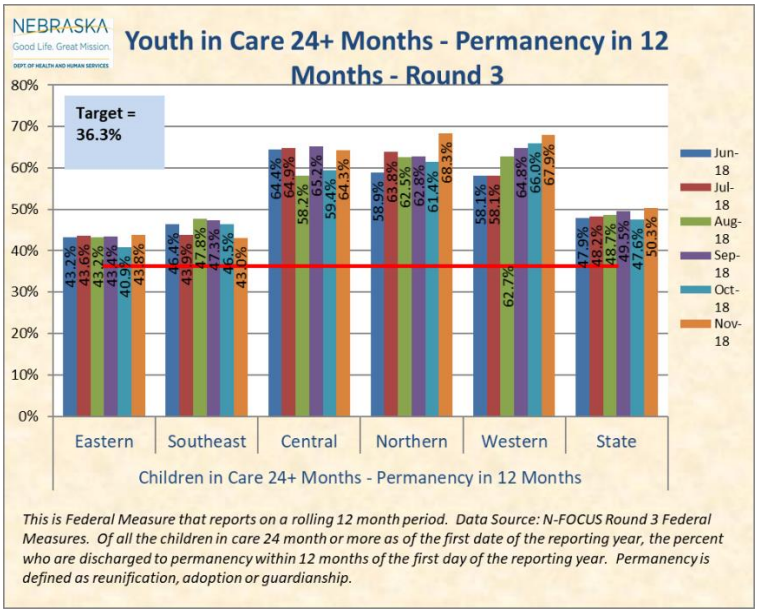
Source: DHHS, December 2018.

Figure 17: Permanency in 12 Months, Youth in Care 12-23 Months, June – October 2018.



Source: DHHS, December 2018.

Figure 18: Permanency in 12 Months, Youth in Care over 24 Months, June – October 2018.



Source: DHHS, December 2018.

As with the Round II measures, most of the Service Areas have consistently met the performance targets for most of the measures. As of November 2018, the State's performance meets the targets for six out of seven measures. Exceptions include:

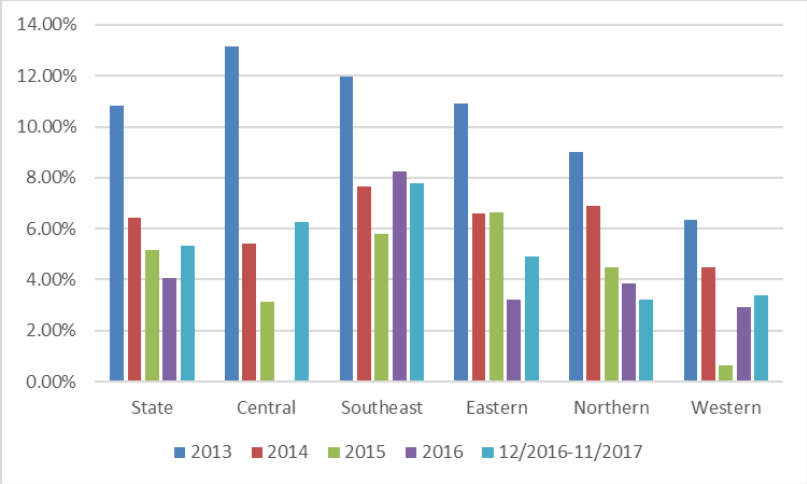
- The Southeast Service Area is not in compliance with the Recurrence of Maltreatment.
- All Service Areas and the state are not in compliance with Youth Entering Care Achieving Permanency in 12 Months.

As with the Round II measures, the Eastern Service Area has a passing score on all of the measures but one, but that is a measure that all five Service Areas are struggling to meet, which suggests that there are system issues involved and not issues unique to the ESA.

5.3. Other Child Safety Outcomes

In addition to the child safety outcomes included in the CFSRs which are for children in care (out-of-home cases), TSG analyzed recidivism (recurrence of maltreatment) for all populations of cases served by DCFS.

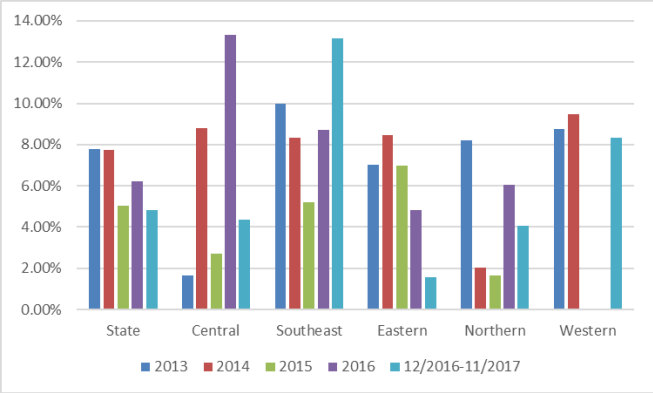
Figure 19: Substantiated Intakes with Active Court Case: 2013 – 2017.



Source: DHHS, December 2018

Notes: This chart reflects the Federal Round 3 12-month Maltreatment measure. Per DHHS, the years represent the year of the first substantiation and include if there was a recurrence within 12 months. The most recent year provided is 12/2016 – 11/2017 to provide for a full 12-month follow-up period.

Figure 20: Substantiated Intakes with Active Non-Court/AR Case, 2013 – 2017.

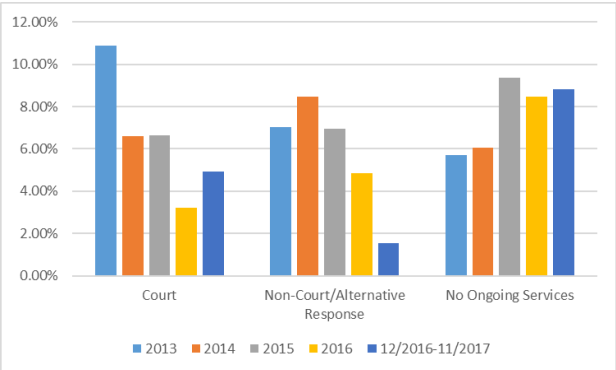


Source: DHHS, December 2018.

This series of charts depicts state-wide 12-month maltreatment recurrence rate by case type (out-of-home, in-home/Alternative Response (AR), and cases in which the family received no ongoing services) and Service Area. Observations from this data include:

Generally, and with exception to 2013, the highest rates of recurrence are among families where no ongoing services were received and there was an increase between 2016 and the time period of 12/2016 – 11/2017. Over the past several years, the rate of maltreatment recurrence alternated in being higher among out-of-home vs. in-home/AR cases, with out-of-home having a higher rate in the most recent year of data available.

Figure 21: Substantiated Intakes in Eastern Service Area with Active Case, by Type, 2013 – 2017.



Source: DHHS, December 2018.

Notes: This chart reflects the Federal Round 3 12-month Maltreatment measure. Per DHHS, the years represent the year of the first substantiation and include if there was a recurrence within 12 months. The most recent year provided is 12/2016 – 11/2017 to provide for a full 12-month follow-up period.

Since 2015, the highest rates of recurrence have been among those with no ongoing services. The rates of recurrence have alternated between being higher for out-of-home and in-home. In the most recent year, the rate of recurrence for in-home/AR was much below that of out-of-home. One issue to keep in mind is that PromiseShip does not provide case management for AR families. However, the relatively small amount of AR cases should not have too great of an impact on this difference.

5.4. Other Permanency Outcomes

Nebraska struggles statewide with a permanency measure in both CFSR Rounds II & III and has many initiatives in place to improve performance. Because it can take many years to improve permanency outcomes, TSG examined additional related measures to assess whether there were any early signs of progress or areas where the ESA outperformed the rest of the state. TSG found this is an area where the state, including the ESA, has made significant progress, though the ESA remains below state performance in some measures. It is also important to consider performance in the context of case mix differences.

Table 4: Reunification rate for children where termination of parental rights does not occur

	Central	Eastern	Northern	Southeast	Western	State
SFY 16	53.1%	62.7%	67.5%	52.0%	55.3%	59.8%
SFY 17	57.5%	65.4%	57.6%	53.5%	54.3%	59.7%
SFY 18	66.3%	60.3%	59.5%	53.8%	67.8%	60.8%

Source: DHHS, November 2018.

For this measure, a higher rate is desirable. The Eastern Service Area out-performed the state average and the performance of multiple regions in 2016 and 2017; in 2018, its performance is close to the state average and above that of the Central, Southeast, and Western Service Areas.

Table 5: Time to permanency: Median Months to Reunification

	Aug-15	Aug-16	Aug-17	Aug-18
Eastern	9.5	8.1	9.7	9.9
Southeast	8.6	9.6	8.1	8.6
Central	7.5	10.4	7.6	8.0
Northern	6.8	7.0	6.2	10.9
Western	7.0	7.6	7.1	8.5
State	8.2	8.0	8.2	9.4

Source: DHHS, November 2018.

This measures the median months to reunification and a lower number is desired. TSG looked at four points in time: in August of 2015 – 2018. TSG found that the Eastern Service Area's median has exceeded state median over the past four Augusts and has tended to be longer than that of the other Service Areas.

Table 6: Adoption rate for children where termination of parental rights does occur

Children Legally Free for Adoption and Adopted in < 12 Months: Trend for the last five years										
	Sep-13	**Mar-14**	**Sep-14**	**Mar-15**	**Sep-15**	**Mar-16**	**Sep-16**	**Mar-17**	**Sep-17**	**Mar-18**
State	65.10%	70.30%	71.10%	74.00%	73.70%	73.80%	77.70%	74.20%	67.40%	73.40%
Central	46.40%	56.00%	79.50%	89.70%	75.00%	74.60%	84.70%	81.00%	74.70%	80.30%
Eastern	59.80%	70.30%	72.40%	72.60%	72.40%	74.90%	75.10%	69.60%	61.50%	69.10%
Northern	48.10%	52.70%	68.40%	84.90%	82.90%	61.50%	65.60%	71.90%	64.20%	65.30%
Southeast	74.30%	76.40%	70.20%	70.40%	70.30%	74.80%	82.90%	77.90%	74.80%	84.90%
Western	93.60%	77.60%	66.70%	63.90%	80.00%	82.10%	78.60%	76.40%	65.20%	63.00%

Source: DHHS, November 2018.

This is a measure where a higher percentage is desired. The State has improved its performance in this area by 8.3% over the last five years. Along with the State, performance in the Eastern Service Area has also improved over that time period (by 9.3%), though the Eastern Service Area's overall performance is below the State's. Although the Eastern Service Area has trended below the other Service Areas, as of March 2018, its performance is in the middle of the Service Areas.

Table 7: Time to permanency: adoption

Median Months in Care: Trend for the last five years										
	Sep-13	Mar-14	Sep-14	Mar-15	Sep-15	Mar-16	Sep-16	Mar-17	Sep-17	Mar-18
State	30.6	30.1	31.7	32.8	30.6	27.9	26.8	27.6	27.6	27.7
Central	28.3	30.0	32.3	34	33.4	28.3	26.2	26.2	27.6	27.7
Eastern	34.8	31.3	30.7	33.5	31.8	28.8	29.9	30.9	29.9	28.4
Northern	23.0	24.4	35.5	36.9	32	25.2	27.1	29.5	28.1	32.0
Southeast	28.1	31.8	33.1	29.1	26.3	26.2	24.9	25.8	25.9	27.3
Western	26.0	26.3	28.1	32.3	31.3	29.5	23.8	24.9	26.8	23.3

Source: DHHS, November 2018.

This is a measure where a lower number of months is desired. Over the last five years, the state has reduced the median months in care by 2.9. Although the ESA's median months in care exceeds the state's, it has reduced the time to permanency by 6.4 months since 2013 and is now outperforming one region and achieving comparable performance to several other regions.

Table 8: Rate of exit to relative guardianship

	Central	Eastern	Northern	Southeast	Western	State
SFY 16	11.1%	6.6%	11.4%	8.0%	18.1%	9.5%
SFY 17	7.2%	5.9%	12.2%	9.8%	18.7%	9.3%
SFY 18	6.7%	8.0%	10.3%	11.4%	9.5%	9.0%

Source: DHHS, November 2018.

This measure should be considered in the context of other rates of exit. This is a measure in which the state's rate of exit to guardianship has been declining over the past three years. The ESA's rate of exist decreased between 2016-17 but then increased between 2017-18.

Table 9: Percent of youth are aging out of care

	Central	Eastern	Northern	Southeast	Western	State
SFY 16	5.3%	6.7%	4.6%	7.8%	3.4%	6.0%
SFY 17	3.8%	6.5%	5.4%	7.7%	3.0%	5.8%
SFY 18	3.0%	5.0%	4.7%	5.6%	0.9%	4.3%

Source: DHHS, November 2018

This is a measure where a lower rate is desired. The state's rate has been declining over the past three years, as has the ESAs rate, even though the ESA's rate has exceeded the state's each year.

5.4.1. Average Number of Placement Moves for Children Exiting Care:

Table 10: Reunification

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	120	569	295	234	131	1349
Average # of Placements	1.80	1.76	1.62	1.87	1.54	1.73
SFY 17						
Number of Children	184	652	245	229	145	1455
Average # of Placements	1.70	1.87	1.60	1.42	1.37	1.68
SFY 18						
Number of Children	177	612	203	221	229	1442
Average # of Placements	1.58	1.92	1.58	1.51	1.45	1.69

Source: DHHS, November 2018

A lower number of moves is desired. The state's average number has trended down overall between 2016-2018, while the ESA's number has trended up and is the worst among the Service Areas.

Table 11: Adoption

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	62	206	58	139	39	504
Average # of Placements	2.13	2.48	1.88	2.87	1.72	2.42
SFY 17						
Number of Children	97	190	69	116	58	530
Average # of Placements	1.87	2.69	2.17	2.29	2.31	2.34
SFY 18						
Number of Children	62	253	57	116	68	556
Average # of Placements	1.90	2.36	2.68	2.42	1.78	2.29

Source: DHHS, November 2018

The state's average has trended down between 2016-2018, while the ESA's number has increased and decreased. The Eastern and Southeast Service Area's performance are the worst among the Service Areas.

Table 12: Emancipation

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	12	61	20	35	8	136
Average # of Placements	9.08	9.21	6.70	10.71	6.00	9.03
SFY 17						
Number of Children	12	65	23	33	8	141
Average # of Placements	5.42	7.66	4.22	10.82	2.38	7.35
SFY 18						
Number of Children	8	51	16	23	3	101
Average # of Placements	7.63	6.86	6.25	6.91	4.33	6.76

Source: DHHS, November 2018

Note that the ESA has approximately half of the state's youth that are emancipating in a given year. A lower number of moves is desired. The state's average number has trended down overall between 2016-2018, as has the ESA's. In the most recent year, the ESA's performance was in the middle of the other Service Areas on this measure.

Table 13: Guardianship

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	25	60	50	36	43	214
Average # of Placements	1.92	2.25	2.06	2.61	1.93	2.16
SFY 17						
Number of Children	23	59	52	42	50	226
Average # of Placements	1.74	2.03	1.85	2.40	1.80	1.98
SFY 18						
Number of Children	18	81	35	47	32	213
Average # of Placements	1.89	1.96	2.74	2.85	2.25	2.32

Source: DHHS, November 2018

A lower number of moves is desired. The state and ESA's average number has trended down overall between 2016-2018 and in the current year, the ESA performed in the middle of its peers.

5.5. Well-Being Outcomes

Generally, TSG finds that the ESA has done well in terms of reducing congregate care, increasing relative placement, placing children within 25-30 miles of home, and maintaining school connections.

Table 14: Rate of congregate care use vs. foster home settings for children in out of home

SFY 16

Facility Type	Central	Eastern	Northern	Southeast	Western	State
Kinship Foster Care	11.1%	**13.3%**	13.4%	12.3%	21.7%	13.6%
Medical Facility	1.4%	2.5%	2.0%	2.9%	1.2%	2.3%
Non-Relative Foster Care	30.7%	36.8%	31.0%	35.2%	30.4%	34.4%
Relative Foster Care	28.1%	**37.1%**	41.2%	32.1%	37.0%	35.4%
Residential	24.7%	6.4%	8.0%	13.2%	6.2%	10.4%
Therapeutic	4.1%	3.8%	4.4%	4.2%	3.6%	4.0%

SFY 17

Facility Type	Central	Eastern	Northern	Southeast	Western	State
Kinship Foster Care	13.1%	**14.9%**	15.5%	12.0%	27.9%	15.3%
Medical Facility	1.8%	3.5%	2.4%	3.3%	1.2%	2.9%
Non-Relative Foster Care	38.5%	40.3%	38.2%	36.9%	34.6%	38.6%
Relative Foster Care	32.5%	**42.0%**	46.7%	40.3%	58.2%	42.4%
Residential	24.5%	6.4%	7.4%	11.0%	6.6%	9.9%
Therapeutic	4.3%	3.6%	3.3%	3.8%	5.1%	3.9%

SFY 18

Facility Type	Central	Eastern	Northern	Southeast	Western	State
Kinship Foster Care	10.0%	**14.6%**	12.7%	12.7%	23.0%	14.1%
Medical Facility	1.4%	3.5%	2.2%	1.9%	2.5%	2.6%
Non-Relative Foster Care	33.1%	36.5%	33.4%	33.5%	31.9%	34.7%
Relative Foster Care	27.7%	**38.8%**	36.8%	34.0%	56.5%	37.7%
Residential	19.9%	5.3%	5.4%	8.6%	4.4%	7.9%
Therapeutic	4.8%	3.4%	4.4%	2.6%	5.4%	3.7%

Source: DHHS, November 2018

This is a measure for which increased use of kinship and relative foster care is desired, as well as a general use of either kinship or foster care over congregate settings and institutions. In reviewing the last three years of data, the ESA has been able to increase use of kinship foster care and relative foster care overall between 2016 and 2018 (with some internal fluctuation), and where ESA is performing well relative to the state.

Table 15: Rate of relative placement (for out of home cases)

Rate of Children Placed with Relatives During the SFY						
	Central	Eastern	Northern	Southeast	Western	State
SFY 16	39.7%	56.6%	56.3%	46.4%	50.5%	51.6%
SFY 17	43.8%	62.9%	62.1%	57.0%	65.3%	59.2%
SFY 18	40.9%	60.6%	52.3%	53.0%	63.5%	55.8%

Source: DHHS, November 2018.

This is a measure for which increased relative placement is desired. In reviewing the last three years of data, the ESA has been able to increase use of relative placement overall between 2016 and 2018 (with some internal fluctuation), and where ESA is performing better than the rest of the state.

Table 16: Placement moves

SFY16	Central	Eastern	Northern	Southeast	Western	State
Number of children	692	2785	1195	1134	625	6431
Average Number of Placements	2.17	2.59	2.28	2.95	1.77	2.47
SFY 17						
Number of children	785	2861	1141	1176	740	6703
Average Number of Placements	1.99	2.66	2.28	2.53	1.75	2.40
SFY 18						
Number of children	701	2724	852	1125	759	6161
Average Number of Placements	2.08	2.81	2.31	2.46	1.76	2.46

Source: DHHS, November 2018

This is a measure for which a lower number is desired, both for achieving permanency and child well-being. ESA's average has exceeded the state's each year. The state has remained relatively constant during the last three years, while ESA's average number of placement moves has been increasing.

Table 17: Rate of placement with siblings

	2016		2017		2018	
	Percent with All Siblings Together	Percent with at Least One Sibling	Percent with All Siblings Together	Percent with at Least One Sibling	Percent with All Siblings Together	Percent with at Least One Sibling
Eastern	60.3%	81.3%	57.4%	81.4%	57.8%	80.8%
Central	65.6%	83.8%	71.7%	89.1%	69.9%	84.1%
Northern	69.6%	85.7%	68.4%	83.3%	69.9%	84.1%
Western	81.4%	89.8%	78.3%	90.0%	78.6%	83.3%
Southeast	64.9%	84.1%	67.7%	84.3%	68.1%	82.3%
State	65.0%	83.5%	64.5%	84.0%	64.7%	82.3%

Source: DHHS, November 2018

This is an area in which a high percentage is desired. Overall, there is a relatively high rate of placement with at least one sibling, but the percent of all siblings placed together is much lower. Both the state and the eastern service area are trending down, while at least two Service Areas have made progress in this area over the last three years.

Table 18: Rate of placement within 25-30 mile radius from home

SFY 16
Placements' Distance from Child's Home - Percent of Placements

Distance	Central	Eastern	Northern	Southeast	Western	State
0-20 Miles	47.4%	94.6%	52.6%	60.4%	58.3%	74.3%
21-50 Miles	14.6%	2.3%	20.6%	15.9%	12.8%	9.4%
51-100 Miles	14.7%	1.2%	15.2%	12.5%	9.7%	7.4%
100+ Miles	23.3%	2.0%	11.6%	11.2%	19.2%	9.0%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

SFY 17
Placements' Distance from Child's Home - Percent of Placements

Distance	Central	Eastern	Northern	Southeast	Western	State
0-20 Miles	51.6%	95.9%	55.8%	66.0%	59.1%	76.2%
21-50 Miles	13.8%	1.4%	18.2%	15.6%	12.2%	8.7%
51-100 Miles	11.0%	0.9%	14.9%	10.3%	9.4%	6.4%
100+ Miles	23.6%	1.8%	11.2%	8.1%	19.3%	8.7%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

SFY 18
Placements' Distance from Child's Home - Percent of Placements

Distance	Central	Eastern	Northern	Southeast	Western	State
0-20 Miles	48.7%	96.7%	52.4%	66.5%	59.6%	77.0%
21-50 Miles	13.9%	1.6%	18.0%	14.4%	11.0%	8.0%
51-100 Miles	9.9%	0.7%	17.0%	11.0%	8.8%	6.2%
100+ Miles	27.5%	1.0%	12.6%	8.1%	20.5%	8.8%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DHHS, November 2018

This is a measure where a higher percentage is desired. The ESA excels in this measure, but this is a measure where it is difficult to compare across Service Areas due to the urban nature of the ESA and the rural nature of most of the other Service Areas. This is not to undercut progress made by the vendor, but this is a measure where the ESA would be expected to do well relative to the other regions.

Table 19: Rate children remaining within same school districts after out of home placement

6/20/2016	Central	Eastern	Northern	Southeast	Western	State
Same	64.0%	77.9%	54.7%	69.2%	59.3%	70.6%
Different	36.0%	22.1%	45.3%	30.8%	40.7%	29.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6/26/2017						
Same	50.5%	75.4%	54.9%	71.6%	65.7%	68.8%
Different	49.5%	24.6%	45.1%	28.4%	34.3%	31.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6/25/2018						
Same	53.4%	74.0%	53.4%	71.4%	65.2%	68.0%
Different	46.6%	26.0%	46.6%	28.6%	34.8%	32.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: DHHS, November 2018

Note: This is point-in-time data and excludes any children for which the home or current school district fields in N-FOCUS are blank.

This is a measure where a higher percentage is desired. The ESA excels in this measure, but like placement close to home, this is a measure the ESA would be expected to do well relative to the other regions because of the urban nature of the Service Area.

5.5.1. Rate of children where parental visitation is occurring

Parent/child visitation is a critical variable, linked to reunification outcomes. TSG requested but was unable to obtain data from DHHS on the percent of children who are having regular visits with their parents.

5.5.2. Medicaid/Health

TSG requested Medicaid utilization data by Service Area, including data on EPSDT compliance, but was not able to receive the data in time to include it in this assessment.

5.6. Outcomes Related to In-Home Cases

Going forward, DHHS will need to capture additional data regarding its in-home cases. TSG requested some data which is included here, but there were some measures the Department could not produce. This data, as well as measures related to monitoring for FFPSA compliance, will be needed.

Table 20: Rate of removal from in-home cases.

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Removal After In-Home Case Started	10%	9%	15%	14%	17%	11%
In Home No Removal	90%	91%	85%	86%	83%	89%
Grand Total	100%	100%	100%	100%	100%	100%

SFY 17	Central	Eastern	Northern	Southeast	Western	State
Removal After In-Home Case Started	10%	8%	10%	11%	14%	10%
In Home No Removal	90%	92%	90%	89%	86%	90%
Grand Total	100%	100%	100%	100%	100%	100%

SFY 18	Central	Eastern	Northern	Southeast	Western	State
Removal After In-Home Case Started	5%	4%	5%	3%	6%	4%
In Home No Removal	95%	96%	95%	97%	94%	96%
Grand Total	100%	100%	100%	100%	100%	100%

Source: DHHS, November 2018

A lower measure is desired. This measure assesses whether safety can be maintained in in-home cases. For the last three years, the Eastern Service Area has performed better or equal to the State average.

5.6.1. Time to case closure for in-home cases

TSG requested this data by Service Area but was not able to receive the data in time to include it in this assessment.

5.6.2. Rate of families are completing services in the family plan

TSG requested but was unable to obtain data from DHHS on the percent of families who complete the services identified in their family plans as a means of assessing family engagement with services. TSG recommends that the agency begin to capture this measure going forward.

6. FINANCIAL REVIEW – COST PER CASE

Using a determination of total state expenditures by Service Area and Total Case Count, with some adjustments recommended by DHHS, TSG calculated the average cost per case. In conducting this analysis, TSG uncovered discrepancies between DHHS and PromiseShip's case counts, which required reconciliation.

PromiseShip revenues and expenses are summarized in the table below[3].

Table 21: PromiseShip Summary Revenue and Expenses

	SFY 2016	SFY 2017	SFY 2018
Revenue			
Program service revenues	59,723,649	65,491,200	70,494,362
Other revenue	351,749	604,107	246,871
Total revenue	60,075,398	66,095,307	70,741,233
Expenses			
Personnel	17,346,181	18,919,104	20,913,293
Contract services	41,181,868	44,242,494	45,528,822
Other expenses	3,185,323	3,155,979	4,307,006
Total expenses	61,713,372	66,317,577	70,749,121
Net contribution to fund balance	(1,637,974)	(222,270)	(7,888)

Reviewing the above, TSG notes:

- Revenues have grown at a compound annual growth rate (CAGR) of 8.6% since 2016
- SFY 2018 revenues are 99.7% from the State contract
- Personnel costs have grown from 28% to 30% of total expenses, while contracted services have fallen from 67% to 64%
- Over the past 3 years, PromiseShip has accumulated loss to its fund balance of $1.9MM

6.1. State Program Reimbursement under the Vendor Contract

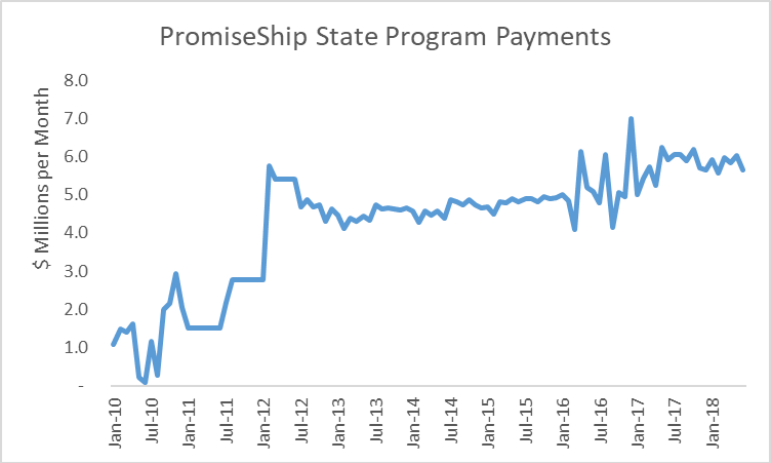
The chart below presents monthly program service revenues January 2010 through June 2018. During the period January 2010 through January 2013, PromiseShip (then NFC) was gearing up. In December of 2010, they took on case management responsibility in the ESA. By January

[3] TSG analysis of interim (unaudited) financial reports provided by PromiseShip in the file: 5 - 3 Year Budget Comparison 10.29.18.xlsx

2013, PromiseShip reimbursements "settled down" into a long term, fairly steading payment pattern.

Overall, over the four and a half years between January 2013 and June 2018, PromiseShip monthly program reimbursements increased at a steady compound annual growth rate of 4.4%[4].

Figure 22: PromiseShip State Program Payments, 2010 – 2019.

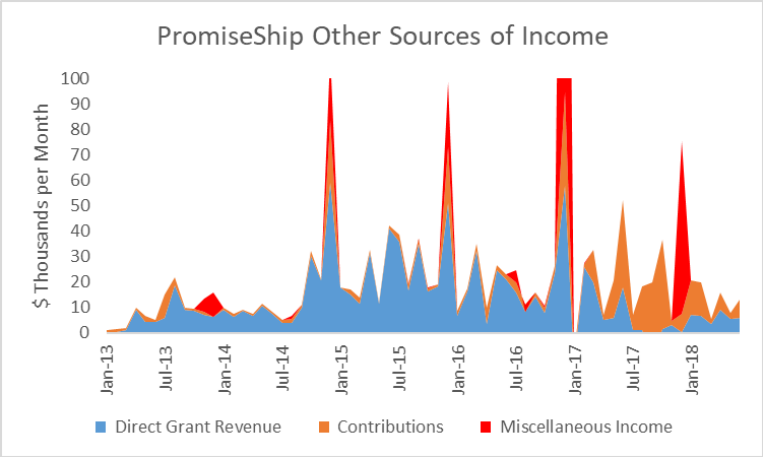


6.2. Other Sources of Revenue

TSG understands that one objective of the public private partnership with PromiseShip is to leverage state funds with private contributions. In the period since January 2013, PromiseShip has typically raised between $20,000 and $40,000 per month in contributions and another grant revenue, as shown in the chart below[5]. In addition, PromiseShip has raised a total of $599,000 since 2010 in miscellaneous income. These are the annual (red) spikes in the graph.[6] In total, these other sources account for about 3% of PromiseShip's annual revenue.

[4] TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx
[5] TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx
[6] Note that the y-axis scale is adjusted in the chart so the top of the January 2017 bar does not appear. That amount is $168,000. In addition, Miscellaneous Income ran slightly negative in several months, presumably accounting-related adjustments, none sufficiently material for TSG to investigate in the scope of this assessment

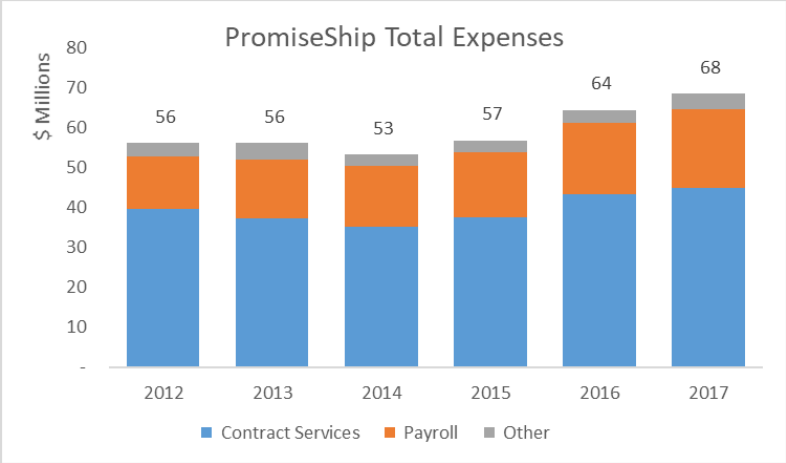
Figure 23: PromiseShip Other Sources of Income, 2013 – 2018.



6.3. PromiseShip Cost Structure

Since 2012 total expenses have grown at 3.4% per year, as shown in the graph below[7]. These amounts are totaled by State Fiscal Year through June 2018[8].

Figure 24: PromiseShip Total Expenses, 2012 – 2017.

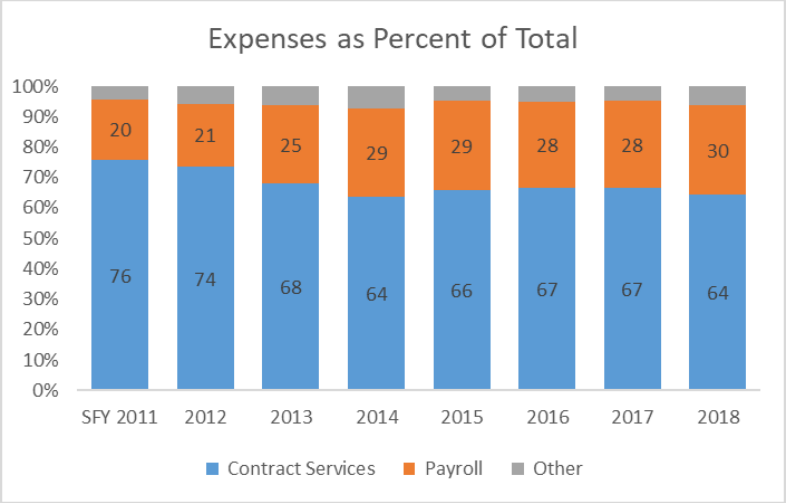


[7] Expenses have grown at a CAGR of 7.7% since 2016, using the three-year numbers in the table at the top of this section

[8] TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx

Payroll increased as a percent of total expenses through 2013 as PromiseShip took on case management responsibility. Since 2014, labor has remained consistently around 29% of total: labor and contracted services are used in the same proportion year to year[9].

Figure 25: Expenses as Percent of Total, 2011 – 2018.

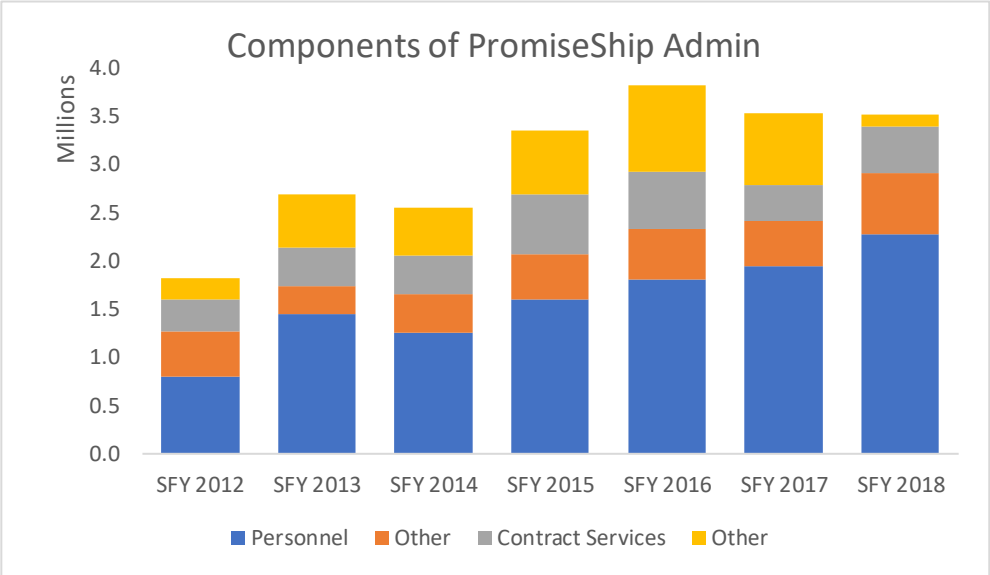


6.4. Administrative Costs

Administrative costs are expenditures other than those related specifically to case work. In total, Administration costs have not changed significantly over the past years, as shown in the chart below[10].

[9] TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx
[10] TSG analysis of PromiseShip data in the file: 6 - Admin Breakdown.xlsx

Figure 26: Components of PromiseShip Administrative Costs, 2012 – 2018.



The table below describes the components of Administration for the past 7 years.

Table 22: Administrative Cost Detail, 2012 – 2018.

	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Personnel	795,713	1,444,694	1,252,107	1,598,628	1,800,648	1,939,746	2,269,509
Other	466,555	289,071	397,184	462,985	532,939	469,663	632,771
Contract Services	338,618	396,545	409,421	623,201	586,006	376,356	488,325
Other Facility	81,576	278,368	243,944	271,184	300,324	194,385	285,443
Professional Fees	18,057	52,117	16,066	58,359	171,695	128,704	172,783
Advertising/Mrktg	4,576	43,935	45,751	9,637	31,737	57,988	142,450
Building rent	118,327	181,726	185,009	326,316	388,920	367,313	-482,215
	1,823,422	2,686,456	2,549,481	3,350,310	3,812,269	3,534,155	3,509,066

Note that in terms often used by the State, "Administration" is something different, it is the fixed portion of the annual payment. That vantage does not factor into the TSG analysis of administration. In SFY 2018, the occupancy amount is negative because of a $480,000

reclassification of space from administration to program costs. PromiseShip describes this as correction of previous accounting error.

6.5. PromiseShip Costs to Include in the Cost per Case Assessment

The easiest and most meaningful cost for analysis is the amount the State pays PromiseShip for its services. This bears directly on the question of how much it costs for the State to continue using PromiseShip to manage cases. However, this ignores some complications, each of which is relevant to some type of cost per case analysis.

- PromiseShip Admin. PromiseShip costs include overhead that are not directly related to managing cases. For example, they have administrative leadership, facilities, a computer system, and so forth. Thus, including these makes the comparison "unfair" in the sense that such a comparison is not really case-cost to case-cost. However, the question TSG was asked to address is whether the overall relationship is economically justified, not whether the direct costs of one case worker are equivalent. Thus, PromiseShip Admin needs to be included
- PromiseShip Other Revenue. PromiseShip has a small amount of revenue outside the State contract. This offsets some of PromiseShip's costs and could be used to off-set the case cost. However, though these revenues are a "cost to society" for child welfare, they (once again) do not bear on the question of viability of the outsourcing relationship today. If the PromiseShip "went away" so also would the revenue, presumably. So, TSG has not included this in the case cost comparison.
- PromiseShip Other Costs. PromiseShip incurs costs other than those reimbursed by the historic payment method. Each month, there is a modest amount by which reimbursement exceeds or is less than actual costs. The TSG analysis ignores these. Once again, the purpose of this analysis is whether the economic relationship makes sense. Where the State did not pay for costs other than the contracted amount, these are not relevant to this particular cost per case analysis.

Thus, for purposes of the TSG case cost analysis, we have counted as cost the amount paid by the State through the PromiseShip contract. It does not matter whether the amount paid was as a fixed or variable payment—TSG looked only at the total.

6.6. Additional Costs for Comparability with Other Regions

For the analysis, TSG needs to compare all the costs for all the cases in a manner that is consistent across regions. Looking to the way cases are managed, the best method of comparing is full costs. This includes direct costs (and case units) of investigations, alternative response for all regions. It also includes all administrative costs, both State and PromiseShip.

TSG is thus comparing all the costs of supporting cases in a region. This is different from analyzing just the costs of PromiseShip and represents the most meaningful method of

comparing. It accounts for any inefficiencies related to handoff or duplication across the organizations. Thus, TSG is looking at the system-wide effect of outsourcing, not just at one component.

While PromiseShip manages ongoing cases in the ESA, they do not manage all cases: the State manages initial investigations as well as "alternative response". In addition, the State incurs overhead costs that are allocated to the work of the Eastern Service Area.

Thus, to arrive at total costs that may be compared across regions, TSG adds:

- State N-FOCUS payments. These are providers charges paid on behalf of children in the region. For the Eastern Service Area, these are in addition to the charges paid through PromiseShip. In the case of the other regions, they comprise all the provider charges. Provider payments include payments made on behalf of investigations. This is to capture the full costs of a case. However, investigations cases are not included in the case count—to avoid double counting.
- State internal costs. These include allocations the state applies to each region[11]:
    - State-Wide Cost Allocation
    - Termination Benefits
    - Chief Executive Officer
    - Internal Audit
    - HRD Human Resources
    - FS Accounting
    - FS Budget Unit
    - CLS Communications Services
    - SS Administration Support
    - SS Records Mgt, Wp, Scanning
    - SS Procurement
    - Building Division
    - SS Contracts & Subawards
    - SS Field Office Rent
    - IST Customer Services Administration
    - IST Customer Services Help Desk
    - IST Technical Services
    - IST Application Svcs Administrative Services
    - Information Security Office
    - Termination Benefits
    - Chief Executive Officer

[11] TSG analysis of information provided by DHHS in an email dated 11/19/2018

- Internal Audit

- PromiseShip Payment. In the table below, TSG uses the amount per the State payment system[12]. The amount per the state system (below) differs from the amount in the PromiseShip internal accounting reports, which is $70,976,021. This is different from the State number below by less than 1%.

6.7. Date of Costs Included

Payments to providers can be delayed from a few months to several years. In addition, the State does not record payments into N-FOCUS until after they are paid. N-FOCUS records could allow TSG to use either date of service or date paid. Neither is "right." Date of service is better according to private sector GAAP. However, the State is on a cash basis.

Including cost by service date will seclude a tail of payments still not made as of October (4 months after year-end close). On the other hand, including cost as of payment date will include some costs paid for services in prior years. If caseload were constant, including case by paid date would be the best, because the payments for prior year services would "wash" in comparison to the payments delayed to future years. Caseloads dropped for PromiseShip in 2018. However, PromiseShip provider costs are included in the analysis as part of the total payment, not directly from N-FOCUS. Thus, it depends.

To sort this out, TSG considered cost pre-case both based on service and paid date. The two approaches produced nearly the same result. This is because the total statewide difference was only $1,740,128 out of $74,897,190 provider payments paid outside the PromiseShip contract.

This ambiguity about whether to use service or paid date further underscores the need to consider cost per case comparisons only within a range of +/-5%.

6.8. Costs Not Included

TSG excluded from costs:

- Provider services and transportation for YRTC cases, as these are Juvenile Justice cases.
- Adult Protection Services provider services. Although the labor costs include about 12 APS case workers. This is only because State accounting did not enable them to be separately identified. TSG estimates that roughly $600K in labor costs are spread across all Service Areas, including Eastern Service Area.
- Any costs related to B2i cases. as these are not part of the child welfare program. Both provider payments and case workers are excluded, as well as case counts.

[12] TSG analysis of data provided by DHHS in the file NFC monthly payments data based on E1.xlsx

6.9. Total Costs Used in the Cost per Case Calculation

Therefore, total costs for the cost per case analysis are shown in the table below. The SFY2018 ESA costs are $82,249,069[13][14][15]. State N-FOCUS Payments are according to date paid, since PromiseShip payments are as paid. State Internal Costs include allocations as described above. Direct Payment to ESA is the sum of checks paid to PromiseShip.

This amount differs from PromiseShip books for 2018 by $600K (yet another reason to compare case costs within a range of +/-5%). Direct Payments to Northern Region are paid to three tribal offices for case management and administration. Note, that TSG adjusted our analysis based on DCFS input to adjust for: Native American cases, YRTC cases and one outlier case.

Table 23: Total Costs, by Service Area, 2017 – 2018.

	2017				2018			
	State N-FOCUS Payments	State Internal Costs	Direct Payments	Total	State N-FOCUS Payments	Internal Costs	Direct Payments	Total
Central	13,123,828	6,602,121		19,725,949	13,631,231	6,464,973		20,096,204
Eastern	1,950,965	10,441,844	63,311,114	75,703,923	1,789,339	9,271,199	71,188,531	82,249,069
Northern	17,644,623	7,723,001	3,176,053	28,543,677	19,365,453	7,517,637	2,430,190	29,313,280
Southeast	25,692,184	13,460,715		39,152,899	26,322,443	12,551,779		38,874,222
Western	12,065,366	7,540,293		19,605,659	13,184,762	7,149,798		20,334,560
Statewide	70,476,965	45,767,974	66,487,167	182,732,106	74,293,228	42,955,386	73,618,722	190,867,335
Non-Eastern	68,526,001	35,326,130	3,176,053	107,028,183	72,503,889	33,684,187	2,430,190	108,618,266

6.10. Cases

Calculating average cost per case is meaningful in the context of establishing trends against prior periods and comparing with the rest of the state. Thus, in order to make a meaningful comparison, TSG worked to make case counts consistent region to region and over time.

6.10.1. Using the Right Case Counts

There are several ways to count cases. Foremost, the key is to use a common method for PromiseShip and State cases. TSG counted cases as follows:

[13] State Internal Costs are TSG analysis of DHHS data provided in the file: Foster Care Administration Data for Stephen Group.xlsx
[14] N-FOCUS costs are provider payments and are a result of TSG analysis of data provided by DHHS in the file: Foster Care Administration Data for Stephen Group.xlsx
[15] PromiseShip payment is the result of TSG analysis of data provided by DHHS in the file: NFC monthly payments Data based on E1.xlsx

- Court-involved cases. TSG counted individual youth involved in court cases. In some situations, an individual case might have more than one youth. TSG counted youth or "wards."
- Non-court cases. These are more complicated, as they typically involve not only several youths, but also one or more adults in the household. Thus, it would become quite complicated to count individual youths. The standard applied by both PromiseShip and the State is to count non-court cases by family or "master case." So, this is the convention TSG used.

Counting cases is thus a mix of individuals (court) and families (non-court). This is really adding apples and oranges. However, it is the only sensible approach, and TSG applied it consistently.

Cases reported for external purposes sometimes break out Native Americans separately. The TSG analysis incudes cost and case counts of 337 Native American cases as of October 2108.

Cases can be reported in many ways. However, TSG used case count on the first day of each month. For example, one case might be open for seven months of the year, and another for 6 different months. Under the TSG method, these would be counted as 13 case-months. Yet, of course they are only 2 cases.

The TSG approach is much more accurate that considering annual case costs by dividing a whole year costs and cases. In the tiny example above, the annual approach would divide by only two cases - ignoring that neither case was open all year. Of course, the same argument could be made to use daily case counts (or even case counts by the hour). The TSG approach of counting cases by month produces sufficiently accurate and comparable case costs for the purpose of this assessment.

6.11. Reconciling Case Counts Between State and PromiseShip

PromiseShip and DHHS reported case counts from different sources. The reported case counts were not the same. TSG conducted a detailed analysis of October 2018 and found three types of differences[16]. Ultimately, TSG used State case counts for the analysis. This mis-match in case counts could not be reconciled by the State or PromiseShip. This is a major reason TSG compares cost per case within a range of +/-5%.

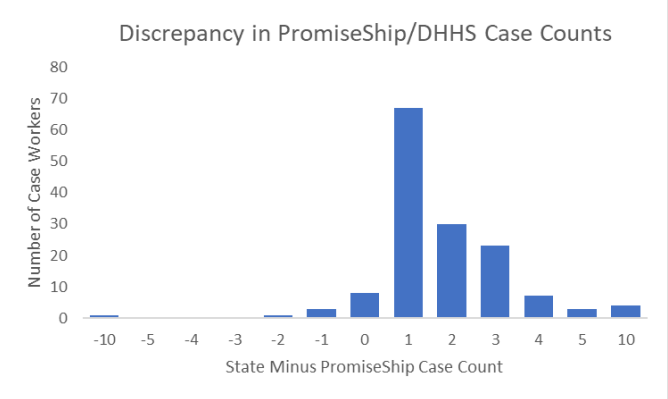
The differences seem to include:

- ESA cases worked by 37 State case workers. These can be Alternative Response or other cases the State retains.

[16] TSG compared the DHHS file:

- 60 Case workers missing entirely from one list or the other. Note: TSG found and corrected for 8 individuals who were obviously the same, but names were entered differently in the two systems, like: Jeff and Jeffery V. There are some others that may have been married, but TSG was not able to confirm they were the same.
- Case counts different in October 2018 by a few cases for 147 case workers, as in graphed below.

Figure 27: Discrepancy in PromiseShip/DHHS Case Counts.



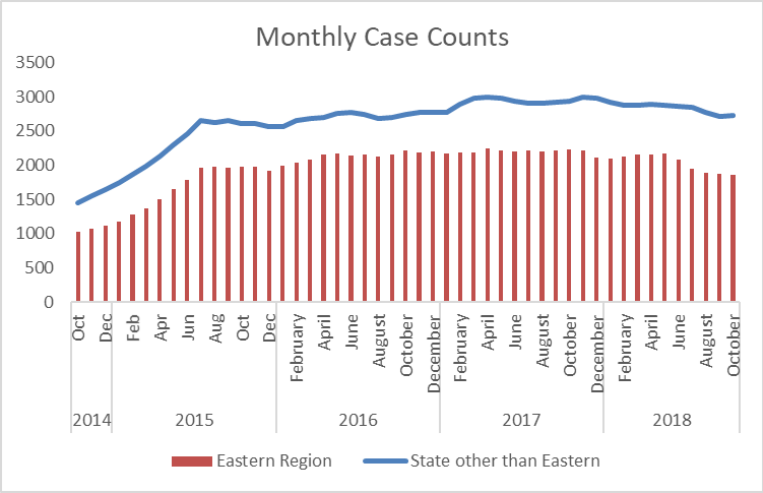
The last two differences could be timing or permanent. We don't know. More importantly DHHS doesn't know and does not appear to have in place a routine for finding differences and correcting the systemic causes.

6.12. Cases Over Time

In the Eastern Service Area, cases grew through June 2014, held steady until June 2018, and has declined since then. In the chart below, case counts per the State are shown by the line, and PromiseShip case counts are the bars. See that the difference has declined from 426 in January 2016 to 252 in October 2018. This seems to be because the total count has remained flat since 2016, while PromiseShip is taking on more of the cases. The case counts start later for PromiseShip only because that is the data TSG obtained.[17]

[17] TSG analysis of PromiseShip case counts provided by PromiseShip in the file: Request 30 Caseload – revised.xlsx State case counts provided in the file: Caseload for Stephens Group v2.xlsx

Figure 28: Monthly Case Counts October 2014 – October 2018.



6.12.1. Eastern Service Area Case Counts Used in the Cost per Case

TSG used case counts as reported by the State in its calculations of cost per case. There could be same error in the result, since the case counts are different between PromiseShip and DHHS. In October 2018, the difference is as follows:

Cases per PromiseShip	1,595
Cases worked by State employees	139
Unidentified differences	113
Cases reported by DHHS	1,847

Thus, unidentified differences represented 6% of the State case count. In addition, State workers managed 7.5% of ESA cases in October. The state count is consistently higher than the PromiseShip count (see chart above), however, that does not mean that the error is always in the same direction. So, TSG is confident in case cost calculation at the level of +/- 5%.

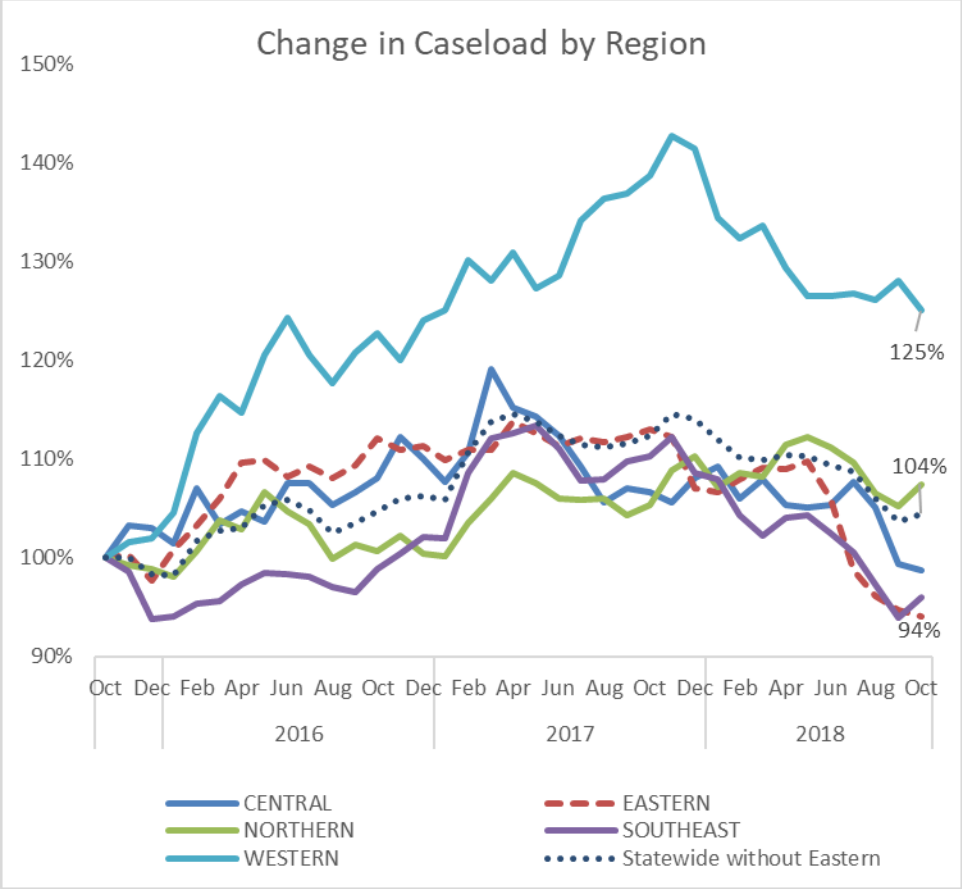
6.13. Case Counts in Other Service Areas

Case counts have increased 4% statewide total over the four years[18]. That growth was experienced differently in each region. The chart and table below show that ESA cases have decreased 6% over 4 years while Western Service Area has experienced the largest rate of case

[18] This is point to point growth, not annual growth

growth, 25%[19]. The most important take-away from the graph below is that overall, case levels are the same as they were in October 2015. Even the Western Service Area's growth expressed in terms of CAGR[20], is only 8% per year. TSG also notes the important decrease in cases since October 2017, especially in the ESA (i.e. PromiseShip).

Figure 29: Change in Caseload by Region, 2016 – 2018.



[19] TSG analysis of State data in the file Caseload for Stephens Group v3.xlsx
[20] Compound Annual Growth Rate is the annual growth rate that would accounts for the increase from October 2015 to October 2018 (3 years)

Table 24: Cases by Region as of October 1 each year, 2015 – 2018.

	Central	Eastern	Northern	Southeast	Western	Statewide	Statewide without Eastern
2015	467	1,971	825	926	395	4,584	2,613
2016	505	2,209	831	915	485	4,945	2,736
2017	498	2,227	869	1,021	548	5,163	2,936
2018	461	1,854	886	889	494	4,584	2,730

TSG used monthly case counts to calculate cost per case month. So, it added the number of cases in each month to arrive at a total shown in the table below. The 2018 total is 57,523 case months. This is NOT the number of youth or families in the system. It is the number of case-months worked during the year. Dividing annual cost by case-months produces a cost per case per month.

Table 25: Annual case-months used in the case cost calculation

	Central	Eastern	Northern	Southeast	Western	Statewide	Statewide without Eastern
SFY 2017	6,208	26,225	10,227	11,601	5,909	60,170	33,945
SFY 2018	5,983	25,953	10,719	11,869	6,374	60,898	34,945

6.14. Cost per Case

TSG calculated cost per case using the costs and annual case moths u cases described above. Given the discrepancy in case counts, TSG shows a range of case costs +/- 5% of the cost for the state other than ESA. Even given the discrepancies in case count, TSG concludes that the ESA is slightly below the cost per case in the majority of regions. Note that ESA case cost increased in 2018 because case counts dropped, and total costs increased in 2018.

Figure 30: Cost per case per month – comparing regions, SFY 2017 & 2018

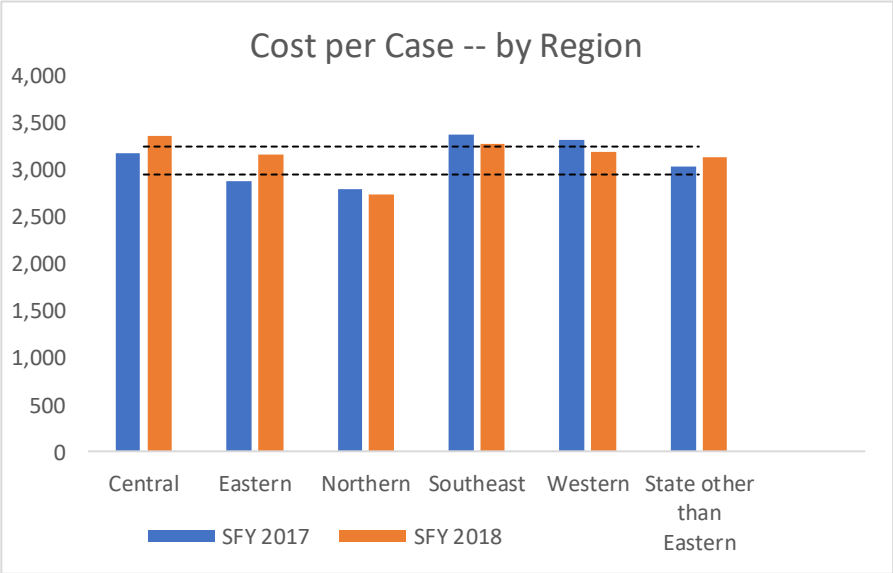


Table 26: Costs per Case per Month, rounded to the nearest $100.

	SFY 2017			SFY 2018		
	Costs	Cases	Cost/Case	Costs	Cases	Cost/Case
Central	19,725,949	6,208	3,200	20,096,204	5,983	3,400
Eastern	75,703,923	26,225	2,900	82,249,069	25,953	3,200
Northern	28,543,677	10,227	2,800	29,313,280	10,719	2,700
Southeast	39,152,899	11,601	3,400	38,874,222	11,869	3,300
Western	19,605,659	5,909	3,300	20,334,560	6,374	3,200
All State	182,732,106	60,170	3,000	190,867,335	60,898	3,100
State other than Eastern	107,028,183	33,945	3,200	108,618,266	34,945	3,100

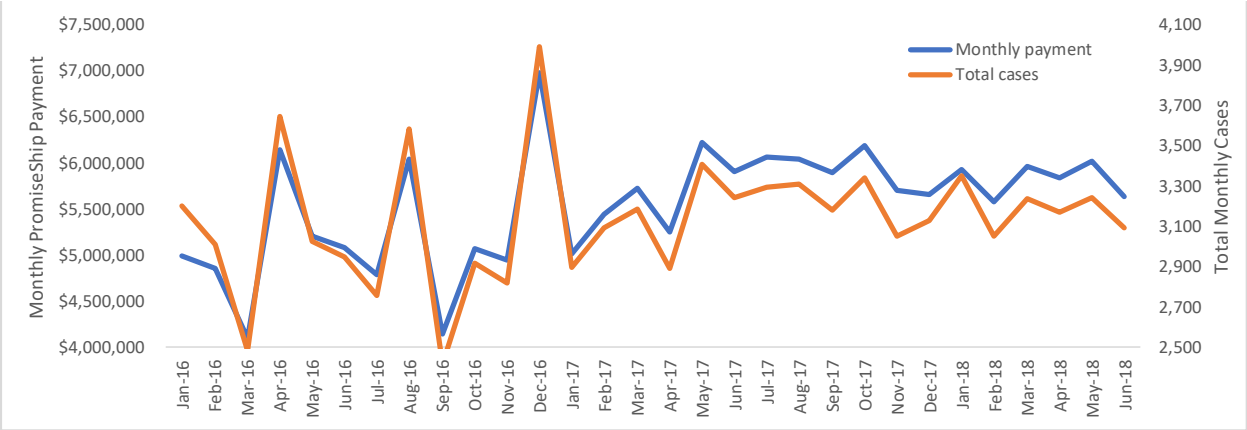
Some have suggested that the Southeastern Service Area is most similar to the ESA, in that it also contains urban areas. TSG notes that case costs in Southeastern Service Area are nominally higher than ESA. However, the difference is $100 in 2018, less than the 5% confidence interval. So, given the discrepancy in case volumes the difference is insignificant.

6.14.1. Cost per Case – PromiseShip Only, to View in Greater Historic Detail

The chart below shows PromiseShip State payments and the cases worked and reported by PromiseShip. It is presented because it is "clean" in that it involves fewer assumptions or adjustments. This is useful for historical perspective, but not for comparing with other regions.

Notice the abbreviated y and z-axes in the chart. See that the costs have tracked with cases, reflecting that costs have historically been adjusted to actual through a "true-up" process.

Figure 31: Monthly PromiseShip Payments and Cases, 2016 – 2018.

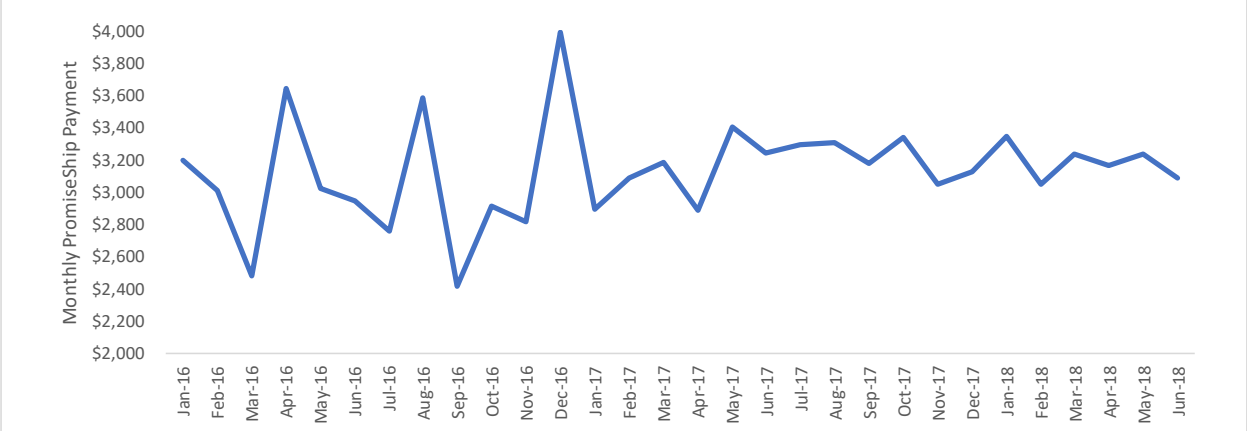


The chart below shows PromiseShip payment per case, which has ranged quite a bit over the past years. PromiseShip payment per case has moved as high as $4,000 and as low as $2,400.

Notwithstanding some swings, the per case amount is nearly the same in June 2018 as it was in January 2106. The three-year average is $3,100 per case per month[21]. Wide swings in cost per case do not merely reflect changes in caseload or the underlying PromiseShip costs. Rather, they reflect a payment method that trued-up costs periodically.

[21] This is calculated: sum of costs for the range of months / sum of cases per month

Figure 32: Monthly PromiseShip State Payment per Case, 2016 – 2018.



TSG's historical analysis of PromiseShip payments compared to PromiseShip-only cases reveals:

- Case cost has remained flat for the period since 2016
- Historical "Administration" payments cause wide swings in the graph, but do not represent changes in case cost
- Viewed in this narrow manner, 2018 case cost turns out to be the same as the fully-loaded method above, $3,100 per case.

6.15. Findings from Case Cost Assessment

Overall, TSG found that the promise of lower costs through outsourcing is not being realized. ESA costs per case are the same as the rest of the state. This has happened in part because the PromiseShip relationship is neither constructed nor managed in a manner that would likely lead to lower costs (combined with higher outcomes).

1. DHHS lacks a definitive set of reports on which to base cost management. TSG's assessment was challenged by not having unambiguous data:
    a. PromiseShip case counts and cost numbers did not agree with those from the State
    b. The State had difficulty creating a set of case and cost numbers
    c. TSG was not able to compare the data provided to a definitive set of financial and operations reports that had been reviewed and discussed monthly by DHHS leadership. (No benchmark against which to gauge the rest of the numbers)

TSG was not able to obtain "the monthly report" by which DHHS management regularly manages costs. Without a report that has been through monthly management scrutiny, DHHS has limited ability to truly manage its costs.

2. DHHS lacks a regular process of managing case costs, as does PromiseShip. Without an accurate ability to build in controls to manage to cost per case, it would be nearly impossible to collaborate on areas of cost savings without accurate data on cost per case.
3. DHHS and PromiseShip manage costs independently. Although both are aware of significant differences in costs and case counts, neither is working to reconcile them. While DHHS and PromiseShip are different agencies, they are still working together to achieve the same goal: better case outcomes at lower cost. Yet, TSG found little on-going work to assure that efforts to manage the finances of cases in the ESA are coordinated. TSG also found instances in which the two sides know they are not working together and have not taken steps to correct it. For example:

    a. Inconsistent case counts
    b. FAMCare and N-FOCUS do not agree
    c. Even the State's record of FAMCare and the report from PromiseShip do not agree

4. DHHS and PromiseShip use different systems, because they cannot agree on how to account for cases. PromiseShip's FAMCare system is a case management system, where N-FOCUS is primarily a case accounting system. PromiseShip purchased a new system because DHHS would not willing to accommodate innovation in provider services codes. This upgrade cost PromiseShip millions that added to the cost of overhead, instead of being used for services or returned to the taxpayers.
5. DHHS and PromiseShip know there are difference in the numbers they use for management, but have not addressed the differences
6. Case cost management is confounded by lack of clear definitions. TSG found that DHHS and PromiseShip do not share a common definition of:
    a) When costs are incurred (cash versus accrual)
    b) Terms used for tracking cases (wards, youth, master case, in/out of home...)
7. DHHS and PromiseShip do not collaborate on case cost management. TSG found no mechanism by which PromiseShip and DHHS are actively working together to find opportunities to reduce cost. TSG believes that taking advantage of private sector orientation to cost improvement is a fundamental reason for outsourcing in the first place. However, the two organizations are working in silos instead of collaborating together to improve costs.
8. TSG was impressed with the abilities demonstrated by individual analysts. This assessment would not have been possible without the support of both State and PromiseShip analysts. However, DHHS does not have accounting staff responsible for monitoring, assessing and recommending improvements to case costs and neither has a

team assigned to the job of cost management. DHHS should have a function working to report costs and then to find ways of improving them. They should partner in this endeavor with PromiseShip.

6.16. Summary Findings from Financial Review

1. Cost-plus. The current payment structure (Effective September 2018) is cost plus. It provides little incentive for PromiseShip to improve cost performance.
2. Manual data re-entry. PromiseShip re-enters provider payments manually into N-FOCUS. To save time, PromiseShip sometimes manually sums provider payments outside he system. This requires a staff of four. This wastes resources, introduces opportunities for error and could be easily replaced with Robotic Process Automation22.
3. Different service codes. PromiseShip and DHHS use different service codes for provider payments. DHHS was unaware if there is a crosswalk between the two lists. Accordingly, DHHS has no ability to compare provider payment practices across the FAMCare and N-FOCUS systems. It depends on the "recoding" PromiseShip clerks perform as they re-enter payments into N-FOCUS. This is wasteful, introduces the opportunity for error and prevents dependable analysis.
4. Financial controls. TSG is not convinced that the silo-based controls between PromiseShip and DHHS are strong. TSG is not an audit firm and defers to professionals in that area. However, TSG has seen enough to suggest that a study of inter-organizational controls is needed. The controls TSG observed lack coordination, analytical controls, reconciliations and management reporting—all crucial aspects of control systems.
5. Cost analysis. DHHS does not typically report or manage its total costs through cost analysis. DHHS is apparently not tracking trends or ratios of its operating costs or costs per case. TSG was not able to obtain a budget report that listed all case management costs. Without regular reports that are reviewed by management, it is hard to say that DHHS is managing its costs. Regular management analysis is a crucial form of management—offering far greater potential for control than tracking individual documentation or procedural violations. DHHS should develop a set of financial reports to manage child welfare costs. These should be reviewed by management on a monthly basis to assess and correct cost trends. These reports should include: total direct and fully-loaded case cost, case volume, and cost per case. This should be done by region

[22] For an explanation of RPA capabilities as well as providers and software, see for example the discussion published by Gartner, available at: https://www.appian.com/resources/gartner-robotic-process-automation-rpa-competitive-landscape-consulting-and-system-integration-service-providers-google/?google_ad_keyword=robotic%20process%20automation%20software&matchtype=e&google_ad_campaign=881255669&utm_source=google&utm_medium=cpc&utm_campaign=amcl-2018&gclid=Cj0KCQiAoo7gBRDuARIsANeJKUbnig1Bh2dlrjIGcf4cA3jM5I2a1XMwmU4pRlek1lT1DaUSX5Vvy3MaAji7EALw_wcB

and by type of case. Reporting should be done for each major aspect of cost: labor, provider charges and administration. Cost management. Nebraska used outsourcing to try to manage costs. What it really needs to do is manage costs. However, that requires on-going reports and analysis. DHHS will have an effective cost management system when leadership discusses every month a report of variances in cost per case…and when variance reports are used to adjust staffing and contracting decisions. While social service bears little resemblance to manufacturing, it this one respect the tools will be helpful: DHHS would benefit from a cost accounting system. It also requires a team of analysts with the charge to both build regular reports and also to "explore" in the data—finding new relationships and trends.

6. Unaccountable caseloads. DHHS was not able to easily provide case volumes for analysis. The data source DHHS used archives cases after 12 months. Thus, DHHS has no record that users can use for analysis and management. Trend analysis is a crucial form of control. DHHS should develop a data repository suitable for on-going analysis of management questions. This should include direct case costs and labor as well as indirect costs, details about case demography, case performance, outcomes and so forth. The repository should be suitable for user reporting. In addition, DHHS should assign appropriately-skilled staff the responsibility to report trends, ratios and custom queries every month Financial management. DHHS is not supported by tools that allow it to evaluate the effect of case practice over time. This is the essence of evidence-based practice, the new foundation of child welfare services. This goes beyond cost accounting (above). This suggests that DHHS should be constantly looking for patterns and trends in the data. When the numbers present something notable, DHHS analysts and management should use that as a clue to finding new ways to manage cases for better results.
7. Unreconciled differences. DHHS reported that it suspects that there are differences between N-FOCUS and FAMCare but has not reviewed this as part of a process to eliminate differences. DHHS provided files of provider payments, and they did not agree—however the differences were not as they expected. Furthermore, TSG found that the unreconciled differences were millions per year. DHHS should conduct analysis on differences between FamCare and N-FOCUS, working to correct difference to nearly zero within one year. DHHS should makes sure that provider costs per N-FOCUS tie to FAMCare and PromiseShip financials.
8. Consistent numbers. DHHS has several conflicting sources of data and doesn't reconcile what the data it has. This is a significant amount of spending in the ESA that DHHS needs to control effectively. Also, the misalignment of N-FOCUS and FAMCare means it is also hard for PromiseShip to control. The opportunity extends beyond better managing between N-FOCUS and FAMCare. DHHS should be analyzing provider costs across $120MM of provider services in all regions…what costs more or is more effective? TSG did not find a group of analysts within DHHS using the data to consider these questions. Analytical management should be a core competence.
9. Custom reports from N-FOCUS. PromiseShip cannot obtain custom reports from N-FOCUS. This is an important control and cost management issue as well.

10. Concentration of services. Many PromiseShip services are contracted with only a few providers. Fully 27% are sourced from a single provider. TSG found that 96% of services have 20 or fewer providers. TSG found that 71% of PromiseShip service charged were paid to 12 providers, while 96% of providers billed less than $2 million over the past 3 years. DHHS and PromiseShip should work to expand the competitive nature of services. The original justification TSG heard for privatization of case management was to obtain better advantage from competition. Yet, PromiseShip's services are very concentrated, not seeming to take advantage of competition in a manner much different from what the State does. Competition. The logic of outsourcing was allegedly to achieve the benefits of competition. However, TSG found a concentrated industry, not one characterized by the benefits of competition. See **Appendix C**.
11. Service rates. TSG heard a rumor that PromiseShip provided different billing rates by provider. This appears not to be the case, except for Foster Families. DHHS and PromiseShip should establish a regular two-way flow of information about management and accounting issues. The two groups should meet regularly. The two groups should work together to implement a collaborative quality improvement program. Open communication. See **Appendix C**.
12. Trust. TSG found far too much "management by rumor". Culture of Distrust. TSG observed a level of distrust between State and PromiseShip not conducive to an effective partnership. This form of we/they relationship breaks down controls. Fixing this culture of distrust is core to achieving the benefit of working as partners.
13. Smaller caseloads. PromiseShip caseloads are lower than in the rest of the State. This raises the question, do smaller caseloads lead to better case performance, or at least lower turnover. TSG found no evidence that PromiseShip achieved better results through lower caseloads. This is not to say that lower caseloads are not better, only that TSG found no evidence. Caseload (i.e. staffing level) seems as though it should be a core management decision. Both PromiseShip and the State could do a better job of managing caseloads (staffing) to achieve optimum performance. See **Appendix C**.
14. Turnover. The DHHS method of reporting case worker turnover underreports the true impact. Looking at the frequency with which individuals stop working caseloads, turnover is 7%, not the 3% the state reports each month. Turnover of 3% would still be a big issue. The equates to 36% per year—a serious cost and performance challenge. However, TSG observes that statewide the rate is 59% annually (63% for ESA). TSG found that 95% of DHHS (100% of PromiseShip) case workers leave before they have been at it for 36 months. This is a very significant problem. PromiseShip has not done a better job at reducing turnover than DHHS. See **Appendix C**.

7. STAKEHOLDER ASSESSMENT

TSG considered stakeholder input as a qualitative source of information about the outsource in the ESA. This included review of PromiseShip's annual survey and meeting with many stakeholders, as identified in the Approach Section, to assess their experience with the outsource in the ESA and relationship with the current vendor.

7.1. 2018 PromiseShip Annual Survey

In January 2018, PromiseShip piloted a new survey methodology, transitioning from a 10-week survey administration process to an annualized ongoing methodology. The new methodology ensures participants are offered the opportunity to participate in the survey year-round rather than during a short and specified timeframe. There was a decrease in total number of completed surveys compared to 2017 due to the change in survey administration. It is anticipated that the 2019 Survey will result in a significantly higher response rate as the survey will be administered over the course of a year, as opposed to the 7-month pilot.

PromiseShip developed the original Annual Survey in 2014, which was used for the 2018 Annual Survey to allow for comparison of items over time. There are four participant groups surveyed:

- Community Stakeholders—includes judges, guardian's ad litem (GALs), attorneys, providers, and community members.
- Foster Parents—includes licensed foster parents and relative/kinship families.
- Parents of Youth—includes parents who are currently or previously receiving services from PromiseShip.
- Youth—includes youth who are currently receiving services from PromiseShip and who are at least 9 years of age and older.

Survey questions focused on perceptions of PromiseShip, including professionalism, collaboration with others, and quality of services provided. The survey questionnaire remained the same. All rating items used a 5-point Likert scale with 5 being 'Excellent' and 1 being 'Fail.'

- In 2018, PromiseShip received survey responses from 193 Youth ages 12 and older. Although there were slight fluctuations in the individual item ratings there was no difference in the overall rating compared to previous years. Similar to past years' results, the top rating for the Youth survey continued to come from the item: "My FPS treats me with respect." This item rating was 4.7, which is a 0.1 increase from last year.
- Parents represented the largest group of respondents in the 2018 pilot. The overall average rating for the Parent survey in 2018 was 4.0. The item "My FPS schedules meetings that are convenient for my schedule" rated highest on the Parent survey with a 4.3 rating. In addition, the Parent and Youth surveys included the greatest number of positive comments about PromiseShip and/or the specific Family Permanency Specialist

(FPS) with whom they were working. Although the overall rating for parents was 0.2 lower than in 2017, there was a considerable amount of positive comments.

- Foster Parent respondents included both licensed and unlicensed foster parents. Of the 211 Foster Parents who completed the survey, 69 identified themselves as licensed foster parents, 134 as kinship/relative providers, and 8 did not self-identify. The overall average rating by Foster Parents in 2018 was 4.0, which is consistent with previous years. Overall ratings averaged 4.0, which is 0.1 point less than 2017 survey results. Ratings of 4.0 or above were given for items related to: FPS visits; Family team meetings; Monthly visits; and Professionalism of the FPS.
- In the 2018 Pilot, PromiseShip received 157 Community Stakeholder completed surveys. The overall average rating by Community Stakeholders was 3.2. Community Stakeholder ratings slightly decreased compared to the 3.5 rating in 2017, with an overall average rating of 3.3. Stakeholders included community members and professionals in education and the legal system (i.e., judges, attorneys, and GALs).

7.2. TSG Stakeholder Feedback

TSG interviewed the following stakeholders:

- Inspector General
- Judges (Sarpy and Douglas County)
- State Executive Leadership for CASA, as well as CASA leadership in Sarpy and Douglas counties
- Guardians ad litem
- Douglas Juvenile District Attorney Office
- Foster Care Review Board
- Nebraska Family Support Network
- Project Harmony
- Conducted a provider call with providers operating in both State and ESA
- Individual Service Providers: Nebraska Children's Home Society, Capstone BH Services, Cedars

TSG asked each stakeholder if they had witnessed any quality issue or how they would compare DCFS caseworkers and PromiseShip caseworkers. Although not every comment was positive, on balance, TSG was unable to substantiate any quality or safety issue related to the outsource or the vendor's performance. TSG has provided some sample comments below by major theme. TSG does not suggest making policy by anecdote but provides these comments only to offer some context into the types of discussions TSG had with stakeholders.

They spoke of the lack of vision for the outsource:

"There has never been a commitment from policy leaders to make this work. There was never a vision and the legislature was not even involved."

Some spoke of the difficulty of the transformation. Some felt there was eventual benefit to the Service Area:

- "Privatization was poorly implemented when it was rolled out and there was a significant impact in the rural areas of the state."
- "The transition was a real problem."
- "It has been difficult, but it has brought system transformation."
- "[The] Service network has become much stronger."
- "Having a separate entity leads to a check and balance for the system."

They spoke of the positive aspects of working with the vendor:

- "We have found PromiseShip to be data driven and more flexible than the bureaucracy of DCFS."
- "There is more flexibility in determining the right service with PromiseShip as they think out of the box in working with families."
- "PromiseShip always looks beyond the menu of services and there is not a one size fits all approach."
- "PromiseShip is very willing to bring providers to the table."
- "They are not as rigid as the state when it comes to services needed"

Some raised critical issues related to working with the vendor:

- "PromiseShip is putting too many inappropriate cases into voluntary services out of purview of the court."
- "We spend more money in case management than we do on treatment"
- "The ESA vendor has been in self-protection mode ever since the start of the contract. They are constantly running out of money. The outcomes are worse than before. Their staff are poorly trained, and they do not have a workforce that thinks critically."
- "Staff are not proactive when it comes to working on court cases in terms of case plans and are need better training in affidavit writing."

8. OBSERVATIONS ABOUT PARTNERSHIP BETWEEN DCFS AND ESA VENDOR

States outsource child welfare case management for many reasons, but chiefly they do so to:

- Promote community ownership and accountability, and achieve quality outcomes;
- Allow for tailoring of services and a focus on meeting the needs of children and families in a local community or region; and,
- Provide for flexibility to create innovative solutions to meet local needs and to rapidly adapt to changing conditions.

In order to achieve these objectives, the state agency needs to collaborate with its vendor. The state contract needs to provide incentives toward high performance and allow for flexibility. Some of the factors TSG has observed in successful system as critical to effectiveness of the model include:

- Trust
- Communication
- Stability
- Shared purpose
- Inter-dependence

TSG finds that the relationship between DCFS and the ESA vendor is lacking in these essential building blocks. While the relationship has significantly improved, especially under the current leadership at DCFS, TSG finds that the relationship can be characterized by:

- Independent problem solving
- Missed learning opportunities
- Absence of communication which breeds misperceptions
- Unproductive competition
- Poor data sharing, especially financial data

This section of the report summarizes TSG's review of the history and current state of the partnership. In general, it has improved recently. However, it still could best be characterized by a low level of communication, trust and collaboration, and by a form of ineffective competition.

This lack of collaboration manifests in many of the problems we have seen: FAMCare on top of N-FOCUS, numbers that are not reconciled, decisions on case transfer, and gaps in the case transfer process. This lack of collaboration, combined with a lack of clear shared vision and purpose for the outsource and a cloud of uncertainty that has loomed over the contract for many years, has also created a challenging environment for the vendor to operate. These are issues that must continue to be addressed with the current vendor, as well as with any future vendor in the

ESA. Failure to address these issues will limit the value the state of Nebraska will obtain from such an outsource.

8.1. Collaboration not Competition

Throughout our field work, TSG identified several concrete challenges that could be resolved through collaboration. The perpetuation of these challenges suggests the lack of a productive working relationship between DCFS and PromiseShip. Some examples include:

- Difference in case counts and the absence of effort on the part of DCFS or the vendor to reconcile these differences;
- Adherence to the agreed-upon case transfer protocol;
- Collaboration of continuous quality improvement resources and achievement of systems improvement; and,
- The challenge of building an evidence-based service array for FFPSA compliance.

Today, DCFS and the vendor approach problems like this independently.

In the absence of true collaboration, TSG is concerned that even with a performance-based contract that provides for greater accountability and an enhanced contract oversight approach at DCFS, the Department may not receive maximum value from this outsourced project due to a lack of collaboration.

- A truly collaborative case transfer process could improve permanency outcomes, if the Initial Assessment (IA) worker felt connected to the permanency work done by the vendor. It could improve the quality of the casework if an effective hand-off occurs.
- A collaborative approach to CQI could allow DCFS and the vendor to learn from each other's findings and improve statewide quality. The vendor has a robust continuous quality improvement program and is performing many types of case reviews, root cause analyses, and using a collaborative cross-department committee structure to tackle organizational problems. Today, DCFS does not have visibility to this program, nor does the vendor have visibility to the state's work because collaborative CQI meetings have been paused.
- A collaborative approach to service development with the vendor and providers could benefit children and families in all regions. The vendor has also developed new services collaboratively with its providers to meet the needs of children and families in the service area. The DCFS and the vendor could be working together to build new services so that other regions may benefit as well.

Besides the opportunity for DCFS and PromiseShip to work more effectively together, there is also an opportunity to improve collaboration among DCFS, State Medicaid, the MCOs, DCFS field offices and PromiseShip. This should include data sharing.

8.1.1. Collaboration

Unfortunately, collaboration seems to be one of those words people use without thinking about what it truly means. "Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible[23]." The objective of collaboration is to create a richer, more comprehensive appreciation of the problem among stakeholders than any one of them could construct alone.

Collaboration goes beyond tightly-worded contracts. It is more than meetings. It cannot be drawn into an organization chart. Nor can it be effectively written into performance requirements. TSG evaluated the current level of collaboration by investigating the preconditions that were set up for collaboration, the process created between DCFS and PromiseShip, and the outcomes that can be attributed specifically to collaboration.[24]

1.1.1.1 Preconditions for collaboration

- Stakes are high and the parties are interdependent.[25] Surely the stakes are high for youth and families in the system. However, are the stakes high for the two main players: DCFS and PromiseShip? TSG found nothing to suggest that either organization would suffer from poor system performance, nor benefit greatly from exceptional performance. DCFS would face federal penalties if compliance metrics are not met. However, such penalties have not been levied, nor are they linked in a way that drives performance at the caseworker level. Likewise, PromiseShip could be fined if the state were fined and if PromiseShip were negligent. However, this seems not to present a serious threat.
- A glaring need for (or significant benefit from) working together[26]. TSG observed nothing in the contract, management of PromiseShip, or PromiseShip management of itself suggested that the organizations faced meaningful consequences if they fail to work together.
- Shared understanding of the underlying causes of the problem. TSG did not find any evidence that PromiseShip and DCFS are working together to a common understanding of the underlying causes of involved families. They both use SDM, but in different

[23] One of the most respected authors on collaboration is Barbara Gray. Here, TSG quotes from her book, Collaborating: finding common ground for multiparty problems. 1989. Jossey-Bass
[24] TSG borrowed this list from table 2 in: Toward a Comprehensive Theory of Collaboration, he Journal of Applied Behavioral Science 27(2):139-162 · June 1991
[25] Logsdon, J. M. (1989) Silicon Valley Traffic Congestion and Measure: A case of private-sector participation in collaborative problem solving, Paper presented at the Academy of Management Meeting, Washington D.C. cited in xxx
[26] F Westley, H Mintzberg, Visionary leadership and strategic management, Strategic Management Journal 10 (S1), 17-32

manners. The two parties are working independently to improve their understanding of the underlying causes of reduced family safety. We did not find evidence that the two parties believe it is important to work together to address those causes. Instead, we found a culture that is focused on individual cases, not how the learnings from individual cases can be brought together across both agencies to improve care

- Incentives for (and lack of barriers to) breaking down the organizational walls. TSG found few incentives for breaking down the barriers to working together. Such incentives would provide at least the perception of greater personal or institutional rewards from working together. We found a few attempts to hold meetings (such as for reconciling provider payment records). However, these broke down quickly, with no repercussions to either organization or the involved individuals.
- How the parties are organized enabling them to collaborate. TSG observed nothing in either organization that suggested points for inter-organizational work. We observed this even where the benefits of working together are obvious, such as collecting accounting costs.
- Shared purpose. Surely, both organizations work to increase the safety of individual cases for which they have authority. However, TSG did not find that the relationship has been set up in a manner that DCFS is working to the purpose of increasing PromiseShip performance and vice versa. Instead, the relationship is set up as a form of competition, with the State trying to prove that they can do the job better, and PromiseShip fighting to prove relevance of the outsourced model. This is not a framework for collaboration or sustained success.

1.1.1.2 Process through which collaboration occurs

- Some form of institutional mediator. TSG did not observe any one person, or collection of people responsible for building integrated work. We expected to find a contract manager and did find one.
- Negotiated order. TSG found no evidence that DCFS and PromiseShip worked together to define the relationship between the organizations.
- Joint decision making. TSG did not find examples of joint decision-making. For example, case decisions are made first by DCFS, then handed off to PromiseShip, who then manages cases without State involvement in decision making.
- Agreed upon rules. TSG found that DCFS pushes rules onto PromiseShip, rule-making is not done through a process of agreement.
- Interactive processes. TSG found no examples of interactive processes. Instead, TSG observed linear process, during which the work is "thrown over the wall" and back.
- Temporary structure. The most relevant aspect of temporary structure in child protective services might be the case itself. This is a temporary team set up to achieve a "common" goal of improving family safety. A temporary structure to achieve collaboration would create some form of case management process through which State and PromiseShip

worked together—bringing their unique values to the case. However, PromiseShip cases are managed independently from the State. The case is "thrown over the wall" at which time PromiseShip is responsible. The two entities do not work together for the benefit of the children and families in need.

1.1.1.3 Outcomes of collaboration

- Enduring bridges and shared understanding. TSG found few bridges across which case "traffic" flowed both ways. TSG found little effort to develop shared understanding. Instead, we found both organizations using inconsistent terms and processes. For example, PromiseShip calls their case workers PFSs. PromiseShip uses different services codes.
- Distributed risks and costs of goal attainment. TSG found one example of distributed risk and cost of goal attainment. If the State is penalized for poor federal compliance, then PromiseShip might be penalized for the level to which it contributed to the fine. However, the mechanics are not spelled out, so it is hard to imagine how some risk might be realized
- Evidence that working together is responsible for success. Of the stories TSG heard concerning success, working together was never attributed as a cause. For example, federal compliance has improved in all regions. However, the local folklore is that the State and PromiseShip independently raised their individual performances—not that improvement resulted from working together.

8.1.2. Building the foundations of collaboration in the future

Building collaboration requires[27]:

- The stakeholders are interdependent. Family safety is not something that any one party can create. DCFS and PromiseShip will collaborate only when their success is mutually interdependent. Things have to change. Going forward, DCFS cannot see itself as "winning" when PromiseShip loses. PromiseShip cannot be allowed to manage cases as if their case workers were the sole factor leading to safer families
- Solutions emerge by dealing constructively with differences. TSG found no regular process for identifying and resolving differences. Instead, we found that differences are sometimes ignored instead of trying to immediately resolve them.
- Joint ownership of decision. TSG found some examples where the parties had tried to work together, but that was stopped. The most significant decision made in the system is how to manage a case. TSG found in Texas a regular process of including investigators

[27] The following two lists are adapted from Barbara Gray, Here, TSG quotes from her book, Collaborating: finding common ground for multiparty problems. 1989. Jossey-Bass

and case managers in a case staffing at the point of handoff. The underlying belief in Texas is that the best-case management comes from working together. Nebraska needs to achieve at least this level of working together to achieve high case results.
- Stakeholders assume collective responsibility for the future direction of family safety. Both at the macro and case levels, family safety will best be achieved when DCFS and PromiseShip share responsibility for building better child protective services
- Collaboration is allowed to emerge (not written into a static contract). Contracts are not the best tools to build collaboration. DCFS should build a new form of vendor management today and with any future vendor in the new form of interaction that is designed to adapt to the changing opportunity to work together to improve family safety.

TSG observes that building this sort of collaboration will require:

- Both DCFS and PromiseShip must be held jointly accountable for improving family safety in the whole state, and especially in the ESA.
- DCFS and PromiseShip must work together to overcome the current culture of "we/they" silos. The relationship must be redefined as a joint effort.
- Systems must be adapted for collaboration. For example, PromiseShip must have access to custom reports from N-FOCUS. DCFS should learn from the benefits of FAMCare as a case management system—and work together with PromiseShip to find a unified systems strategy.
- The case management process must be integrated. This is not merely the systems. It is more than a common record of case assignments and events.
- The Legislature should give DCFS a clear mandate to work in common purpose with PromiseShip, and any future vendor.
- Accountability must clearly require both DCFS and PromiseShip, or any future vendor, to achieve better family safety in the whole state, and especially in the ESA. For example, PromiseShip should be accountable for transferring the innovative solutions that have proven successful.

8.1.3. Contract Monitoring is not Collaboration

The closest thing TSG found to collaboration was contract monitoring.

Instead of collaboration, we found it to be focused on a minimal legal compliance style of monitoring, due in large part to the fact that the contract deliverables are not clearly outlined and therefore become nearly impossible to monitor. Monitoring focus primarily on compliance with statutorily required documentation, such as staff background/criminal record checks.

The historical nature of the relationship with PromiseShip has the contractor accountable. There is nothing articulated in the contract that would encourage accountability around "practice" issue improvements. There is often confusion from State staff about how to respond when practice issues must be addressed to ensure the appropriate changes occur.

Further, while PromiseShip appears to have a fairly robust continuous quality improvement process, many times that information is not thoroughly shared to reduce suspicion that State concerns are being addressed and ameliorated. Developing clearly articulated rules for discussion regarding practice issues would provide a platform for communication and learning for both the State and PromiseShip, all while strengthening a rather anemic monitoring process. The adage "what gets measured gets done," clearly applies in the contract monitoring arena.

With clearly communicated contracted expectations that specifically address "how" work is to be completed along with a process for addressing issues that arrive will be imminently beneficial to both parties and provide a considerable benefit in reducing myths and miscommunications.

8.1.4. Florida Case Study

The Florida Community-Based Care model provides an instructive experience Nebraska could learn more about how to build public-private collaboration by investigating the Florida experience.[28]

Over the past two decades, Florida has created a more collaborative approach to sharing responsibility for child welfare. Community-Based Care is a comprehensive redesign of Florida's Child Welfare System. It combines the outsourcing of foster care and related services to competent service agencies with an increased local community ownership of service delivery and design. This innovative statewide reform increases accountability, resource development, and system performance. This innovative new system includes key features that address common problems and challenges in child welfare systems, such as:[29]

- Partnering with, local lead agencies through competitive procurement to engage community stakeholders in designing their system of care, and to develop and maintain a service delivery network within their service area.
- Formation and support of Community Alliances of local stakeholders, community leaders, client representatives, and other agencies funding human services. An Alliance may cover one or more counties, as determined locally. Duties of Community Alliances include, but are not limited to, joint planning for resource utilization, needs assessments and establishment of community priorities, determination of local outcome goals supplemental to state outcome requirements, and community education and advocacy.
- A formal process was developed for assessing and preparing local Department units and Lead Agencies to safely transition services from the state to the local provider network. The Department's readiness assessment process uses an external team of peer

[28] The following is adapted from Florida DFC at: http://www.myflfamilies.com/service-programs/community-based-care
[29] http://www.myflfamilies.com/service-programs/community-based-care

experts to assess the development of the local infrastructure and transition plans, as well as provide technical assistance to both parties prior to initiating transfer of any services.

Florida State University has assessed the Community Based Care results year after year.[30] They find, "Two areas of strength in the collaboration between Child Protective Investigations and Community-Based Care lead agencies, which can potentially be expanded, are the use of resource specialists and diversion staffings." Florida continues to improve, as Child Protective Investigations works to allow Investigators (state employees) direct access to private partner resources including basic interventions such as flex funds, family support workers, daycare and other Community-Based Care lead agency resources. In addition, Florida is building up communication between the Investigator and the private case manager should after the case is handed off from the investigator.

8.2. Lack of Clearly Articulated Vision

Nearly ten years ago, Nebraska took a bold step into a new type of public private partnership, sourcing large sections of its child protective services to three private organizations. As with any new venture, that required a clear understanding of how the new sourcing strategy would improve on the old one.

TSG has investigated the mission of this re-sourcing by considering how the state expected the business model to change by sourcing through a private organization. Business model may seem like an odd term to apply in a social services arena. However, all private organizations work to a business model. Thus, partnering with a private organization demands that the state understand the motivations and expectations of its new partner.

Neither the enacting legislation, contract nor DCFS leadership communicated a vision with various stakeholders. TSG heard from providers, other agencies and interest groups that they were not clear at the outset and are still unclear about the objectives. Many of these are private organizations (non-profit), so they support the notion of privatization. However, they were never included in developing or at least told what the PromiseShip privatization was to achieve.

In the absence of a clearly articulated vision, TSG concludes that the relationship was set up for the purpose of enabling compliance, with some unstated assumption that this compliance is linked somehow to how individual families would express the "job to be done." TSG found no evidence that the State anticipated that PromiseShip would aggressively seek out better ways to meet the needs of children and families as they would express them. Their job is to follow the rules. For example:

[30] Report to the Legislature Evaluation of the Department of Children and Families Community-Based Care Initiative, University of South Florida, Submitted to the Florida Department of Children and Families

- DCFS prescribed the training for case worker. PromiseShip was not encouraged (or technically allowed) to find better ways to train its case workers. This is especially onerous since PromiseShip case managers use FAMCare in addition to N-FOCUS
- DCFS prescribed that PromiseShip use only its N-FOCUS system, which is not technical based on a case process management technology. In addition, DCFS required that PromiseShip only paid approved codes. The state is not interested that PromiseShip's 5-day bed hold has proven to be less expensive and less disruptive to youth
- DCFS requires that PromiseShip use the same case management manuals—ignoring the opportunity for innovation.

All in all, the relationship is not one of peers collaborating to achieve better family safety.

8.3. Instability

The pall of uncertainty surrounding the privatization contract and assessments of the success or failure of the model have contributed to create a challenging environment.

With no clear vision, PromiseShip has made costly decisions, such as investing in a separate case management tool, FAMCare. Unlike the State, where investment is not accounted for in the operating budget, the private sector must amortize costly investments like this. It cannot make important investments if it does not know the duration of the contract.

Two years ago, it entered into a contract, and now is faced with the threat that the private operation could be returned to the state. Business cannot make effective investment decisions in such uncertainty. Since it might take years to build a new service or family program, and there is uncertainty about whether the vendor will remain in place to deliver the new service in a year, this disincentivizes investment in innovation.

In a similar fashion, grant partners and donors may be unwilling to offer support under such uncertainty. For example, PromiseShip believes it has lined up an investor who will provide substantial investment toward a building. However, that is awaiting clarity about the continuity of the relationship. TSG was told that this is but one example of the barriers uncertainty has placed in front of outside investment.

PromiseShip leadership described the effect of this uncertainty as "traumatic for workforce" and said it is hard to retain staff. We are told that many PromiseShip workers are looking for new employment, in anticipation of losing the contract. A large provider has said that "limbo has created an environment of us vs. them…they can't relax…people are worried about their jobs".

TSG found no evidence proving this (turnover rates seem about the same as the State's own). Yet, that only makes sense—workers need to manage their own households and they may leave for more stable employment. Even though turnover does not show it yet, the effect is surely there. Fear (such as losing your job) creates a challenging environment in which to do your best work.

TSG is not suggesting any particular duration for a contract. Rather, we are observing that the uncertainty around duration has limited PromiseShip's ability to invest in better services and this fact needs to be taken into consideration with any future RFP and contract.

8.4. Summary

It is laudable that PromiseShip has done well in such an adverse situation. It is not clear that the contract set up a good relationship. DCFS and PromiseShip have not collaborated in the true sense of public/private sector collaboration. It's hard to describe the relationship as one that clearly puts in place innovative new measures to improve child safety. It suffers from no clear mission, no collaboration, mixed incentives, lack of analysis, and uncertainty. However, these are not endemic to privatization, nor the result of bad vendor performance. The root cause of the problem is that the parties failed to create an effective working relationship. This can be solved.

9. CONTRACTS AND CONTRACT MONITORING REVIEW

9.1. Contract Between the State and Vendor

TSG has reviewed the terms of every contract entered into by DHHS and NCF (now PromiseShip), since June of 2009, up to the most recent amendment of November 30, 2018. This review also included all contract amendments and attachments, as well as documents referred to in the contract that are binding upon the state and the contractor by agreement in the contract. These contracts and amendments are summarized in the Table below.

TSG also reviewed state contracts for similar outsource models in other states and made a comparison for best practice.

9.2. History

In June of 2009, the state entered into two contracts with Six Agencies: Boys and Girls, CEDARS, The Alliance for Children and Families/Region 3, KVC, NFC, and Visinet, for child welfare service coordination, to begin in November of 2009, with full implementation across the state to begin January 1, 2010. One contract was for infrastructure support and the other was for full service coordination (referred to in Table 27 as Original Contract). The contracts were for a five-year period, ending on June 30, 2104.

Table 27: DHHS and NCF Contract Summary.

	Contract	Time Period	Purpose
1	Contract for Infrastructure	June 15, 2009 to December 31, 2009	Develop infrastructure, staffing and services. $908,600 for each contractor
2	Original Contract – Service Delivery	November 1, 2009 to June 30, 2014	$19,185,452.07 to provide system of care services to families and children in ESA
3	Amendment One to Infrastructure	October 20, 2009 to March 31, 2010	Extended time for Infrastructure
4	Amendment Two to Original Contract	March 4, 2010 to June 30, 2014	Added services to scope of services
5	Amendment Three to Original Contract	July 2, 2010 to June 30, 2014	Added funding to infrastructure not to exceed $1,147,045.66 and to service delivery $20,664,740.93
6	Amendment Four to Original Contract	July 29, 2010 to June 30, 2014	Additional funding added performance measures section M to Article II scope of services
7	Amendment Five to Original Contract	October 14, 2010 to June 30, 2014	Additional funding not to exceed $23,664,740.93 and scope of services amended to include

	Contract	Time Period	Purpose
			additional responsibilities for state and contractor
8	Amendment Six to Original Contract	December 16, 2010 to June 30, 2014	Added Case Management Services
9	Amendment Seven to Original Contract	January 1, 2011 to June 30, 2014	Additional funding not to exceed $71,958,384.72 and Scope of Service changes
10	Amended and Restated Contract	August 16, 2011 to June 30, 2014	Additional funding not to exceed $125,325,119.64 and added new Section on Performance Measures tied outcomes to Operational Manual
11	Amendment One to Restated Contract – Service delivery and case management	February 28, 2012 to June 30, 2014	Additional funding not to exceed $136,733,797.00 and Scope of Service change – assume KVC cases
12	Amendment Two to Restated Contract	June 29, 2012 to June 30, 2014	Additional funding not to exceed $162,856,438.00
13	Amendment Three to Restated Contract	June 27, 2013 to June 30, 2014	Additional funding not to exceed $181,134,004.12 and added language to Section on Performance Measures and Specific Outcomes identified in contract
14	Second Contract - Service Delivery and Case Management	July 1, 2014 to June 30, 2015	New contract covering similar scope of service and added section on Performance Measures tied to outcomes. Contract amount not to exceed $59,951,000.00
15	Amendment One to Second Contract	July 23, 2014 to June 30, 2015	Excluding responsibility over certain services
16	Amendment Two to Second Contract	June 6, 2015 to June 30, 2016	Extending the time period/additional funding not to exceed $119,902.000
17	Amendment Three to Second Contract	November, 15, 2015 to June 30, 2016	Updating compliance with newly agreed to Operations Manual of 9/22/15
18	Third Contract - Service Delivery and Case Management	July 1, 2017 to June 30, 2019	New contract covering same scope of services Contract amount not to exceed $71,500,000.00
19	Amendment One to Third Contract	January 3, 2018 to June 30, 2019	Added provision on consent to treatment
20	Amendment Two to Third Contract	February 12, 2018 to June 30, 2019	Changes to scope of services

	Contract	Time Period	Purpose
21	Amendment Three to Third Contract	August 30, 2018 to June 30, 2019	Additional funding
22	Amendment Four to Third Contract	November 30, 2018 to December 31, 2019	Extending time period and adding $35,750,00.00 for July 1, 2019 to December 30, 2019

After a series of amendments and issues mostly related to funding, there remained only two outsourced contractors when DHHS subsequently amended the Original Contract to include caser responsibility for case management services on December 16, 2010, DHHS (Amendment Six to Original Contract). The two remaining contractors, NFC and KVC, had case management responsibility for most of the ESA coverage area.

After a few more amendments adding additional funding and some minor scope of service changes, the state issued a new contract (referred to as the Restated Contract in Table 27) on August 16, 2011. This contract completed the state's decision to transition all child welfare cases within the Eastern Service Area (ESA) to NFC. By February 2012, and through the second amendment to the Restated Contract, NFC assumed all of KVC's cases, whose contract with the state ended in April of 2012, and there was one sole contractor operating under the terms of the original contract, and the successive amendments.

The actual Second Contract with the contractor, not to include any amendments to the original contract, was entered into on July 1, 2014 by the state and NFC for the continued case management for all of the ESA, but this time this contract was for a one-year period, ending on June 30, 2015. That contract had very similar terms and conditions from the original contract and maintained the requirement that the Contractor follow the most recent state Operations Manual. There were three successive amendments to this contract, one excluding certain services and the other two extending the contract our one additional year from July 1, 2015 to June 30, 2016 and then from July 1, 2016 to June 30, 2017.

The State then renewed its full contract with NFC for the Third time on July 1, 2017 until June 30, 2019. This is the contract that NFC is currently operating under and, once again, the state followed suit in requiring NFC to agree to similar provisions that were contained in both prior contracts.

Most of the revisions centered around additional funding and some minor scope changes other than assuming responsibility for case management in 2010. This Third Contract was amended three times, with the most recent coming on November 30, 2018, extending the time frame to the end of 2019. PromiseShip currently is required to meet all the terms and conditions of this Third Contract, including the Operations Manual dated January 2, 2018, which has been updated from the one referenced in the Third Contract, which was dated April 15, 2016.

9.3. Contract Provisions

The contract entered into by Nebraska DHHS and NFC is logically broken up into the following five sections. Section I covers the Period of Performance and Termination; Section II covers the Amount of the Subaward; Section III the Statement of Work; Section IV General Terms and Assurances; and, Section V. Business Associate Provisions.

The purpose is stated as providing case management and an individualized system of care for families and their children and youth who are wards of the Nebraska DHHS involved in the child welfare or Juvenile Court system or who are non-court involved children and families involved in the child welfare system. The following three functions are required: Service delivery, service coordination, and case management for children and families in the ESA. The contract is a no reject, no eject subaward, so the subrecipient, by contract, agrees to accept and serve all children, youth and families referred by DHHS.

The key financial requirements are set forth in Section II, which include a capped allotment of a certain dollar amount, which it is estimated to cost the state for the delivery of the service for a one-year period. There is a fixed and variable payment structure identified and payments are made based on actual days in care. In addition, the contractor is required to track and report quarterly and annually its federal and state expenditures, including administrative costs in a format developed and designated by DHHS. This includes reconciling monthly statements to invoices for services for purposes of the state claiming federal reimbursement under Title IV-E. If at the end of the year the amount the state allocates is more than the actual cost of service, the contract requires that the difference be repaid by the contractor to the state.

Moreover, if there are any financial penalties assessed to the state for the contractor's failure to comply with a court order, or with any Federal standard, the contract requires that the Subrecipient pay the penalty or reimburse the state for the complete amount of the penalty.

Section III contains the Statement of Work, and this section is very prescriptive and outlines the specific scope of services that the state is contracting for in the ESA. The subsections that contain specific requirements of the Subrecipient include, but are not limited to:

- Abiding by all state and Federal law and policy, including complying with the most recent Department Operations Manual
- Providing service coordination and case management functions for both court-involved, and non-court involved children, youth and families
- Paying foster families for foster care consistent with rates approved by DHHS
- Recruiting foster parents and reporting on foster care capacity
- Allowing DHHS access to any and all information and data collected
- Accepting that DHHS maintains guardianship authority
- Maintaining a complaint process;

- Having an incident reporting process where DHHS is immediately notified of certain critical incidents
- Providing transportation to children
- Ensuring proper licensing and approval requirements
- Having a notification process for consent to treatment
- Responsibility over subcontractors
- Requirements for reporting abuse and neglect by staff
- The development of protocols for the referral process
- Substantive service coordination and case management functions
- Providing a complete continuum of non-treatment, non-Medicaid funded services, supports and placement resources
- Appropriate child placement practices
- Ensuring home studies and safe environment prior to placement
- Assuring Multi-ethnic placement training
- Compliance with Indian Child Welfare Act
- Requiring court attendance and court requirements
- Compliance with administrative standards, such as background checks, hiring standards
- Requiring documentation and reporting
- Requirements surrounding information system access and reporting
- Performance of quality assurance and the development of a quality assurance program
- Required Insurance coverage
- Required professional development training
- Required performance outcomes and accountability
- Compliance with state law regarding cooperation with Foster Care Review Office
- Requirements around Cost Allocation Plan for purpose of Title IV-E claiming
- Governance structure requirements
- N-Focus documentation requirements
- Agreement to be jointly responsible with DHHS to Federal reporting measures

Section IV General Terms and Conditions and Section VI Business Associate Agreement are standard terms for all state contract vendors to agree to.

9.3.1. Operation Manual

In each of the three contracts entered into by the State and NFC, that contract includes a specific provision under Section III, A 3 of the Statement of Work requiring the subrecipient to "comply with the most recent DHHS Operations Manual." The most recent contract provision requires the contractor to: "Comply with the Operations Manual dated April 15, 2016 (hereinafter the Manual) as amended hereinafter by mutual consent of the parties. The Manual will describe in detail the parties' required operational duties during the entire subaward period." That Manual has been updated by agreement today to January 23, 2018.

A review of the Operations Manual of January 23, 2018, and each prior Operations Manual going back to the beginning of the State/ESA region contractor relationship, contains a number of substantive provisions related to operations, data and financial reporting, collaboration, and accountability. The Manual is considered part of the contract. The Manual also states its purpose to provides direction to the subrecipient in greater detail on the expectations for standardization in the operation and delivery of case management and related services.

The Operations Manual has a number of sections that, as stated, describe in detail the operational expectations and duties of the contractor as well as the state. It starts by delineating in detail the roles and responsibilities of the state and Subrecipient and even provides a roles and responsibilities matrix that defines the responsibilities associated with the day to day operations of delivering case management to children and families in the ESA. The current Manual covers the following areas:

- Referrals from the state to the Subrecipient
- Structured Decision Making practice
- Intake process
- Initial Assessments
- Safety Planning
- Out of Home Assessments and Placement
- Coordinated Response Initiative
- Background checks
- Process for approval of placements in relative and kinship care
- On-going case management responsibilities of subrecipient
- Adoption and guardianship practice
- Practice for handling dually adjudicated youth
- Interstate Compact On Placement of Children
- Incident reporting

The Manual also expands upon a number of areas in the contract and covers in great detail key areas of operation in the ESA, including, but not limited to:

- Caseload Ratio Requirements
- Documentation and File Retention, including N-Focus documentation
- Record keeping, including home study, criminal history record check, training records, etc.
- Standards for transporting youth
- Required reports, including monthly, quarterly and annual financial reporting, caseworker training reports, and an Annual Report including reporting on collaboration, coordination with tribes, disaster plan, monthly case worker visits, adoptions, continuous quality improvement, independent living, how the contractor uses evidence-based models, programs,

- Continuous Quality Improvement program and including support in meeting the statewide Federal Child and Family Service Reviews (CFSRs)
- Insurance requirements
- Professional development staff training
- Professional accountability, with outcomes of safety, permanency and well-being
- Responsibility for cases transferred to and from the ESA
- The development of an individualized Transitional Living Plan with the involvement and leadership of youth, which describes how youth of various ages and stages of independent living will be assisted in the following areas
- Following the state foster care and guardianship rates and process as outlined in DHHS regulation and policy

9.4. Performance Standards and Outcomes

One of the key areas of focus in a child welfare contract that outsources any aspect of service delivery, service coordination and case management are performance standards and outcomes. From the Original Contract in 2009, to the current contract entered into in 2017, DHHS has assured that the contract terms, including the language agreed to in the Operations Manuals, contained identified language related to performance standards and outcomes. Each contract has required the subrecipient to be responsible for meeting specific outcome measures related to safety, permanency and well-being.

The outcome measures that the subrecipient must meet in the current contract are contained in Section 12 of the Operations Manual, entitled Professional Accountability. These outcome measures are standard Federal child welfare safety measures and are consistently used throughout the national child welfare industry to meet the objectives of enhanced safety, well-being and permanency. They are made applicable to the subrecipient in the contract by way of the Operations Manual.

Section three, subsection 27 of the contract Statement of Work also makes reference to the fact that the Subrecipient is responsible for meeting the outcome measures established by DHHS and federal authorities. This provision also requires the subrecipient develop strategies which contain the action steps necessary to achieve the outcome measures, and "when quarterly indicators are not met, notification must be given to the subrecipient by DHHS and then the subrecipient would be required to develop a Performance Improvement Plan within 14 days. The provision stops short, however, of addressing what takes place if the subrecipient fails to develop a performance improvement plan or continues to fail to achieve the outcomes.

9.4.1. Accountability

As mentioned, the contract performance measures are appropriate child welfare performance measures, since the mainly follow the Federal guidelines. However, under the terms of the

existing contract they have acted more "to guide and measure performance" rather than incentivize desired outcomes.

There are no documented incentives or rewards for meeting the performance measures and there are no real measurable consequences outlined for failure to meet any of the outcomes. When the Subrecipient is unable to meet the desired performance, they are only held to developing and submitting a "Performance Improvement Plan" and there is no well-defined process for assuring the Performance Improvement Plan is acceptable to agency standards, is guided by quality, and will have a substantial likelihood of improving performance. Thus, the contract remedy is vague and unenforceable.

In the past when PromiseShip failed to meet the desired outcomes, DHHS would send a letter to PromiseShip from the ESA and PromiseShip would meet the terms of the contract and submit to the state its Performance Improvement Plan, but there would be no further action or consequences and TSG could find no evidence of any penalties being assessed for failure to meet any of the same outcomes in future reporting periods. Nor could TSG find any evidence of on-going monitoring to ensure that the PromiseShip was in fact making the Improvement Plan practice changes in the next quarter.

In the current contract, the only ability for the state to actually assess any penalties or remedies for non-performance is limited to the following two defined areas:

1. The subrecipient fails to comply with a court order and the court imposes a financial penalty or sanction on DHHS; or
2. The subrecipient fails to comply with any Federal standards or requirements and such financial penalty or sanction is imposed by the Federal Government upon the state as a result of such failure to comply.

Thus, the state's current ability to penalize PromiseShip is very limited and is not directly connected to any failure to meet safety, permanency and well-being outcomes.

By contrast, the states of Florida and Texas operate similar child welfare case management outsource models and have developed contracts with clearly defined consequences for failing to achieve desired outcomes.

In Florida, for example, the contract requires that each community-based care agency acknowledge and agree that its performance under the contract will meet the Federal outcome measures or the state will "provide for graduated penalties for failure to comply with contract terms." The contract goes on to specifically allow for "financial penalties, enhanced monitoring and reporting, corrective action plans, and early termination of contracts or other appropriate action to ensure contract compliance" when any of the Federal and State outcomes are not met. Finally, the Florida outsource contract specifically requires that any financial penalties incurred as a result of not meeting any of the performance measures "require the subrecipient Agency to reallocate funds from administrative costs to direct care for children."

In Texas, where the State outsources service coordination and case management for all pre-foster care "at risk" children and youth, who have been part of an abuse or neglect investigation, in the El Paso region, the state contract with the outsourced contractor identifies the performance measures that the contractor is required to meet, which are based on three key areas: reducing recidivism, successfully closing cases within defined criteria, and reducing the time by which cases are kept open. Texas goes beyond Nebraska in tying these specific outcomes to incentives and remedies, however. The Texas contract specifically incentivizes the contractor to achieve the desired outcomes by providing rewards and remedies tied directly to the outcomes. Where the contractor fails to meet any of the desired outcomes, the contract provides that a portion of the daily rate, which is retained by the state in the form of a holdback, "will be retained" by the state "as a remedy," and where the contractor meets the desired outcome, the "retainage will … accrue" to the contractor. This is a clear example of a performance-based contract with accountability.

9.5. Specific Findings Related to the Actual Contract

1. Lack of clear purpose for outsource: In reviewing the original Nebraska contract, as well as successive contracts and amendments, the purpose defined in the contract sets the base level as to what the State intends to do, rather than why the state is doing so. This purpose is rudimentary and fails to provide guidance to potential vendors and contractors to deliver the best outcomes in a community setting, using community resources. There is no provision that truly embraces such a desired community-based purpose.
2. Contract Terms and Conditions Satisfy Baseline Operational and Financial Standards: The contract terms and conditions adequately cover the key financial and operational standards and the Operations Manual clearly delineates the roles and responsibilities of the parties. The contract also evinces a spirit of collaboration and cooperation in its literal terms, and the state has set appropriate parameters to guide expectations around satisfactory performance.
3. The Contract Lacks Meaningful Incentives and Consequences: As mentioned above, the penalties for failure to meet any of the contract conditions are specifically tied to situations where there has been a monetary fine assessed by a court against the state, or where the Federal government has assessed a fine or penalty against the state for the subrecipient's failure to meet any Federal standards or outcomes. These penalties are not connected to the key safety, permanency and well-being outcomes the state lists in the Operation Manual, and there are no incentives to promote and reward quality outcomes. That is something the state should improve going forward. In the future, there should be an incentive for vendors to do a great job, not merely a good job, especially when it concerns the health and welfare of children.
4. Contract Stability Lacking: There have been successive contracts and amendments with different durations, and there has been a lack of continued stability in the contracting. The initial term was for a five year period, the second contract was for a one year period, and the third one for a two year period. There were successive amendments throughout

extending deadlines and providing for additional funding. Normally, a state contract of this size and magnitude involves a number of employees, subcontracted service providers, and stakeholders, and terms are for extended periods of time with the state having the option to exercise renewals after the original term concludes. This gives both the state and vendor, as well as stakeholders, the sense of stability needed to ensure a well-experienced, dedicated and tenured workforce, as well as the opportunity to make significant capital investments that will improve the quality of services. To the extent the state continues to have short term contracts for the outsource model, it will continuously be forced to plan for a transition back to an insource model, which consumes valuable resources from the organization.

5. The Contract Lacks Flexibility for Innovation: In reviewing the state contract, the Statement of Work, including the Operations Manual, very specifically identifies all the operational expectations and requirements in a manner that does not bode well for any innovation or thinking "out of the box." Understandably, the state wants to assure that any contracted vendor in an outsourced model is abiding by the most appropriate "practice model" especially where the safety and well-being of children in the state's care are involved. However, a number of provisions in the contract that relate to the practice model can be improved upon by a vendor or contractor given the flexibility to deviate, so long as the changes are in line with enhancing child safety and well-being. An important component of a privatized model is for the private vendor to bring to the state enhancements and innovations from the private sector. Thus, where the contract's Statement of Work has requirements that are beyond following Federal or state law or rules, the state could benefit by identifying the standard and then providing for private sector innovation in allowing the vendor to submit a plan to be approved by the state. Here the state would retain the ultimate authority for approval, and the vendor would not be constrained to follow the exact letter of every practice guideline and could utilize enhancements from the private sector.
6. Need for Transparency: Nebraska is lacking some of the public transparency measures used in other states. For example, the Florida Community-Based Care contract requires that the outsourced agencies post on their websites, at a minimum, the following information:

    - The performance on each Federal outcome measure for the previous 12 months;
    - The average caseload of case managers, including only filled positions;
    - The turnover rate for case managers and case management supervisors for the previous 12 months; and,
    - The percentage of required home visits completed.

7. Need for Transition Plan: One of the most important requirements in an outsourced contract is to assure that there is an efficient transition back to the state, if, for some

reason, the contractor no longer offers the service, or another vendor where to be chosen during a subsequent re procurement to assume the contract. We did not find any such provision in the original ESA contract. The Florida contract, for example, contains the following language related to the requirement up front of a transition plan for any selected vendor:

"The Lead Agency shall submit a transition plan six (6) months prior to any contract ending date unless notified by the Department that it intends to renew or extend the contract. If a new provider is awarded the contract, the Lead Agency will meet with the Department and new contracted Lead Agency to develop a mutually agreed upon transition plan."

Nebraska needs to include a similar transition plan requirement in its contract.

8. Need for Further Collaborations: There are a number of state agencies that the outsourced vendor will need to interact with, including the state child investigators on every hand off of a case to case management services. There are also interactions with state and local agencies involved with health, education and law enforcement. Having a clear understanding of roles and responsibilities, as well as ensuring the most effective collaborations will only enhance the case management and foster care experience for a child. The contract should, therefore, place the burden on the outsourced vendor to work collaboratively with all of these agencies and also develop more formalized collaborations so as to reduce any blurred lines and also promote seamless and efficient case management. An example of this is seen at Appendix D where the Florida community-based care agencies are required by contract to enter into a number of different collaborative agreements with state, county, and local community stakeholder agencies.

9.6. Contract Monitoring and Oversight

In a child welfare system reliant on the performance of private providers, contract monitoring and continuous quality improvement are separate, yet inextricably linked components of a comprehensive approach to managing outcomes. This is particularly true in a performance-based or shared risk environment where quality-related outcomes may result in financial rewards or penalties. As DCFS seeks to develop and incorporate performance-based payment criteria into contracts with their subcontracted provider(s), collaboration and coordination between contracting monitoring and continuous quality improvement (CQI) efforts become increasingly important.

Contract monitoring typically reviews and evaluates organizational compliance with statutorily mandated legal and procedural requirements such as employee criminal record / background checks, fingerprinting, training activities, staff turnover and records maintenance. In an integrated system, monitoring must also evaluate fiscal and programmatic components, including compliance with federally mandated sub-recipient requirements, expenditures and cost

allowability, as well as contractually established family and child safety, permanency and well-being outcome expectations.

Quality assurance/CQI activities ensure compliance with federal child-welfare requirements, such as those established within ASFA and monitored through the CFSR but should also focus on validating ongoing compliance with case-specific state policy requirements, adherence to nationally recognized best practices, and the analysis of performance data. This function is responsible for the identification of performance shortfalls, completion of root-cause analysis, development of improvement initiatives, and ongoing monitoring for changes in performance. Together, these efforts and the regular review of performance outcome data drive systems improvement.

TSG met with State Office and ESA staff to identify all of the resources involved in the oversight of the PromiseShip contract. TSG assessed the level of staff resources, qualifications of staff, and the scope of monitoring responsibilities performed and found that that contract oversight staff are experienced, tenured, and express an understanding of the importance of contractual requirements and the linkage between these expectations and a provider's ability to generate quality outcomes. However, while the Contract and Operations Manual provided for clear direction and collaboration around oversight, DCFS has not enforced or continued to carry out these activities. As DCFS shifts toward a truly performance-based contract, a much more structured, coordinated, and better resourced approach to contract monitoring, quality assurance, and utilization management is needed.

TSG found few contract monitoring/oversight activities were contractually delineated. This is consistent with discussions with DCFS leadership staff; leaders confirmed that at the time the state originally outsourced operations in the ESA and later when the case management function transferred to the vendor, the state's approach to managing this contract was intended to be "laissez-faire" and state staff were directed to take a limited approach to contract oversight.[31] This approach fostered a historical relationship between DCFS and PromiseShip that largely allowed the vendor to be independently accountable for their performance.

Over time and especially in recent years as the state identified different needs for oversight, the approach to monitoring the contract evolved. In some cases, the state scaled back resources for monitoring, and in other cases added staff. As an example of the former, the state originally used Child and Family Outcome Monitors (CFOMs) to attend court and conduct document review (of placement changes and court reports). These positions were part of the day-to-day quality assurance activities conducted by DCFS in overseeing the vendor's performance of case management. By January 2018, those positions were reallocated and DCFS amended the contract with PromiseShip so that the state would no longer review and sign off on these tasks. This was viewed positively as a way to reduce cost and redundancy, and evidence of growing trust

[31] Doug Beran phone call 12/12/18.

between DCFS and PromiseShip. Conversely, the state has also added staff. Following the Nebraska Auditor of Public Account's 2018 audit, DCFS created a dedicated position to conduct financial oversight of the vendor.

Although the approach and resources used to manage the contract with PromiseShip have been fluid over time, TSG identified the following current resources at DCFS who are involved with management of the PromiseShip contract:[32]

- State Office contract monitoring: This function is responsible for conducting contract monitoring of all DCFS contractors. The director of this function reports to the Deputy Director Research, Planning and Evaluation. The resources dedicated to this function include 1 director, 1 supervisor, and 14 contract monitors. Of the 14 contract monitors, 1 is dedicated to the PromiseShip contract (though not exclusively, this resources also performs monitoring of other contractors in the Eastern Service Area who do business in other parts of the state). This team performs compliance-oriented monitoring with contractual requirements.
- Eastern Service Area contract management: The Regional Administrator (RA) for the Eastern Service Area is the day-to-day contract manager and provides programmatic oversight of the vendor. The RA is responsible to address concerns and issues as they arise related to the vendor operations, but not the contract. The RA does not have staff solely dedicated to contract management responsibilities; the RA and leadership team perform these duties in addition to their other responsibilities.
- Financial oversight: DCFS recently created a new Financial Administrator position at State Office, who reports to the DCFS Deputy Director. The position has been allocated but DCFS has not yet received approval to fill it.[33] Prior to this dedicated resource, financial data was examined episodically by CFOs or other staff, but no formal financial monitoring activities were built into the contract.

Major findings identified related to contract monitoring:

- It is hard to overcome initial "laissez-faire" approach.
- Contract oversight has been inconsistent.
- Some of the "best practices" in the contract have been watered down or not enforced (i.e., CQI state and local meetings).
- Existing monitoring resources fragmented and can be at odds.
- The monitoring level not tied to contract scope and amount.
- There have been no Utilization Management and weak financial controls until 2018.

[32] Interview with Ross Manhart, 12/12/18.
[33] Email Lori Harder, 12/12/18.

- Transformation of the contract oversight function is needed to manage a truly performance-based contract. Contract monitoring staff will have to be trained and provided with tools to be able to shift to a more performance-based contract monitoring approach.
- Today's monitoring is compliance-based not performance-based: This approach is driven by the fact that the existing contract is not a performance-based contract – staff cannot assess remedies or incentives based on performance so there is a separation between review of the vendor's performance and review of the vendor's contractual compliance. Contract monitoring staff are performing compliance-oriented reviews of the vendor's performance; reviews are not linked to the vendor's performance. There is also a lack of connection between review of performance data and review of financial data and contract requirements.
- Existing staffing resources for monitoring are not aligned to the size and scope of the contract. There is only one part-time monitor on the contract monitoring team assigned to this contract and the financial administrator position has not yet been filled.
- Existing staff resources has been fluid and piecemeal, and the result is fragmentation: Over time, DCFS' approach to managing this contract has changed due to internal and external direction.
- Contract monitoring activities are not data driven: The State Office contract management team does not review performance data and does not review Performance Improvement Plans (PIPs). PIPs are reviewed by the DCFS Director and the Eastern Service Area Administrator, but that review is disconnected from the Contract Monitoring function.
- Staff have indicated that the existing contract is difficult to monitor because contractual language is "broad and vague" and deliverables are not clearly articulated.

10. CONTINUOUS QUALITY IMPROVEMENT

10.1. State CQI Program

TSG identified the following current resources at DCFS who are involved with quality assurance/continuous quality improvement related to the PromiseShip contract:[34]

- State Office Continuous Quality Improvement: This function is responsible for conducting CQI related to all of the Service Areas, including the Eastern Service Area. The Deputy Director of Research, Planning and Evaluation oversees this function, which includes:
    - A case review team (21 allocated positions) who perform CFSR reviews, other targeted reviews, and data analysis and a systems team. For the next two years, this team will be focused primarily on CFSR-related work.
    - A systems team responsible for data analytics and N-FOCUS system changes (approximately 4 allocated positions).
- Eastern Service Area Quality Assurance: The Regional Administrator for the Eastern Service Area conducts programmatic quality assurance activities, including meeting with the vendor on a quarterly basis. There are not dedicated positions for this function; the RA and leadership team are responsible for these activities.

10.2. PromiseShip CQI Program

By contract, the vendor is required to establish a continuous quality improvement program and perform quality assurance activities: "The Subrecipient will develop, implement and monitor improvement plans based on outcomes of quality assurance and subaward/contract monitoring results conducted by DHHS and Subrecipient's internal Quality Assurance system."

Further, required CQI activities (see attachment) are described in the Eastern Service Area's Operations Manual as covering areas of:

1. Federal Compliance including state and federal CFSR reviews,
2. Participation in state CQI activities and workgroups,
3. Provision of information for statewide and local quality assurance reviews,
4. Out-of-home care providers (foster, adoptive, residential, relative),
5. Personnel files,
6. Participation in site visits.

[34] Interview with Ross Manhart, 12/12/18.

A review of PromiseShip's approach to CQI indicates their efforts exceed contractual and operating expectations articulated by DCFS. Further, as an accredited organization, CQI activities are robust, aligned and compliant with recognized standards of best practice.

The structure and approach of their efforts are best described in their Annual Report to DCFS. In summary, the report describes PromiseShip's CQI structure as including five separate workgroups; Operations Management, Quality Management, Risk Management, Staff Management, and Utilization and Network Management. Each workgroup has a specific charter (objective) and annual plan that support PromiseShip's Strategic Plan and agency wide CQI Plan. Workgroups are guided by a chairperson, co-chair, CQI/DM Supervisor, and workgroup members from diverse agency departments and roles.

Workgroups evaluate a variety of inputs (e.g. data reports, survey results, formal and informal feedback) and use these data to inform and develop improvement strategies including formal improvement plans, process updates, and changes to policy and procedure. After initial implementation of an improvement strategy, the workgroups utilize the Plan, Do, Check, Act system to evaluate the implementation, monitor results and make adjustments as needed. PromiseShip workgroups are supported by the CQI/Data Management (DM) Department and the Review and Prioritization Board (RPB). Finally, workgroups are accountable to PromiseShip Executive Team.

PromiseShip's QA staff report they are responsible for conducting a variety of reviews across the agency. These include: operational reviews, case narrative reviews, quality reviews (which include practice specific targeted reviews by worker or topic area), qualitative reviews, and external reviews, including CFSR outcomes. The CQI team is responsible for managing PromiseShip's CQI process and conducting operationalized quality improvement activities. Members of the CQI team attend each QA Workgroup meeting, providing technical assistance and acting as a Subject Matter Expert (SME) to support CQI related activities and improvement strategies. The CQI team also includes oversight of PromiseShip's Records Department. The Records Department is responsible for ensuring the integrity of family case records and managing CQI activities related to the case record.

Similar to DCFS, PromiseShip staff indicate several frustrations with related to their collaboration with the state. In particular, they echo DCFS' quality assurance staff's comments about the limited coordination of quality improvement efforts between the state and provider. For instance, they report the most recent Statewide CQI meeting they participated in was held more than one year ago.

Finally, limitations of the state's data system, N-FOCUS have resulted in the need to procure, implement and utilize external data systems including FamCare and Mindshare to access the information they require to execute effective continuous improvement efforts. In particular, identified issues with N-FOCUS include:

- Data is not current and may be over a month old,

- Data is only accessible via pre-designed reports,
- The provider does not have the ability to create ad-hoc reports,
- The process to have reports created takes an excessive amount of time, and
- The system does not capture usable data for in-home families.

While PromiseShip has robust continuous quality improvement process and has developed internal and external initiatives to address performance shortfalls, it is clear those efforts are not thoroughly shared with the State. As a result, the impression exists that performance concerns are not consistently addressed and ameliorated.

10.3. TSG's findings

The Contract and Operations Manual, which together establish the requirements for the ESA vendor, provide a strong foundation for accountability. However, when examining CQI activities in practice, there are stark differences between what was envisioned and what is occurring. TSG concludes that the state has not maximized its value from the outsourcing of case management but that it is not due to the contract, but rather in oversight provided by DCFS.

Further, state leadership staff (both in State Office CQ and the ESA) are experienced, tenured and well-qualified to complete the work with which they are charged. They relayed ideas to TSG for systems improvement – even improvements that could be implemented within the limits of the existing contract. However, several factors have limited the effectiveness of the CQI program:

- There has been a lack of shared vision and direction provided to internal DCFS CQI resources over the life of the PromiseShip contract on the DCFS approach to managing the contract. Conflicting direction from prior Department executives and the intervention other leaders and stakeholders has resulted in a lack of coordination and clarity in roles and responsibilities between State Office CQI and Eastern Service Area leadership. The result has been some uncertainty and potential duplication. Both entities have been examining performance data on the vendor's performance. Both have had meetings with the vendor (latter is more of a leadership meeting).
- Over time, DCFS has stopped enforcing certain practices which are clearly established in the contract or Operations Manual. For example, the Operations Manual speaks to the use of Performance Improvement Plans (PIPs) when the vendor does not meet performance standards. However, the state has not applied an individual PIP to PromiseShip in several years; PromiseShip is included in the state's PIPs to the federal government but not individually asked to submit a PIP.
- There has been a lack of sustained coordination between DCFS and PromiseShip's CQI functions. The Operations Manual compels the vendor to collaborate with the state and participate in statewide and local CQI meetings. However, these meetings have been suspended due to internal DCFS direction. DCFS's State Office CQI team had been building an inclusive CQI process including meetings with PromiseShip and other

providers and were successful in that effort, but due to resource issues and leadership direction, ceased these activities. As a result, in interviews with TSG, DCFS's CQI staff and PromiseShip CQI staff indicated they have little interaction and do not feel connected to, or collaborative with, quality improvement activities completed by the other.

- In today's contract, there are separate contract managers, contract monitors, financial monitors, and CQI resources. These functions report to different leaders in the organization which may contribute to fragmentation. There may be more efficient ways to use existing resources and improve coordination.
- The level of staff resources is not aligned with the need for CQI. DCFS QA staff expressed the desire to be able to monitor PromiseShip more closely but feel limited due to staff numbers and workloads. The current resources dedicated to the CQI function for this contract are not sufficient. The CQI team has approximately 21 allocated positions statewide, but this team is primarily working on CFSR issues and is not directly related to the monitoring of this contract.

10.4. Utilization Management

Utilization Review or Management is not part of the current approach to DCFS' management of the contract with PromiseShip, although PromiseShip has built its own Utilization Management team who is involved in the authorization of services.

The original contract and its extensions do not discuss establishment of this function at DCFS and DCFS leadership staff have self-identified this gap. The lack of UM function is consistent with the lack of other financial controls in today's contract. A UM function would:

- Compare vendor capacity and the vendor service array with the needs of children and families served;
- Compare vendor capacity to national standards;
- Assess the appropriateness of the amount and scope of services provided to families.

Going forward, as Nebraska implements a performance-based contract with greater financial controls and examines more closely the types of cases it sends to the vendor, the necessity of UM is heightened. This will be discussed further in the Path Forward section of this report.

As noted in the above Contract Section, there is little articulated in the contract that would encourage accountability around "practice" issue improvements and state staff express confusion and feel they have a limited ability to respond when practice issues must be addressed and to ensure the appropriate changes occur. As a result, contract staff express that they do not effectively monitor the public-private partnership to a degree which truly holds the provider accountable.

PromiseShip's contract monitoring staff perform legal compliance reviews of providers they contract with. These reviews are similar in nature and content to the state's contract monitoring

efforts and, in many respects are duplicative. Both state and PromiseShip staff are cognizant of this duplication and, to the degree possible, share significant findings when appropriate.

However, while meeting with staff from agencies that subcontract with both DCFS and PromiseShip, the fact that they are subject to monitoring by both entities was discussed and identified as being somewhat of a burden, as the intent of the reviews are identical. It is worth noting that at least one provider indicated that PromiseShip contract monitoring staff are viewed as being extraordinarily collaborative and accommodating when scheduling and completing contractual reviews.

11. VENDOR PROCESS FINDINGS

TSG compared several aspects of the ESA vendor's process to assess whether the outsource allowed for innovation in the service array, readiness for the Family First Prevention Services Act (FFPSA), and how the vendor performs case management. TSG found:

- The outsourced region has built a robust service array, including several services available nowhere else in the state.
- In preparation for FFPSA, the outsourced region spends a fraction of its budget on preventive services but does place a heavy emphasis on placing children in foster care or kinship care with relatives.
- While the outsourced region's contract limits the ability to implement flexibility in delivering case management, the vendor has worked to improve performance through technology, training and other avenues.
- The case transfer process is lacks clarity and creates challenges for DCFS and PromiseShip.
- DCFS' desire to increase reliance on Alternative Response and Non-Court Voluntary Services should continue since no evidence of harm to safety of children but will require greater collaboration and additional need to reduce case transfer ambiguity.

11.1. Service Array

TSG assessed whether the service array and capacity in the ESA, and whether the vendor demonstrated an ability to build an innovative service array. TSG found that the Eastern Service Area has a more robust supply of providers than the rest of the state and that PromiseShip did built some innovative services in response to the needs of the children and family it serves, through collaboration with providers in the Service Area.

Some of the services could be considered evidence-based by today's FFPSA standards and DCFS may consider evaluating whether any of the new services can be replicated in other regions of the state, since PromiseShip has shown to have a larger array of services than DCFS.

11.1.1. Overview on Nebraska Service Array

Nebraska has been on the cutting edge to provide early intervention services to families through its Maternal, Infant Early Childhood Home Visiting Programs. Nebraska has long been involved in Alternative Response programming in various counties and has focused on poverty screening. These prevention programs are important as Nebraska DCFS works to implement the new federal FFPSA.

With regard to secondary and tertiary prevention efforts, Nebraska has worked hard to reduce its reliance on group care placements and has laid the groundwork statewide to comply with this new federal law. The State of Nebraska has recently embarked on a Statewide child abuse prevention initiative designed to give the local community partnerships a long-term planning

process to address abuse prevention issues in their respective communities. Bring Up Nebraska focuses on preventing crisis through long term planning. The community collaboratives include the following agencies: Dakota County Connections, Douglas County Connections, Families First Partnership (Lincoln County), Fremont Family Coalition, Hall County Community Collaborative, Lancaster County, Life Up Sarpy, Norfolk Family Coalition, Panhandle Partnership, York County Health Coalition and Zero 2 Eight Collaborative. This is cross State agency, public/private not for profit collaborative. It is important to note that the PromiseShip catchment area is included in this overall Statewide effort, but it shows community-based innovation to address issues related to improving safety, permanency and well-being.

However, there are opportunities to continue to improve service delivery and address gaps in the service array. In its 2018 Annual Report, the Foster Care Review Board Annual Report recommends the following to address gaps with the existing service array:

> "Establish an effective, evidence supported, goal driven, outcome-based service array throughout the State to meet the needs of children and families involved in the child welfare system to include the following:
>
> - Preventative services for neglect and substance use in collaboration with DHHS Behavioral Health;
> - Out of home services such a family support and parenting time services that have the least traumatic impact on children;
> - Stabilization of placements and recruitment of foster parents based upon the needs of the child/youth in collaboration with foster care providers;
> - Creation of treatment foster care services which actively engage families and would meet the needs of older youth;
> - In-home supports for foster parents especially relative/kin placements;
> - Mental and behavioral services for children/youth in collaborations with DHHS Behavioral Health;
> - Developmental disability services for children/youth in collaboration with DHHS Developmental Disabilities; and,
> - Enhanced services and case management for older youth."

11.1.2. PromiseShip Requirements Regarding Service Array

The Nebraska DHHS 2017-18 Contract with PromiseShip states that:

> The subrecipient is responsible to develop and sustain an array of services and supports designed to meet the unique needs of children and families. All services and supports must be accessible to all children and families served by the subrecipient in the Eastern Service Area. The service array will include services and supports that assess the strengths and needs of children and families; addresses the need of families in addition to individual children in order to create a safe home environment, enable children to remain

safely with their parents when reasonable and assist children in foster and adoptive placements achieve permanency. The service array must be inclusive of practices that are evidence based, trauma informed and culturally and linguistically appropriate.

11.1.3. TSG Findings about PromiseShip's Array

PromiseShip has demonstrated innovation in its service array, including creation of new programs and use of evidence-based programs.

PromiseShip has developed several services based on needs identified in the Eastern Service Area.[35] These services are not all evidence-based programs, but they have been developed in response to specific needs identified and built in collaboration with other stakeholders in the area.

Some examples of new services developed include:

- Intensive In-Home I and II: This service is used for family stabilization/preservation and includes intensive interventions to help children/families develop skills to achieve safety and stability. Level I is designed for in-home families and Level II is designed for either in-home families or families that are reunifying. The levels differ based on the intensity of services. Level II includes the option of team delivered services, with an involved clinician. Level II is intended to be a more short-term service (90 days), while Level I has the expectation that goals can be accomplished between 120-160 days.[36]
- Integrated Family Care Program: In response to the need to address families with housing issues/homelessness, PromiseShip developed this 90 day program, which places the whole family into a mentor home. There is a second level to the program that allows the family to transition into a rental home.
- Pathways to Permanency program: Out of recognition that families are often going to multiple providers for services which can result in logistical challenges such as transportation and result in fragmented care (i.e., through multiple service plans), PromiseShip, providers, and the Child Saving Institute built an all-inclusive agency model so that families can go to one provider to receive multiple services. There are approximately 6 agencies that offer this service today.
- Professional foster care: In response to a lack of Medicaid-funded services for children with a level of needs, PromiseShip built this program which pays foster parents a higher rate so one of the parents can provide one-on-one care for the child (in lieu of other employment).

[3535] Notes from 10/22/18 meeting with PromiseShip.
[36] Services Quick Reference Guide for CRI.

PromiseShip has also incorporated evidence-based services including but not limited to:

- Nurturing Parenting
- Shared Family Care
- Teaching Family Model
- Common Sense Parenting
- Bridges out of Poverty
- Trauma Systems Theory
- Safe and Connected
- Motivational Interviewing
- Homebuilders IFP model; and,
- Cognitive Behavioral Therapy.

The extent to which these services are used (measured in expenditures and clients served) will be discussed further as part of assessing the state's readiness for FFPSA.

DCFS has expressed concern that some of these services such as professional foster care are not cost effective for the state and the rates paid in the ESA have created challenges for replication. TSG reviewed national data from the Report on a 2012 National Survey of Family Foster Care Provider Classifications and Rates, and the breakdown of rates paid in Nebraska, and finds that the rate is not out of line with what other states pay for their highest needs youth. In addition, this service is only used for approximately 8 children (that is a point in time count in November 2018), so it is not a significant cost driver. It can be one of many tools in the service array, and with appropriate Utilization Management, can be limited for youth with complex needs.

11.2. Alignment with Requirements of Family First Prevention Services Act (FFPSA)

The Bipartisan Budget Act of 2018 (H.R. 1892), signed in February 2018, includes sweeping changes to child welfare funding through the inclusion of the Family First Prevention Services Act (FFPSA). This legislation significantly alters how Title IV-E funds can be spent by states. Prior to the Act's passage, Title IV-E funds could only by used to cover the cost of foster care maintenance for eligible children in out-of-home care; administrative expenses to manage the program; and training for staff, foster parents, and certain private agency staff; adoption assistance; and kinship guardianship assistance.

Under the new law, jurisdictions with an approved Title IV-E plan will be able to use Title IV-E funds to cover the cost of prevention services that would support the ability of youth at imminent risk of entering foster care to remain living in the home of their primary caretaker; parents or relatives. States will be reimbursed for 50% of the cost of prevention services for up to 12 months. Trauma-informed prevention plan must be created, and services are required to be evidence-based, meaning the efficacy and long-term impact of the services implemented have been assessed using a rigorous evaluation protocol.

The Act also seeks to reduce the use of congregate or group care placement while placing a stronger emphasis on the placement of children in the homes of qualified relatives or family foster homes. Unless a child qualifies for placement in a treatment-based setting known as a Qualified Residential Treatment Program, is a victim of (or is at risk of) being sexually trafficked, is pre- or post-natal and in need of parenting support or is in a supervised setting for youth 18 or older, the federal government will not reimburse states for children placed in group care settings for more than two weeks. Residential settings identified as QRTPs must include a trauma-informed treatment model, be accredited by a nationally recognized accrediting body, and employ registered or licensed nursing staff and other licensed clinical staff in the care and treatment of children in their care.

The child must be formally assessed by a party independent of the state agency or residential facility within 30 days of placement to determine if his or her needs can be met by family members, in a family foster home or another approved setting. The lack of available relative of foster family placement is not sufficient to qualify a child for placement in a QRTP. Though federal guidance surrounding the scope and content of this assessment has not been released, the intent of the Act is clear in that it will serve to limit the ability of states to use congregate care placements for all but those youth who have the most significant needs.

As passed, the legislation largely becomes effective in October 2019 (Federal Fiscal Year 2020). However, states, tribes and territories were afforded to delay implementation of FFPSA for a period of up to two years to permit sufficient time to implement policy or systemic changes necessary. The election to delay implementation of FFPSA was to be submitted by November 9, 2018. With the exception of requirements related to the criminal record and registry checks for staff working in child care institutions, DHHS elected to pursue implementation of authorized, eligible prevention services.

11.2.1. FFPSA Eligible Prevention Services[37]

State Title IV-E agencies may claim reimbursement for mental health and substance abuse prevention and treatment services provided by qualified clinicians, and in-home[38] parent skill-based programs that include parenting skills training, parent education, and individual and family counseling that have been rated and approved by the Title IV-E Prevention Services Clearinghouse and are identified in the state's five-year Title IV-E prevention program plan (section 471(e)(1) of the Act). Additionally, interventions designed to offer support and assistance "navigating" the child welfare system will also be eligible for federal reimbursement.

[37] Extracted from ACYF-CB-PI-18-09, published 11/30/18
[38] The term In-home services has been federally interpreted as the setting where the child is continuing to reside rather than the location where the service is offered or provided.

Title IV-E prevention services must be rated as promising, supported, or well-supported in accordance with HHS criteria and be approved by HHS (section 471(e)(4)(C) of the Act) and included as part of the Title IV-E Prevention Services Clearinghouse (section 476(d)(2) of the Act). Revised criteria published by the Administration for Children and Families on November 30, 2018 further clarify their approach to evaluating and assessing evidence-based services as meeting these criteria.

FFPSA requires: "At least 50 percent of the amounts expended by the state for a fiscal year (FY) for the Title IV-E prevention program must be for services that meet the well-supported practice criteria (section 474(a)(6)(A)(ii) of the Act). The state may provide Title IV-E prevention services as specified in the child's prevention plan for up to 12 months beginning on the date the state identifies the child as either a "candidate for foster care" or a pregnant or parenting foster youth in need of those services (sections 471(e)(2)(A) and (B) of the Act) (see section B.1 below). The state may claim Title IV-E reimbursement for prevention services until the last day of the 12th month if services were provided for the entire 12-month period, or if services are provided for less than the entire 12-month period, the end of the month in which the child's Title IV-E prevention services ended.

A state may provide Title IV-E prevention services to or on behalf of the same child for additional 12-month periods, including for contiguous 12-month periods. In order to claim Title IV-E for each additional 12-month period, the state must determine and document in the child's prevention plan that the otherwise eligible candidate for foster care or pregnant/parenting youth meets the requirements in section 471(e)(4)(A) of the Act on a case-by-case basis."

The Clearinghouse will rate a service or program as a 'promising,' 'supported,' or 'well-supported' practice if it meets the below criteria that collectively assess the strength of evidence for a practice and build from the *Study Rating Criteria* [section 471(e)(4)(C) of the Act].

Promising Practice: A service or program will be rated as a 'promising practice' if the service or program has at least one study that achieves a rating of 'moderate' or 'high' on Study Design and Execution and demonstrates a favorable effect on at least one 'target outcome.'

Supported Practice: A service or program will be rated as a 'supported practice' if the service or program has at least one study carried out in a usual care or practice setting that achieves a rating of 'moderate' or 'high' on Study Design and Execution and demonstrates a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome.

Well-Supported Practice: A service or program will be rated as a 'well-supported practice' if the service or program has at least two studies with non-overlapping analytic samples carried out in a usual care or practice setting that achieve a rating of 'moderate' or 'high' on Study Design and Execution. At least one of the studies must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.

Does Not Currently Meet Criteria: A service or program will be rated as 'does not currently meet criteria' if the service or program has been reviewed and does not currently meet the evidence criteria for 'promising,' 'supported,' or 'well-supported" practices.

11.2.2. Evidence Based Services Under Review

Presently, the Title IV-E Prevention Services Clearinghouse is in the process of reviewing and rating services for HHS approval. The first services and programs selected for systematic review met at least two of the following conditions:

1. recommendation from state or local government administrators in response to the FRN;
2. rated by the California Evidence-Based Clearinghouse;
3. evaluated by Title IV-E Child Welfare Waiver Demonstrations;
4. recipient of a Family Connection Discretionary Grant; and/or
5. recommendation solicited from federal partners in the Administration for Children and Families, Health Resources and Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Office of the Assistant Secretary for Planning and Evaluation, and the Substance Abuse and Mental Health Services Administration.

Evidence based services presently being reviewed by the Clearinghouse include:

Mental Health:

a. Parent-Child Interaction Therapy
b. Trauma Focused-Cognitive Behavioral Therapy
c. Multisystemic Therapy
d. Functional Family Therapy

Substance Abuse:

a. Motivational Interviewing
b. Multisystemic Therapy
c. Families Facing the Future
d. Methadone Maintenance Therapy

In-Home Parent Skill-Based:

a. Nurse-Family Partnership
b. Healthy Families America
c. Parents as Teachers

Kinship Navigator Programs

a. Children's Home Society of New Jersey Kinship Navigator Model

b. Children's Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)

Findings from the review of the initial programs being reviewed are scheduled for release in Spring 2019. After completing the review of the initial services selected, the Clearinghouse will select additional services and programs for review on a rolling basis using the revised initial criteria.

11.2.3. State Plan Requirements

The state is required to describe how it will assess children and their parents or kin caregivers to determine eligibility for Title IV-E prevention services and describe the HHS approved services the state will provide, including:

- whether the practices used to provide the services are rated as promising, supported, or well-supported in accordance with the HHS practice criteria as part of the Title IV-E Prevention Services Clearinghouse;
- how the state plans to implement the services, including how implementation of the services will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;
- how the state selected the services;
- the target population for the services;
- an assurance that each HHS approved Title IV-E prevention service provided in the state plan meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (Attachment III); and
- how providing the services is expected to improve specific outcomes for children and families.

In addition, States must include a well-designed and rigorous evaluation strategy for each service they elect to implement, which may include a cross-site evaluation approved by ACF. The Children's Bureau may waive the evaluation requirement for a well-supported practice if the evidence of the effectiveness of the practice is compelling and the state meets the continuous quality improvement requirements identified in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice.

Finally, additional guidance and procedures for states, territories and tribes seeking to implement evidence-based services approved by the clearing house will be published in the upcoming Title IV-E Prevention Services Clearinghouse Procedures Handbook.

11.2.4. Maintenance of Effort (MOE)

The November 2018 Program Instruction provides clarification to states surrounding the calculation of MOE. FFPSA requires states to use Title IV-E prevention services to supplement,

and not supplant, FY 2014[39] "state foster care prevention expenditures", as defined by the Act. After implementing FFPSA, the state agency is then required to maintain at least the same level of "state foster care prevention expenditures" each FY as the amount the agency spent in FY 2014.

Federal statute defines "state foster care prevention expenditures" as:

- State expenditures and federal matching funds provided to the state for Title IV-B, Temporary Assistance for Needy Families (TANF), and the Social Services Block Grant (SSBG); and
- State expenditures for foster care prevention services and activities under any other state program (except Title IV-E).

ACF has clarified that state foster care prevention services and activities must have been approved by the Title IV-E Prevention Services Clearinghouse as being allowable for Title IV-E prevention reimbursement and meeting the standards outlined in the statute at section 471(e)(4) of the Act as follows:

- Services or activities are one of the allowable types of services:
    - Mental health and substance abuse prevention and treatment services; or
    - In-home parent skill-based programs that include parenting skills training, parent education, and individual and family counseling;
- Populations served are children who are candidates for foster care, pregnant or parenting youths in foster care, or their parents and kin caregivers;
- Services are rated as well-supported, supported, or promising as outlined in the law and in accordance with HHS practice criteria as part of the Title IV-E Prevention Services Clearinghouse; and,
- Services or activities are trauma-informed.

Finally, "state foster care prevention expenditures" must include only those prevention services or activities that have been approved by the Title IV-E Prevention Services Clearinghouse at the time the state submits its initial five-year prevention plan.

11.2.5. Payor of Last Resort

Federal requirements have identified Title IV-E to be the payor of last resort for interventions which may be covered by public or private third-party payors, including private insurance or Medicaid. However, use Title IV-E prevention program funding may be used, pending

[39] States with less than 200,000 children may opt to use an alternate funding year to calculate their MOE baseline.

reimbursement from the public or private source that has ultimate responsibility for the payment, to prevent delaying the timely provision of appropriate early intervention service.

11.2.6. Alignment of PromiseShip's Service Array with FFPSA

As the subcontracted provider responsible for the largest child welfare service area population in Nebraska, the ability of PromiseShip to establish and provide an array of well-supported evidence-based services is critical to the State's ability to draw down federal funding for prevention activities provided to children at imminent risk of entering foster care.

DCFS has taken a pro-active approach to the new legislation and, as previously mentioned, intends to implement Title IV-E reimbursable prevention services in October 2019. A series of workgroups and committees have been established, each responsible for a separate requirement of the act or within the state Title IV-E plan. These groups have begun to meet and are actively publishing their progress on a department-maintained website[40]; In addition, the department is preparing an RFP for evidence-based prevention services which is scheduled for release in the imminent future.

Through correspondence and interviews with DCFS staff, TSG has determined that the only contracted evidence-based child welfare service is a Family Centered Treatment (FCT) pilot project initiated in November 2018. However, this service is not presently being evaluated by the federal FFPSA Clearinghouse and is listed on the California Evidence-Based Clearinghouse as a Promising Practice. While the intervention is relevant for the child welfare population, it is unlikely to reach the level of a Well-Supported Practice in the near future. As a result, this intervention will only be federally reimbursable if statewide Well-Supported practices are implemented, offered with fidelity and account for 50% of evidence-based service related expenditures. Presently, there are other child welfare services available across the state which may contain a component of an evidence-based model but are not provided with full fidelity to the model.

Similarly, PromiseShip reports having contracts with multiple providers who offer evidence-based interventions as part of the program model or prevention services they are contracted to provide. It is important to note that only three of the following interventions, Trauma Focused Cognitive Behavioral Therapy, Parent Child Interactive Therapy and Motivational Interviewing, are currently being reviewed by the FFPSA Clearinghouse. Of the remaining therapies offered, those rated Promising, Supported or Well Supported by the California Clearinghouse are likely to be similarly rated by the FFPSA Clearinghouse. Beyond the timelines for service approval already articulated by ACF, it is not clear when additional services may be selected for review. Services provided by PromiseShip's subcontractors include:

[40] http://dhhs.ne.gov/children_family_services/FamiliesFirst/Pages/Agendas-and-Minutes-.aspx

Table 28: Services Provided by PromiseShip's Subcontractors.

Intervention	CEBC - Scientific Rating	Currently Under Review by FFPSA Clearinghouse
Cognitive Behavioral Therapy	1 - Well Supported by Research Evidence	
Cognitive Processing Therapy	1 - Well Supported by Research Evidence	
EMDR	1 - Well Supported by Research Evidence	
Incredible Years	1 - Well Supported by Research Evidence	
Motivational Interviewing	1 - Well Supported by Research Evidence	Yes
Parent Management Training	1 - Well Supported by Research Evidence	
Parent Child Interactive Therapy	1 - Well Supported by Research Evidence	Yes
Trauma Focused Cognitive Behavioral Therapy	1 - Well Supported by Research Evidence	Yes
Child-Parent Psychotherapy	2 - Supported by Research Evidence	
Common Sense Parenting	2 - Supported by Research Evidence	
Homebuilders	2 - Supported by Research Evidence	
Seeking Safety (adult)	2 - Supported by Research Evidence	
Circle of Security	3 - Promising Research Evidence	
Life Space Crisis Intervention	3 - Promising Research Evidence	
Nurturing Parenting	3 - Promising Research Evidence	
Systemic Training for Effective Parenting (STEP)	3 - Promising Research Evidence	
Teaching Family Model	3 - Promising Research Evidence	
Celebrating Families	NR - Not able to be Rated	
Strengthening Families	NR - Not able to be Rated	
Trauma Systems Therapy	NR - Not able to be Rated	

Intervention	CEBC - Scientific Rating	Currently Under Review by FFPSA Clearinghouse
C3 De-Escalation	Not listed on CEBC	
Dialectical Behavioral Therapy	Not listed on CEBC	
Living in Balance	Not listed on CEBC	
Moral Recognition Therapy	Not listed on CEBC	
Shared Family Care	Not listed on CEBC	

While service providers under contract with PromiseShip may offer the above-referenced evidence-based services, there is no evidence that they are offered with a high degree of fidelity to the model or that data is collected to support the efficacy of individual interventions. The requirement to do so is new and will be imperative when it comes to implementing and being reimbursed for services rated less than well-supported by the FFPSA Clearinghouse.

In addition, during fiscal year 2018, PromiseShip reports expenditures of $2.5 Million for intensive in-home services (level I, and II), approximately 3.63% of a $70 million budget. While expenditures of this level for prevention services is commensurate with budgets reported by other private child welfare lead agencies in states such as Florida, funding at this level is extraordinarily low in consideration of the intent of FFPSA.

The following table offers a breakdown of provider payments for Intensive In-Home (preservation) services, as those expenditures are most likely to be eligible for reimbursement under FFPSA. These providers are often paid on a case-rate basis and expenditures were not tracked by intervention type, as a result it is difficult, if not impossible, to accurately assess the degree to which expenditures were made for well-supported interventions. It is worth noting, the requirement to expend prevention-related funding on the basis of a particular type or level of intervention has never been a federal requirement and has only been a consideration since passage of the Act in early 2018. Services listed on the California Evidence Based Clearing house which are offered by these providers and likely to be qualified as Promising, Supported or Well Supported by the FFPSA Clearinghouse are also identified in the chart.

Table 29: Services listed on the California Evidence Based Clearing house

In-Home Preservation Service Level & Provider	CEBC Listed EB Practice(s) Provided for Intensive In-Home	FY2018 Expenditure
Intensive In-Home Level 1		
APEX	Nurturing Parenting	$12,451
Boys Town	Teaching Family Model, Common Sense Parenting	$512,252
CSI	Circle of Security, Nurturing Parenting	$ 92,758
Heartland Family Service	Nurturing Parenting, Circle of Security, Cognitive Processing Therapy, Incredible Years, TF-CBT	$208,766
KVC	Motivational Interviewing	$76,798
OMNI	Kazdin Parent Management Training, Homebuilders	$80,817
Owens and Associates	Motivational Interviewing and Nurturing Parenting	$14,411
Paradigm Inc.	Nurturing Parenting, Motivational Interviewing, Cognitive Behavioral Therapy, Systemic Training for Effective Parenting	$125,882
Release Ministries	Strengthening Families, LifeSpace Crisis Intervention	$ 224,630
Total Expenditures Level 1		$ 1,348,765
Intensive In-Home Level 2		
APEX	Nurturing Parenting	$3,903
Boys Town	Teaching Family Model, Common Sense Parenting	$291,447
CSI	Circle of Security, Nurturing Parenting	$28,628
Heartland Family Service	Nurturing Parenting, Circle of Security, Cognitive Processing Therapy, Incredible Years, TF-CBT	$307,839
KVC	Motivational Interviewing	$59,487
OMNI	Kazdin Parent Management Training, Homebuilders	$ 175,956
Paradigm Inc.	Nurturing Parenting, Motivational Interviewing, Cognitive Behavioral Therapy, Systemic Training for Effective Parenting	$77,364
Release Ministries	Strengthening Families, LifeSpace Crisis Intervention	$250,501
Total Expenditures Level 2		$ 1,195,126

Therefore, TSG recommends that DCFS continue to work with PromiseShip to ensure that it is spending the appropriate focused attention, time and money on the types of prevention services that are classified or will be classified as "well-supported" by the Federal government and that the spending on prevention-related programs meets applicable Federal standards. The fact that

access to providers who have been trained or have the ability to be trained and offer these programs is greater in the ESA than other areas of the State, should cause concern to DCFS that PromiseShip is spending such a low amount today on high fidelity prevention. This could substantially impact the State's ability to draw down Federal funds in the next few months when the FFPSA funding kicks in. DCFS should continue to work with PromiseShip on this issue today, but also ensure that the next contract requires that the vendor meet certain benchmarks related to FFPSA or be held liable to meaningful consequences for failure to meet the required level and program funding and fidelity.

11.2.7. Licensed Relative Foster Care

FFPSA places a heavy emphasis on placement of youth into licensed relative foster homes. In order to maximize title IV-E reimbursement, it will be imperative that all areas of the state, but in particular the Eastern Service Area, seek to maximize federal reimbursement for youth in out-of-home relative care.

As depicted in Table, fiscal Year 2018 expenditures for relative foster care totaled $7,690,957. Of this $571,333.50 (7.43%) was for children in licensed relative placements.

Further delineating expenditure data by IV-E eligible and non-eligible expenditures identifies 44.81% of expenditures as being made for title IV-E eligible children. PromiseShip presently identifies approximately 17% of relative/kinship providers are licensed. This is typical in that relative caregivers often perceive licensing requirements to be intrusive or onerous considering they are providing care to children they are related to. During FY2018, $3.18 million dollars were expended for title IV-E eligible children placed in the homes of unlicensed relatives. As a result, these expenditures were not federally reimbursable, as shown in Table.

Table 30: Fiscal Year 2018 Expenditures for Relative Foster Care

	Qtr1	Qtr2	Qtr3	Qtr4	FY 2018 Total
CRI FC – Relative/Kinship Licensed (0-5)	$40.00			$140.00	$180.00
CRI FC – Relative/Kinship Licensed (12-18)				$175.00	$175.00
CRI FC – Relative/Kinship Licensed (6-11)				$161.00	$161.00
CRI Relative/Kinship FC (0-5)	$12,520.00	$7,600.00	$8,420.00	$7,740.00	$36,280.00
CRI Relative/Kinship FC (12-18)	$7,950.00	$6,400.00	$2,450.00	$4,525.00	$21,325.00
CRI Relative/Kinship FC (6-11)	$8,349.00	$5,681.00	$7,015.00	$7,475.00	$28,520.00
FC – Relative/Kinship Licensed (0-5)	$45,935.00	$56,992.50	$64,767.50	$80,615.00	$248,310.00
FC – Relative/Kinship Licensed (12-18)	$10,842.50	$21,315.00	$34,350.00	$37,590.00	$104,097.50
FC – Relative/Kinship Licensed (6-11)	$39,502.00	$50,935.50	$62,186.50	$65,786.00	$218,410.00
Relative/Kinship FC (0-5)	$673,300.00	$639,232.50	$602,807.50	$579,472.50	$2,494,812.50
Relative/Kinship FC (12-18)	$562,747.00	$573,833.00	$546,827.50	$550,360.50	$2,233,768.00
Relative/Kinship FC (6-11)	$598,902.50	$598,796.00	$566,094.50	$541,125.00	$2,304,918.00
Grand Total	$1,960,088.00	$1,960,785.50	$1,894,918.50	$1,875,165.00	$7,690,957.00

Table 31: Non-IV-E Eligible Expenses

IV-E Non-Eligible	Qtr1	Qtr2	Qtr3	Qtr4	FY 2018 Total
CRI FC – Relative/Kinship Licensed (0-5)	$40.00			$140.00	$180.00
CRI FC – Relative/Kinship Licensed (12-18)				$175.00	$175.00
CRI FC – Relative/Kinship Licensed (6-11)				$161.00	$161.00
CRI Relative/Kinship FC (0-5)	$11,700.00	$4,920.00	$8,400.00	$5,140.00	$30,160.00
CRI Relative/Kinship FC (12-18)	$7,675.00	$6,175.00	$2,450.00	$4,225.00	$20,525.00
CRI Relative/Kinship FC (6-11)	$7,659.00	$3,818.00	$7,015.00	$4,301.00	$22,793.00
FC – Relative/Kinship Licensed (0-5)	$30,980.00	$25,650.00	$28,817.50	$39,285.00	$124,732.50
FC – Relative/Kinship Licensed (12-18)	$4,575.00	$11,270.00	$21,500.00	$21,192.50	$58,537.50
FC – Relative/Kinship Licensed (6-11)	$22,533.50	$30,728.00	$34,090.50	$33,951.00	$121,303.00
Relative/Kinship FC (0-5)	$396,087.50	$319,552.50	$309,335.00	$277,032.50	$1,302,007.50
Relative/Kinship FC (12-18)	$352,794.50	$353,243.00	$340,065.00	$332,975.50	$1,379,078.00
Relative/Kinship FC (6-11)	$327,679.00	$286,357.00	$281,141.50	$289,663.00	$1,184,840.50
IV-E Non-Eligible Total	$1,161,723.50	$1,041,713.50	$1,032,814.50	$1,008,241.50	$4,244,493.00
IV-E Eligible					
CRI Relative/Kinship FC (0-5)	$820.00	$2,680.00	$20.00	$2,600.00	$6,120.00
CRI Relative/Kinship FC (12-18)	$275.00	$225.00		$300.00	$800.00
CRI Relative/Kinship FC (6-11)	$690.00	$1,863.00		$3,174.00	$5,727.00
FC – Relative/Kinship Licensed (0-5)	$14,955.00	$31,342.50	$35,950.00	$41,330.00	$123,577.50
FC – Relative/Kinship Licensed (12-18)	$6,267.50	$10,045.00	$12,850.00	$16,397.50	$45,560.00
FC – Relative/Kinship Licensed (6-11)	$16,968.50	$20,207.50	$28,096.00	$31,835.00	$97,107.00
Relative/Kinship FC (0-5)	$277,212.50	$319,680.00	$293,472.50	$302,440.00	$1,192,805.00
Relative/Kinship FC (12-18)	$209,952.50	$220,590.00	$206,762.50	$217,385.00	$854,690.00
Relative/Kinship FC (6-11)	$271,223.50	$312,439.00	$284,953.00	$251,462.00	$1,120,077.50
IV-E Eligible Total	$798,364.50	$919,072.00	$862,104.00	$866,923.50	$3,446,464.00
Grand Total	$1,960,088.00	$1,960,785.50	$1,894,918.50	$1,875,165.00	$7,690,957.00

12. REVIEW OF PROMISESHIP CASEWORKER PROCESSES

TSG engaged in a review of PromiseShip's operations to identify similarities and meaningful differences in how it performs the case management function and the related outcomes it achieves. TSG met with PromiseShip leadership/administrative staff, supervisors, and Family Support Workers (caseworkers), including staff from Douglas and Sarpy counties.

TSG observed many similarities in how PromiseShip's and DCFS' caseworker and supervisory staff perform case management for ongoing cases; the vendor is subject to the same state and federal requirements and the contract and Operations Manual are prescriptive.

The Operations Manual explicitly states that PromiseShip must meet all statutory, DCFS regulations, policy, administrative memos, and local protocol for ongoing cases including court and non-court families. The Operations Manual does not create exemptions from such requirements. In addition, the vendor must mirror the processes used by the state in several key areas which informs how workers do the day-to-day job:

- Training: All Family Permanency Specialists and Family Permanency Specialist Supervisors at PromiseShip must participate in the same pre-service training related to Child and Family Services, which is offered by the University of Nebraska-Lincoln Center on Children, Families and the Law.
- Decision Making: PromiseShip staff must be trained in and use the same Structured Decision Making® (SDM) assessment tools (and same construction of safety and risk) throughout the life of the case, which informs key case actions (i.e., decision to remove, decision to reunify, placement).

TSG also observed areas in which PromiseShip's FSRs operate differently from the state, in the areas in which it has been permitted to innovate. Some examples (not an exhaustive list) of these differences include:

- Additional proprietary training program;
- Organization of teams by court/judge to maximize efficiencies;
- Mobile workforce, aided by technology;
- Electronic filing of court reports (in Douglas County);
- Creation of a 24-hour "after hours" unit to respond to intakes and emergencies after hours (which could otherwise be a worker responsibility)

Some findings from staff interviews and observation:

1. It is unrealistic to expect significantly different performance outcomes if so, much of how the vendor has to do the job is the same as the State's.

2. PromiseShip has implemented process improvements over time and shown the ability to identify innovative practice solutions. A vendor could go further if permitted to by Contract or Operating Manual.
3. Ambiguity remains in the case transfer process. Although the Operations Manual addresses this process, but TSG found gaps in comprehensiveness of this process and staff. Staff indicated there was a general process flow and provided TSG with high level flow charts. However, in interviews, they identified points in the process where ambiguity exists and where staff do not always adhere to the process.

There is a need to clarify the case transfer process to ensure the state and vendor have an understanding of the roles involved, responsibilities, tasks, and sequence of the process. Process mapping is a business planning and management method that describes and illustrates the flow of work by formal components of a system. Process mapping has many uses including planning, assuring effective and efficient work flow, identifying gaps or ambiguous processes, operations monitoring, and can be an evaluation tool when tied to process and outcomes related data.[41]

Based on TSG's experience with the Texas child welfare system, TSG has found value of process mapping for leadership, managers, and caseworkers in terms of process compliance and the ability to identify process improvements. In order to accurately map the "as is" case transfer process, so that recommendations can be made for the "to be" process, TSG conducted focus groups with PromiseShip and DHHC caseworkers and supervisors in both Douglas and Sarpy Counties. Our objectives for this task were to document the case transfer process (from the point of intake through the transfer of case management to PromiseShip), assess overall process compliance with the Operations Manual[42] for the Intake, In-Home, and Out-of-Home casework processes in the Eastern Service Area, and identify any operational concerns and recommendations for improvements.

The following process maps are swim lane diagrams, which capture tasks in the swim lane of the responsible party. The maps begin in the upper left corner and are read from left to right and top to bottom. The rectangles are process steps and the diamonds represent decision nodes where multiple outcomes are possible.

12.1. Hotline Intake Process

The Hotline Intake Process Map illustrates the process steps and responsible DCFS roles from the point of receipt of a telephone call through the assignment to an Initial Assessment (IA) worker for an investigation. Using the SDM Intake Screening decision-making process, hotline workers accept or reject the intake. Intakes that are not accepted may be closed or referred to the

[41] "Using Concept Mapping as a Planning Tool: Child Welfare Citizens Review Panels"; J. J. Miller and Blake Jones; Evaluation and Program Planning; Vol. 53, Dec., 2015, pp. 99-106
[42] Eastern Service Area Operations Manual; 1/23/2018

Alternative Response model, FAST, or a community resource. Accepted intakes are assigned a priority and assigned to an IA worker.

12.2. In-Home Case Transfer Process Map

The In-Home process map illustrates the process from the point of assignment of a case to an IA worker through the point at which case management transfers to the PromiseShip caseworker. The pentagon shape with the text “In-Home Link” connects the prior map to this page in the upper left corner.

Unlike the previous process for the intake function which is performed exclusively by state workers, this process map includes the roles of state and vendor staff. This map is not inclusive of every task performed by an IA worker during an investigation and some attempts were made to consolidate tasks related to gathering evidence and completing the Safety and Risk Assessments.

The map captures the decision logic on which cases transfer to PromiseShip. In-Home cases may be Safe or Conditionally Safe with a Plan. If the IA worker finds the family is Unsafe, the path followed flows onto the Out-of-Home process map. In addition to a determination of Safety/Risk, the decision to transfer a case to PromiseShip is ultimately determined based on whether the IA worker discerns that the family needs case management or can be referred directly to community providers.

The transfer process culminates in a staffing, after which case management is transferred to the PromiseShip worker, though the IA worker has some final tasks in N-FOCUS to complete. The process also includes an optional joint family visit if the workers agree it may be helpful for the family.

12.3. Out-of-Home Case Transfer Process Map

The Out-of-Home process map begins at the point in which the IA worker determines the child/youth is unsafe, and is inclusive of the tasks performed by DCFS, the county attorney, and PromiseShip staff through the transfer of case management. As depicted, DCFS staff engage PromiseShip at different points in the organization throughout this transfer process, including initially if services are needed, and later when case management transfers. During the engagement of PromiseShip Utilization Management staff to start services, the IA worker remains the primary worker on the case.

The formal case transfer occurs after the Protective Custody Hearing, though as with In-Home cases, the IA worker has remaining tasks to complete.

Figure 33: Eastern Service Area Intake Process

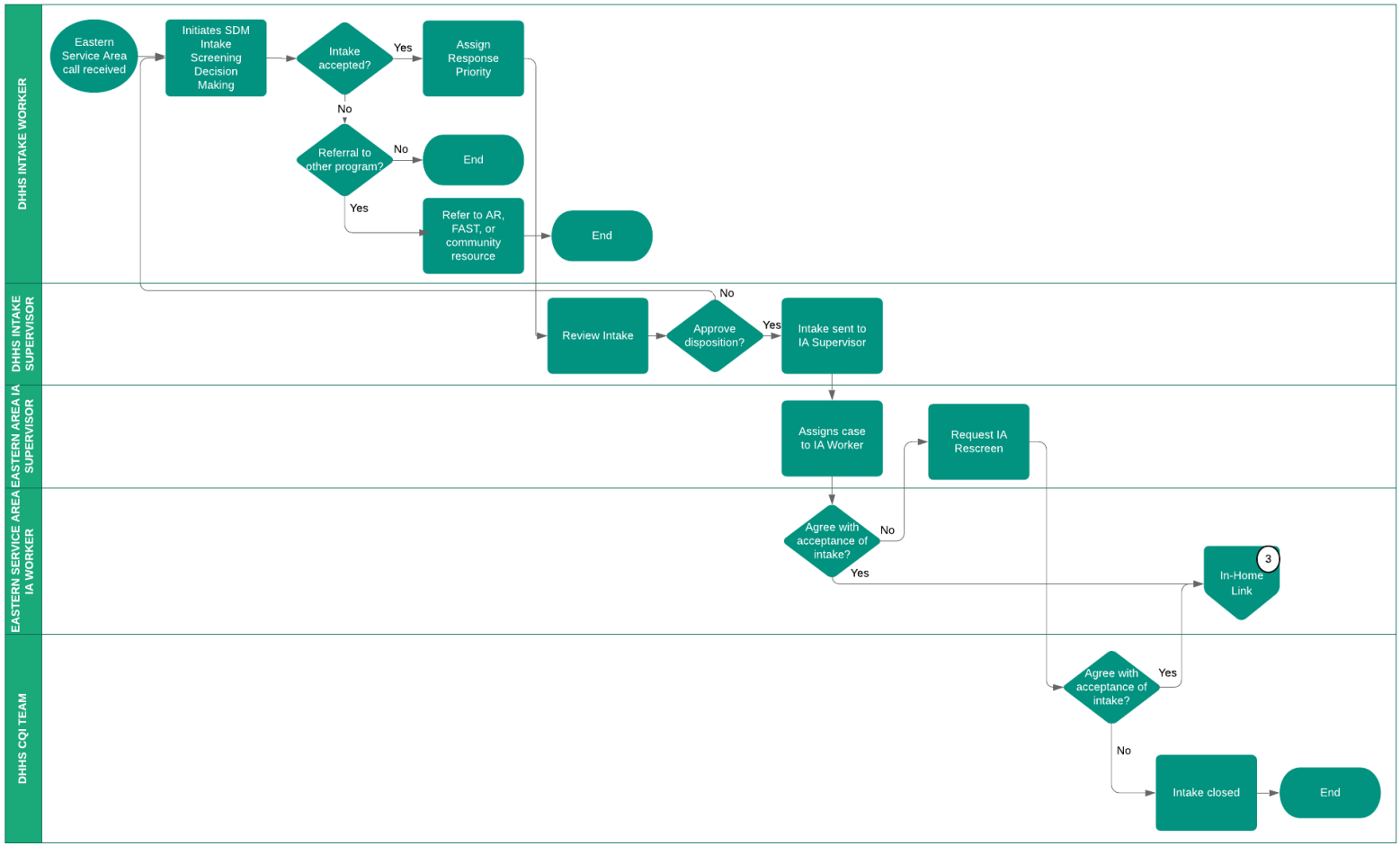


Figure 34: Eastern Service Area In-Home Case Transfer Process Map

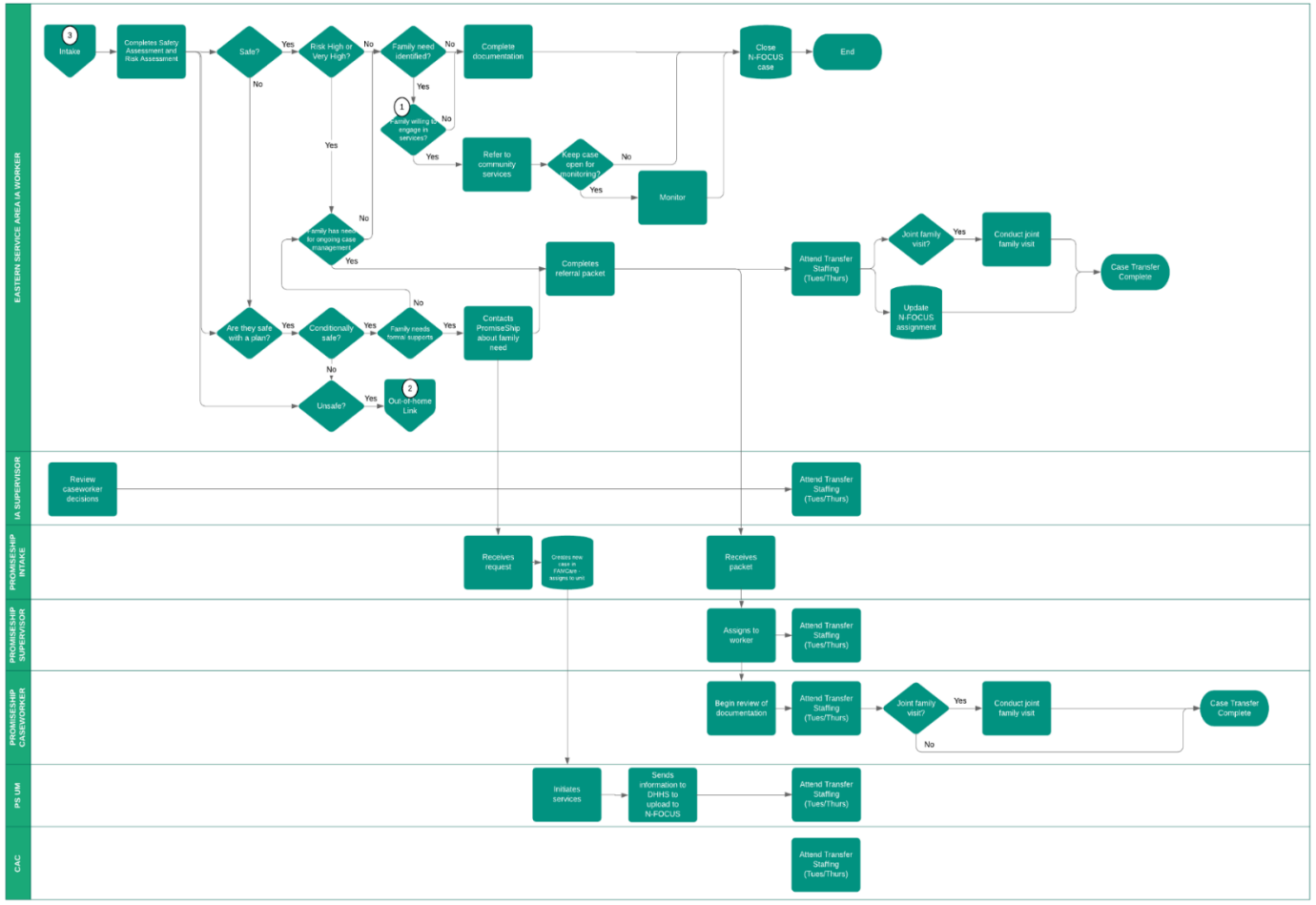
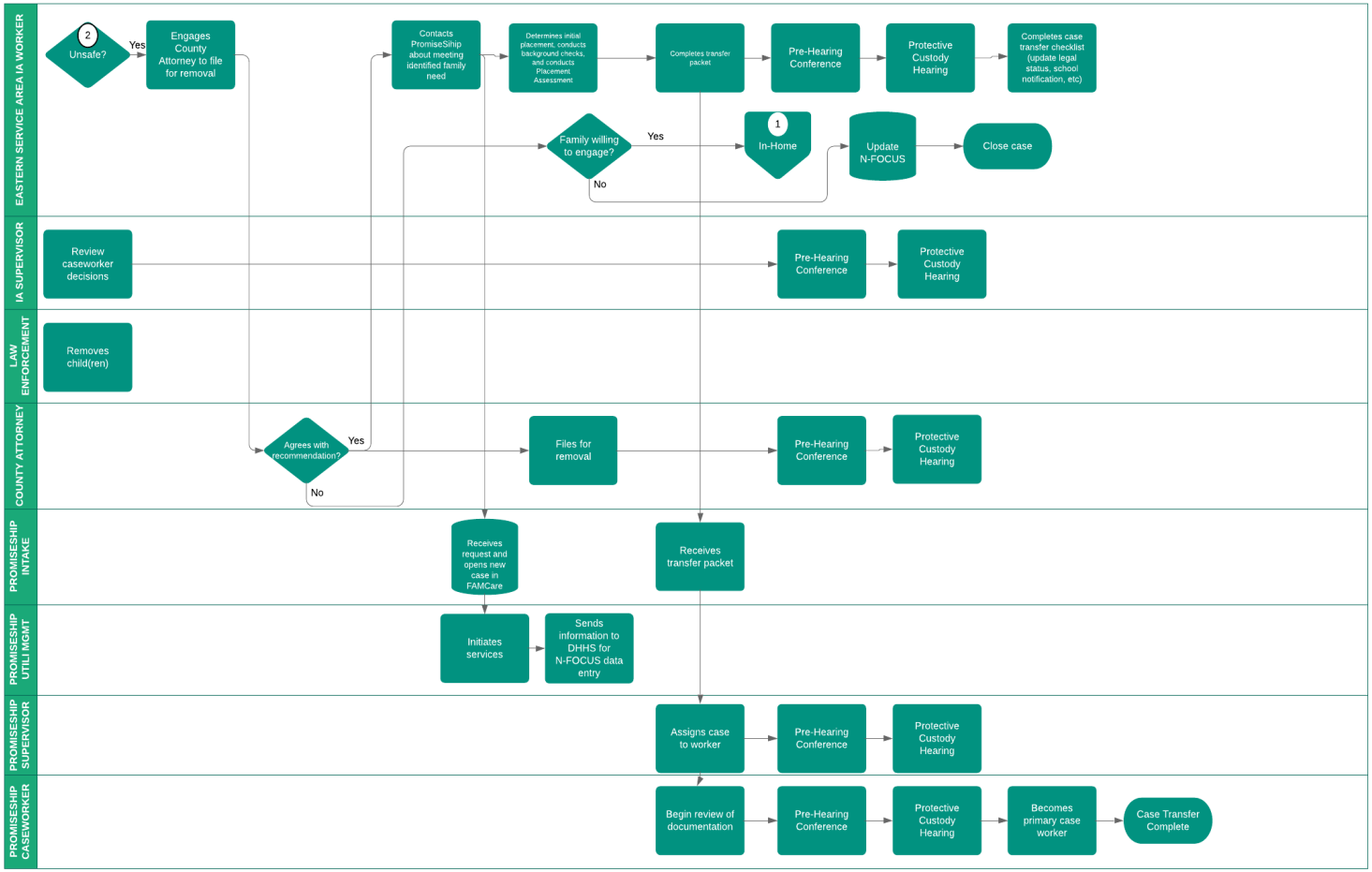


Figure 35: Eastern Service Area Out-of-Home Case Transfer Process



12.4. Process Mapping Findings

TSG appreciates the experience and insights of DCFS Eastern Service Area administration, management, supervisors, and caseworkers, as well as PromiseShip leadership, management, supervisors, and caseworkers and found them to be engaged and enthusiastic about working collaboratively to identify and improve the case transfer process, not only for their own benefit but to improve safety, permanency, and well-being for the children and families they serve.

Generally, the casework practice and process followed in the Eastern Service Area comport with the Operations Manual and attending state law, rules, and policy, but there is room for significant improvement. During TSG focus groups, participants from DCFS and PromiseShip agreed on the need to clarify several of the same process points they labelled as "messy" and "areas of gray."

TSG's findings include:

1. One "area of grey" involves the process of IA case workers calling PromiseShip Utilization Management for services during the SDM Safety/Risk Assessment process before the IA case is closed. When UM agrees with the services requested by IA and proceeds to assure the services are provided there is no problem. In cases where UM does not agree with the services requested by the IA case worker, the services provision process can proceed without timely UM feedback to the IA case worker on changes to the services requested allowing for IA case worker input. IA still has full case management responsibility during these circumstances.
2. Another "messy" process point involves In-Home cases after the process of transferring full case management responsibility from the Eastern Service Area Office to PromiseShip has been completed. When a new allegation of child maltreatment is determined after case transfer PromiseShip may call the Hot Line based on state law mandatory reporting requirements and may prepare an affidavit that should be reviewed by DCFS. We heard concern from Hot Line leadership that there is some ambiguity regarding the correct application of Protection and Safety Procedure #33-2012: "Subsequent Intakes on Current Initial Assessments" (10/16/12) and the lack of available IT licensed technology for face to face communication with the Hot Line during these circumstances in the Eastern Service Area when it is available across the rest of the state. We heard several process concerns about ambiguity regarding which organization does the case work for a resulting Court Case for a new maltreatment allegation under these circumstances as well as issues with timely documentation into NFOCUS by IA or PromiseShip for the new allegation and related important information. Immediate issues are worked out at the supervisory level. However, systemic ambiguity appears unresolved. Eastern Area Office and PromiseShip case work supervisors also agreed there is often ambiguity about responsibility for such tasks as transportation and moving the child/youth's belongings during these types of cases.
3. There are several process points where staff do not always follow the process including making joint family visits and conducting warm transfers. We could not identify a

standard policy reference in the Eastern Service Area Operations Manual regarding joint visits and warm transfer of In-Home cases.

12.5. Opportunity to Expand AR, Community Referrals, and Voluntary Non-Court Cases

With this understanding of the process flow for a case, TSG asked DCFS for data to breakdown what types of cases are transferred to PromiseShip, as defined by various safety/risk combinations assessed using the SDM tools. Table 32 illustrates the cases that were transferred to PromiseShip in 2018 (as either court or non-court cases) and cases that were not (either referred to Alternative Response or closed), by risk level.

Generally, there are patterns, which suggest consistency in how DCFS assesses and transfers cases. For example, most cases with a finding of "conditionally safe with a plan" and "unsafe" are transferred to PromiseShip regardless of risk, and most cases with a finding of "safe" are not transferred to PromiseShip. Of these cases, the typical cases that are transferred have "Very High" or "High" risk.

As the chart indicates, there are a non-trivial number of cases have the same risk level that are not handled the same. There are instances in which PromiseShip receives lower risk cases or does not receive higher risk cases, as might be expected. The occurrence of some of these variations is expected within an SDM framework. However, TSG finds as shown in the process maps above, that there are ambiguous decision nodes in the case transfer process where discretion influences the case transfer decision.

Table 32: Disposition of Eastern Service Area Intakes, by Safety and Risk Level, 2018

Safety & Risk Level	PromiseShip Involvement			No PromiseShip Involvement			Total
	Cases Transferred to PromiseShip (Court)	Cases Transferred to PromiseShip (non-court/ Voluntary)	% PromiseShip Involvement	AR	Closed	% No PromiseShip Involvement	
Safe-Very High Risk	20	62	41.4%	15	101	58.6%	198
Safe-High Risk	51	273	31.0%	53	669	69.0%	1,046
Safe-Moderate Risk	24	12	3.9%	66	812	96.1%	914
Safe-Low Risk	1	2	1.8%	34	132	98.2%	169
Safe-No Risk Determination	2	3	27.8%	3	10	72.2%	18
(Conditionally) Safe w/Plan-Very High Risk	9	58	90.5%	0	7	9.5%	74
(Conditionally) Safe w/Plan-High Risk	21	139	88.4%	1	20	11.6%	181
(Conditionally) Safe w/Plan Moderate Risk	4	63	75.3%	0	22	24.7%	89
(Conditionally) Safe w/plan Low Risk	0	8	80.0%	1	1	20.0%	10
Safe w/No Risk Determination	1	1	28.6%	1	4	71.4%	7
Unsafe-Very High Risk	118	5	93.9%	0	8	6.1%	131
Unsafe-High Risk	91	17	93.9%	0	7	6.1%	115
Unsafe-Moderate Risk	29	3	91.4%	0	3	8.6%	35
Unsafe-Low Risk	6	0	85.7%	0	1	14.3%	7
Unsafe-No Risk Determination	25	0	96.2%	0	1	3.8%	26
No Safety Decision-Very High Risk	0	0	#DIV/0!	0	0	#DIV/0!	0
No Safety Decision-High Risk	0	2	100.0%	0	0	0.0%	2
No Safety Decision-Moderate Risk	0	0	#DIV/0!	0	0	#DIV/0!	0
No Safety Decision-Low Risk	0	0	#DIV/0!	0	0	#DIV/0!	0
No Safety Decision-No Risk Determination	10	2	15.2%	3	64	84.8%	79

Source: DHHS, December 2018

Table 33: Share of Cases Sent to PromiseShip, by Select Safety and Risk Levels, 2016 – 2018

	2016		2017		2018	
Safety & Risk Level	Sent to PromiseShip	Not Sent to PromiseShip	Sent to PromiseShip	Not Sent to PromiseShip	Sent to PromiseShip	Not Sent to PromiseShip
Safe-Very High Risk	40.0%	60.0%	36.2%	63.8%	41.4%	58.6%
Safe-High Risk	26.5%	73.5%	30.5%	69.5%	31.0%	69.0%

Source: DHHS, December 2018

TSG also examined initial assessments with a subsequent Substantiated Maltreatment by safety/risk level and disposition. The far column "Initial Assessments" presents the rate of maltreatment recurrence (12-month) by safety/risk level and then each of the columns presents the rate for each of the interventions (i.e., the cases sent to PromiseShip and cases not sent to PromiseShip). Overall:

- The recidivism rates among cases sent to PromiseShip are highest for the Safe with "Very High" and "High" risk and Conditionally Safe with "Very High" risk. Cases with similar risk levels that are referred to AR or closed have lower rates of maltreatment recurrence (potentially due to the fact that the reason they scored this way was more due to history than a current issue).
- The rate of maltreatment recurrence for families served by DCFS through the Alternative Response model was 0%.
- The rate of maltreatment recurrence for cases closed by the Department was low, with the exception of Conditionally Safe with a Plan "No Risk Determination" and Unsafe "Very High" risk.

TSG finds that DCFS' strategy to use AR and referrals to community programs is not driving recidivism (though this data is lagged two years and should be monitored closely). In addition, TSG finds that DCFS' strategy has cost savings potential.

If DCFS can refer appropriate cases to community services (where case management is not needed and evidence-based services are not needed), this saves a monthly average of approx. $3,100 if the case was otherwise going to be sent to the vendor for full case management. Based on the average life of a case, this could cut the monthly average cost in half based on experience in other states ($1400 per case - Texas FBSS). (***Note: TSG is working on getting this final estimate from Nebraska for final report***).

In addition, there is a need for a third option: referral to the vendor so the family may access evidence-based services, with case supervision verses case management. Experience from other states such as South Carolina suggests this is also a cost-effective option to consider for some families. For example, in South Carolina, the state uses case supervision with evidence-based services such as the Specialized Alternatives for Families and Youth (SAFY) program, which provides statewide community-based child welfare prevention services at a cost of $1,460 per family.

Taken together, the cost savings potential of employing these three options provides more reason to clarify the case transfer process so DCFS can be assured that cases that should go to the vendor do, and that cases are assigned the appropriate level of case oversight to ensure family needs are met with the most cost-effective approach.

Table 34: Initial assessments with a subsequent Substantiated Maltreatment, Eastern Service Area Intakes, 2018

Safety & Risk Level	Cases Transferred to PromiseShip (Court)	Cases Transferred to PromiseShip (non-court/Voluntary)	AR	Closed	Initial Assessments
Safe-Very High Risk	10.0%	8.1%	0.0%	4.0%	5.6%
Safe-High Risk	15.7%	3.7%	0.0%	1.5%	2.7%
Safe-Moderate Risk	4.2%	0.0%	0.0%	1.2%	1.2%
Safe-Low Risk	0.0%	0.0%	0.0%	0.8%	0.6%
Safe-No Risk Determination	0.0%	0.0%	0.0%	0.0%	0.0%
(Conditionally) Safe w/Plan-Very High Risk	33.3%	3.4%	0.0%	0.0%	6.8%
(Conditionally) Safe w/Plan-High Risk	0.0%	7.2%	0.0%	0.0%	5.5%
(Conditionally) Safe w/Plan Moderate Risk	0.0%	1.6%	0.0%	0.0%	1.1%
(Conditionally) Safe w/plan Low Risk	0.0%	0.0%	0.0%	0.0%	0.0%
(Conditionally) Safe w/plan No Risk Determination	0.0%	0.0%	0.0%	25.0%	14.3%
Unsafe-Very High Risk	2.5%	0.0%	0.0%	12.5%	3.1%
Unsafe-High Risk	1.1%	0.0%	0.0%	0.0%	0.9%
Unsafe-Moderate Risk	0.0%	0.0%	0.0%	0.0%	0.0%
Unsafe-Low Risk	0.0%	0.0%	0.0%	0.0%	0.0%
Unsafe-No Risk Determination	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-Very High Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-High Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-Moderate Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-Low Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-No Risk Determination	0.0%	0.0%	0.0%	3.1%	2.5%
Grand Total	**4.4%**	**4.3%**	**0.0%**	**1.6%**	**2.4%**

13. PATH FORWARD

Based on what the existing vendor has been able to achieve and despite the obstacles that have emerged in the current outsource model, TSG recommends that, should Nebraska continue to use an outsource model in the ESA, DCFS should make some important changes in the manner in which it manages the vendor relationship, which could allow the state to realize the benefits of outsourcing more fully.

Should DCFS continue with the current ESA outsource model, TSG has developed an actionable road map to help DCFS move forward in partnership with the vendor selected to ensure the state maximizes the value of the outsource model. This path includes the following components:

- Clear vision
- Stakeholder engagement
- Performance-based contract with transparency
- Transformed contract oversight model
- True collaboration between DCFS and vendor
- New process for handoff and case supervision
- Utilize innovation to lower costs and improve outcomes
- Prepare for and meet FFPSA
- Improve coordination with Medicaid

TSG's overarching recommendation is for DCFS to prioritize real collaboration with the ESA vendor so that the two entities can partner in addressing any issues as they occur in real time.

One example is for the two entities to work together to develop a new case transfer process that is efficient and maximizes the chance for a successful case outcome (i.e., how can IA staff help permanency objectives? How can the vendor simplify the process for DCFS? How can the vendor have knowledge of the process so staff can anticipate the types of cases that will transfer)? How can DCFS ensure adherence to the process?)

Overall, TSG observes that building this sort of collaboration will require:

Both DCFS and the vendor to be held jointly accountable for improving family safety in the whole state, and especially in the ESA, with the goal of long-term success and improvement.

DCFS and the vendor must work together to overcome the current culture of "we/they" silos. The relationship must be redefined as a joint effort of shared success, not a "vertical competition."

Systems must be adapted for collaboration and knowledge sharing. For example, the vendor must have access to data extracts/custom reports from N-FOCUS. DCFS should learn from the benefits of systems like FAMCare as a case management system—and work together with any future vendor to find a unified systems strategy

The case management process must be integrated. This is not merely the electronic systems, but staff from DCFS and the vendor. It is more than a common record of case assignments and events.

Accountability must clearly require both DCFS and the vendor to achieve better family safety in the whole state, and especially in the ESA. For example, the vendor should be accountable for transferring the innovative solutions that have proven successful to create best practice models statewide.

13.1. Vision

1. Establish a clear vision for the ESA outsource.

As DHHS/DCFS considers a new sourcing relationship, it should have a plan for the benefit of the model. Essentially, benefit happens when the outsourced relationship achieves something the state could not have on its own. The state needs to work with the new partner to define where benefit might come from. The plan must include a clear vision for outsourcing that includes a method for:

- Managing and/or reducing costs;
- Measuring, managing and improving outcomes; and,
- Working together like private-sector partners do to improve performance.

This vision should shape not only the RFP and contract, but also the approach to contract oversight. A vision should describe what the vendor plans to do differently to achieve better results collaboratively. It would describe where the State will encourage innovation and the few areas where innovation is not permitted. It would spell out the outsourcer's responsibility for sharing the goals and how each could support their partner.

Unless DHHS/DCFS fixes the lack of vision, any future outsourcing will likely repeat the mistakes highlighted in this and prior reports. DCFS needs to establish the foundation and process for on-going knowledge of and control over its partner' success. This means that DCFS and the vendor become partners, moving toward shared success, and never competitors.

2. Engage stakeholders around the vision.

A future procurement will present an opportunity for DCFS to start fresh in the inclusion of stakeholders in its vision not only for the purpose of the outsource (i.e., why the state is continuing to outsource, what it hopes to gain), but also its approach to contract oversight.

If Nebraska desires to create a community-based care model where the community takes ownership and accountability for child welfare outcomes, as Florida and other states have done, DCFS should begin by engaging ESA stakeholders to establish consensus and shared ownership of its vision for the outsource. This will be especially important if the state successfully

implements a performance-based contract. Performance-based contracting is relatively new for child welfare providers and many stakeholders and service providers may not be familiar with the concept. DCFS should take a proactive role in managing this significant shift towards collaborative success.

To make this recommendation concrete, TSG suggests the following:

- Stakeholder meeting prior to the RFP release if time allows;
- Community forum and ongoing engagement post-RFP release;
- Establishment of regular, ongoing stakeholder meetings facilitated by DCFS for stakeholder input on how the outsource is functioning;
- Requirement that the vendor increase its stakeholder engagement efforts also by submitting a robust Stakeholder Engagement Plan and implementing the strategies contained therein.

13.2. Performance-Based Contract

3. Create an improved, performance-based contract.

TSG reviewed other state performance-based child welfare contracts and past iterations of the DHHS/NFC (PromiseShip) contract and identified a number of best practice elements that would improve Nebraska's service delivery. TSG recommends enhancement of the RFP/contract with the following elements:

- Clearly articulate DHHS/DCFS' vision in the RFP and contract.
- Include performance objectives, metrics and outcomes, and provide for a mechanism to assign financial incentives/penalties to performance.
- Require the vendor to develop an array of services to meet federal FFPSA requirements, which will ensure Nebraska maximizes federal funding opportunities.
- Include financial controls that were including creation of a Utilization Management function at DCFS and financial reporting requirements.
- Require transparency in contract outcomes. Provide quarterly reports on DCFS website for stakeholders to access.
- Develop a clear data sharing collaboration that allows a learning culture that reinforces the vision and builds focus on shared success.
- Include requirements for a transition process, based on requirements contained in the Florida case management outsource (provided in Contracts Review section) or Medicaid managed care organization contracts.
- Strengthen contract elements related to provider evaluation, including areas such as:
  - The agency's Cost Allocation Plan,
  - Financial transactions (validation of whether they are reasonable, allowable and eligible for federal reimbursement)
  - Timeliness and Effectiveness of Case Intake and Transfer Activities

- Case Management
- Consent for Services and Release of Information
- Purchased Client Services Array
- Quality Assurance Plan and Activities
- Service Network Monitoring
- Workforce Development Plan
- Validation of Self-Reported Performance

In addition, in the contract going forward, DCFS needs to ensure that there is a transition plan requirement so that, if, for some reason the vendor no longer offers the service the vendor is required to submit a transition plan prior to any contract ending date.

13.3. Contract Oversight

While DCFS initially took a limited approach to contract oversight which was difficult to overcome, TSG recommends implementation of strong oversight approach from the beginning of this contract. This approach will integrate Contract Monitoring, Continuous Quality Improvement, and Finance resources to provide a comprehensive means to oversee and drive performance in the ESA and statewide. This effort will focus not on compliance but shift towards a model of shared solutions that resolve problems and improve performance not just in ESA, but across the state.

4. Create an integrated Quality Assurance Team (QAT).

To address fragmentation of existing contract oversight resources, DCFS should establish a team consisting of staff from Contract Monitoring, CQI, Finance, as well as Eastern Service Area administrators. This team should meet internally at least monthly to review vendor performance. At least quarterly, the team should meet with the vendor to discuss findings and opportunities for improving performance.

5. Designate appropriate resources and clarify the responsibilities of all of the resources on the QAT.

DCFS leadership should designate the following roles and clarify their responsibilities in the oversight of the ESA outsource contract:

- Contract Manager – DCFS should designate a single entity as responsible for all contract oversight, including requiring the vendor to complete Performance Improvement Plans (PIPs) and the assessment of financial incentives and remedies. This individual should lead the QAT and attend all internal and external meetings with the vendor.
- Contract Monitor – The Contract Monitoring Team should designate one full-time contract monitor to the ESA outsource contract. This individual should be responsible for conducting on-site visits with the vendor, monitoring vendor compliance with new

contract requirements, using a new contract monitoring tool and working with the vendor to build a collaborative relationship towards the shared vision.

- Continuous Quality Improvement Team – This team should designate the appropriate level of staff resources to conduct oversight of the quality of the vendor's performance through data analytics and live case reads.
- Finance Administrator – DCFS should fill a dedicated Finance Administrator position. This position should be responsible for developing, clarifying and reviewing vendor financial reports and reconciling vendor financial data with DCFS financial data. In addition, this position should advise the QAT on the amount of financial incentives and remedies to provide, based on the vendor's performance.
- Regional ESA administrator/leadership team – On a day-to-day basis, the Regional ESA administrator/leadership team is responsible for resolving issues as they occur between DCFS staff and the vendor. The Regional ESA administrator provides the QAT with input on the vendor's operations.

DCFS leadership should ensure that each of the functional areas included in the QAT remain sufficiently resourced to maintain strong fidelity to the mission and that they remain independent in the execution of their responsibilities.

6. Empower the QAT with the authority needed to carry out roles and responsibilities.

TSG found that previously, DHHS' contracts and Operations Manuals included best practice components, but that dilution of contract requirements and a lack of enforcement prevented the state from realizing the benefits of the contract and left the focus on compliance and not improving performance. The QAT needs to have clear direction and consistent support from DCFS leadership so that it can carry out its roles and responsibilities and implement the contract provisions as intended in achieving the vision for the outsource model.

7. Develop Contract Monitoring staff to engage in performance-based contract monitoring.

Use training and professional development opportunities to develop staff working in the contract monitoring capacity to enable them to participate fully on the QAT and engage in on-site monitoring using a new contract monitoring tool. Consistently work to ensure that QAT staff are connected to the vision and the goals of the model.

8. Develop a new contract monitoring tool.

Develop a new contract monitoring tool aligned with new contract requirements and vision to help the Contract Monitoring staff conduct duties, including on-site visits.

9. Transform CQI from maintaining federal compliance to managing family safety.

When privatization began a decade ago, Nebraska struggled, as did many other states, to achieve compliance with federal outcome targets. The notion of these metrics was that if predefined targets were achieved, then the money spent on child protective services would be achieving an outcome.

To some extent, this flies in the face of the quality revolution in the private sector. Ed Deming and others proved to private companies in the 1980s that arbitrary production goals always reduced performance. (Deming started his career in a federal agency.)

The quality revolution brought to the private sector a new wave of data analysis: statistical process control, averages, variances, control limits, etc. During that same time, private sector cost accounting added a dimension and became Activity-Based Management, determining how process drives costs. To date, DCFS has not changed its business process towards a statistics or cost accounting model that can be useful to improve case management. TSG found little analysis of historical case cost and performance data that could be used to improve outcomes or reduce costs. DCFS is still largely managing by simple target metrics imposed externally.

TSG finds that Nebraska's CQI function has driven significant performance improvement over time and staff are capable and engaged in ongoing systems improvement today. However, the state has not been able to adopt many of the best practices in data analytics used in the private sector and may need additional resources to obtain these marketplace capabilities. A true public-private partnership with a vendor who is using advanced analytics may also offer DCFS an opportunity to benefit in a way it may not be able to on its own.

To conduct the level of analysis it should be doing today, DCFS will need to:

- Build a cross-functional team of analysts;
- Invest in capabilities for advanced data analytics;
- Work collaboratively with the vendor and other private groups;
- Collaborate with other state agencies who share the responsibility for supporting healthy families: Medicaid, mental health, public health, etc.; and,
- Iterate through many generations of learning. This should become a core competence of child welfare services.

10. Use CQI staff to conduct live case reads of the vendor's in-home and out-of-home cases.

Staff already perform case reads for CFSR purposes; this recommendation would be to dedicate some resources to sampling live vendor cases each quarter and provide real-time feedback to the vendor to enable action to be taken immediately to address any issues identified. These reads would give DCFS insight into the quality of case management performed by the vendor.

11. Develop the tools to enable data-driven oversight of the vendor.

The CQI Team should design a vendor scorecard containing key performance indicators (as included in the contract), financial data, and any operational metrics to facilitate the QAT's review.

12. Continue with plans to reinstitute quarterly state and ESA CQI meetings to facilitate collaboration with the vendor's CQI team and other providers.

The DHHS CQI Team should facilitate meetings with the vendor's CQI team, as well as providers, on a quarterly basis at the state-wide level, as well as in the ESA. This will provide for sharing of findings and coordination of resources. TSG understands that the State Office CQI leadership has recommended reinstituting these meetings for 2019.

13. Collaborate with the vendor to establish joint CQI activities.

The DHHS CQI Team should work with the vendor CQI Team to maximize resources available for systems improvement activities. Especially given the state's focus on CFSR reviews, DHHS could delegate monitoring of in-home cases to the vendor and could apply findings to other Service Areas.

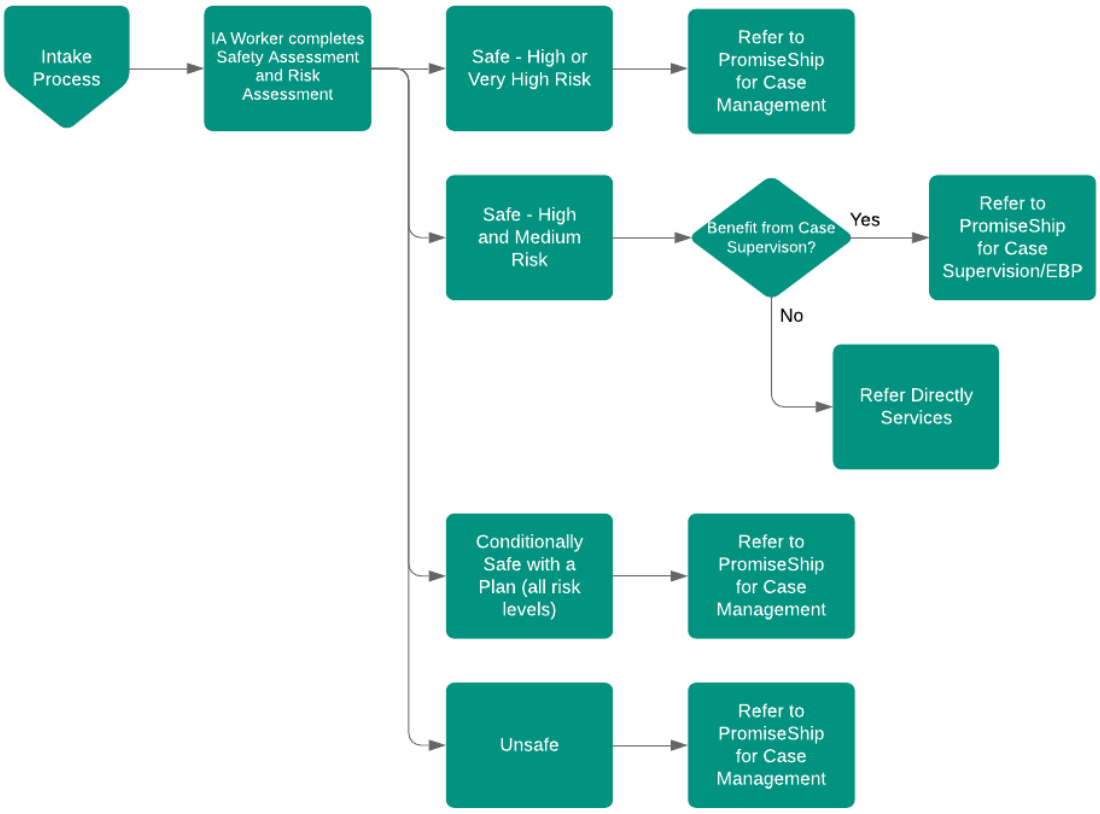
14. Improve collaboration with the vendor on financial management.

- Collaboration: DHHS should lead the way in finding ways to work together on the key issues of financial management: turnover, provider payment, case cost and performance analysis. Collaboration requires an approach to contracting that is quite different from what DHHS has done with the existing vendor in the past. It requires joint work teams, combined quality management, combined efforts to improve analysis. All these must be built on a foundation of trust and respect.
- Shared systems: TSG is well aware that federal rules require that N-FOCUS continue to serve as the official record of provider payments and case activity. However, this need not mean that the vendor is relegated to re-entering information manually and getting no access to custom N-FOCUS reports. The new contract should re-engineer the way systems are used. Ensuring that numbers tie together, eliminating duplicate effort, supporting advanced cost analysis (e.g. Activity Based Costing) and tying costs and performance across the whole system.

15. Develop a multi-tiered case management model, which will maximize cost effectiveness.

DCFS continues to refer more families to AR/non-voluntary community services and is examining closely which cases actually require case management. DCFS can take this concept further through the creation of a three-tiered case oversight model, as shown in Figure 36.

Figure 36: "To Be" Case Transfer Process



In this model, the levels of case management include:

- Highest level: Case management, referral to vendor
- Mid-Level: Case supervision and evidence-based service, referral to vendor (lower rate than case management)
- No case oversight: Direct referral to service provider

Other states, such as South Carolina, have used this approach to achieve significant cost savings – the average monthly payment for case supervision was $1,460. In Nebraska's case, if the average monthly payment to a vendor is $3,100 today and the average in-home case is approximately three months, DCFS can expect to pay $9,300 per case that receives case management. If a case supervision rate is established on par with South Carolina's of $1,460, the per case savings is estimated to be $4,920. If a family is referred directly to a community provider, the savings would be even greater.

It is important to note that this comparison is based on the rate Nebraska has in place today. If Nebraska establishes two rates for case oversight (case management and case supervision), it is likely that the case management rate will increase above $3,100. The current rate is a blended rate for all acuity levels, and if the less complex cases are not included, the cost for the cases requiring case management will increase.

16. Monitor recidivism of families by level of case oversight provided to ensure safety.

DCFS should continue to monitor whether maltreatment recurrence occurs, and by level of case oversight provided, to ensure that families receive the most appropriate level of case oversight.

17. Provide more structure to the case transfer protocol to ensure consistent referrals of appropriate cases to the vendor occurs.

DCFS should revisit the case transfer protocol (specifically the decision node of whether a family requires case management) to ensure consistent criteria are used in this determination. DCFS may consider creation of an internal Utilization Management function for the purpose of ensuring cases are initially classified into the appropriate level of case management and regularly reviewing instances in which families need to move to different level of case oversight (such as from case supervision to case management).

13.4. FFPSA Compliance

There remain to be significant “unknowns” and assumptions surrounding the path to implement the FFPSA at the federal and state levels. For instance, while the Act indicates there will be funding available to implement evidence-based services at the state level, it is unclear whether this funding can be extended to fund the implementation services not yet listed on the federal Clearinghouse but identified in an approved state plan.

While one can presume the Clearinghouse will most-likely approve the twelve interventions currently under review by Spring 2019, it is uncertain when additional services, particularly those potentially meeting the promising or supported levels, will be identified for review or how long it will take for those services to be approved by the Clearinghouse.

18. DHHS should require the vendor to begin to develop a comprehensive array of well-supported, evidence-based services and ensure any future contract has meaningful consequences for the ESA vendor not meeting FFPSA standards

As the entity responsible for the largest population of children and families engaged in child welfare services, it is imperative that the vendor begin to support the development of a comprehensive array of available well-supported, evidence-based services aligned with the provisions of FFPSA. This is not an explicit current contract requirement, however the outsource partner must begin working to build capacity to ensure conformity to the federal law. Services

selected should be aligned with prevalent needs of families with children at imminent risk of removal and be implemented with a focus on fidelity to the model.

The current vendor should make reasonable efforts to expand its in-home prevention efforts to ensure that the entire state will be able to meet the federal prevention programming standards, and the State should ensure in any future contract that the ESA vendor is held responsible for any loss of federal funds due to insufficient array, preparedness or other factors.

19. Develop a statewide plan to implement interventions capable of addressing gaps in the service array or level, in collaboration with the vendor.

Collaboration with the outsource vender will be critical, as the state's Title IV-E Prevention Plan will need to be aligned with, and reflective of, services provided in the ESA. To this end, a statewide plan to implement interventions capable of addressing identified gaps in the available service array, either in service type (focused on mental health, substance abuse, or parenting) or level (promising, supported, well-supported) should be developed.

In the event the plan includes services which are not currently under review by the Clearinghouse, DCFS and the vendor should work with the model developer to create a program summary which provides evidence identifying how the intervention meets the intent and requirements of FFPSA. Such effort may facilitate review and approval of the service by the Clearinghouse.

20. Develop a roadmap for implementing selected services.

Selected interventions require funding and time to implement. Model developers, especially those already identified by the Clearinghouse, have limited capacity to train providers and it is important DCFS and the vendor get ahead of other states in their requests to these developers.

Finally, the ESA has the most robust provider capacity in the state. As a result, undue burden may be placed on the Area to support the state's requirement to expend 50% of funds on well-supported interventions. This should be considered in the development of the statewide plan and reflected in the vendor's efforts to meet FFPSA expenditure requirements.

21. Develop a statewide plan for evaluation of selected services or request a federal waiver of the requirement to evaluate well-supported services.

Not only will the evaluation of selected services require funding but may necessitate partnerships with universities or other qualified organizations capable of completing research-based outcome assessment which rise to the level required by FFPSA. DCFS should develop this evaluation in partnership with the vendor.

22. Align provider agreements with FFPSA requirements and collect payment data by intervention.

The outsource vendor and DCFS must align subcontracted provider agreements with the intent of FFPSA and collect payment data by intervention. The current vendor presently pays many in-home service providers a case rate and is unable to identify payment for specific evidence-based interventions if that provider offers multiple interventions. Going forward, reimbursement should only be available for interventions approved by the Clearinghouse, therefore contractual payment structures must be aligned with this requirement.

23. Maximize federal funding by licensing relative caregivers.

During FY2018, the existing vendor reports spending $3.18 million for relative/kinship providers caring for title IV-E eligible children. PromiseShip reports having a strategy to work with these caregivers to support efforts to license them in accordance with requirements articulated in FFPSA.

Supporting efforts to license of relative/kinship caregivers may necessitate changes to state licensing statute or policy. PromiseShip should continue to work in partnership with the statewide FFPSA workgroups to recommend and advance changes capable of expediting licensing these relative caregivers. Doing so will support maximization of federal title IV-E claims.

13.5. Improve Coordination With Medicaid

The importance of readily available medical, behavioral health, and specialty services cannot be overemphasized for children/youth removed from their homes as a result of a child protective services investigation. Often these children have serious, untreated trauma-related and behavioral health needs, as well as physical health needs.

The pervasive prevalence of behavioral health needs among children/youth in state foster care programs, estimated as high as 80%[43], has spurred many states to actively improve the operational relationship between the child welfare lead agency and the state Medicaid lead agency resulting in integrated child welfare tailored delivery models through managed care.

Through TSG interviews with state DCFS workers, supervisors, and providers; meetings with several divisions of DHHS; conversations with Judges, CASA, and Guardian Ad Litems; and our review of the current Nebraska Medicaid managed care organization (MCO) contract in comparison with several other state Medicaid MCO contracts (e.g. Texas, Washington, and Florida), TSG has identified the following gaps:

- Lack of connection between DCFS and the state Medicaid agency.
- General opinion of caseworkers that MCOs are not responsive when Behavioral Health services are needed.

[43] National Conference of State Legislators: Mental Health and Foster Care; 5/9/2016

- There is a lack of access to specific types of Behavioral Health services, such as Multi-Systemic therapy or waiting lists if the service is available.
- Caseworkers fill the gap and try to find services, as opposed to the MCO serving in this role.
- Medical necessity is often used by the MCOs for residential services discharge purposes for the highest Behavioral Health risk children/youth without a community based plan of care provided through the MCO, leaving DCFS with the medical and psychiatric responsibility for finding adequate care to maintain safety and well-being, often resulting in expensive out of state placements.
- Although MCOs and the Division of Medicaid & Long Term Care host scheduled meetings concerning high needs DCFS children and youth on a case by case basis, these meetings are not as effective as they could be given that the MCOs are limited by the current benefits structure and MCO contractual responsibilities.

Nebraska DHHS has the need, opportunity, and the expertise to develop an integrated Child Welfare Medicaid benefit and delivery structure within its existing Medicaid managed care program. This will ensure timely access, targeted care coordination and case management for high risk/high needs children/youth, and improved access to behavioral health evidence-based treatment models.

In response to these gaps, TSG recommends that:

24. DHHS should create an on-going Child Welfare Leadership Team composed of DCFS, DM & LTC, DBH, and DDD.

The purpose of this team would be to develop a planning path forward for child welfare centric improvements to the next generation Nebraska managed care contracts, focused on improving access; MCO active care coordination for high needs/high risk children and youth; MCO responsibility for finding accessible services in real time; development of Behavioral Health Evidence Based Practice/Best Practice provider capacity based on value based payments and incentives for outcomes; improved use of shared data, and the development of an MCO electronic case record of DCFS enrolled children and youth similar to the Texas Health Passport.

This record would be available for providers, supporting integrated and continuous care, and for DCFS/vendor case workers, supporting due diligence monitoring and active support for each out of home child/youth's overall health, EPSDT periodicity compliance, and Behavioral Health and specialty needed services.

25. Consider adapting the two-week requirement to a 72-hour requirement for a face-to-face assessment of the child's immediate medical status.

Currently state law requires a medical examination within two weeks of a child's removal from their home.[44] Several states are moving in the direction of a more immediate assessment. The shorter timeframe would ensure that children are connected to services more immediately upon entering care.

26. Improve data sharing between DCFS and DM&LTC, about Medicaid utilization of children in foster care.

We have observed that currently there is little capacity to analyze data across both Divisions. During our on the ground work we participated in several meetings where we requested data from Medicaid claims specific to the child welfare enrolled children/youth population, specifically Medicaid utilization by DCFS children and EPSDT periodicity compliance. In another instance we requested data from PromiseShip billings to the MCOs. In both instances we have been unable to access this data during the time period of this project.

Improved data sharing and the implementation of a shared data platform that would include the ESA vendor, would substantially work to make better more timely decisions on interventions, which would benefit the state both in terms of lower costs and improved outcomes. This should be an internal priority within DHHS.

[44] Nebraska Rev. Statute 43-1311

14. APPENDIX A: COMPLETE REVIEW OF PRIOR AUDITS AND REPORTS

TSG reviews past audits and reports as a foundation for its own assessment. This are presented in reverse order. The purpose of TSG briefing of these report is to glean implications, not to merely repeat the findings. For details, readers are encouraged to read the documents themselves, which are cited in the text.

14.1. State Auditor of Internal Accounts, 2018

The State of Nebraska, Auditor of Public Accounts published on August 3, 2018, "Attestation Report of the Nebraska Department of Health and Human Services Program 354 – Child Welfare Aid, July 1, 2016, Through December 31, 2017."[45]

The audit reported that total ESA (PromiseShip) expenditures had risen since 2008:

Table 14-1: PromiseShip Payments According to Audit Report

	FY 2008	FY 2013	FY 2017
Eastern/NFC	$41,819,920	$51,349,900	$63,311,114
Other Areas/DHHS	$65,509,969	$68,663,179	$61,470,119
Eastern/NFC wards[46]	2,683	2,228	1,960
Other/DHHS wards	4,260	3,432	2,438

This table signals two very important questions: why are PromiseShip costs increasing while costs for other areas seem to be declining. The auditor did not divide reported costs by the number of wards to factor out the effect of changes in case volume. TSG simply used the auditor's costs and case units in the table below. It shows ESA cost per ward more than doubling from $15,587 to 32,301.59. That represents a compound annual growth rate[47] of 8.5%. This is much faster growth compared to the other regions, which have grown at 5.8% per year. In 2008, the cost per ward was about the same in ESA, $15,000. Today, the $32,000 PromiseShip cost per ward is 28% higher than the cost per ward for the rest of the State.

[45] Report available at" http://www.auditors.nebraska.gov/APA_Reports/2018/SA25354-08032018-July_1_2016_through_December_31_2017_Attestation_Report.pdf
[46] The term "ward" is used in various manners within child protective services. As used here, TSG surmises that the auditor means youth, as distinct from case
[47] Compound annual growth rate (CAGR) is the annual rate by which the initial value would grow over the number of periods to reach the ending value

Table 14-29: Annual Costs per Ward Calculated from Information in Audit Report

	Annual Cost/Ward			
	FY 2008	FY 2013	FY 2017	CAGR
Eastern Cost/wards	$15,587.00	$23,047.53	$32,301.59	8.5%
Other DHHS Cost/wards	$15,377.93	$20,006.75	$25,213.34	5.8%

The audit acknowledged that a 2014 legislative report had identified cost issues and called for a restructuring of the region, but that no restructuring had happened and that the contract had been extended without bid.

The audit reported several adverse findings, some of which seemed to TSG that they were related to PromiseShip and others to DHHS performance (indicated by parentheses):

1. (PromiseShip) Errors. Of 113 claims randomly selected and paid through NFOCUS, 45 lines tested had errors, a 40% error rate.
2. (PromiseShip) Unreasonable Expenditures:
    - The NFC contract was not competitively bid
    - Monitoring of contract requirements was inadequate
    - A contract amendment contained a provision requiring DHHS to reimburse NFC's losses above $400,000
    - $1,110,337 in questioned costs, including payments for fundraising, gifts, entertainment, and meals
    - NFC ordered 155 computers for $216,735 on 6/29/2017; however, the contract with DHHS ended on 6/30/17
    - Many more items reported
3. (PromiseShip) Duplicate, unsupported and overclaims. The auditor tested 45 claims and noted questioned costs totaling $306,380, including charge for one client that totaled $274,562.59
4. (PromiseShip) Activity Not recorded accurately in NFOCUS. NFC explained that it did not record certain accounts in NFOCUS; these accounts totaled $1,677,374 during fiscal year 2017
5. (DHHS) Federal funds not fully utilized for adoption assistance. At least $962,485 which DHHS failed to charge Federal funds for respite care costs arising from adoption assistance agreements
6. (DHHS) Spending authority exceeded. As of June 30, 2017, DHHS had exceeded its appropriated spending authority by at least $8,744,997
7. (DHHS) Inadequate support for rates: Rates for various child welfare services totaling millions of dollars were not adequately supported
8. (PromiseShip?) Payments more than two years after service: Auditors noted 129 claims, totaling $97,263.93

9. (DHHS) Contractual aid payments not adequately monitored: DHHS did not obtain adequate documentation to support expenditures paid to contractors and subrecipients. Seven of 10 payments tested were not adequately monitored
10. (DHHS) No evidence of contractor financial stability: Contrary to an express statutory requirement, DHHS did not obtain evidence of financial stability or liquidity before contracting

14.2. Letter to Senator Merv Riepe

Nebraska Revised Statute §43-440 required that DCFS provide a report of NFC (PromiseShip) performance[48]. This was done most recently in a letter to Senator Merv Riepe. That reported outcomes in three groups:

- Outcome 1: Safety, PromiseShip exceed the federal target
- Outcome 2: Permanency, PromiseShip exceeded the federal target for two of three indexes, and failed on the third (timeliness and permanency of reunification)
- Outcome 3: Well-Being, PromiseShip exceeded federal target (though performance has been dropping over the past months)

In addition, DCFS assessed and reported results of having participated in the Federal Round 3 Child Family Services Review (CFSR) the week of June 5 – 9, 2017. This assessed 18 detail-level process metrics as well as seven outcomes. Results are reported below. The report shows many process elements for which PromiseShip falls short.

[48] This report is available at: https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Health_and_Human_Services__Department_of/305_20180905-092602.pdf

Table 14-310: Child Family Services Review as Reported

	DOUGLAS		
ITEMS	Overall Scores	Foster Care Scores	In Home Scores
Number of Cases	33	20	13
Item 1 Timeliness of Investigations (DHHS Only)	71%	73%	70%
Item 2 Services to prevent Removal or Re Entry	82%	100%	67%
Item 3 Risk and Safety Assessment and Mgmt	58%	70%	38%
Item 4 Stability of Foster Care Placement	75%	75%	NA
Item 5 Permanency Goal	65%	65%	NA
Item 6 Achieving Permanency	45%	45%	NA
Item 7 Sibling Placement	81%	81%	NA
Item 8 Parent/Sibling Visitation	71%	71%	NA
Item 9 Preserving Connections	80%	80%	NA
Item 10 Relative Placement	90%	90%	NA
Item 11 Child/Parent Relationship	64%	64%	NA
Item 12 Needs & Services (Child, Parent, Foster P)	48%	50%	46%
Item 12A Needs & Services - Child	79%	90%	62%
Item 12B Needs & Services - Parents	52%	56%	46%
Item12C Needs 7 Services - Foster Parents	65%	65%	NA
Item 13 Child and Family - Case Planning	63%	68%	54%
Item 14 Caseworker visit with Child	82%	90%	69%
Item 15 Caseworker visit with Parents	52%	50%	54%
Item 16 Educational Needs of the Child	82%	89%	33%
Item 17 Physical Health of the Child	79%	80%	75%
Item 18 Mental/Behavioral Health of the Child	59%	71%	38%

OUTCOMES	ALL	Foster Care Only	In Home Only
Safety Outcome 1 (Item) (DHHS Only)	71%	73%	70%
Safety Outcome 2 (Items 1 & 2)	58%	70%	38%
Permanency 1 (Items 4 - 6)	40%	40%	NA
Permanency 2 (Items 7-11)	70%	70%	NA
Well-Being 1 (Items 12-15)	45%	50%	38%
Well-Being 2 (Item 16)	82%	89%	33%
Well-Being 3 (Item 17 & 18)	55%	60%	44%

14.3. Letter to Patrick O'Donnell, Clerk of the Legislature

Nebraska Revised Statute 68-1207.01 requires that DCFS submit an annual report to the Governor and Legislature outlining child welfare and juvenile services caseloads, factors considered in their establishment, and the fiscal resources needed to maintain them[49]. This letter dated September 15, 2018 is that report. The report observed that 95.2% of ESA case workers are in compliance with caseload standards, highest in the state.

[49] See report at: https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Health_and_Human_Services__Department_of/538_20180905-092427.pdf

Table 14-4: Case Work Compliance as Reported

Total Staff			
Average of June 2018			
Service Area	Total Staff	Staff In Compliance	Percent In Compliance
Central	60	57	95.0%
Eastern	208	198	95.2%
Northern	66	57	86.4%
Southeast	98	81	82.7%
Western	51	42	82.4%
State	483	434	89.9%
Green indicates improvement from prior month			
Red indicates regression from prior month			

This report is based on the following required caseload per worker:

- Out of home youth standard <=16
- In home families' standard <=17
- Initial assessment Standard <=1 (does not apply to PromiseShip)

The report also presented that PromiseShip has the higher case worker tenure compared to the Southeast region, which is also urban. PromiseShip tenure is higher than some other regions, which is widely understood to be a reflection of the alternate job opportunities in urban areas.

14.4. Letter to Patrick O'Donnell, Clerk of the Legislature

Nebraska statute 43-4406 requires and annual report to the Legislature. This letter of September 15, 2017 is that report. This report presents a number of useful headcount metrics, costs, training metrics and the like. None of the information in the report is parsed in a manner than enables understanding the effect of outsourcing.

14.5. Nebraska Child Welfare Blueprint Report March 2017

14.5.1. Findings

This is an opportune moment in the evolution of state's child welfare reforms to continue strengthening the child welfare agency's response to the needs of children and families while also strengthening community capacity to meet families' needs. In short, now is the time to stay the course and continue making progress for Nebraska's children and families.

Keeping children out of foster care and safe and stable at home

- Home visiting is a powerful intervention that holds promise for reducing child maltreatment across the state, but it is not reaching all the families who could benefit.

Targeting these interventions to communities with high rates of child maltreatment could go a long way toward supporting families before maltreatment occurs.

- Bring Up Nebraska initiative is identifying best practices for implementing partnerships focused on prevention and will focus future efforts in counties with high rates of child maltreatment. Partners in the initiative include the DHHS, the Nebraska Children and Families Foundation (NCFF), the Office of the First Lady, the Child Abuse Prevention Fund Board, Casey Family Programs, and the Sherwood Foundation. Continued commitment to this effort will help Nebraska position itself as a national leader on prevention.
- An initial evaluation of Alternative Response (AR) showed promising results on some key measures. These include: children in AR have remained just as safe as children in traditional response, families receiving AR are more likely to receive appropriate services, and they seem to receive those services more quickly than families in traditional response.
- Key questions that should be addressed as the state continues to expand AR include:
    - Are families able to access the services that meet their needs?
    - How many families involved with AR later become involved with the child welfare agency?
    - Does AR engage families in a voluntary process, or do families feel they don't have the option to decline services?
    - Do child and family outcomes improve as a result of the intervention?
    - How does the AR approach of working with lower risk families inform future prevention efforts, such as how to identify what families need to prevent deeper systems involvement?

Ensuring children and youth in foster care are safe and their need s are met

- All caregivers, whether kin or non-kin, must have the training and support to meet the needs of children who have experienced trauma.
- The number of children in foster care who are placed in kinship care — relatives or close family connections — has grown steadily since 2012, from 28% in 2012 to 49% in 2015. Despite this impressive progress, there are some remaining concerns about the state's kinship care strategy.
    - There are still too many kinship foster parents in the state who are not licensed. Unlicensed kinship placements do not receive training and support and are also not eligible for federal Title IV-E foster care funding.
    - Family Finding practices are not consistently used across the state. There should be more consistent application of these strategies so that searching for and engaging family for children and youth in foster care is standard practice across the state.
    - Engaging all potential family connections early and effectively can prevent delays in children exiting foster care as quickly and safely as possible.

- Less than 8 percent of children in foster care are now in a group care placement, defined as any placement that is not with a family. Stakeholders should monitor whether children in group care are receiving the services that match their needs and pay close attention to how they are supported for transitions back to their families and communities.

Creating a sense of urgency so that all children and youth leave foster care to permanent, loving families and adult connections

- Families who have had their children returned to them and those who have adopted or granted guardianship of children need access to the same community supports to help children and youth heal from trauma.
- Through the Eyes of the Child Initiative (TTEOC), has helped remove systemic barriers to timeliness of court hearings for children in foster care, but delays remain that must be addressed to help children leave foster care safely and quickly. Areas for improvement identified by stakeholder groups include:
    - Additional court staff to schedule hearings within required deadlines, particularly in regions with large child welfare populations.
    - More timely filing of Termination of Parental Rights (TPRs) to prevent delays in adoption.
    - On-going training and education for judges and attorneys on the impact of court timeline on outcomes for children and families, and adherence to progression standards for juvenile courts, recommended by the Supreme Court Commission for the Protection of Children in the Courts.
    - More consistent efforts to ensure legal representation for every youth and to engage young people in court.
- The Barriers to Permanency Project, initiated in 2013, resulted in a comprehensive review of children who had been in foster care for 3 years or more and identified the top barriers to helping children with timely exit from foster care. The review found that the three primary barriers were court delays, lack of caseworker continuity, and lack of relative searches early in the case. Resulting in:
    - 55% of the children whose cases were reviewed left foster care shortly after the review was completed.
    - DHHS made improvements to its computer systems to make relative searches easier and the findings of search efforts more accessible to caseworkers.
    - The time period for appellate court decisions decreased after an internal review of the appeals process prompted a change in procedures.
- Young Adult Bridge to Independence Act in 2013 extends services and support to youth aging out of foster care from age 19 to age 21 and allows them to choose whether or not to stay in foster care with case management support, Medicaid and a monthly stipend.
    - 89% of eligible youth participate in the program and almost two-thirds of program participants are either working or attending school.

  - Only 16% of program participants qualify for federal Title IV-E funding. DHHS should
  - strengthen their processes for assessing eligibility.
  - More robust data collection protocols and a stronger evaluation design should be developed to accurately measure program success and better understand the experiences of youth in the program.
- It is critical that programs designed to build community networks for families be available to children after they return home or leave foster care for guardianship or adoption. The supports families need — when they need it — to prevent entry in or return back to the child welfare system.

Recommendations

Continued progress will be dependent on staying the course on the programs and policies that have already contributed to improved outcomes and doubling down on some of the more intractable challenges that continue to get in the way.

- Address gaps in behavioral health services for children and families. Gaps in substance abuse treatment and mental health services were two of the most commonly cited areas of concern.
  - Create a comprehensive plan to address substance use and child welfare involvement. Parental substance use is the second biggest reason children are removed from their families.
  - Focus on access to community based mental health services. Efforts to ensure statewide access to high quality mental health services in communities have fallen short. Access to trauma-informed and culturally responsive mental health services is a critical component of any child welfare system and must be available for both parents and their children.
  - More strategic use of Medicaid can be applied across the continuum - to prevent child welfare involvement, support children youth and families already in the foster care system, and to address the occasional crisis for children who have already left foster care but are still dealing with the impact of the earlier trauma they experienced.
  - The Nebraska Systems of Care Initiative (NeSOC), holds promise for continuing to monitor progress in accessing behavioral health services for children and families. The stakeholders involved in NeSOC are already in the process of mapping out available behavioral health services in the state and identifying gaps that need to be filled.
- Create partnerships with foster parents to meet children's needs.
  - Support and training for all foster parents. Nebraska should assess the current capacity to provide foster parents with the knowledge and skill necessary to meet children's needs and to be full partners in achieving better outcomes.

  - Treatment foster care for children with serious social, emotional and behavioral issues is not a robust part of the continuum of child welfare services in Nebraska and currently, there is no payment structure to support it.
  - Use of a combination of federal Title IV-E, Medicaid and mental health funding to support treatment foster care could help Nebraska reduce placement moves and achieve more timely return home, adoption or guardianship.
- Understand and address racial inequities.
  - Stakeholders recommended that the Nebraska Children's Commission form a Race Equity and Inclusion committee to further examine racial disproportionality and provide targeted policy recommendations.
  - Future efforts should involve the tribes and the Indian Child Welfare Act Coalition.
- Address workload and turnover issues. The Office of Inspector General and the Foster Care Review Office have made several recommendations to improve workforce challenges:
  - Develop a formula to accurately measure current caseloads
  - Provide appropriate funding levels to support the right number of staff
  - Support an in-depth study of workforce issues
  - Providing adequate training, supports, and mentoring to retain staff
- Develop standardized data measures. In 2014, DCFS developed a monthly continuous quality improvement (CQI) process to standardize how performance outcomes are tracked. The process has begun to transform how the agency approaches service delivery and helps the agency prioritize resources and services. However, more standardization is needed.
  - Common data measures will go a long way toward ensuring that investments are targeted in the right places to improve outcomes for children and families.

  Data would also track movement in and out of the child welfare system, referred to as longitudinal data, rather than relying on a specific point in time, which does not give a full understanding of children's experiences while involved with the system.

14.6. OIG Annual Report, 2016-2017

In 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and oversight of the child welfare and juvenile justice System

and assist in improving system operations.[50] Much of this report covers topics unrelated to privatization.

Through investigations and reviews, the OIG reports having repeatedly uncovered evidence that high caseload and workload burdens, staff turnover, and vacancy issues for CFS staff have negatively impacted child welfare operations in Nebraska. The OIG has repeatedly noted in Annual Reports that DHHS has never complied with the minimum caseload standards required by Nebraska law since 2012.[51] TSG notes that the message seems confused about caseloads, as the DHHS report to Patrick O'Donnell (reviewed below) suggests that 89.9% of caseworkers statewide and 85.2% of PromiseShip case workers were compliance with caseload standards (Note the date of this report, 6 years ago). OIG complains that DHHS (statewide) has not fully addressed recommendations related to staffing, especially supervisory staffing, at the Child Abuse and Neglect Hotline. OIG does recognize that its recommendations for enhancing efforts to reduce caseworker turnover have been fully implemented. None of the findings in the OIG annual report indicated problems especially linked to PromiseShip or privatization.

14.7. Hornby Zeller, 2014

In December 2014, Hornby Zeller Associates delivered a second report this one prepared for the Nebraska Legislative Council. This reported an evaluation of the privatization "pilot project":

- Comparison of the performance of case management functions by Nebraska Families Collaborative (NFC) in the Eastern Service Area with that of the Department of Health and Human Services (DHHS) in the remainder of the State
- Analysis of whether case management should be a duty of the DHHS or performed by a private entity pursuant to a contract with the Department and whether the cost is reasonable, given the outcomes and cost of privatization
- Update to the information and data from the 2012 Assessment of Child Welfare Services in Nebraska report

This report began with speculation about the generic reasons for outsourcing Child Protective services. Years after-the-fact, the outsourcing was re-dubbed a "pilot" and Zeller projected objectives onto it. Their list is not bad, though the need to do that years down the road evidences the poor method by which outsourcing was launched in the first place. The report reminds us of what Lewis Carrol wrote, "If you do not know where you are going, then any road will get you there." Except it seems in 2009 DHHS neither knew the destination, nor found a useful road.

[50] This report is available at: https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20170913-145750.pdf
[51] Neb. Rev. Stat. § 68-1207.

Regarding outcomes, Zeller concluded there had been no benefit from outsourcing:

"At this point in the evolution of privatization in Nebraska, roughly five years since the start of the process and nearly three full years since the privatization of case management, it is clear that the outcomes achieved for families and children by NFC are no better than those produced by DHHS. Neither are they any worse.

"Noting that the results NFC has achieved are essentially the same as those DHHS produces does not, however, settle the question of whether privatization of the case management function should continue. If those results can be achieved at a lower cost, the State may still find privatization attractive, although that situation could no longer be characterized as a reform of child welfare."

Regarding cost savings, Zeller concluded costs were lower for PromiseShip:

When we looked simply at the total costs of serving child welfare cases, we concluded that DHHS spends an average of $98 per case per day, while NFC spends an average of $75. These are total costs, without regard to the source of the funds, i.e., state or federal. [Zeller did not provide the basis for these numbers, nor was TSG able to replicate them.]

In addition, Zeller observed disallowances of federal Title IV-E funds, which cost Nebraska over $20 million. These resulted from the structure of the privatization contracts where fixed payments were not linked to individual children and families.

Zeller laid out three options going forward. It dismissed the first as only avoiding disruption. It acknowledged that failure to achieve better outcomes favored the second. It argued that the third works to better address the underlying issues.

1. Stay the Course – leave the basic division of labor as it is now
2. Reverse Course – bring case management services back in house
3. Re-tool for Reform – fix the method of managing outsourced AND internal services

14.8. Digital Commons, University of Nebraska

In 2013, the Digital Commons center at University of Nebraska's Department of Psychology reported a "Case study of the effects of privatization of child welfare on services for children and families: The Nebraska experience".[52] The report reviews "twelve considerations in a description of the large-scale effort to privatize child welfare services in the state of Nebraska that began in 2008." The report concludes that, "the cost of child welfare services in Nebraska

[52] This report is available at:
https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1825&context=psychfacpub

increased by 27% and the private agencies invested over $21 million of their own funds as they attempted to uphold contracts."

The report struggles to apply general observations to the PromiseShip case. It lays out a generic mission for privatization:

"It is argued[53] that marketplace competition increases efficiency by making service providers motivated to be as productive as possible without wasted expense. It is also argued that effectiveness is increased through creation of a situation in which providers most capable of producing desired outcomes of child welfare services are rewarded by continued and increased funding. Further, some view the private sector as more capable of developing new services and changing in response to consumer needs. Finally, consumer choice and competitive bidding for government contracts is proposed to make agencies more accountable for delivery of desired outcomes."

If those were the reasons for the Nebraska outsourcing, the PromiseShip relationship is not established to drive improvement:

1. Efficiency. The contract as currently structured, provides cost advances, and protects Promise ship on the downside. It also provides no upside, were PromiseShip to improve cost performance
2. Providers are rewarded for outcomes. PromiseShip is offered no performance incentives, and faces no penalty for low case performance (other than the threat of sharing part of a federal fine)
3. Developing new services. TSG could not find any extent to which DHHS has encouraged (even allowed) PromiseShip to innovate in services practice. For example, PromiseShip created a 5-day-bed-hold to assure a placement is still available after a youth leaves the home. DHHS would not even record those charges in NFOCUS. In fact, PromiseShip has developed a number of innovations. However, TSG observed no window DHHS has into those innovations.
4. Consumer choice. The Nebraska outsourcing is not structured to enable families (youth) to select. The contract has not been rebid since inception—even the State has abrogated its prerogative of choice

The report highlighted a 2002 Child and Family Services Review (CFSR) that assessed seven safety, permanency, and wellbeing outcomes in regard to the provision of child welfare services.

[53] The Digital Commons report does say who established these as the objectives of the Nebraska case. Alas, why the State outsourced is core to understanding whether privatization has achieved its objectives. This is also addressed at the beginning of the TSG report

That audit reported that the state failed to achieve substantial conformity with any of the seven outcomes.[54]

The Digital Commons report goes on to explain that in September 2008, Nebraska's Division of Children and Family Services released their Recommendations for the Reform of Out-of-Home Care. That report made recommendations for reforming out of home care. Under the proposed framework, the DCFS would retain responsibility for "initial assessments of child or community safety and…for all key case decision making, such as decisions related to safety assessments, case plans and court reports, treatment needs, and recommendations for case closure, including adoptions". Responsibility for day-to-day provision of child welfare services and services coordination was to be allocated to private, contracting agencies. This is what led to the current contract with PromiseShip[55].

By 2011, most of the private agencies contracted by DHHS were failing. A state audit found that the cost of child welfare services in Nebraska increased by 27% over the course of the reform effort and the private agencies invested over 21 million dollars of their own funds as they attempted to uphold contracts. Further, the privatization effort had not created the intended improvements in the range and quality of services for children and families. [56]

The Digital Common report considered the effectiveness of privatization along ten dimensions. Along each dimension, the report concluded that DHHS was ill-prepared and failed to execute the privatization well.

The report reviews a federal report[57] and suggests that, "privatization alone is not capable of improving the quality of child welfare services or reducing their cost". The report suggests how important it is that "capability of the private sector to adequately deliver services must be carefully assessed". TSG did not find strong evidence to suggest that DHHS conducted such an assessment at the beginning. The report also argues that, "cost savings should not be a key reason for privatization, as they may not materialize". TSG did not find strong evidence that DHHS has documented a strong case one way or the other for cost reductions.

[54] U.S. Department of Health and Human Services (U.S. DHHS), Administration for Children and Families, Administration on Children, Youth and Families, Hubel et al. in Children and Youth Services Review 35 (2013) 30 Children's Bureau (2003). Final Report: Nebraska Child and Family Services Review. http://nlc1.nlc.state.ne.us/epubs/H8060/B002-2002.pdf

[55] As well as other private organizations, in the beginning

[56] Nebraska Department of Health and Human Services (DHHS), Auditor of Public Accounts (2011). Attestation report of the Nebraska Department of Health and Human Services Child Welfare Reform Contract Expenditures: July 1, 2009 through March 31, 2011. Lincoln, NE: Nebraska Auditor of Public Accounts

[57] U.S. Department of Health and Human Services (U.S. DHHS). Office of the Assistant Secretary for Planning and Evaluation (2007). Child welfare privatization initiatives: Assessing their implications for the child welfare field and for federal child welfare programs. http://aspe.hhs.gov/hsp/07/CWPI/site/report.pdf

The Digital Commons study concluded that, "Nebraska's experiment with privatization provides a clear warning to other states considering similar initiatives: the cost of providing services for the children that need child welfare services will increase if the government shifts responsibility for service provision to a private agency while remaining responsible for oversight of these services, at least in the near term." It further concluded that services outcomes had not improved as a direct result of privatization.

14.9. Hornby Zeller, 2012

The Center for the Support of Families and Hornby Zeller Associates was retained under authority of Legislative Bill 1160 conducted an evaluation of privatization efforts. 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. Readiness and capacity of any lead agency or the department to perform child welfare services
3. Usage, cost, and outcomes of residential placements within the past three years.

The overarching subject of the report was 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.

The report addressed 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?

Findings

Zeller looked at CFSR metrics, finding at 2011 that PromiseShip failed every target—and that the State also failed many (red italics) indicates failed federal CSFR target):

Table 14-5: 2011 CFSR metrics as Reported in Zeller

	Federal Target	Promise Ship	State	SE Region
Safety	94.6%	88.7	92.0	91.2
Reunified within 12 Months	48.4%	35.4	41.3	34.8
Re-entering Care within 12 Months	9.9%*	27.3	11.8	12.0
In Care 17+ Months Who Get Adopted	22.7%	10.9	23.0	28.1
In Care 17+ Months Who Are Freed	10.9%	10.7	13.3	14.9
Get Adopted within 12 Months	53.7%	23.7	56.5	71.1
In Care 24+ Months, Discharged to a Permanent Home	29.1%	22.4	37.1	39.3
Discharged to a Permanent Home	98.0%	94.3	97.5	99.4
In Care Less than 12 Months, Two or Fewer Placements	86.0%	82.9	86.4	87.5
In Care 12-24 Months, Two or Fewer Placements	65.4%	61.8	62.5	65.2
In Care 24+ Months, Two or Fewer Placements	41.8%	37.0	34.7	34.7

* Lower is better

In addition, Zeller reviewed the results of what they called a "Mini CFSR". That focused on more detailed process measures. For the 2010 PromiseShip received no "strength" ratings and failed all but six metrics. However, in the 2012 audit, PromiseShip failed only four metrics and received a "strength" rating in three areas. A dramatic improvement.

The 2012 report concluded:

1. It is not at all clear that privatization improved outcome achievement. Nor is it clear that it detracts from that achievement.
2. Whether the services are delivered privately or publicly, the approach will need to change if the outcomes are to improve.
3. 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
4. Inadequate measures were being used to guide internal operations. 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

14.10. Platt Institute, 2012

The Platt Institute published a report suggesting, Next Steps for Child Welfare Reform in Nebraska.[58] That report found:

Nebraska should follow the path of other states with difficult privatization implementation issues and fix the underlying systematic issues. The one unintended and painful benefit of privatization in Nebraska is that it has spurred the legislature to take comprehensive actions to fix child welfare services in a way that years of poor performance by the state agency did not. Privatization brings all the ongoing structural issues to the forefront of the discussion. Kansas and Florida, the two states with statewide implementation of privatized case management, had privatization difficulties similar to Nebraska. However, they did not turn back case management function to the state child welfare agency. Instead they persevered to develop a higher-quality child welfare system.

…the evidence does not justify returning all child welfare case management back to state provision. In fact, state provision of services is also suffering from similar negative outcomes for children. Rather than institute yet another reorganization plan, the legislature should give DHHS an opportunity to present and implement their operational plan

…Given that … these agencies along with DHHS have been working together to develop an operational plan to resolve many of the issues in the Health and Human Services Committee's December 15 [2011] report, they should be invited in to participate in a collaborative effort to rectify all the specific issues."

14.11. DHHS Report to the Legislature: Legislative Resolution 37 (2011): Review, Investigation and Assessment of Child Welfare Reform

In this report, DHHS says, "Privatization is a tool, not an end in itself, to child welfare reform."[59] The report goes on to admit, "The success of states and communities in addressing child welfare is primarily predicated on ensuring that all three branches of government are involved in the development of a strategic plan and an implementation plan *prior to initiating contracting with statewide lead agency*." (TSG added italics)

This report acknowledges: "a contractor's ability to perform will be limited by many of the same barriers faced by the previous public system…Private agency workers experience the same frustrations that public agency workers experience such as high stress, lack of career advancement opportunities, and lack of educational preparation for child welfare work.

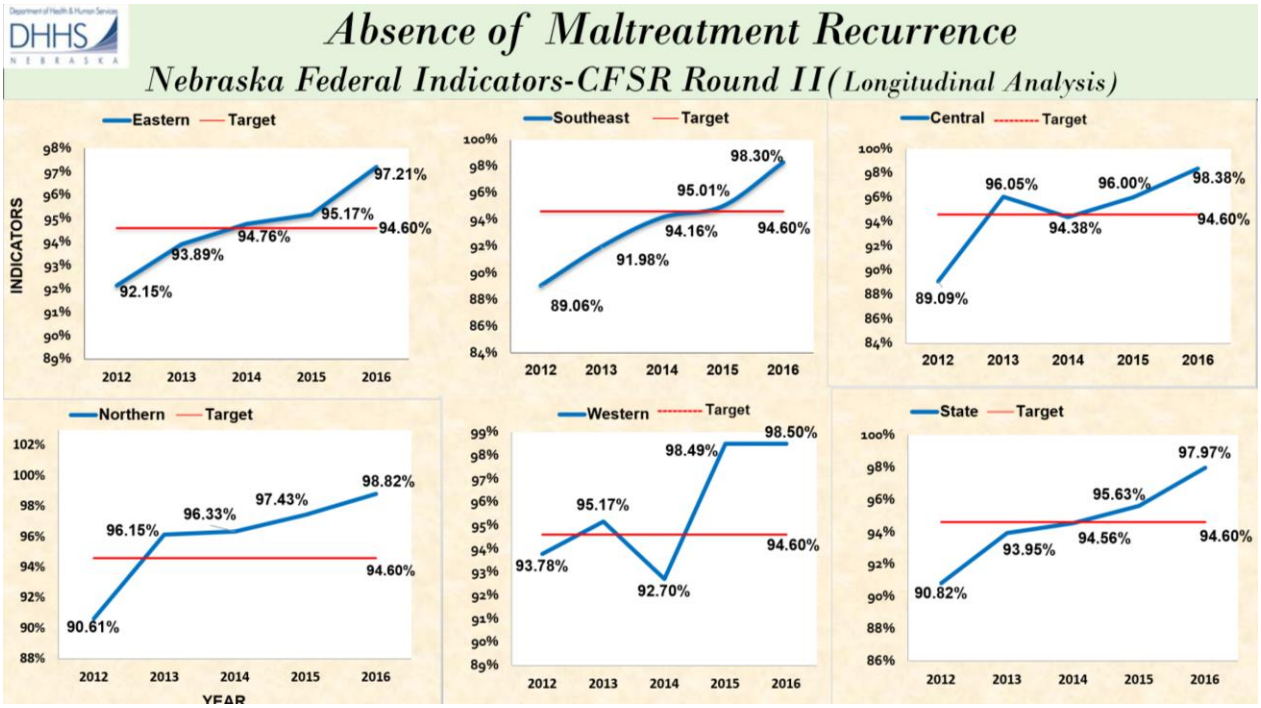
[58] This report is available at: https://www.platteinstitute.org/Library/docLib/20120208_Child_Welfare_report.pdf
[59] This report can be viewed at: https://nebraskalegislature.gov/pdf/reports/committee/health/lr37_intro.pdf

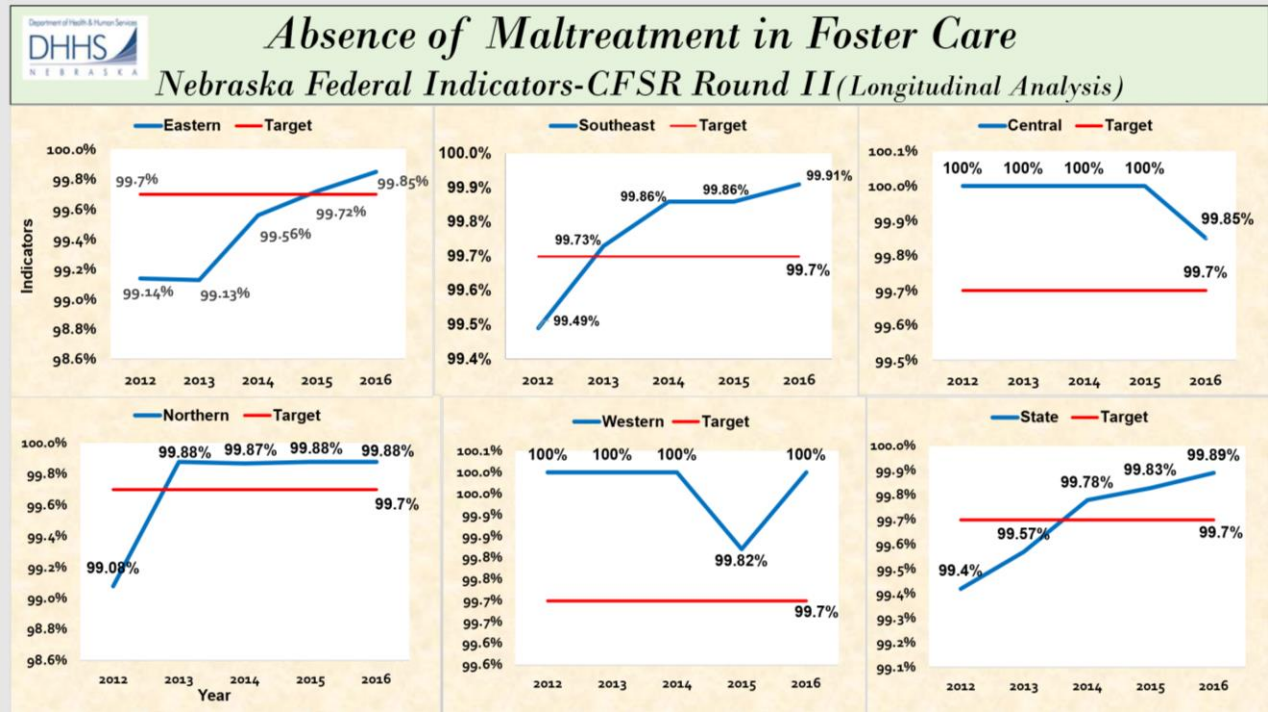
Early results indicate that simply transferring case management and decision making to the private sector may not improve case outcomes without adequate social, physical, and mental health resources; and foster and adoptive homes in communities; and qualified agency staff that are offered ample supports."

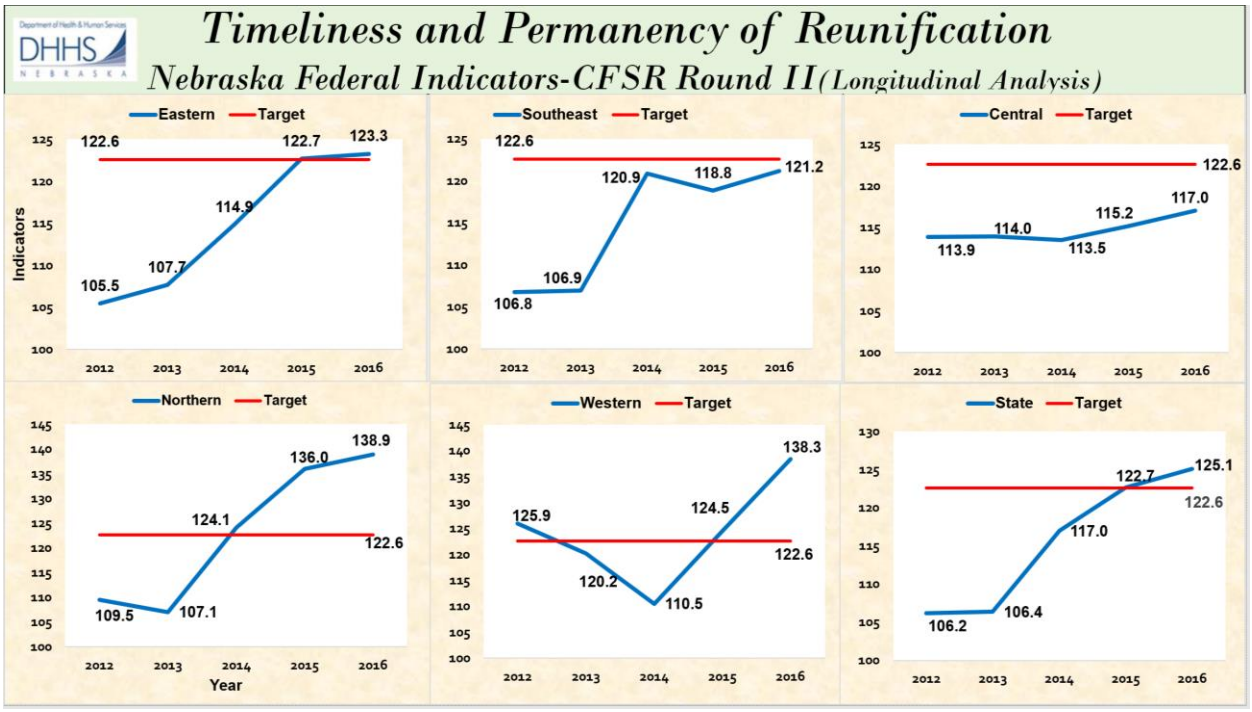
This DHHS report is essentially a forecast of the ensuing six years—while DHHS acknowledged the challenges, it did not address them.

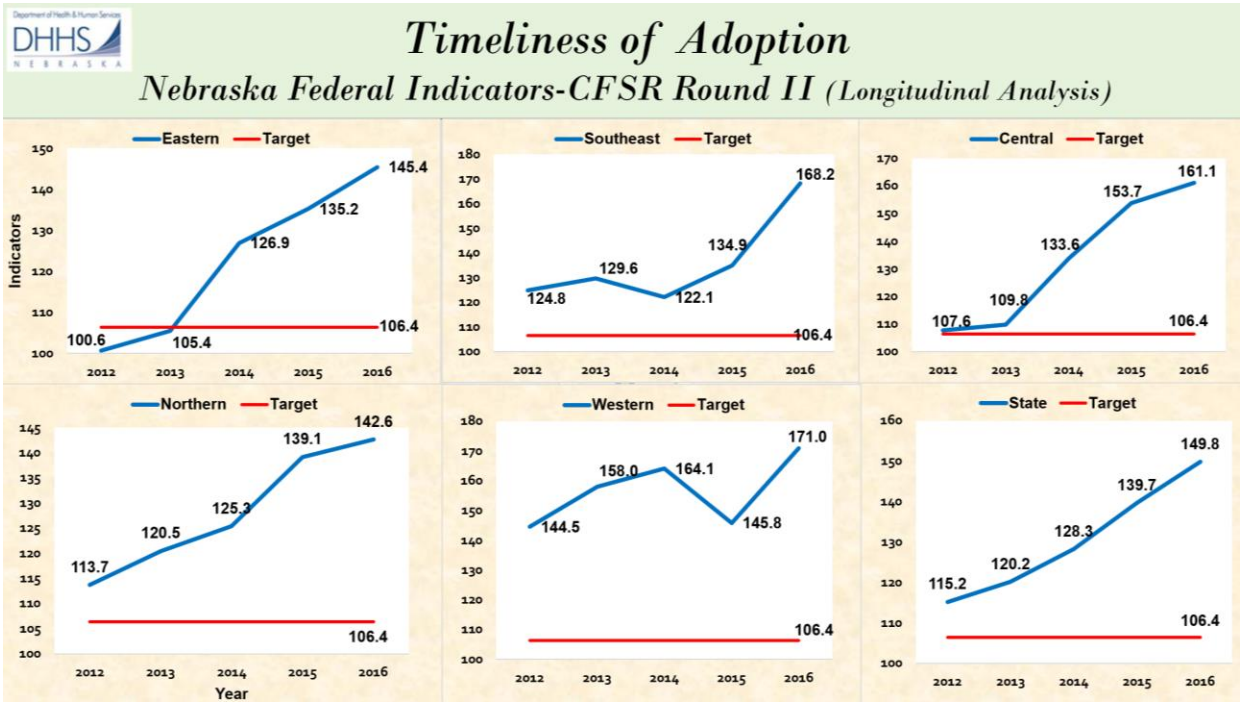
15. APPENDIX B: PERFORMANCE ON CFSR ROUND II MEASURES

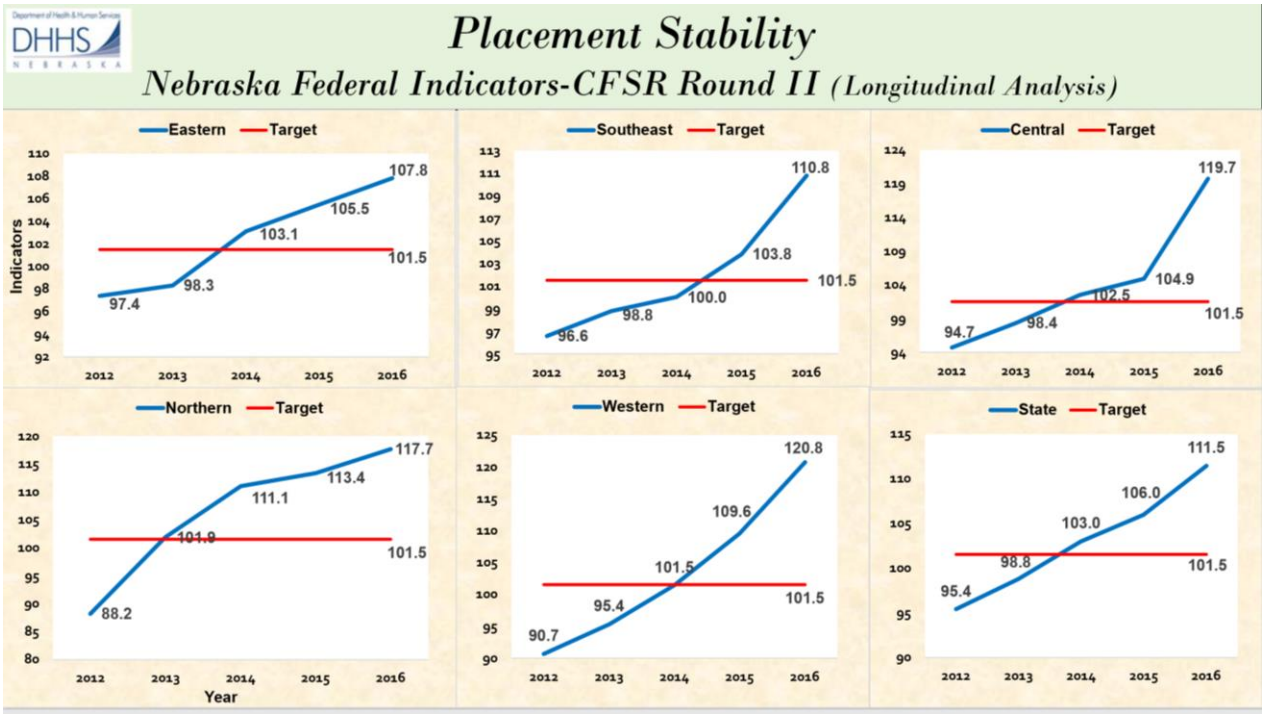
Note that the following graphs were prepared by DHHS and shared with TSG in December 2018.




Absence of Maltreatment in Foster Care
Nebraska Federal Indicators-CFSR Round II (Longitudinal Analysis)
Eastern Target
99.7% 99.7% 99.7% 99.7% 99.7%
99.14% 99.13% 99.56% 99.72% 99.85%
Southeast Target
99.7% 99.7% 99.7% 99.7% 99.7%
99.49% 99.73% 99.86% 99.86% 99.91%
Central Target
99.7% 99.7% 99.7% 99.7% 99.7%
100% 100% 100% 100% 99.85%
Northern Target
99.7% 99.7% 99.7% 99.7% 99.7%
99.08% 99.88% 99.87% 99.88% 99.88%
Western Target
99.7% 99.7% 99.7% 99.7% 99.7%
100% 100% 100% 99.82% 100%
State Target
99.7% 99.7% 99.7% 99.7% 99.7%
99.4% 99.57% 99.78% 99.83% 99.89%
Indicators
Year
2012 2013 2014 2015 2016


Timeliness and Permanency of Reunification
Nebraska Federal Indicators-CFSR Round II (Longitudinal Analysis)
Eastern Target
122.6 122.6 122.6 122.6 123.3
105.5 107.7 114.9 122.7 123.3
Southeast Target
122.6 122.6 122.6 122.6 121.2
106.8 106.9 120.9 118.8 121.2
Central Target
122.6 122.6 122.6 122.6 122.6
113.9 114.0 113.5 115.2 117.0
Northern Target
124.1 124.1 124.1 124.1 122.6
109.5 107.1 124.1 136.0 138.9
Western Target
124.5 124.5 124.5 124.5 122.6
125.9 120.2 110.5 124.5 138.3
State Target
122.7 122.7 122.7 122.7 122.6
106.2 106.4 117.0 122.7 125.1
Indicators
Year
2012 2013 2014 2015 2016


DHHS NEBRASKA
Timeliness of Adoption
Nebraska Federal Indicators-CFSR Round II (Longitudinal Analysis)
Eastern Target
100.6 105.4 126.9 135.2 145.4 106.4
Southeast Target
124.8 129.6 122.1 134.9 168.2 106.4
Central Target
107.6 109.8 133.6 153.7 161.1 106.4
Northern Target
113.7 120.5 125.3 139.1 142.6 106.4
Western Target
144.5 158.0 164.1 145.8 171.0 106.4
State Target
115.2 120.2 128.3 139.7 149.8 106.4
Indicators
Year
2012 2013 2014 2015 2016


DHHS NEBRASKA
Placement Stability
Nebraska Federal Indicators-CFSR Round II (Longitudinal Analysis)
Eastern Target
97.4 98.3 103.1 105.5 107.8 101.5
Southeast Target
96.6 98.8 100.0 103.8 110.8 101.5
Central Target
94.7 98.4 102.5 104.9 119.7 101.5
Northern Target
88.2 101.9 111.1 113.4 117.7 101.5
Western Target
90.7 95.4 101.5 109.6 120.8 101.5
State Target
95.4 98.8 103.0 106.0 111.5 101.5
Indicators
Year
2012 2013 2014 2015 2016

16. APPENDIX C: ADDITIONAL FINANCIAL ANALYSIS BEYOND COST PER CASE

TSG also analyzed differences in caseload and turnover between ESA and the other Service Areas.

16.1. Provider Payment Structure

The contract as currently amended pays PromiseShip a monthly advance with a true-up to "actual and allowable" costs. The contract was most recently amended August 30, 2018[60]. Key payment provisions now include,

"Fixed payment of $1,750,000 each month for services provided July 1,2017 through August 31, 2018, ... ln addition to the above fixed payments, DHHS will pay to Subrecipient an advance payment of $5,500,000.00 each month for actual and allowable costs of services provided from September 1, 2018 through June 30, 2019

"No variable payment shall be due and owing for services provided on or after September 1, 2018

"lf Subrecipient's total actual and allowable costs pursuant to this subaward are less than the total advance payments paid to Subrecipient under Article ll, Section B (1), (2), and (3) for the period of reconciliation, DHHS may withhold the difference from the next advance payment, and if the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS shall reimburse Subrecipient for the difference"

"If Subrecipient's total actual and allowable costs pursuant to this subaward are less than the total advance payments paid to Subrecipient under Article ll, Section B (1), (2), and (3) for the period of reconciliation, DHHS *may* withhold the difference from the next advance payment, and if the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS *shall* reimburse Subrecipient for the difference up to and including the total subaward specified in Article II, Section A. At the end of the subaward term, DHHS will conduct a final reconciliation consistent with the terms of this Agreement, and if the total actual and allowable costs reported pursuant to this subaward are less than the total compensation paid, Subrecipient shall repay the excess funds to DHHS." (italics added)

Thus, PromiseShip is no longer paid a variable rate for services, but a fixed amount of $5.5 million per month ($66 million annualized). This advance payment amount is considerably less than prior year payments totaling $70.8 million for SFY 2018. However, these payments are considered an "advance" and the contract requires a true-up. The contract anticipates

[60] Case Management Subaward Between the Nebraska Department of Health and Human Services and Nebraska Families Collaborative Amendment Three, dated February 12, 2018

"reconciliations" of actual cost, not more often than monthly. As a result of the reconciliation, the State "may" recover any overpayment and "shall" reimburse for any shortfall.

The contract says that PromiseShip must repay any amount that payments exceed actual costs. However, it seems to leave open the question of what happens if actual expenses exceed the amount of the original contract in 2016. Also unclear is what happens if actual expenses are between $66 million and $71 million.

16.1.1. Fee for service, value-based and performance-based contract elements

TSG did not observe any aspects of the contract or payment structure that hold PromiseShip accountable (or reward PromiseShip) for outcomes performance. PromiseShip seems to be at risk if the State incurs a penalty for underperforming the federal metrics. PromiseShip is at risk if the whole state falls below the federal standards, and then to the extent federal penalties derive from PromiseShip performance. However, the mechanics of implementing that seem unclear, and are untested.

16.1.2. Controls

PromiseShip reports it has controls over provider payments at several points:

- A provider payment cannot be initiated unless the case is set up in N-FOCUS, then again in FAMCare
- Services cannot be ordered without a Services Referral, which is approved by the Supervisor as well as Utilization Management
- Rates for services are set in the system, not subject to change outside the rate approval process
- Rates for services are the same across all providers
- Utilization Management verifies the availability of Medicaid or third-party insurance in 100% of cases before the services are initiated
- Payments are initiated by the system only, not manually. Using system-level controls

TSG is not in a position to test compliance of these controls. State Internal Audit has already reviewed and reported on the question of compliance.

However, without testing the controls, TSG does feel controls are not especially strong:

- Manually entering into two systems is inherently a control issue
- Manual reconciliation of the two systems is weak control
- Summing some charges outside the system is a dangerous practice—one which unnecessarily adds changes for error
- Failure to automatically compare the entries in both systems invites inevitable differences
- Delays alerting FAMCare of case closure inevitably leads to billing errors

- Supervisor and Utilization Management reviews offer a weak form of control. The practice makes sure the PFS knows "someone is watching," but this form of control is not a strong method of assuring that charges are appropriate
- Ultimately, building a trusting, collaborative work relationship between DHHS and PromiseShip would offer the best form of control. TSG did not find that sort of relationship. TSG was not made aware of any efforts toward collaboration on addressing the control issues both parties seem well aware of.

16.2. Description of Provider Base and Payments

16.2.1. Services are spread across 316 providers

PromiseShip has paid for services provided by 316 payers in the past three years[61]. KVC is the largest, and formerly shared case management in the region with PromiseShip as one of the outsourced services providers. Father Flanigan's is also known as Boys Town.\

Table 16-1: Services Concentration

	SFY 2016	SFY2017	SFY2018
KVC Behavioral Healthcare Nebraska	4,206,625	3,830,084	4,090,474
Father Flanagan's Boys' Home	4,146,647	4,684,543	4,064,499
Omni Behavioral Health	2,877,408	3,275,215	3,291,796
Beneficial Behavioral Health S	2,659,165	3,282,573	2,913,813
Apex Foster Care, Inc	2,056,733	2,491,433	2,755,903
Heartland Family Service	968,411	1,233,037	1,835,108
Child Saving Institute	1,487,732	1,688,449	1,665,877
Lutheran Family Services	2,123,185	1,823,670	1,601,821
Nebraska Children's Home Society	1,403,767	1,607,398	1,481,236
Owens & Associates, Inc	1,402,552	1,681,204	1,339,610
Release Ministries, Inc.	667,582	670,641	1,285,372
Children's Square U.S.A.	803,699	1,144,590	1,231,665
Christian Heritage	857,804	1,034,879	1,044,891

[61] TSG analysis of PromiseShip data in the file "7 - Contract network details - Oct 18.2018.xls"

16.2.2. Many Services are Contracted to Only a Few Providers

PromiseShip contracts with multiple providers for most charge codes. FAMCare includes 247 charge codes for different services type. Some of the most competitive charge types are listed in the table below. PromiseShip draws on 60 providers for Individual Therapy and 20 for Group Therapy[62].

Table 16-2: PromiseShip Multiple Providers

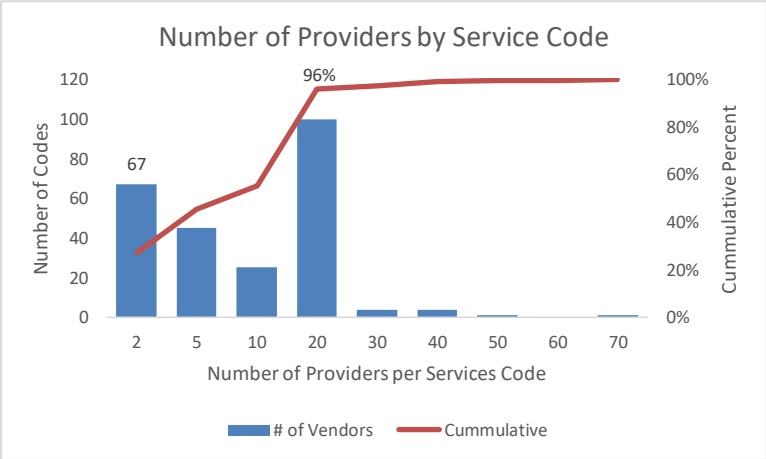
Sample of Largest Service Types	Number of Providers
Individual Therapy	60
Initial Diagnostic Interview	43
Family Therapy	37
Interpreter/Translation Services	34
Parenting Time (Visitation)	32
Psychological Testing	32
Family Support Services	27
Child Care-Daily	24
Child Care-Hourly	23
Group Therapy	20

The largest providers by amount are listed in the table below, which lists all providers with 2018 payments greater than $1 million.

For many services codes, PromiseShip draws on fewer providers. Fully 27% of services codes are sourced from a single provider. The chart below shows that 67 codes have only one provider (i.e. fewer than 2), and that 96% of charge codes draw on fewer than 20 providers. Or, said another way, only 4% of services are competed to 20 or more providers. TSG is not in a position to have an opinion on whether this is "enough," only observes a high incidence of services being contracted to a few providers.[63]

[62] TSG analysis of PromiseShip data covering contracts between 7/2017 through 10/2018. This data comes from a PromiseShip file: "Contract network details - Oct 18.2018.xls"
[63] TSG analysis of PromiseShip data in the file "7 - Contract network details - Oct 18.2018.xls"

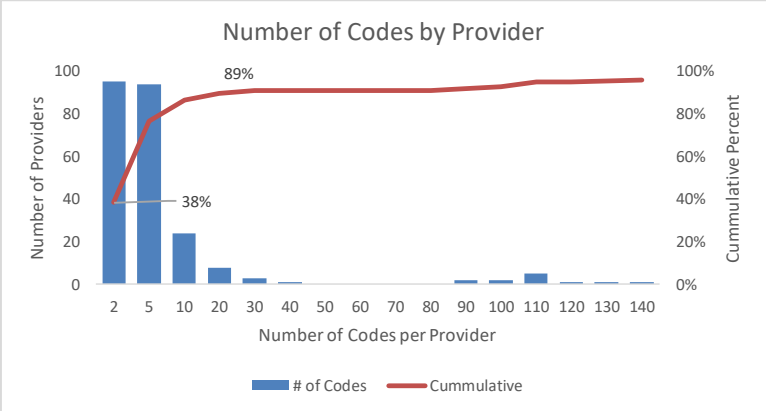
Figure 16-1: PromiseShip Number of Services by Provider



16.2.3. Many Providers Provide Narrowly-focused Services

PromiseShip providers tend to provide services under only a few billing codes. TSG found that 89% of providers bill fewer than 20 codes. 38% bill only one code (i.e. fewer than 2 in the chart).[64]

Figure 16-2: PromiseShip Number of Codes by Provider



The table below shows the providers with the broadest services offerings.

[64] TSG analysis of PromiseShip data in the file "7 - Contract network details - Oct 18.2018.xls"

Table 16-3: PromiseShip Number of Service Codes by Provider

Sample of Largest Providers	# of Service Codes
Boys Town	131
OMNI	125
CSI	112
Lutheran Family Services	106
APEX	105
NOVA Treatment Community	103
NE Children`s Home	101
KVC	100

16.2.4. Dollar Value of Services Highly Concentrated

TSG found that 18% of the $129 million of contract payments over the past 3 years has been to Kinship Foster Parents managed directly by PromiseShip. Boys Town (Father Flanagan's Boys' Home) received 10% of contract payments. TSG found that 95.5% of PromiseShip providers (other than Kinship Parents) billed less than $2 million over the past 3 years.[65]

[65] TSG analysis of PromiseShip data in the file "8 - PromiseShip payments by provider State FYs 2016 – 2018.xls"

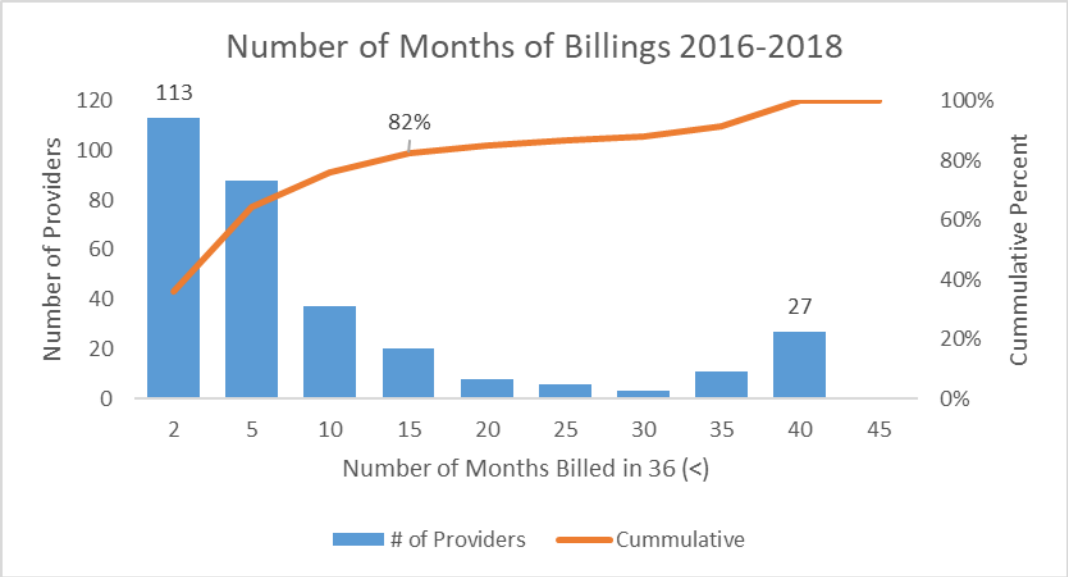
Table 16-4: PromiseShip Provider Concentration

Sample of Largest Providers	Amount over 3 Years	Percent of All Contracts
Kinship foster parents	$22,796,200	18%
Father Flanagan's Boys' Home	12,895,689	10%
KVC Behavioral Healthcare Nebraska	12,127,183	9%
Omni Behavioral Health	9,444,419	7%
Beneficial Behavioral Health S	8,855,552	7%
Apex Foster Care, Inc	7,304,069	6%
Lutheran Family Services	5,548,677	4%
Child Saving Institute	4,842,058	4%
Nebraska Children's Home Society	4,492,401	3%
Owens & Associates, Inc	4,423,365	3%
Heartland Family Service	4,036,556	3%

One aspect of these small relationships with many providers is that providers do work for PromiseShip on an on-and-off basis. The chart below shows that only 27 of 313 providers billed all 36 months during the period. Most (82%) providers billed for services fewer than 15 months out of the past 36. The chart also shows that 113 (36%) billed for only one month of services during the three years. Accordingly, PromiseShip maintains a great many provider relationships for which it only rarely contracts services.[66]

[66] TSG analysis of PromiseShip data in the file "8 - PromiseShip payments by provider State FYs 2016 – 2018.xls"

Figure 16-3 PromiseShip Number of Billing Months by Provider



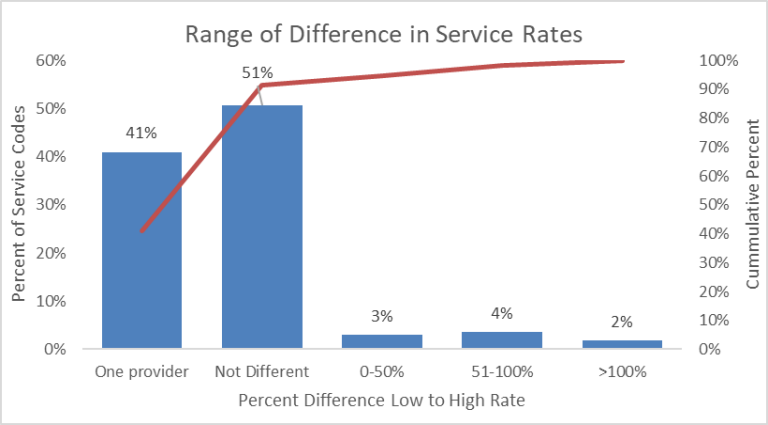
16.2.5. Payment rates vary little by provider

PromiseShip pays the same rates for most services types. PromiseShip provided detail charges by provider for all provider charges in September 2018, this represented 9,741 charges. TSG requested this sample, as a reasonable representation of actual charges (not depending merely on rate books).

For 41% of services types, PromiseShip uses only one provider. For the next 51% (total of 92%) there is no rate difference between the providers. The remaining 8% have percentage differences as shown. Most (83%) of the total payments where rate variance is large was for kinship payments. Thus, services rates were the same for virtually all payments to commercial providers in September.[67]

[6767] TSG analysis of PromiseShip data in the file "8 - PromiseShip payments by provider State FYs 2016 – 2018.xls"

Figure 16-4: PromiseShip Range of Service Rate Differences



16.2.6. The five-day bed-hold

One notable difference between the State and PromiseShip cost structures is the "5-day bed hold." These contracts provide emergency agency supported family foster care beds for up to five days and allow PromiseShip to avoid the tragic experiences of other states, where children in transition are forced to sleep in cars, motels, offices or other unsuitable arrangements. PromiseShip contracts for these services with KVC and Omni Behavioral Health. The Auditor of Public Accounts' report questioned these costs. PromiseShip supports this service as necessary and reasonable[68]:

- Prevents the tragic experiences of other states
- Places children in a safe supported family setting
- Prevents night to night placements that harm children
- Provides a short period of time to coordinate the appropriate next long-term placement / treatment setting for these youths
- Provides time to coordinate services that allowed 5 children to return home, preventing an extended stay in foster care
- Allows providers to build specialized targeted family foster homes specifically designed to serve this unique group of youth, avoiding costlier residential placement

PromiseShip paid for 5-day bed hold services on behalf of 130 children. According to PromiseShip, the total cost of 5-day bed hold for these children was $142,850[69]. This included $36,450 that was paid to the providers to ensure that a specialized placement was available

[68] TSG analysis of the arguments provided by PromiseShip in the document 23 - 5-day bed Fact Sheet v2.pdf
[69] TSG is merely reporting numbers provided by PromiseShip in the document 23 - 5 day bed Fact Sheet v2.pdf

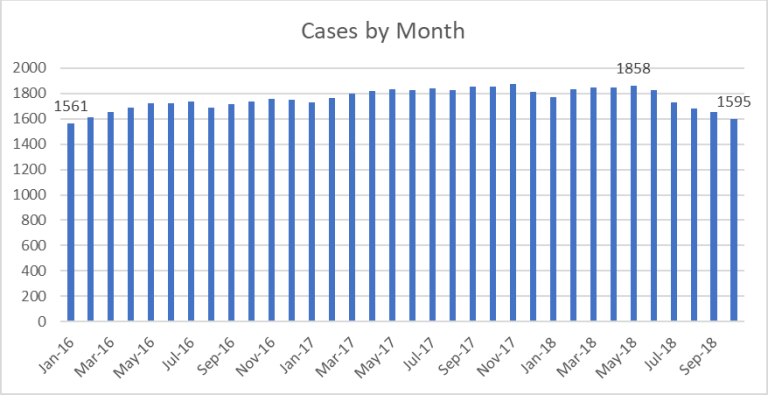
whenever it was needed and $106,400 paid for the actual bed days utilized. TSG observes that the argument for benefit seems strong and the overall financial impact is relatively small.

16.3. Caseloads

16.3.1. Total number of ESA cases, past 3 years

The total number of cases managed was about the same in October 2018 as in January 2016. Cases grew modestly through 2017 and have recently been declining. See table below.[70] Note that this data is from PromiseShip and differs slightly from the data used for the cost per case analysis. This data was used in this section of the report because the assessment is about PromiseShip and its operations, not comparing to other Regions.

Figure 16-5: PromiseShip Cases by Month



The mix has shifted to court cases, which have increased from 78% to 88% of total cases since January 2016. Much of this has resulted from a shifting away from complex cases, which have dropped from 10% to 3%. In addition, the percentage of non-court cases has dropped from a high of 10% to the current 7%.

PFSs working court cases tend to have larger caseloads. PFS

16.3.2. Individual caseloads

PromiseShip PFSs are managed in teams linked to the court their cases are in, so the non-court cases are managed in a separate team as well. While the average SFY 2018 PromiseShip caseload is 11.1, individual monthly caseloads range from 1 to 25 in the ESA, and up to 48 in the rest of the state[71]. Caseloads are lower in the ESA, as shown in the table and chart below. The

[70] TSG analysis of PromiseShip data in the file "Request 30 Caseload – revised.xlsx"
[71] TSG analysis of data from DHHS in the file, "Caseload for Stephen Group v3.xlsx"

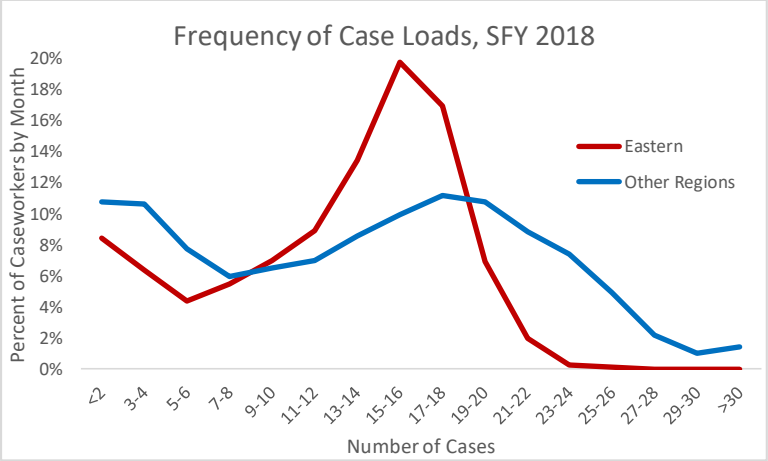
number of monthly PFS caseloads managed by PromiseShip was 2,298 in SFY2018; that is roughly 200 case workers for 12 months.

TSG notes how the ESA caseload distribution is more concentrated around the average, while in the rest of the state caseloads are spread out across a wider range as well as a higher average.

Table 16-5: Caseload Average Compared

	Eastern	Other Regions
Average	11.1	12.2
Median	13	12
Max	25	48
Number of monthly caseloads	2,298	2,819

Figure 16-6: Frequency of Caseloads by Caseworker

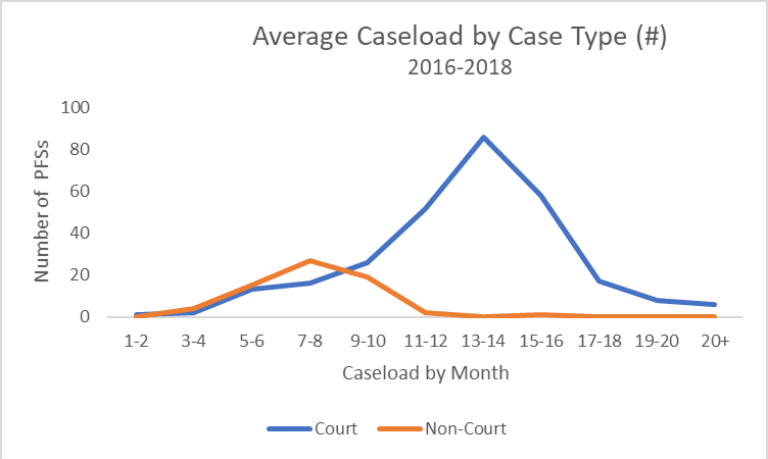


16.3.3. Caseloads, comparing court and non-court

PFSs who work court caseloads carry larger caseloads. The chart below graphs monthly caseload for court and non-court PFSs since 2016[72]. The first chart shows that relatively fewer PFSs work non-court cases. The most frequent (mode) caseload for a non-court PFS is 7, while for a PFS working court cases is 13. The averages are 12.4 and 6.9 respectively.

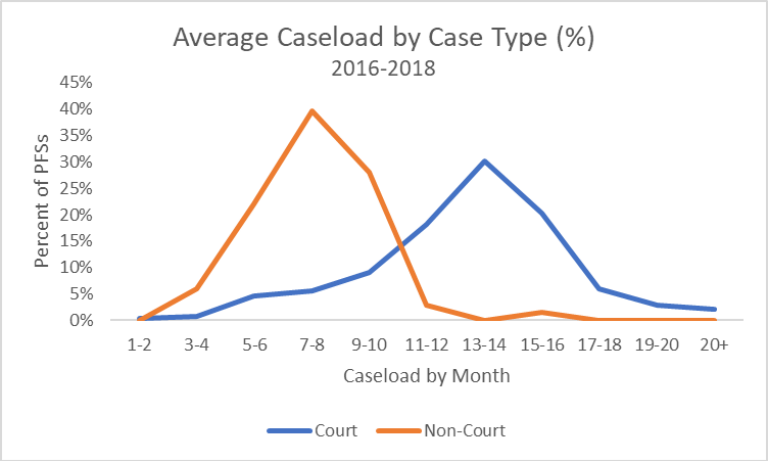
[72] TSG analysis of PromiseShip data in the file "Request 30 Caseload – revised.xlsx"

Figure 16-7: Average Caseload by Case Type – Number



The second chart, below, graphs the same information as a percent of total cases. This demonstrates that PFSs working court cases have a wider range of caseloads[73].

Figure 16-8: Average Caseload by Case Type – Percent



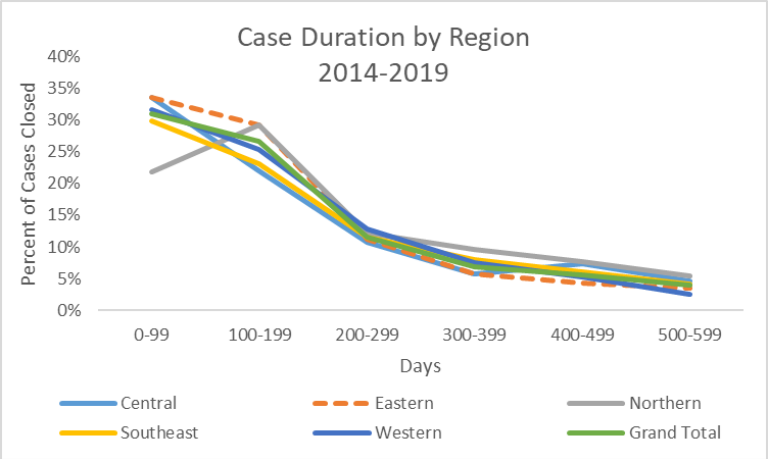
16.3.4. Case duration

Cases tend to stay open about the same length of time across all regions. The chart below presents the percent of each region's cases (y-axis) that closed in various numbers of days (x-

[73] TSG analysis of data provided by PromiseShip in the file, Request 30 Caseload – revised.xlsx

axis)[74]. The data covers cases closed in the calendar years between 2012 and September 2018. Each region tends to close between 30 and 35% of cases within 99 days. In ESA (PromiseShip), 12% of cases remained open longer than 599 days, in Southeast region, 17% (not shown). Thus, Eastern cases may be closed a bit faster than cases in other regions, but not by a significant amount.

Figure 16-9: Case Duration by Region

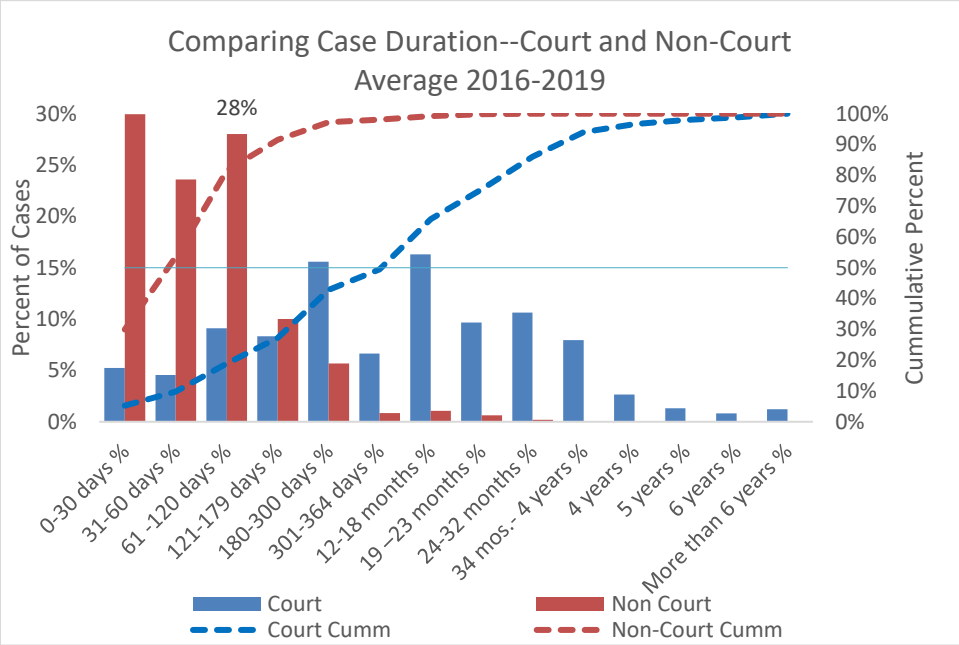


16.3.5. Case duration comparing court to non-court

Court cases are typically placed out of home. The chart below shows the percent of cases that are open at points of time. It compares cases with "court involved youth", to those that are without court supervision. For example, on average over the past 3 years, 28% of Non-Court cases have been open 31-60 days (two months). The median[75] range for Court cases is in the range 301-365 days, nearly 3 years[76].

[74] TSG analysis of data from DHHS in the file, Stephens Group Days Case Open.xls
[75] Half of cases are older, half newer. That is, where the cumulative percent line crosses 50%
[76] TSG analysis of PromiseShip data in the file, 26 - Data Request #26.xls

Figure 16-1024: Comparing Case Duration Court and Non-Court



The chart above suggests a strong benefit for PromiseShip when cases are taken on by the court: they last 3 years instead of 2 months. Under the payment method of per case per month, PromiseShip is paid on average 18 times as much for a Court vs. Non-court case. Note that this is average. The chart shows that some Court cases are sometimes be closed more quickly that some Non-court cases. However, on the median, court cases last much longer.

16.3.6. Caseload comparing Court and Non-court, In and Out of Home

Court cases are generally out of home, but not always. While only 1% of cases are non-court cases managed out of home, fully 16% of court cases are managed in-home. This is shown in the table below[77]. The "Other" category includes cases that were moved in or out of court during the month, and complex cases.

[77] TSG analysis of data provided by PromiseShip in the file: Request 30 Caseload – revised.xlsx

Table 16-6: Caseload comparing Court and Non-court, In and Out of Home

	Court	Non-Court	Other	Total	Court	Non-Court	Other	Total	Court	Non-Court	Other	Total
Out of Home	1,189	14	54	1,257	84%	12%	82%	79%	95%	1%	4%	100%
In home Master Case	219	107	12	338	16%	88%	18%	21%	65%	32%	4%	100%
Total Cases	1,408	121	66	1,595	100%	100%	100%	100%	88%	8%	4%	100%
In Home Youth	347	261	23	631								
Youth/Master Case	1.6	2.4	1.9	1.9								

16.3.7. Caseloads compared to federal standard

Another important aspect of cases in shown in the table above. Throughout the TSG analysis, we use master case count for in-home cases and youth count for court-involved cases. See that for PromiseShip, court-involved cases average 1.6 youth, while non-court cases involve 2.4 youth.

16.3.8. Caseload by PFS over time, comparing court and non-court

Median caseloads have increased since SFY 2017[78]. In 2017, the median caseload for a PromiseShip PFS working court case was 14. In contrast, the median caseload for a non-court case was 9. Caseloads in 2018 have dropped considerably. Median court caseload dropped from 14 to 12. Median Non-Court caseload dropped from 9 to 5.

Table 16-7: Caseload by PFS over time, comparing court and non-court

	Oct 2017			Oct 2018			Non-Court/Court Caseload	
	Court	Non-Court	Total	Court	Non-Court	Total	2017	2018
Average Cases	13.8	9.8	13.2	11.5	5	10.3	71%	43%
Median Cases	14	9	14	12	5	11	64%	42%

[78] The analysis in this section is based on data provided by PromiseShip in the file, 28 - Data Request #28.xls

Thus, all caseloads have declined for both court and non-court cases. In addition, the relationship between court and non-court caseloads has widened considerably. In 2017 a non-court case worker carried 64% of the median caseload for a court worker. Today, the gap has widened to 42%.

16.4. Caseloads Compared to Federal Standard

Caseload standards are offered by the Council on Accreditation.[79] The standard is, "Ongoing and preventive services workers should be working with no more than 15-18 families (cases) at a time, with no more than 10 children that are in an out-of-home placement. The table below is taken from a federal compliance report for October 2018 and shows that each region except Northern meets the caseload hurdle. It also confirms that the ESA (PromiseShip caseloads are smaller than other regions.

Table 16-8: Statewide Report of Federal Caseload Compliance

Statewide Report of Federal Caseload Compliance			
Average of October 2018			
Service Area	Total Staff	Staff in Compliance	Percent in Compliance
Central	60	56	93.3%
Eastern	203	196	96.6%
Northern	61	52	85.2%
Southeast	95	87	91.6%
Western	53	43	81.1%
State	473	436	92.2%
Green indicates improvement from prior month			
Red indicates regression from prior month			

16.5. Turnover

Turnover is the subject of a confusing array of methods. DHHS and PromiseShip reported it in a different manner. Federal compliance metrics do not seem to point to the real question. Turnover is important because when a case manager leave case work a new case worker must be

[79] For further information, see: https://coanet.org/standard/cps/14/

trained. It takes many months of training and experience to reach full performance. The cost is high when Nebraska loses a caseworker—both financially and to case continuity.

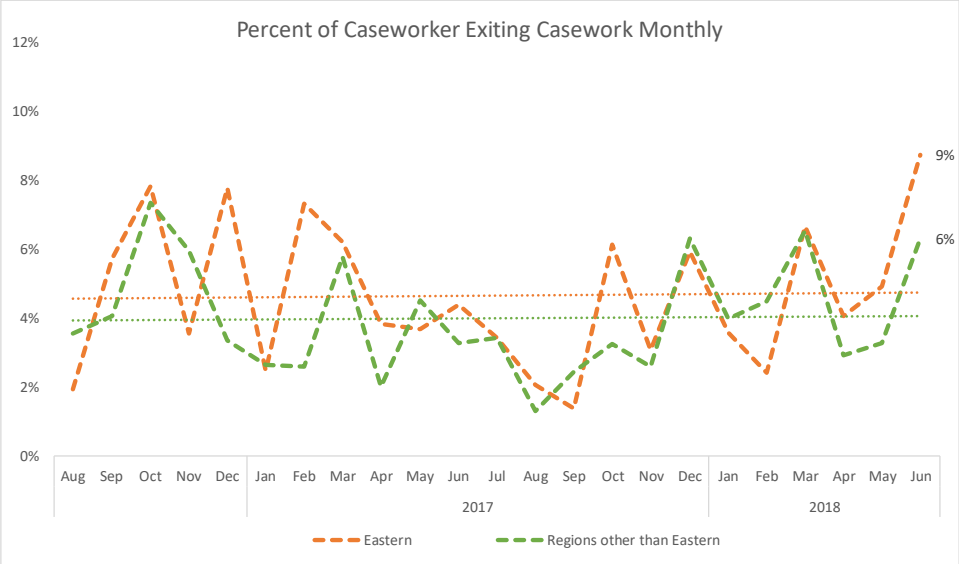
16.5.1. Assessing Turnover by Observing Case Workers' Actual Case Assignments

TSG assess caseworker turnover by looking not at employment, but at actual case assignments. For this analysis, it is less important whether a person left employment—rather whether she is still working cases. A state caseworker can transfer to other positions within the State, while a PromiseShip employee has more limited options for transfer. The TSG analysis factors all this out—looking simply at whether the worker is managing cases.

The method was to observe by individual whether the number of cases was non-zero. When an individual stopped working cases, that was deemed an "exit".[80]

Using this method, TSG found that in the ESA about 4% of caseworkers stop carrying cases each month, a rate that has held consistently through the past two fiscal years. This is similar to rest of the State.[81] PromiseShip believes it is experiencing slightly more turnover recently because of uncertainty about the future of the DHHS contract.

Figure 16-11: Percent of Caseworkers Exiting Case Work

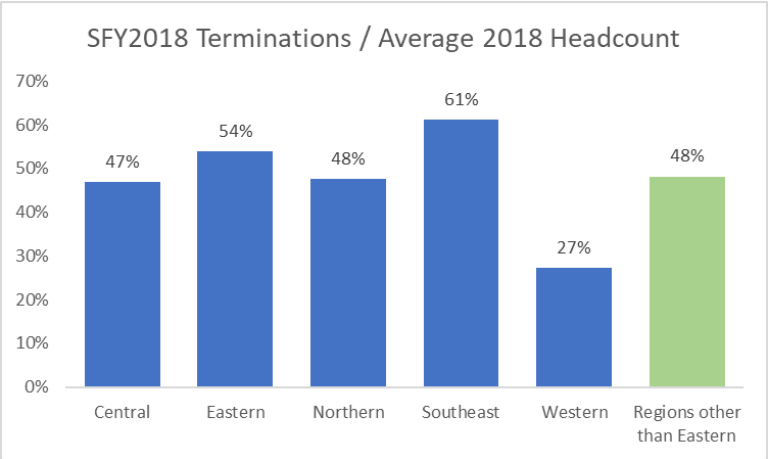


[80] TSG is using the term "exit" to distinguish from "termination" which suggests change in employment. The purpose is to observe when an individual must be replaced as a case manager

[81] TSG analysis of DHHS data from the file "Caseload for Stephens Group v3.xlsx"

Annually, 51% of caseworkers leave case work each year across the state. The rate is slightly higher in ESA, as shown in the chart below.

Figure 16-12: Terminations / Count of Caseworkers

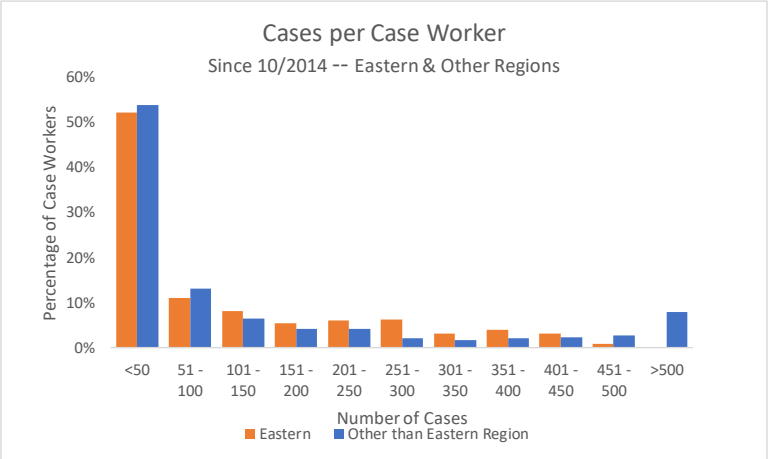


16.5.2. Case Workers Working Cases for Fewer than 36 Months

TSG recognizes that turnover is costly. After completing formal training, 95% of caseworkers work cases for fewer than 36 months. The chart below shows that 41% of ESA case workers manage cases for fewer than 6 months (37% for the rest of the state). It shows a tendency for a few case workers to remain longer—well beyond 36 months. In general, state case workers carry heavier caseloads (analysis above) and stay longer than PromiseShip PFSs. However, both groups lose case workers quickly, which is also a national trend. This compares with data from PromiseShip showing that the average length of employment for people who left employment in the past 90 days is 499 days—less than 18 months.[82] However, TSG recognizes that PromiseShip has only been working cases for a few years.

[82] TSG analysis of PromiseShip data in the file "18 - #18 Terms for FPS 90 Day.xlsx"

Figure 16-13: Cases per Case Worker



16.5.3. Low Experience Level of Case Workers

A related metric is how many cases a caseworker works. TSG looked at total cases, assuming that case work experiences a "learning curve". A caseworker that has worked hundreds of cases is likely to perform better than one than has not—no matter how many months those cases cover. TSG found that 59% of caseworkers across all regions work fewer than 50 cases in their career. Indeed 80% work fewer than 200 cases. Thus, TSG observes that most case workers never get "far down the learning curve"—they fail to gain the experience level required to achieve high case performance.

Looking to traditional turnover information from PromiseShip, a similar picture emerges. PromiseShip reports having lost 252 PFSs since the beginning of calendar 2015: 227 voluntary and 25 involuntary[83]. Note that the TSG method found 257 "exits"—essentially the same number as terminations[84]. ESA caseworker "exits". PromiseShip also reports having hired 343 new PFSs in the same period.[85]

16.5.4. State Reported Turnover

DHHS provided TSG a file that reported turnover rates of 3-4% per month[86]. However, that report seems to underreport the number of case workers leaving "active duty" and overreport the number of case workers. According to the DHHS count in the turnover report, the agency had

[83] TSG analysis of PromiseShip data in the file "17 - FPS Termination Data Update B.pdf"
[84] This number is created by summing the terminations graphed using the "exit" method described above over the period January 2015 through October 2018.
[85] TSG analysis of PromiseShip data in the file "19 - Number of New Employment Offers to Caseworkers.pdf"
[86] DHHS data in the file "Headcount and turnover for state 2018.xlsx"

430 case workers: 362 working cases and 68 working cases. This is only DCFS employees. However, the state N-FOCUS system listed 411 unique individuals working cases, including those employed by PromiseShip. Of those, 183 were in the ESA and 228 in the rest of the state. TSG was not able to obtain solid information about which of the ESA caseworkers are employed by PromiseShip. However, 51 of the 183 are not listed in the PromiseShip records. Thus, TSG's best estimate is that DCFS had 279 caseworkers in its employ with active caseloads in September 2018—not 362 as reported in the turnover report.

In addition, the DHHS turnover report listed 19 separations during August (average of 14 in each month of SFY2018). Confirming that number, DCFS's case files show that 19 case workers ceased have caseloads during September. TSG found an average of 16 caseworkers stopped working caseloads each month in calendar 2018—a few more than DHHS reported for the other months in the year.

Thus, it appears that DHHS' reported turnover numbers include far more workers in the denominator (and possibly a few too few in the numerator), thus under-reporting the real business effect of turnover. TSG recognizes that DHHS is compelled to report turnover using standard federal methodology. However, the purpose of the TSG assessment is to assess to business facts of the situation, not federal reporting compliance. Accordingly, TSG has observed the real impact on DCFS' need to replace and train new case workers—by using the "exit" method described above.

Turnover is thus a serious issue for child protection in Nebraska. The problem seems to effect DCFS and PromiseShip equally. In fact, other states nationally face high caseworker turnover. However, TSG finds that the State seems to be under-reporting the true dimension of the problem. In addition, TSG found no indication that DCFS is collaborating with PromiseShip to improve turnover.

17. APPENDIX D: FLORIDA REQUIRED COLLABORATIONS

In Florida for example, the contract requires the following such agreements and collaborations:

- "The Lead Agency shall work in partnership with local agencies on the implementation and ongoing management of local interagency or working agreements.
- The Lead Agency shall work with the Department's regional, circuit, or county staff to establish and take the lead on maintaining working agreements with other providers and Department entities, local housing authorities, local work force initiatives, and other local organizations in order to fully implement the requirements of the local child welfare System of Care. Working agreements shall clarify roles and responsibilities, establish a shared vision, and promote integrated community support and services in order to improve outcomes for families involved in the child welfare system.
- The Lead Agency shall establish and maintain working agreements to include joint operating procedures with entities providing child protective investigations in counties served by the Lead Agency under this Contract.
- The Lead Agency shall assist the Department's regional staff in developing interagency working agreement(s) with Federally Qualified Health Care Centers or Rural Health Care Centers that are located in its area of operation to address at least the following areas where applicable: dental services for children and families; medical and behavioral health care services for children and parents, including for parents without health care insurance coverage; nursing case management and health care coordination; and supportive services, such as transportation.
- The Lead Agency shall work in partnership with the Department and its local Managing Entity on the development and implementation of a working agreement addressing the integration of child welfare and behavioral health.
- The Lead Agency shall dedicate resources to the execution of, and work in conjunction with the Department on the implementation and ongoing management of local and state plans for the promotion of adoption, support of adoptive families, post adoption services and support, and prevention of abuse, abandonment, and neglect of children ….;
- The Lead Agency shall dedicate resources to the execution of, and take the lead on, the implementation and ongoing management of local action plans for the early development and education of children and youth in out-of-home care. The goal of the local action plan is to improve the educational, employment and life skill outcomes for children and will address the need to identify any barriers that stand in the way of their doing well in school and work. The plan should also include assisting young children in school readiness, including access to quality child care, Early Head Start or Head Start, early childhood special education, Early Steps, and other early development and learning opportunities;
- The Lead Agency shall participate in regional, local and community level task forces related to human trafficking….;

- The Lead Agency shall work with the Department's regional criminal justice staff to establish and maintain working agreements with all local law enforcement agencies contained within the Lead Agency's service area. These working agreements shall clarify the roles, responsibilities, and information-sharing requirements as they relate to the reporting, investigation, and recovery of missing children. The Lead Agency will also ensure that it has provided and continually updates all law enforcement agencies

THE STEPHEN GROUP

SDM Design and Technical Assistance Project

Final Report

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Table of Contents

I. Summary Findings and Key Recommendations

Findings

Nebraska has significantly decreased its child removal rate over the last eight years, despite the increase in new cases in the number of children served. The state has done this by increasing the number and percentage of children served in-home. This is entirely in alignment with the goal of keeping families together by delivering the appropriate services in a timely fashion.

The Strategic Decision Making (SDM) tools that Nebraska implemented in 2012 have been critical to this effort – allowing the Division of Children and Family Services (DCFS) to identify when the Department case workers need to intervene and when it is no longer necessary due to the achievement of safety and the mitigation of risk. The tools provide a means to assess and document safety and the level of risk in a household throughout DCFS' interventions and assist in the decision to close a case (i.e., closure of an in-home case, reunification) in a consistent and uniform manner.

Nebraska has implemented best-practice national SDM tools and fidelity to these tools remains high. Staff are well-trained on use of SDM tools. There are, however, opportunities to improve timeliness of tool completion and increase use of mobile technology in completing critical assessments.

Nebraska's Hotline effectively screens out the nearly two-thirds of intakes that do not meet state criteria, but opportunities exist to refer more individuals to Alternative Response and community resources, to ensure timely and appropriate service to allow families to stay intact. Consequently, the number of unsubstantiated calls from the Hotline to caseworkers is lower than the national average.

DCFS identified improvements to the Intake Assessment and Safety Assessment to sharpen the identification of safety factors, which will improve the quality of casework. Hotline staff are well-trained on the intake assessment SDM tool.

While Hotline staff are well-trained in SDM tools, DCFS supervisors have not been trained on how to supervise staff using these tools and may not have internalized the same importance of timeliness and fidelity to the tools. This represents a gap in ensuring consistency across staff engagement with families.

DCFS' decision to implement the Safety Organized Practice (SOP) model aligns well with and reinforces SDM. The case practice structure benefits to build a best-practice structure to improve outcomes and will help to ensure compliance with the newly implemented federal Family First Prevention Services Act (FFPSA) of 2018.

While the assessment finds no significant misuse of the Family Strengths and Needs Assessment (FSNA) tool, there is no process to analyze how FSNA works to inform the case plan and services and if the result was a good case outcome. The represents a missed opportunity for DCFS to utilize a continuous improvement function to drive performance and quality.

There are situations where workers take case actions counter to the SDM tools. While this is not unique to Nebraska, it can result in poorer outcomes for children and families, undermine the important goal of consistency statewide for all cases, and expose DCFS to risk.

Additionally, gaps in stakeholder knowledge about the safety and risk paradigm used by DCFS and the SDM tools more generally result in challenges for DCFS and potential disagreements about case decision-making. This can foster an erosion of the agency's credibility and drive calls for change that can destabilize performance enhancements, which can set back important steps for quality improvement.

In related findings, TSG notes that there are many opportunities to improve collaboration between DCFS and the Division of Medicaid and Long-Term Services, as well as Medicaid managed care organizations, to meet the behavioral health needs of children in Nebraska's care. In addition, suicide assessment and prevention remain a significant priority for Nebraska, as case workers are trained on the use of a suicide assessment tool. Finally, the Comprehensive Addiction and Recovery Act (CARA) has the potential to affect Nebraska's Hotline operation and caseworker caseload, but it remains too early to assess the impact.

Key Recommendations

Nebraska's DCFS Hotline has made significant strides since the implementation of SDM. However, there are a number of opportunities for improvement which can move the state into a lead position nationally for child protection intake services.

In order to ensure that Nebraska continues to enhance its SDM system using best practices, DCFS should engage the National Council on Crime and Delinquency/Children's Research Center (NCCD) to:

1. Re-evaluate implementation of the SDM system;
2. Conduct a recalibration exercise; retain the existing tools and consider adding additional available tools; and,
3. Modify existing tools to address concerns identified by staff.

These steps will ensure that the state is up-to-date and allow the sharing of critical knowledge that can assist in the improvement of other state systems as well.

While SDM has delivered improvements to date, DCFS should continuously focus on implementing it in the most effective manner possible, to ensure that it is delivering best practices. However, that process should work in a manner that does not overwhelm staff. DCFS should select an SDM project management team that can manage the SDM model revisions that will assume internal coordination and efficient use of time.

DCFS may want to adopt updated case and service plans, and also an improved template for court room testimony and DCFS should work to review and implement these through SOP or NCCD. This is an area that will improve integration of the tools with key planning and reporting documents used in case decision making and can also reduce caseworker burden by improving the translation of tool findings to these documents.

One immediate recommendation is that DCFS should review the timeliness of SDM tool completion, especially the Safety and Risk Assessments, and ensure supervisors are looking at aware of this issue and develop accountability mechanisms for staff to remain faithful to the model for implementation, which will deliver more consistent results. DCFS should implement monitoring protocols and use appropriate performance dashboards to ensure review of situations where case action is taken counter to the SDM tools and corrective action is quickly utilized to realign action in accordance with the practice model.

In order to emphasize the well-being of families, DCFS should improve the linkage between DCFS and available resources for families such as Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families (TANF), Women, Infants, and Children (WIC), Medicaid, and other community supports. Awareness of these resources and a connection to these programs will be beneficial not only to Hotline staff, but also investigation and ongoing caseworkers who continually assess family needs and may want to include these other resources in the care plan development. This should be done also in concert with an outreach and education campaign for the reporting community, so that they are aware of the difference between poverty and abuse/neglect, and that it may be more appropriate to refer families to these community resources instead of calling the hotline to make an allegation of abuse/neglect.

Training is a critical component to implementation of SDM. There are a number of areas where training would benefit Hotline and front line staff to better support families and to reduce unsubstantiated claims. These training opportunities include:

- Utilizing training for Motivational Interviewing and Alternative Response, which will produce more robust engagement with reporters and families and will work to identify resources for those families whose needs do not fully align with child protective services;
- Expanding training on SAMHSA tools and resources for suicide prevention; and
- Building understanding of resources available for substance abuse through CARA and about including data in the case file to support future decision making,

In addition, DFCS should continue to train Hotline staff and caseworkers about CARA resources, create a routine report of CARA-related intakes for management review with data-rich analysis of CARA-related trends so management can stay appraised of the situation and act swiftly if state response is needed, and develop a CARA decision making and process map, based on Nebraska's CARA Implementation Plan, to be shared with birthing hospitals, stakeholders, and Hotline staff.

In addition to programmatic and training enhancements, DCFS should look to improve IT capabilities to support Hotline staff and give them more decision support tools, as well as to allow them to provide more data to caseworkers for referrals.

These enhancements should include an improved data sharing agreement with the Department of Medicaid, including a field in N-FOCUS, to allow Hotline staff to know immediately whether a child receives Medicaid services and what Health Plan that child is enrolled, or if a child is enrolled in CHIP.

DCFS should also work with NCCD and add additional fields to SDM Assessment tools that will help to identify other safety factors that will support caseworks if the case is referred. Other states, for example, have added questions to SDM tools relating to substance abuse and domestic violence. The SDM tools "other" category is broad and not descriptive enough to identify issues related to substance abuse and domestic violence and NCCD has already assisted other states in revamping their tools to address this same issue and Nebraska should take advantage of these changes in revamping its tools.

Finally, DCFS should prioritize a robust stakeholder engagement plan about the SDM tools generally, and modifications anticipated, specifically. This will help them understand how SDM works to deliver

consistent, quality services, while also giving groups the chance to offer meaningful feedback about improvements.

II. Background

The Nebraska Department of Health and Human Services (DHHS), Division of Child and Family Services (DCFS) has a mission to provide the least disruptive services when needed, for only as long as needed, to give children the opportunity to succeed as adults, help the elderly and disabled live with dignity and respect, and help families care for themselves. DCFS has prioritized the outcomes of improved child safety, well-being, and family functioning.

In 2012, DCFS contracted with the National Council on Crime and Delinquency Children Research Center (NCCD/CRC) to customize and implement the Structured Decision Making® (SDM) assessment system for all phases of its Child Protective Services (CPS) program to improve the quality and consistency of decision-making and better achieve agency goals and outcomes. SDM is an Evidence-Based Practice at all stages of child/family casework and is used in over 25 states and several countries.

Since the implementation of SDM in 2012, DCFS staff have consistently identified issues regarding the SDM process and tools. More recently, issues have included but are not limited to questions and/or policy interpretations with the SDM Intake Screening tool (also known as the "Hotline"), the Initial Safety Assessment, the utility of the Family Strengths and Needs Assessment (FSNA), and the Reunification Assessment. These issues require NCCD/CRC attention, change, and/or policy clarification.

DCFS contracted with The Stephen Group (TSG) to perform a targeted assessment of the SDM-related concerns, impact, and field experience with the SDM instruments. In addition, DCFS requested that TSG examine related topics including the needs of a child/youth removed from their homes that are in need of behavioral health or substance use disorder services and access to these services through linkages with the Division of Developmental Disabilities, Division of Medicaid and MCOs serving child welfare-eligible children and youth in Nebraska through Nebraska's Heritage Health Medicaid managed care plans. Finally, TSG was asked to review whether the SDM tools were sufficient to assess the risk of suicide, as well any suggested improvements to the process used by the Hotline related to reports received pursuant to the Comprehensive Addiction and Recovery Act (CARA).

TSG's research was informed by the DCFS scope of work and DCFS leadership priorities, and included the following:

- Focus groups with management staff
- Focus groups with investigative caseworkers and supervisors
- Interviews with DHHS partner divisions
- Data analysis
- Literature review of relevant past reports and other documents
- Interviews with NCCD/CRC

This report assesses the areas of concern prioritized by DCFS and recommends strategies for improvement related to the SDM tools and process, and related issues. The information and recommendations made in

this report focus on assisting DCFS in achieving the systemic improvement in child safety, well-being, and family functioning they have prioritized.

III. Structured Decision Making in Nebraska Child Welfare

The Nebraska Division of Family and Child Services effectively implemented the best practice Structured Decision Making System® in 2012. The SDM System is a product of the National Council on Crime and Delinquency Children's Research Center (NCCD/CRC). All of the tools are research-based, and the Risk Assessment tools are actuarially sound (using their robust national database to create models that predict risk). The suite of instruments that DCFS implemented and continues to use are reflected in Figure 1.

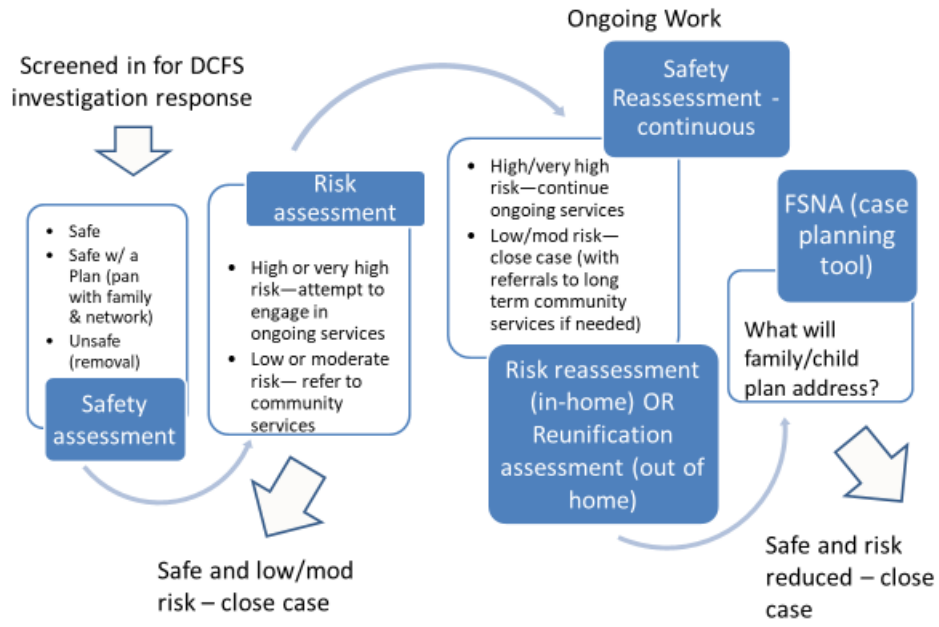
Figure 1. SDM Tools used in Nebraska Division of Children and Family Services, 2018.

Stage in Life of a Case	Tool	Requirement
Intake	Intake Screening (Hotline)	Performed by intake staff.
Initial Assessment	Safety Assessment	At first face-to-face contact with family, when a new allegation of abuse or neglect is received, when new information becomes available, or prior to recommending case closure.
	Assessment of Placement and Stability	When there is an investigation of alleged abuse/neglect, there are concerns regarding behaviors among children in a placement, and there are significant changes in a placement.
	Risk Assessment for Abuse/Neglect Cases	Upon conclusion of initial assessment and prior to decision to recommend ongoing services or to close the case (within 30 days).
	Prevention Assessment	Within 30 days of assignment to Lead Contractor or to ongoing services, prior to first case plan.
Ongoing Services Assessment	Prevention Assessment	For in-home cases: Within 30 days of assignment to Lead Contractor or to ongoing services, prior to first case plan. For out-of-home cases: Prior to completing initial assessment and making decision to transfer to ongoing services or close case.
	Safety Assessment	Whenever new information becomes available and prior to recommending case closure.
	Family Strengths and Needs Assessment (FSNA)	Prior to initial case plan (within 3- days of assignment to Lead Contractor or to ongoing services); every 3 months.
	Risk Re-Assessment	Every 3 months or 3 months following family reunification.
	Reunification Assessment	Every 3 months from initial case plan.
	Assessment of Placement Safety and Suitability	When there is an investigation of alleged abuse/neglect, there are concerns regarding behaviors among children in a placement, and there are significant changes in a placement impacting child safety.

Sources: NCCD/CRC, SDM procedures manuals for Nebraska.

The tools are designed to work together to assist a child welfare caseworker in making consistent evaluations of the family's safety and risk, which inform case decision-making (i.e., decisions to provide ongoing services, remove a child from the home, reunify a family, close a case) and service planning. Figure 2 shows the interaction of the core tools used to assess a family's safety and risk over the life of a case.

Figure 2. SDM System and Case Flow.



Source: NCCD/CRC, permission provided.

IV. Identified Staff Concerns about SDM

Since their implementation, DCFS leadership, administrators, managers, and caseworkers have identified questions and issues related to the SDM tools. Some of the more recent issues identified include:

- Intake Assessment/Safety Assessment: That the tools do not allow staff to identify substance abuse and domestic violence-related factors, which are increasing in the population served by DCFS.
- Family Strengths and Needs Assessment: That the tool is redundant and can be replaced by another instrument.
- The lack of alignment among Nebraska's court report and case plan templates, and the SDM tools.

DCFS leadership also identified concerns related to the implementation, impact, and outcomes of the SDM tools, including but not limited to the following:

- General:
  - Lack of focus on child well-being.
  - Challenges with stakeholder understanding of SDM tools and the impact on case outcomes.
- Intake:
  - There are perceptions that the tool is "screening-in" too many cases and that certain cases that are closed quickly upon investigation, both of which result in use of resources which

could be targeted toward working with families where there are confirmed allegations of abuse and neglect.
    - Some portion of Hotline reports do not meet acceptance criteria, which could be prevented.
- Intake-related issues:
    - Comprehensive Addiction and Recovery Act (CARA): potential impact on the number of Hotline cases reported, substantiated, unsubstantiated, and impact on caseworker workload.
- Family Strengths and Needs Assessment (FSNA):
    - Appropriate use/misuse of the tool.
    - No one is analyzing how the FSNA informs the case plan and service use, and whether that results in good case outcomes.
- Instances in which case decisions do not align with recommendations of the tools:
    - In-Home Cases: Inappropriate case closing for high/very high risk cases where parents refuse services and leaving low-risk cases open.
    - Misuse/ignoring Reunification Assessment when tool says to close, but staff override
- Training:
    - Lack of supervisor training on SDM tools.
    - There is an opportunity to improve intake and caseworker staff skills to engage callers/parents/caregivers.
    - There is an opportunity to improve caseworker ease of use of data and access to data on the SDM tools.

While these are not exhaustive lists of the issues identified by staff related to the SDM tools and implementation, they demonstrate that staff are already very aware of some of the issues and challenges surrounding these tools and are evidence of the solution-focused culture at DHHS, which has already resulted in implementation of strategies to address some of these issues.

V. Scope and Approach

As a result of management and frontline staff feedback, DCFS is considering engaging NCCD to review the functioning of its SDM System and make modifications to its existing tools. Prior to doing so, DCFS contracted with The Stephen Group (TSG) to perform a targeted assessment of the SDM tools and processes, within a time period of 30 days. This assessment will be used to inform discussions with NCCD/CRC.

In addition, DCFS requested that TSG consider related topics including how well children/youth removed from their homes that are in need of behavioral health or substance use disorder services are able to access these services through Nebraska's Heritage Health Medicaid managed care plans, the impact of the federal CARA legislation on the DCFS Hotline and caseload, and intake procedures related to suicide.

TSG performed this targeted assessment based on the scope of work, and using the following methods:

- Meetings with DCFS leadership to obtain project scope and identify leadership concerns with regard to the SDM tools and process.
- Focus group meetings with management staff, caseworkers, and supervisors across multiple DHHS service areas.

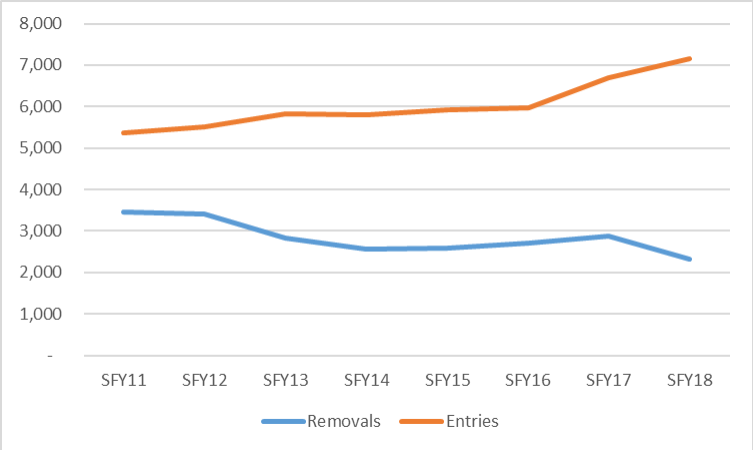
- Interviews with DHHS divisions including Division of Developmental Disabilities, Division of Behavioral Health, and Division of Medicaid and Long-term Care.
- Literature review of relevant reports and federal data.
- Interviews with NCCD/CRC.
- Data requests related to SDM, quality, and specific outcomes (see requested information in Appendix A).

VI. What We Found

Nebraska has significantly decreased its child removal rate over the last eight years, as shown in Figure 3 (a decrease of 32.7%), despite the increase in the number of children served in new cases. Nebraska has done so by increasing the share of children served in-home.

The SDM tools were implemented in 2012 and have been critical to this effort – allowing DCFS to identify when state's intervention is needed and when it is no longer necessary due to the achievement of safety and the mitigation of risk. The tools provide a means to regularly assess and document safety and the level of risk in a household throughout DCFS' interventions and assist in the decision to close a case (i.e., closure of an in-home case, reunification).

Figure 3. Number of New Intakes and Removals, SFY2011 – 2018.



Source: DCFS, October 2018.

1. Nebraska has implemented the full suite of SDM tools, which is a best practice.

Nebraska invested in the SDM tools across the entirety of its child welfare program. According to NCCD, the implementation of this suite of tools in Nebraska was based on the standard tool content and format, scoring models, policy and procedures manual, and statistical validation used in other states and customized for Nebraska.

These tools are designed by NCCD to complement one another and to be used in tandem. TSG finds that the value of a quality and high fidelity SDM system is to directly inform case practice throughout the life

of a case. Consistent integration of the SDM tools in practice leads to consistent casework, documentation, and decision-making, which is foundational to the achievement of positive outcomes for children/youth and families involved with the state's child welfare system.

Further, TSG finds that the agency's decision to implement the Safety Organized Practice (SOP) model is a very positive case practice innovation that will reinforce the SDM system. According to the Academy for Professional Excellence at the San Diego State University School of Social Work, this model is based on the safety of the child in the family setting, and integrates several evidence-based and best practice approaches including:

- Structured Decision Making
- Solution-focused practice
- Signs of Safety
- Child and family engagement
- Risk and safety assessment research
- Trauma-informed practice
- Group Supervision and Interactional Supervision
- Appreciative Inquiry
- Motivational Interviewing
- Consultation and Information Sharing Framework
- Cultural Humility

The timing of DCFS' implementation of the SOP model in conjunction with DCFS' intention to adjust SDM assessment tools is fortuitous in light of the pending implementation of the Family First Prevention Services Act (FFPSA) of 2018.

The case practice integration of the SDM system within the SOP model should enhance Nebraska's ability to take full advantage of the opportunity for states to use Title IV-E funds for families at risk of entry into the foster care system, the provision of up to 12 months of mental health, substance abuse treatment, and in-home parenting training including parents, kinship, and caregivers based on trauma-informed plans of care (Section 50711) as well as the new limitation on the use of Title IV-E funds for only two weeks of group home placements unless the child is placed in a qualified residential treatment program (QRTP) that provides trauma informed treatment and specialized prenatal or parenting support or supervised living for youth over 18 years of age. The FFPSA permits states to delay the congregate care provisions for up to two years, but the state loses prevention services funding for the same period of time (Sections 50741, 50742, 50743, 50744, 50745, and 50746).

1a. Nebraska continues to require the use of all its current tools, including the Family Strengths and Needs Assessment (FSNA).

TSG assessed the value of management and staff experience with all of the SDM tools. Generally, TSG found in focus groups with leadership, management, and frontline staff that the DCFS staff culture at all levels of the organization to have a strong positive commitment to the SDM system, and the insights to identify issues and problems that could improve the effectiveness and efficiency of SDM system implementation. We found generally positive comments focused on ease of use and support of the decision-making logic of the instruments.

TSG asked management staff about all of the SDM tools identified in Figure 1. Overall, they indicated that staff like the tools and find them (especially the Safety and Risk Assessments) user friendly. The caseworkers interviewed generally shared this view. They noted that the tools help with documenting their reasoning and engaging families. In a caseworker/supervisor focus group, one participant indicated, "SDM was very exciting. It gives us evidence…when we go to court, which holds more weight."

TSG conducted additional research on utility of the Family Strengths and Needs Assessment (FSNA), which is used to inform the case plan due to specific issues raised with DCFS leadership. In a focus group of management staff, staff concerns about the FSNA tool were raised including that "There is not one person who likes it" and it has "No value." Management suggested that based on the timing of when the FSNA assessment is completed, it does not inform service planning and that other instruments might be simpler and more effective (such as the Protective Factors Questionnaire, which is used in the Alternative Response model). Also, there was a concern that the focus on needs related to safety was sometimes lost, and that caseworkers made referrals without seeing how the services apply to safety.

TSG validated these claims with NCCD, as well as DCFS caseworkers and supervisors. According to NCCD, the FSNA serves several purposes.

- It provides an objective means of consistently assessing a family's strengths and needs.
- It facilitates collaboration in the needs assessment and case planning processes.
- It provides a means of assessing a family's strengths and needs over time, which can demonstrate the progress a family has made.
- Data from FSNAs helps child welfare agencies identify the needs families have and develop services.

TSG convened a caseworker and supervisor focus group on October 9, 2018 specifically to ask about what was working well and not well with the FSNA. Staff indicated strengths that the FSNA promoted family engagement, lead to consistency between workers, gave staff the opportunity to engage in and document critical thinking, was helpful when passing on a case to another staff person, and that it was helpful with service planning and in making service referrals for families. They disputed the idea that the tool does not keep a focus on needs related to safety, indicating that the tool has a mechanism for staff to note whether a need is safety-related.

In terms of what was not working well, staff indicated that there is a challenge related to the independent living assessment within the child section in that it requires the caseworker to enter a score for the Ansel-Casey assessment, which is not required in in-home cases. Another complaint was that the tool is repetitive in nature, though staff appreciate the new copy-forward functionality in N-FOCUS.

TSG also explored the Protective Factors Questionnaire as an alternative to the FSNA. It is used as a pre- and post-assessment in the Alternative Response model. Staff felt the tool has a lot of questions and can be overwhelming or even irritating when done with families at the first meeting. They also identified some repetitiveness. TSG did not identify evidence that staff would prefer to substitute the Protective Factors Questionnaire for the FSNA.

1b. There are additional related tools Nebraska may consider adopting.

DCFS leadership asked TSG to identify whether "off-the-shelf" court reports and safety plans exist that are compatible with the SDM tools, as there may be opportunities to adopt new tools that reduce caseworker

burden by pre-populating information captured on the tools or better aligning with the tools. Here, there are opportunities for DCFS to adopt new safety and case plans. A new safety plan format has been incorporated by NCCD into the latest safety assessment tool and NCCD has worked with other states to develop a case plan with a better alignment to the tools. The SOP model should include a court report/testifying piece, so it may be unnecessary to engage NCCD for this tool.

In addition, NCCD reported to TSG that newer versions of the existing tools Nebraska uses may be available. For example, for the Risk Assessment, the most current version is a single stream of questions, rather than two indices, that still gets to the same conclusion, but with a reduced number of questions for the worker to answer. This is one example of efficiencies that can be gained by Nebraska in this update of its tools.

Recommendations:

- DCFS should establish a project management team to manage the SDM model revisions that will assure internal coordination, efficient use of time and resources, and achieve identified outcomes. This should include a work plan, with assigned tasks and due dates for each task.
- DCFS should develop a comprehensive scope of work draft document of the issues, concerns, specific tasks, expected outcomes, and timelines they want to discuss with NCCD/CRC before beginning a formal dialogue, draft contracts, and develop cost projections.
- DCFS should initiate dialogue with NCCD to re-evaluate implementation of the SDM system tied to the scope of work identified. TSG suggests negotiating on subject matter, deliverables, and cost based on an hourly/overhead/travel basis or a negotiated bundled rate.
- DCFS should work with NCCD to conduct a recalibration exercise for the entire SDM suite. According to NDDC, CRC has not conducted an updated risk validation and recalibration analysis for any of Nebraska's tools, which is recommended every five years. This is needed to ensure accuracy of the tools. TSG agrees that this would be a sound approach, but in order to minimize costs, DCFS should prioritize the Safety Assessment, Risk Assessment, and Reunification Assessment instruments based on the role they play in critical decision-making points in the course of an individual case.
- DCFS should retain use of the FSNA and address staff issues through training. TSG identified a wide range of opinions about the utility of the FSNA (difference of opinion between management and front-line staff). TSG suggests that DCFS discuss these concerns with CRC, with a focus on the role of the tool in the continuity of casework and related tools, review the policy and procedures related to the FSNA, and review the detailed content of current training materials related to the FSNA to clarify appropriate use and utility of the tool.
- DCFS should consider implementation of new safety and case plans and newer versions of the tools, which may reduce some duplication. DCFS staff have a high degree of fidelity to the SDM model with opportunities for continued improvement.

2. DCFS staff have a high degree of fidelity to the SDM model with opportunities for continued improvement.

Fidelity to the SDM model measures the degree to which staff use the tools as intended, which is linked to the outcomes of reliable and valid decision-making.

2a. Fidelity to the tools is high.

Two key external assessments found that DCFS was effectively implementing and managing the SDM system with high fidelity and adherence to the decision-making logic of each tool. NCCD/CRC found in a November 2016 audit of the intake tool that on almost all of the case reading questions designed to assess the quality of implementation, Nebraska DCFS workers scored 90% or better including:[1]

- 97% of cases screened in correctly
- 98% of identified safety threats correct
- 93% final risk level correct attained a 90% or better correct completion rate.[2]

The federal Administration for Children and Families found during its Child and Family Services Reviews (third round), that Nebraska has continuous quality improvement (CQI) processes in place to assess fidelity of its SDM tools, writing: "Nebraska utilizes various methodologies to asses Service Area and statewide SDM fidelity. Nebraska tests for accuracy of the item scores based on a comprehensive analysis of completed assessments. Case reviews are also completed to support SDM fidelity. Results from the fidelity reviews are discussed during the statewide CQI meetings and strategies are developed to address areas needing improvement."[3] In addition, ACF identified the DCFS continuous quality improvement approach was found to be "integral" in driving case practice.[4]

DCFS also conducts an internal analysis on the use of some of the SDM tools as part of its quality assurance activities. In a February 2018 review of 166 Hotline calls between October – December 2017, DCFS found:

- 99.4% - information gathered and documented was adequate to determine if the report met screening criteria
- 96.4% - closing status reason was correct based on the SDM Intake Tool
- 92.7% - staff displayed a courteous and professional tone
- 97% - CFSS staff used active listening

The report did identify opportunities for improvement such as improving documentation for overrides (correct at rate of 65%), improving action to address immediate safety concerns (72.7%), and engagement of law enforcement when an intake involves injuries to a child (76.9%).

In the most recent DCFS analysis available on the Safety Assessment, published in July 2017 (which reviewed 9,078 safety assessments completed for the purpose of Initial Assessment between 9/1/2016 and 5/31/2017), DCFS found evidence of improved fidelity of Safety Assessment scoring from the prior reporting period.

- 98% of the Safety Assessments with a final decision of "Unsafe" had supporting information
- 77% of the Safety Assessments with a final decision of "Safe" had supporting information.
- 68% of the Safety Assessments with a final decision of "Conditionally Safe" had supporting documentation.

While staff excel in documenting decisions where the finding is "Unsafe," opportunities exist to improve the documentation in cases with other final dispositions. While this could be a function of staff prioritization

[1] NCCD/CRC SDM Case Reading Report, 11/2016, p. 11.
[2] NCCD/CRC SDM Case Reading Report, 11/2016, p. 11.
[3] ACF, letter of 4/26/17, CFSR Review, Round 3, Statewide Assessment Report, p. 77.
[4] Nebraska, CFSR Final Report, p. 2.

and not a lack of understanding or training, this remains a performance issue to address to ensure the tools are used as intended during the investigation.

2b. Timeliness of Tool Completion is an area where focused improvement is needed.

An area where DCFS staff improvement is needed is in the timeliness of SDM tool completion. Figure 4 shows the timeliness of completion of critical SDM tools used in the initial investigation of a case, for a three-month snapshot.

Figure 4. Timely Completion of Select SDM Tools, June – August 2018.

	Central	Eastern	Northern	Southeast	Western	State
Safety Assessments in Ready for Review in 24 Hours						
Actual	228	419	229	400	74	1,350
Required	280	925	332	563	235	2,335
Percent	81.4%	45.3%	69%	71.0%	31.5%	57.8%
Risk/Prevention Assessment in Final Status in 30 Days						
Actual	138	414	152	308	100	1,112
Required	177	674	186	387	178	1,602
Percent	78.0%	61.4%	81.7%	79.6%	56.2%	69.4%

Source: DCFS, October 2018. (Note: For the Timely Completion of Select SDM Tools, the data on priority level are not available)

Although still not in compliance with policy, this is an area where recent performance has been improving. DCFS has made progress in the average number of days to the initial risk assessment, as shown in Figure 5.

Figure 5. Average Days to Initial Risk Assessment, FY 2016 – 2018.

Priority/Risk Level	2016	2017	2018
Priority 1	97.4	58.7	29.4
Priority 2	89.0	60.2	30.5
Priority 3	80.1	57.2	30.0
Total	**87.0**	**59.0**	**30.2**

Source: DCFS, October 2018.

For the initial FSNA completion, the statewide mean days to completion was 65.56. This is consistent across regions except the Central Region, which averages 35.9.

Figure 6. FSNA Average Days to Completion of First FSNA.

Region	Average Days
Central	35.9
Eastern	69.3
Southeast	74.6
Western	61.2
Northern	67.3
Statewide	**65.6**

Source: DCFS, October 2018. Note: Date range for data not provided.

Recommendation:

- DCFS leadership should establish clear performance goals for each region and the state for the timeliness of each tool and hold regional management accountable for these goals. These targets should be built into the training for the tools.

3. While generally effective, opportunities to improve training on the SDM tools exist.

The primary training on SDM occurs as part of the 14-week new caseworker training model and is delivered by the University of Nebraska's Center on Child, Families, and the Law (CCFL). Generally, focus group comments specific to SDM training were positive. Staff felt they received adequate preparation to use the tools effectively in the field and that desk aides were very effective in resolving questions as they occurred. The fidelity data previously provided validates the effectiveness of the SDM training.

Gaps identified in the new caseworker training include a lack of Motivational Interviewing training and Alternative Response Training.

- Motivational Interviewing training is a critical tool in family engagement. It can improve the quality of information gleaned by staff in the Hotline, during investigations, and in on-going casework (both in-home and out-of-home). Caseworker use of the SDM tools is enhanced with more accurate and complete information obtained during casework. Motivational Interviewing skills training is offered for all DCFS supervisors and caseworkers as an in-service (after initial training).
- Alternative Response training is currently under development. This model represents an opportunity for the state to serve more families outside of the traditional in-home and out-of-home (court) model. This model is well-suited for families whose needs do not align directly with the criteria for traditional child welfare services. This gap is in the process of being addressed; there is a new caseworker module under development and a training for existing workers is under consideration.

Outside of caseworker training, a major gap related to the SDM tools is the lack of supervisor SDM training. Supervisors received training on SDM from the worker perspective (how to use the tools) but have not received training on how to manage to the tools or how to manage staff in using the safety/risk paradigm.

DCFS is aware of this gap and has included a training plan for supervisors as part of its Child and Family Services Review Round 3 Program Improvement Plan for FY2018.

Recommendations:

- DCFS should use the revision of the SDM tools as an opportunity to conduct refresher training for staff on all of the SDM tools. This training could address the timeliness issues and documentation issues identified internally by DCFS in its own assessments, as well as those identified by TSG.
- DCFS should include a CCFL representative in SDM modernization project meetings, to assist in developing new curricula.
- DCFS should consider requiring Motivational Interviewing training in the 14-week new caseworker training.

4. Opportunities to improve technology use related to the SDM tools exist.

Caseworkers relayed to TSG that DCFS has made IT-related improvements for caseworkers such as carry-forward functionality in N-FOCUS, which decreases administrative burden for staff by reducing the need to retype the information on multiple screens.

Staff identified that they do not currently use their phones or other mobile devices in the field when completing SDM documentation requirements. While internet connectivity may be an issue in certain parts of the state, the development of smart phone capability for caseworkers to complete SDM documentation requirements using mobile devices would further increase efficiency in the field and could help to address the lack of timeliness of completion of certain assessments.

Recommendation:

- Discuss options with NCCD to use mobile devices to complete SDM assessments.

5. The Intake Assessment and Hotline Process significantly reduces the number of intakes, resulting in fewer investigations.

TSG was asked to examine the Hotline intake tools and process, in order to assess Nebraska's effectiveness and efficiency, relative to other states. There was concern that Nebraska may be expending too many resources on cases that could be "Screened out," that could be redirected toward serving families where allegations of abuse and neglect are confirmed. To accomplish this task, TSG requested a variety of Hotline data (see Appendix A), including the number of calls accepted and not accepted, and compared this data to other states.

Data for the FY 2016-2018[5] indicates that approximately two-thirds of all calls are screened out, with an increasing trend (see Figures 7 and 8).

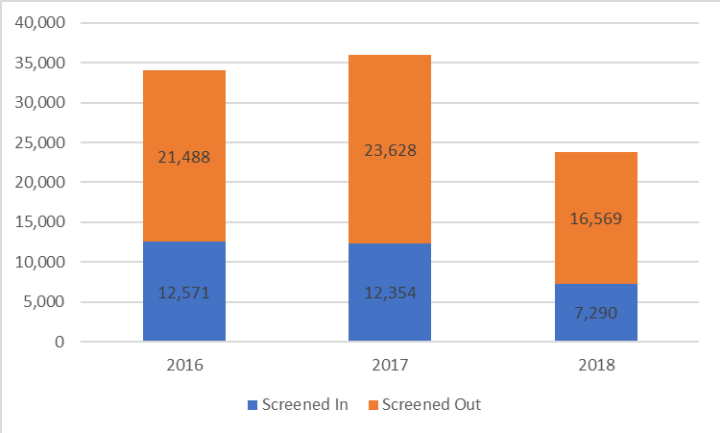
[5] 2018 data is year to date

Figure 7. Intake Disposition, 2016 – 2018 (to date).

	2016	2017	2018
Screened In	12,571	12,354	7,290
Screened Out	21,488	23,628	16,569
Total	**34,059**	**35,982**	**23,859**
Screened In	36.9%	34.3%	30.6%
Screened Out	**63.1%**	**65.7%**	**69.4%**

*FY2018 is year to date. Source: DCFS, October 2018.

Figure 8. Screened out and Screened in Cases, 2016 – 2018.



Source: DCFS, October 2018.

Even though the screening process allows for a systematic, evidence-based tool to be used in assessing which intakes to accept and not to accept, the process of screening cases out requires significant staff resources. According to Hotline officials, in addition to time spent with a caller, staff often make collateral calls during the course of assessing a given intake. Through these efforts, many intakes are "Screened Out."

Figure 9 shows the reason for intakes that are "Screened Out." The largest reason for screened out calls by far is the "Does Not Meet the Definition" (82%). This suggests a need to educate the general public about policy and definitions as a strategy to reduce intakes that are not accepted.

Figure 9. Screened Out Intakes, by Disposition, 2016 – 2018 (to date).

	Number			Percent		
Disposition for Screened Out Intakes	**2016**	**2017**	**2018**	**2016**	**2017**	**2018**
Does Not Meet Definition	17,788	19,464	13,665	82.8%	82.4%	82.5%
Law Enforcement	1,127	1,330	1,129	5.2%	5.6%	6.8%
Multiple Reporter	1,948	1,968	1,140	9.1%	8.3%	6.9%
Placement Concerns	533	761	540	2.5%	3.2%	3.3%
Referred for Service	0	1	0	0.0%	0.0%	0.0%
Unable to Identify	89	101	74	0.4%	0.4%	0.4%
Open Intake	3	3	21	0.0%	0.0%	0.1%
Grand Total	**21,488**	**23,628**	**16,569**			

Source: DCFS, October 2018.

Of the cases that are screened out, in some instances, an over-ride is used. Figure 10 shows the types of over-ride used, by "Screened Out" reason.

Figure 10. Screened Out Cases by Reason and Type of Override Used.

Disposition for Screened Out Intakes	2016	2017	2018
Screened Out			
Does Not Meet Definition	**17,788**	**19,464**	**13,665**
Discretionary Override	1.2%	1.1%	0.8%
Policy Override	5.4%	5.3%	3.3%
No Override	93.3%	93.5%	95.9%
Law Enforcement	**1,127**	**1,330**	**1,129**
Discretionary Override	1.6%	2.3%	1.9%
Policy Override	92.1%	91.4%	91.1%
No Override	6.3%	6.3%	7.0%
Multiple Reporter	**1,948**	**1,968**	**1,140**
Discretionary Override	0.6%	0.8%	0.4%
Policy Override	10.3%	7.0%	8.6%
No Override	89.1%	92.2%	91.1%
Placement Concerns	**533**	**761**	**540**
Discretionary Override	0.4%	0.3%	0.6%
Policy Override	1.1%	3.0%	2.4%
No Override	98.5%	96.7%	97.0%
Referred for Service	**0**	**1**	**0**
No Override	0.0%	100.0%	0.0%
Unable to Identify	**89**	**101**	**74**
Discretionary Override	2.2%	3.0%	0.0%
Policy Override	7.9%	10.9%	6.8%
No Override	89.9%	86.1%	93.2%
Open Intake	**3**	**3**	**21**
Discretionary Override	0.0%	33.3%	0.0%
No Override	100.0%	66.7%	47.6%
No Override Info Documented	0.0%	0.0%	52.4%
Grand Total	**21,488**	**23,628**	**16,569**

*FY2018 is year-to-date. Source: DCFS, October 2018.

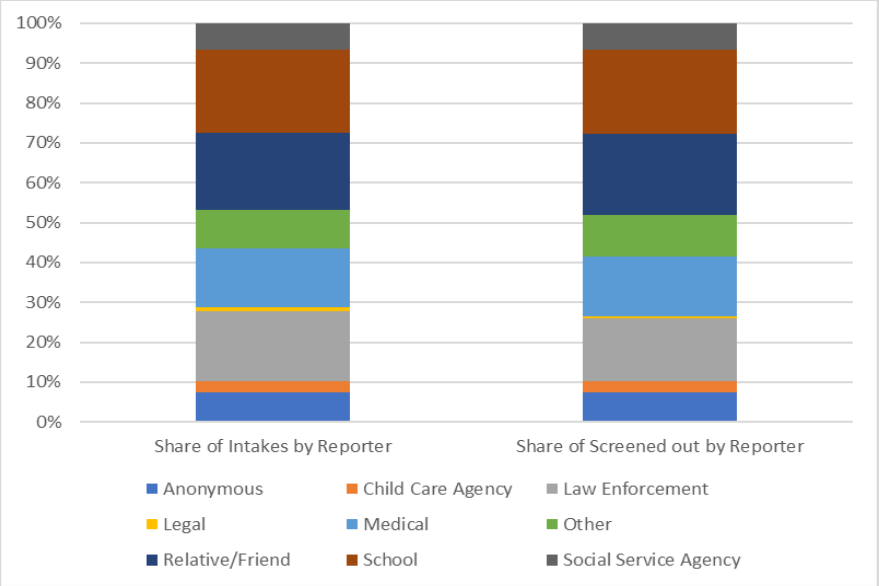
When looking at intakes screened out, by reporter type, important trends emerge. The top four reporter types include: school, relative/friend, law enforcement, and medical (see Figure 11). Each reporter type is responsible for a share of the screen outs that is close to their share of total intakes (Figure 12). There is no one group that stands out more responsible for a greater share of screen-outs than the number of their reports would suggest. Most intakes are screened out (65.7% overall), however, some reporter types had a greater percent of their intakes screened out than others (i.e., child care agencies who had three-fourths of their intakes screened out), which suggests they would also benefit from an understanding of the requirements (see Figure 13).

Figure 11. Child Abuse/Neglect Intakes and Screen Outs, by Reporter Types, 2017.

	Intakes	Share of Intakes by Reporter	Screened Out	Share of Screened out by Reporter	Rate of Screen Out/Intake
Anonymous	2,668	7.4%	1,717	7.3%	64.4%
Child Care Agency	957	2.7%	715	3.0%	74.7%
Law Enforcement	6,333	17.6%	3,738	15.8%	59.0%
Legal	351	1.0%	112	0.5%	31.9%
Medical	5,371	14.9%	3,519	14.9%	65.5%
Other	3,457	9.6%	2,482	10.5%	71.8%
Relative/Friend	6,957	19.3%	4,774	20.2%	68.6%
School	7,491	20.8%	5,015	21.2%	66.9%
Social Service Agency	2,397	6.7%	1,556	6.6%	64.9%
	35,982		**23,628**		**65.7%**

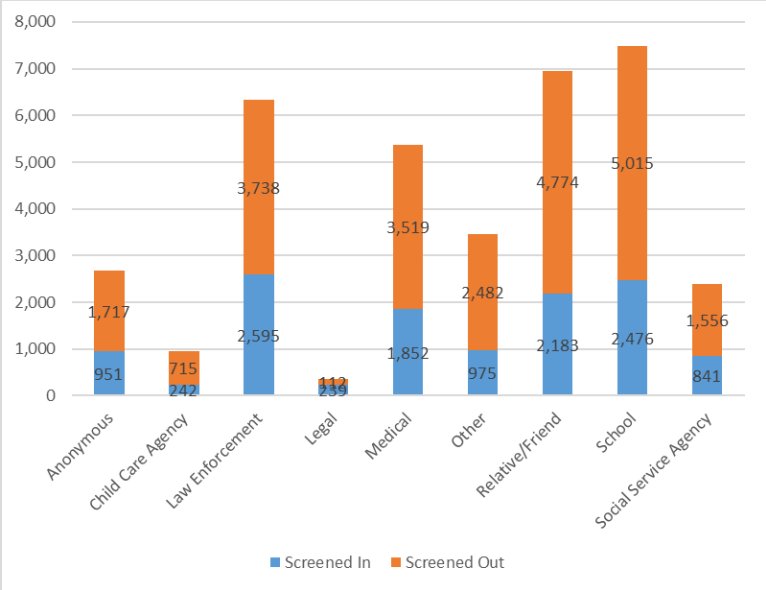
Source: DCFS, October 2018.

Figure 12. Share of Reports and Share of Screened Out, by Reporter.



Source: DCFS, October 2018.

Figure 13. Number Screened In/Screened Out by Reporter Type.



Source: DCFS, October 2018.

Figure 14. Use of Overrides for Screen Outs (Where Decision to Screen Out Requires an Override).

	2016	2017	2018	2016	2017	2018
Screened Out Reason	**Number Screened Out**			**Percent of the Number Screened Out due to either Policy or Discretionary Override**		
Does Not Meet Definition	17,788	19,464	13,665	6.7%	6.5%	4.1%
Law Enforcement	1,127	1,330	1,129	93.7%	93.7%	93.0%
Multiple Reporter	1,948	1,968	1,140	10.9%	7.8%	8.9%
Placement Concerns	533	761	540	1.5%	3.3%	3.0%
Referred for Service	0	1	0	0.0%	0.0%	0.0%
Unable to Identify	89	101	74	10.1%	13.9%	6.8%
Open Intake	3	3	21	100.0%	100.0%	47.6%
Total	**21,488**	**23,628**	**16,569**			

Source: DCFS, October 2018.

Generally, over-rides are used in a small percent of cases and for predominantly the "Screened Out" reason of law enforcement.

Recommendations:

- DCFS should consider auditing these cases (or doing live case reviews of these cases since this is an example of where the determination differs from the tool) (see Finding 9).
- Refined public education on appropriate reporting, with a focus on schools, medical, and the general public, as well as childcare facilities.
- DCFS may want to adopt a strategy to standardize the separation of calls based on specific assessment criteria for routing purposes. This is an approach being explored by several states, including Mississippi. Mississippi is considering separating intake calls, routing processes, and responsiveness based on Hotline calls where high risks have not been identified. [6] The criteria under considered for routing calls includes:
  - Does the report indicate allegations of abuse/neglect/human trafficking?
  - Is the report alleging a policy violation in a resource home (licensed) facility?
  - Does the report meet criteria for Resource Linkage/I&R?
  - Does the report meet criteria for case management?
  - Does the report meet criteria for CHINS/Voluntary Placement/Safe Baby/Prevention services?
  - Does the report meet criteria as a resource inquiry?

[6] MDCPS: Internal Document; 5/2018 (MS is considering integrating the TN SDM Hot Line tool into the proposed model).

6. Nebraska performs well compared to neighboring states in terms of screening out Hotline intakes and unsubstantiated investigations; opportunities to increase referrals to Alternative Response exist, which will decrease the number of investigations.

Nebraska's "Screen-Out" rate is almost 20 percentage points higher than the U.S. average, which may be due to several factors: the use of decision-making tools by Hotline staff, the collateral calls performed by staff, and the overall tenure/skill of Hotline staff in obtaining information from callers. Figure 15 includes data on Nebraska's neighboring states, two large states (provided for illustrative purposes only, not to suggest comparison), and the U.S. total. According to the Administration for Children and Families, the "Screened-in" rate includes those that receive an investigation or alternate response. The "screened-out" rate includes those that do not meet criteria for a referral. As shown in Figure 15, the only neighboring state with a higher "Screened-Out" rate is South Dakota.

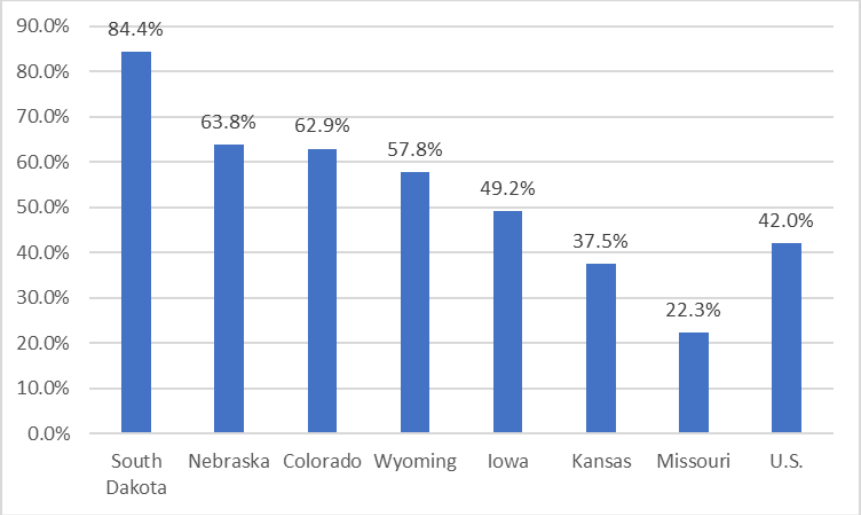
Figure 15. Data on Intakes, by State, 2016.

	Number Screened-In	Number Screened-Out	Total Calls	Percent Screened-In	Percent Screened-Out
Colorado	33,306	56,539	89,845	37.1%	62.9%
Iowa	24,923	24,143	49,066	50.8%	49.2%
Kansas	23,760	14,234	37,994	62.5%	37.5%
Missouri	69,293	19,838	89,131	77.7%	22.3%
South Dakota	2,504	13,521	16,025	15.6%	84.4%
Wyoming	2,916	3,998	6,914	42.2%	57.8%
Nebraska	**11,806**	**20,799**	**32,605**	**36.2%**	**63.8%**
Florida	166,465	58,708	225,173	73.9%	26.1%
Texas	186,024	51,509	237,533	78.3%	21.7%
U.S.	1,897,196	1,374,053	3,271,249	58.0%	42.0%

Note: U.S. total for 45 states who provided complete data.

Source: Administration for Children and Families, "Child Maltreatment," 2016, https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf

Figure 16. Rate of Intakes Screened-Out by Hotline in Nebraska and Neighboring States, 2016.



Source: Administration for Children and Families, "Child Maltreatment," 2016, https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf.

A second issue is where Nebraska falls in comparison with neighboring states on the percent of investigations that are unsubstantiated. States want to minimize this percentage so that resources are not expended on investigations that prove to be unfounded, especially if the intake tool could be refined to exclude a portion of them.

Nebraska has an Alternative Response (AR) program, but it is in its infancy and due to regulatory exclusions, many families who could potentially benefit from this intervention as opposed to traditional response are not able to be served. In FY2016, there were only 435 children served through this model. DCFS is aware of this issue and is in the process of amending its rules to allow for more individuals to be served using this model.

For comparative purposes, TSG also considered Nebraska's rate of unsubstantiated investigations and compared Nebraska to neighboring states. Figure 17 shows the percent of number of children who received an investigation or Alternative Response (AR). Note that the chart is based on children (not charts which are based on intakes that could involve multiple children).

Figure 17. Other State Comparison – Children who Received an Investigation/AR by Disposition, 2016.

State	Use of SDM Tools or Similar	Substantiated	AR	Unsubstantiated	Other	Total	% AR	% Unsubstantiated/ Total Children Who Received INV or AR	% Investigations Unsubstantiated
Colorado	SOP	11,943	10,511	28,313	4	50,771	20.7%	55.8%	70.3%
Iowa		9,560	12,956	16,870	9	39,395	32.9%	42.8%	63.8%
Kansas	SDM Go Live January 2019	2,492	-	31,736	309	34,537		91.9%	91.9%
Missouri	SDM Tools	5,741	56,162	35,756	3,617	101,276	55.5%	35.3%	79.3%
South Dakota		1,297	-	3,087	200	4,584		67.3%	67.3%
Wyoming		1,004	4,778	291	0	6,073	78.7%	4.8%	22.5%
Nebraska	SDM Tools	**2,899**	**435**	**16,948**	**7,965**	**28,247**	**1.5%**	**60.0%**	**60.9%**
Florida	SDM Risk Assessment only	44,155	-	227,304	80,391	351,850		64.6%	64.6%
Texas	SDM Tools	59,308	19,014	200,958	23,995	303,275	6.3%	66.3%	70.7%
U.S.		692,235	582,621	2,346,273	570,613	4,191,742	13.9%	56.0%	65.0%

Source: Administration for Children and Families, "Child Maltreatment," 2016, https://www.acf.hhs.gov/sites/default/files/cb/cm2016.pdf.

When looking at just children whose intakes result in an investigation, Nebraska's rate of unsubstantiated accepted cases is 61% (a lower score is desirable). This rate is below the U.S. average and all but one of its neighbors. A greater share of intakes that make it through the Hotline screening and result in an investigation are substantiated in Nebraska compared to other states.

When looking at all children whose intakes result in an investigation or AR, Nebraska's rate of unfounded is 60%. This rate is above the U.S. average and Nebraska falls in the middle of its neighbors. This is because Nebraska's utilization of AR is low relative to its neighbors (1.5% of children who receive an investigation/AR compared to the U.S. average of 13.9%).

Recommendation:

- DCFS should continue with the plan to amend the exclusion criteria for AR referral so more eligible families may participate. Because Nebraska's intake assessment tool already significantly reduces the number of accepted intakes, this may be the most effective way to reduce the number of new investigations that prove to be unfounded, while meeting the needs of these families through a different program.

7. Expand the FAST program to additional counties which could also decrease the number of investigations, while meeting family needs.

The Families and Schools Together (FAST) program operates in four Nebraska counties. It is an early-intervention program linked to improved family functioning, school performance, and the prevention of substance abuse.[7] The FAST model connects families to economic assistance programs and community resources to address any social determinant needs (i.e., housing, food insecurity) and strengthen the family.

[7] Nebraska Children, "Families and Schools Together," https://www.nebraskachildren.org/our-approach/evidence-based-strategies/fast.html.

When the Hotline staff identify families where the underlying issue is poverty, as opposed to child maltreatment, and ultimately "Screens-Out" the intakes, the Hotline staff refers the families to the program. The reach of the program is limited to four counties currently.

Recommendation:

- DCFS should prioritize the expansion of this model to additional counties as a strategy of helping connect families to stabilizing resources, while also reducing potential investigations that would later be "unfounded." This may involve the need to identify public-private partnerships and explore private funding support.

8. There are opportunities to improve the Intake and Safety Assessments by adding additional fields, which will sharpen the identification of safety factors and improve the quality of casework.

DCFS self-identified the need to improve the Intake and Safety Assessment tools to identify additional safety factors. There are no options for staff to identify certain safety factors such as substance abuse and domestic violence (which affect an increasing share of cases), aside from selection of "other." The lack of specificity affects both the Intake and the Safety Assessment tools. The Intake Screening tool has an "other" category, and the Safety Assessment tool has an "other" category at Question 12.

Because "Other" is broad and not descriptive, it can be difficult for staff to craft a service plan and refer to services to address the parents' needs if they are not clearly identified. In the case where children are removed, it may be difficult to identify what needs to change in the family to reunify, given the lack of specific safety factors identified.

TSG requested the following point-in-time data to assess the frequency of the use of "other" and the impact it has on the resolution of in and out-of-home cases:

- Of children who have not achieved permanency, what number/percent have "Safety Threat #12" checked (as the only reason)?
- Of families with open in-home cases, what number/percent have "Safety Threat #12" checked (as the only reason)?

Although it is used infrequently, in 10.1% of out-of-home cases where children have not yet received permanency, "Other" is the only safety factor identified. For families receiving in-home services, 5.9% had only "Other" identified as a safety threat, in the absence of any other safety factors identified.

Figure 18. Data on Use of Other, October 2018.

Children Who Have Not Receive Permanency	
Safety Threats Selected	
Count	2,259
Percent	71.8%
Only 'Other' Selected (Safety Threat 12)	
Count	319
Percent	10.1%
No Safety Threats Selected	
Count	568
Percent	18.1%
Total Count	**3,146**

Families with In Home Services	
Safety Threats Selected	
Count	588
Percent	34.5%
Only 'Other' Selected (Safety Threat 12)	
Count	100
Percent	5.9%
No Safety Threats Selected	
Count	1,017
Percent	59.6%
Total Count	**1,705**

Source: DCFS, October 2018.

Recommendation:

- DCFS should engage NCCD/CRC to modify the Intake and Safety Assessments. Other states have modified their tools to add this specificity. For example, the Texas and Delaware versions of the Safety Assessment include these questions and maintain "Other" for unforeseen circumstances.[89] It should not be a problem achieving the specificity in the SDM Safety Assessment tool DCFS seeks; however, it is important that the tool be revalidated after the changes are planned and before they are implemented in the field. It is likely NCCD/CRC will reconsider their certification of the tool only with revalidation.

9. There are situations where case actions are taken contrary to the expected actions based on findings documented using the SDM tools, which could result in poorer outcomes for children and families and expose DCFS to risk.

DCFS policy and procedures manuals provide staff with instruction on the case actions to take depending on the outcomes of each assessment. In conversations with DCFS management and executive staff, concerns were raised about situations in which case actions are taken contrary to the expected actions and/or DCFS staff recommendations.

NCCD/CRC expects some degree of deviation, and certain policy over-rides are included in each tool to allow for staff to document the reason for over-riding the tool. In other instances, discretionary over-rides occur, for a variety of reasons. These over-rides can result in inconsistent decision-making, potentially poorer outcomes for children and families, and can expose DCFS to risk (such as in reuniting a family too quickly or delaying reunification too long which can be unnecessary and costly).

[8] Texas Procedures and Policy Manual, Safety and Risk Assessment, Version 1.4; p. 10, May 2018.
[9] Delaware Structured Decision Making Procedures and Policy Manual, July, 2016; p. 41.

According to DCFS, there are some oversight procedures in place to prevent these situations from occurring. At the individual case level, supervisors are required to review the following:

- Any SDM Assessment in which an override is utilized.
- Every SDM Assessment for a CFS Trainee during their first 6 months or until the Trainee is promoted to a CFS Specialist;
- Random sample of SDM Assessments. One SDM Assessment each month for each CFS Specialist.

Quality Assurance Reviews may also identify issues with the use of SDM tools. However, at the individual case level, there are no system level analyses completed to regularly assess where over-rides occur and analyze the underlying reasons behind those over-rides.

TSG reviewed data from DCFS on instances in which case actions are taken contrary to the recommendations in policy, noting that there are opportunities to over-ride all of the tools using logic built into the tools.

Risk Assessment

There are in-home cases with a Safety Assessment finding of "Safe," but who are identified through the Risk Assessment as having "High/Very High Risk" and are ultimately closed with no services because the family declines to participate. This is a group of cases with an elevated level of risk and DCFS would prefer to continue serving the family if not for the family's refusal to participate. Figure 19 demonstrates the frequency of these cases (464 in FY2016 and 345 in FY2017). Of note, these cases where the family does not receive any services or interventions are at a higher rate of recidivism (12.8% and 9.6% in FY2016 and 2017, respectively) compared to the general population of cases that are closed (between 6.1-6.3% over June – August 2018).

Figure 19. Intakes with Safe and High or Very/High Risk that are Closed with No Services.

	Central	Eastern	Northern	Southeast	Western	Total
2016						
Intakes	498	1,236	493	961	445	3,633
Subsequent Substantiated Maltreatment	60	135	58	166	45	464
Rate of Subsequent Substantiated Maltreatment within 12 months	12.0%	10.9%	11.8%	17.3%	10.1%	12.8%
2017						
Intakes	497	1,155	515	938	491	3,596
Subsequent Substantiated Maltreatment	46	70	50	127	52	345
Rate of Subsequent Substantiated Maltreatment within 12 months	9.3%	6.1%	9.7%	13.5%	10.6%	9.6%
2018						
Intakes	308	594	293	515	208	1,918
Subsequent Substantiated Maltreatment	17	24	19	31	13	104
Rate of Subsequent Substantiated Maltreatment within 12 months	5.5%	4.0%	6.5%	6.0%	6.3%	5.4%

Source: DCFS, October 2018.

Figure 20. Recurrence of Maltreatment within 12 months.

Jun-18	Jul-18	Aug-18	Target	Region
4.5%	4.4%	4.0%	7.9%	Eastern
9.8%	9.3%	9.8%	7.9%	Southeast
3.6%	4.3%	4.5%	7.9%	Central
5.0%	4.4%	5.0%	7.9%	Northern
4.7%	4.3%	3.8%	7.9%	Western
6.3%	5.8%	6.1%	7.9%	State

Source: DCFS, October 2018.

TSG also examined data on Risk Assessments for children in in-home cases with low or moderate risk (which implies that a caseworker could begin to close the case). TSG found an average of 13.6% of cases meet this definition. TSG did not have data to assess how long the cases had been open after a Risk Assessment reflected low or moderate risk. If most caseworkers take steps to begin closing these cases upon completion of a Risk Assessment with these findings, then there may not be an issue. If caseworkers are risk adverse and do not want to close cases despite changes occurring in the family, there may be a need to do additional staff coaching.

Figure 21. In-Home Risk Assessments with Low or Moderate Risk (point in time October 2018).

Region	Number	Total In-Home	Percent
Central	21	196	10.7%
Eastern	45	409	11.0%
Northern	31	185	16.8%
Southeast	82	472	17.4%
Western	18	188	9.6%
Total	197	1450	13.6%

Source: DCFS, October 2018.

Assessment of Placement Safety and Suitability

Deviation from the recommended actions related to this tool is rare. Point-in-time data for October 1, 2018 were provided by DHHS to TSG showing that only 3 out of 3,013 children are currently in an unsafe placement (rate of 0.1%).

Reunification Assessment

NCCD/CRC expects between a 5-10% override count in the Reunification Assessment tool. TSG requested data on children in care on 10/1/18 whose most recent Reunification Assessment had a safety determination of 'Safe' or 'Conditionally Safe', a risk level of 'Low' or 'Moderate' and a primary caregiver parenting time result of acceptable (implying could go begin to reunify)

Figure 22. Children in Care on 10/1/18 with a Reunification Assessment indicating reunification can begin.

Region	Number	Total Out-of-Home	Rate
Central	7	292	2.4%
Eastern	46	1,444	3.2%
Northern	17	409	4.2%
Southeast	14	527	2.7%
Western	12	341	3.5%
Total	96	3,013	3.2%

Source: DCFS, October 2018.

This finding is within NCCD/CRC's expected range. It is not possible to discern from this data how long ago the Reunification Assessment occurred. If completed recently, there may be no delay in reunifying families (either due to DCFS or external parties in the judicial system).

Recommendation:

- DCFS should establish reports for regular executive and management review of all of the instances in which case action is taken contrary to the tools and on the types of over-rides used, which would allow trends to be identified at a system level and interventions to be designed as appropriate (i.e., staff coaching or re-training).

10. There are opportunities to improve engagement of stakeholders on safety, risk, and the SDM tools.

DHHS and DCFS leadership, management, supervisory, and caseworker staff identified opportunities to improve stakeholder (i.e., judges, CASA, guardian's ad litem, county attorneys, law enforcement, public) knowledge of how DCFS defines safety and risk, and the underlying evidentiary basis, methodology, and use of the SDM tools. Gaps in stakeholder knowledge about the approach to safety/risk and the SDM tools create challenges for DCFS including:

- Reports to the Hotline that cannot be accepted as intakes because they do not meet definitions to be "Screened in." These intakes require staff resources to be vetted and ultimately screened out.
- Instances in which DCFS staff and stakeholders disagree over case decision-making (i.e., the decision to close an in-home case, change a placement, or reunify a family).
- Instances in which case actions are taken contrary to the logic and recommendations of the SDM tools (i.e., children remaining in a placement identified as unsafe, a case remaining open past the point at which safety has been achieved and the risk level has been reduced).

When the SDM tools were initially implemented, DCFS conducted outreach to stakeholders and offered training on the tools. TSG identified recent efforts by DCFS leadership to engage legal stakeholders about the tools, and instances in which training has been offered but may not have been well attended.

Recommendations:

- Implement a comprehensive stakeholder engagement plan on the SDM tools, to coincide with implementation of any revisions coming out of work with NCCD. This should include training, facilitated discussions with judges, county attorneys, CASA, guardian ad litems, community advocates, and any other relevant stakeholder.
- DCFS should consider use of a tool to engage community stakeholders about reporting of child abuse and neglect, consistent with the state's definitions, such as the Child Protection Reporting Guide developed by NCCD. The goals of this tool are to help the community understand its responsibilities for reporting, provide reporters with guidance, and help the state child welfare agency to concentrate its resources on the most appropriate cases, according to NCCD.
- DCFS staff should receive training on how to explain the tools and the underlying decision processes used when interacting with stakeholders and in court.

11. DCFS should build an SDM management dashboard as part of its quality assurance process

It is important for DCFS management to monitor caseworker and supervisor performance and use of the SDM suite of tools in order to maintain fidelity and also to enhance safety and well-being going forward. We found a robust amount of data related to the use of the SDM tools available during our research, but management is not using the data systemically to identify real time issues related to possible inappropriate decision making, misuse, inappropriate supervision, or delays in timeliness of completion. Using existing data and making the data available to regional management, by way of useful performance management dashboards which can be incorporated into the DCFS quality assurance process, would enhance the future fidelity, as well as child safety and well-being.

Recommendation:

- DCFS should also build an SDM Regional Management Dashboard and incorporate it into its existing quality assurance process using existing data, to include some of the following suggested key performance indicators:
    - Hotline intakes:
        - Number and percent of cases screened in and out by region
        - Over-rides by region (noting type as policy or discretionary)
    - Timeliness of completion by region for:
        - Safety Assessment
        - Risk Assessment
        - FSNA
        - Risk Re-Assessment
    - Number of overrides, per tool, broken out by type (policy or discretionary)
    - Number and % of Risk Assessment with Safe with High or Very High Risk that are closed without service and recidivism of this population relative to recidivism of all closed cases

- Number and percent of open in-home cases where Risk Assessment shows Low or Moderate risk
- Number and percent of children in out-of-home cases where Risk Re-Assessment indicates reunification can begin
- Number and percent of cases where Assessment of Placement and Stability indicates a child is placed in an unsafe placement

VII. Related DCFS Priorities

Behavioral Health, Medicaid, and the Child Welfare Population

The American Academy of Pediatrics has found that access to behavioral health services represents "the greatest unmet need for children and teens in foster care."[10] A 2016 *Medicine* article found that "Mental disorders affect a substantially greater proportion of children and adolescents in the child welfare system than in the general population. The 49% pooled prevalence for any mental disorder is nearly 4-fold greater than the prevalence among the general population."[11] The National Conference of State Legislators writes that "Up to 80% of children in foster care have significant mental health issues, compared to approximately 19-22% of the general population."[12] These facts, along with the ground breaking "Adverse Childhood Experiences (ACEs) study on the effects of trauma on children and youth,[13] are well known by child welfare professionals and advocates.

Throughout the DCFS staff focus groups, TSG found a high degree of caseworker commitment in accessing behavioral health services for the children/youth in care. There was a great deal of consistency around the challenges that DCFS faces in accessing behavioral health services through the Medicaid managed care organizations (MCOs) including the lack of:

- evidence-based practices (MST, trauma informed cognitive behavioral health, fidelity wrap around);
- access to needed services falling back on DCFS;
- adequate provider network;
- mutual understanding of how each system works ("lack of knowledge on each side"); and,
- access to MCO data in the Medicaid data warehouse to track case progress.

TSG identified several positive, action-oriented strategies occurring among DCFS, Division of Medicaid and Long-Term Care (MLTC), and the MCOs that include:

- Weekly call-in meeting between DCFS offices and the MCOs to discuss individual cases.

[10] American Academy of Pediatrics: Healthy Foster Care America.
[11] Medicine: The Prevalence of Mental Disorders Among Children and Adolescents in the Child Welfare System: A Systemic Review and Meta-Analysis"; G. Bronsand, MD, Ph.D., Marine Allessandrini, MD; Volume 95, Number 7, 2/2016; p. 1.
[12] National Conference of State Legislators: Mental Health and Foster Care; 5/9/2016
[13] Adverse Childhood Experiences Study: Kaiser Permanente/CDC, 1998; American Journal of Preventive Medicine: "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults"; 1998; Volume 14; pp. 245-258.

- MLTS call-in meeting between MCOs and DCFS on complex cases, chaired by Dr. Lisa White, Medicaid Medical Director.
- The Division of Behavioral Health (DBH) sponsors the development of the Nebraska System of Care Community Response model that funds ten Community Response collaborations across the state. The model is a prevention initiative designed to reduce the need for higher-end systems and services. Implicitly, the model is a very positive initiative to reduce the number of children, youth and families from entering into the DCFS system yet does not directly impact the lack of access to evidence based services in the state's Medicaid MCO system.

DCFS children/youth in foster care are enrolled in the MLTS Heritage Health managed care system. DCFS Protection and Safety Procedure #15-2017 (4/21/2017) requires that the "CFS Specialist will ensure" that the child/youth will receive a medical examination within 14 days of home removal as well as dental, vision and behavioral health assessments "as soon as possible." In addition the CFS Specialist is responsible for ensuring all EPSDT well-child screenings occur (based on MCO Table of EPSDT Periodicity) throughout the life of the case. In addition, DCFS requires foster care parents to provide a month update to their DCFS Specialist on the medical status of the child/youth and their receipt or omission of EPSDT age-related screenings. Throughout this process, the need for, access to, receipt of, or lack of service access for needed behavioral health services is processed with the MCOs.

A brief review of Nebraska MCO contract #71164-04 (1/1/2017-12/31/2022) indicates that several critical services and concepts relevant to the child welfare population are missing. The terms "DCFS," "wraparound," "evidence-based practice," and "EPSDT" are not mentioned.[14] The MCO Outpatient Mental Health Services benefit requirements of the contract for individual, family, and group services do not include specific evidenced-based outpatient modalities that are often needed by families and children at risk, such as Multisystemic Therapy.[15]

The crossover point of the utility of the SDM assessment instruments and the need for behavioral health services is the identification of high-risk/high-need children and youth who are removed from their homes as a result of the findings of the assessment and the decision of the DCFS Specialist and supervisory review. The caseworker will often know a child/youth's need for behavioral health services before the case is enrolled in Medicaid, making the response time of the MCO critical to their immediate emotional and mental status.

Recommendations:

- Develop a DHHS/DCFS Leadership Team. This recommendation suggests building on the two existing scheduled meetings (DCFS-MCO weekly calls; Dr. White's DCFS-MCO meeting on complex cases) and the DBBH Systems of Care to create this team. A successful model for Nebraska's consideration is the State Executive Council leadership structure of the Virginia Children's Services Act.[16] The primary duty of the SEC model is to "establish interagency programmatic and fiscal policies" across DHHS and participating agencies through the promulgation of regulations or administrative action with the goal of the multiple state

[14] It is possible that these subjects are referenced in contract amendments.
[15] Contract, pp. 3-4.
[16] Code of Virginia: Section 2.2-2648

agencies/divisions that touch the child welfare population working in an integrated collaborative manner to the extent possible. The SEC leadership model is designed for the long-term coordination, collaboration, and adaptation necessary to assure the medical, behavioral health, and developmental needs of children in care are met, their education is successful, and transitions to adulthood prepare transitional youth for the challenges and opportunities of adulthood.

- Establish a collective round table between DCFS, MLTS, and the MCOs. This would involve establishing consistent, on-going meetings for the purposes of:
  - Developing mutual knowledge of each other's systems;
  - Developing "cross-over" staff training ("Medicaid Managed Care 101/ DCFS System 101");
  - Developing a collaborative communication plan with foster families and youth;
  - Identifying immediate and longer-term challenges and project managed-oriented solutions;
  - Identifying access issues and develop proposed solutions such as network expansion;
  - Appointing a select team that includes DBH for the purpose of identifying the behavioral health evidence and best practice services that are most needed by Nebraska's children and youth in foster care/in-home placements and a plan to develop these services and contractually implement them;
  - Developing and implementing a mid- to long-range plan on growing the supply of credentialed practitioners by working with community colleges and institutions of higher education; and,
  - Considering Alternative Payment Model contractual requirements that are designed to attract more credentialed providers.
- MLTS should consider adding a 24-Hour Behavioral Health Crisis Consultation service and a Behavioral Health Targeted Case Management Benefit for complex cases (eligibility based on clinical assessment) for the purpose of assuring continuity of care and avoiding unnecessary ER visits and psychiatric residential treatment facility admissions.
- MLTS and DCFS should share Healthcare Effectiveness Data and Information Set (HEDIS) across system partners to increase accountability and drive improvement. MCOs are required to report HEDIS measures already. The measures include a series of EPSDT-related information that would be valuable for DCFS, MLTC, and the MCOs, as well as stakeholders, to periodically discuss based on the aggregate number of DCFS enrolled children/youth and overall compliance and possibly low compliance rates.
- DCFS, MLTS, and the MCOs should consider the feasibility of an electronic Health Passport for foster children and youth. Other state models for consideration include the model used in Texas. The Health and Human Services Commission contracts with a single statewide MCO to serve foster children and requires the population of certain health and claims data into an electronic Health Passport. The Health Passport is a secure website that collects key child/youth medical information, including EPSDT wellness checkups, and is accessible by medical consenters, state child welfare caseworkers, health care providers, and authorized state Medicaid staff.

Suicide Assessment and Prevention

In June 2018, the federal Centers for Disease Control (CDC) reported that the rate of age-adjusted suicide across the country increased 30% between 2000 and 2016, rising from a rate of 10.4/100,000 population to

13.5/100,000 population.[17] The 2016 rate of suicide in Nebraska was 13.1/100,000.[18] Of the ten leading causes of death by age group in 2016, the CDC reported that the second leading cause of death among the 10-14, 15-24, and 25-34 age groups was suicide.[19]

Suicide is of particular concern for children in foster care. Research published in the *Child and Youth Services Review* reported an estimated prevalence of suicidal ideation of 24.7% among children and youth in care, compared to 11.4% among the non-care population. The authors estimated that suicide attempts were three times more likely among the in-care population than the non-care population.[20] The Nebraska Foster Care Review Office's 2017-2018 Annual Report also highlighted the importance of professional consideration and response to the occurrence of youth self-injury (cutting, suicide attempts) within the overall mental health needs of youth in state care.[21] The 2017-2018 Annual Report of the Inspector General of Nebraska Child Welfare highlighted their concern about the increasing rate of critical incident reports of suicide attempts by wards of the state.

Figure 23 Number of Critical Incidents Related to State Ward Suicide Attempts, 2016 – 2018.

Year	Number
2016-2017	23
2017-2018	24

Source: Office of Inspector General of Nebraska Child Welfare, 2017-2018 Annual Report.

Recently DCFS added suicide prevention training in response to concerns of the Office of the Inspector General of Nebraska Child Welfare. The QPR Gatekeeper suicide prevention training program is embedded as a 1½ hour learning module during the 14-week new worker training curriculum. QPR is based on the action steps of training caseworkers to recognize the warning signs of a suicide crisis/ideation and implement the "Question, Persuade, and Refer" skills designed to refer a child/youth or parent/caregiver for help. Gatekeeper training teaches caseworkers to recognize the warning signs of suicide, how to offer hope, and how to access help and services. QPR originated in a mental health environment (Spokane, WA Mental Health), has been in existence since 1999, and is considered an emergency mental health intervention with an emphasis on early recognition. Project Harmony also provides QPR training and has scheduled 12/13/2018 as the next available training date.

Suicide recognition and prevention is a public health challenge across the country and illustrates the importance of integrating the recognition, prevention, and treatment of the underlying causes of suicidal ideation and self-harm. During an investigation, the caseworker's ability to recognize the risk of suicide for a child/youth and assess the imminence and need for immediate referral for mental health treatment will be critical components of assuring immediate safety. It will also be important for caseworkers in on-going

[17] CDC/NCHS Data Brief No. 309, June 2018.
[18] CDC: Suicide Mortality by State, https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm.
[19] CDC: National Suicide Statistics, https://www.cdc.gov/violenceprevention/suicide/statistics/index.html.
[20] Child and Youth Services Review: Comparison of suicidal ideation, suicide attempts, and suicides in children and young people in care and non-care populations: Systemic Review and Meta-Analysis of Prevalence"; Rhiannon Evans, James White; Volume 82, Nov., 2017; pp. 122-129.
[21] Nebraska Foster Care Review Office 2017-2018 Annual Report; p. 67.

cases to monitor for the risk of suicide. For children and youth at risk of suicide who are in foster care, continuous assessment is a critical component of assuring that preventive and treatment needs have been met.

Recommendations:

- DCFS, DBH, and DMLTC work together in developing a comprehensive operational pathway to assure that access to psychiatric emergency crisis services and on-going mental health treatment for the underlying causes of suicidal ideation and self-harm is clearly defined for caseworkers who identify children at risk. This will require the Medicaid managed care organizations (MCOs) to be involved and raises the question of what behavioral health crisis service consultation services are provided through the MCOs.
- DCFS should consider discussing the mental health screening assessment process required of the MCOs during the child/youth 14-day medical evaluation after being taken into care. There are several best practice assessment instruments that can be used in the clinical setting (Columbia-Suicide Severity Rating Scale, PHQ-9 Depression Screening tool) and training products such as the Five Step Evaluation and Triage Tool (National Suicide Prevention Hot Line) and the Suicide Tool Kit for Schools (SAMHSA). In addition it is important for DCFS to have a reporting system of some kind documenting the findings of case workers during SDM Initial Assessments and on-going case work based on the use of the QPR Gatekeeper skill set in order to recognize trends, the need for adaptation, and, most importantly the outcomes from the use of this model.
- DCFS should consider discussing suicide assessment with NCCD/CRC by reviewing current training and casework protocols on the QPR in relationship to SDM tools and related policies and procedures.

Comprehensive Addiction and Recovery Act (CARA)

The federal Comprehensive Addiction and Recovery Act (CARA) was signed into law on July 22, 2016 and included an amendment to sections 106(b)(2)(B)(ii) and (iii) of the Title V Child Abuse Prevention and Treatment Act (CAPTA) related to plans of safe care for infants (aged 0-1) who are exposed to substances. Changes include removal of the term "illegal" as applied to substance abuse, which expands provisions to include legal substances, a requirement that safety plans address the needs of infants and their families (or caretakers), and requirements relating to data collection and monitoring.

The original CAPTA provision did not establish a federal definition of child abuse and neglect for infants affected by substance abuse. The provision requires a Safety Plan of Care focused on keeping the infant safe and address the needs of the child and caregivers. Each state was required to submit a CAPTA Plan to the Administration of for Children and Families/Children's Bureau. The states decide what entity is responsible for the Safety Plan of Care. The National Child Abuse and Neglect Reporting System was chosen by ACF/CB to collect CARA. There is Federal Participation for IT adaptations under IVE via Advanced Planning Document.

Each Safety Plan of Care must consider the immediate safety needs of the affected infant and the health and substance use disorder treatment needs of the affected family or caregiver. Considering the need for a continuum of services for any addicted/dependent parent/caregiver there is a need for collaborating

partners, agencies, MCOs, and health insurance providers to be included in the development of each Safety Plan of Care.

The Nebraska CARA Plan of Implementation includes several key clarifications designed to assist Nebraska's birthing hospitals in complying correctly with reporting requirements, including:[22]

- Correct definition of reportable conditions (prenatal drug exposure or Fetal Alcohol Spectrum Disorder);
- Clarifies that a CARA notification is not a Maltreatment Report to the Hotline;
- Identifies prenatal exposure conditions requiring a CARA notification: 1) Mother is stable and engaged in medicated-assisted treatment with a licensed physician; 2) Mother is being treated with opioids for chronic pain by a licensed physician; and, 3) Mother is taking medication as prescribed by her licensed physician.
- Clarifies the Safety Plan of Care "will be completed by the treating professional or health care provider and provided to the infant's primary care physician for ongoing monitoring" when there are no safety concerns.
- Clarifies that reporting birthing hospitals should call the DCFS Hot Line if there is "*any* reason to believe that there is child abuse or neglect." The current acceptance criteria for substance exposed infants is based on the Structured Decision Making™ Intake Screening Policy and Procedures Manual.
- Provides a DHHS email address and fax number for CARA notifications when there are no safety concerns. DHHS will collect and report CARA specific data. This process should avoid or at least control unnecessary CARA Hotline calls.
- New worker training on CARA has been integrated into covering Notifications, Reports Not Accepted, and Reports Accepted (expect MCO involvement in Safety Plans of Care for necessary covered services).

State child welfare programs have been significantly impacted by the opioid epidemic over the past several years. A March 2018 study by the federal Office of the DHHS Assistant Secretary for Planning and Evaluation estimated that for every 10% increase in opioid deaths there has been a 4.4% increase in child entry into foster care.[23] The Nebraska 2016 rate of drug-related deaths was 6.4 per 100,000/120 total deaths compared to national average of 19.8 deaths per 100,000.[24] Preliminary 2017 data indicates Nebraska's drug-related deaths increased to 164, a significant increase and cause of concern. The Robert Wood Johnson Foundation's County Health Rankings website reports that Buffalo, Lancaster, Lincoln, and Sarpy counties had high rates of opioid-related deaths relative to other Nebraska counties. Although Nebraska's rate of opioid-related deaths has been significantly lower than the U.S. average, the current trend is noteworthy and requires considerable monitoring and attention related to the potential growth of prenatal exposure.

[22] All information sourced from the Summary Document of Nebraska's CARA Implementation Plan as of September, 2018
[23] ASPE Research Brief: "Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study"; March 2018; p. 3.
[24] CDC Drug Overdose Death Data, https://www.cdc.gov/drugoverdose/data/statedeaths.html.

In TSG interviews with Hotline staff, staff indicated that CARA has not yet had an impact on call volume. TSG requested data on these calls but was instructed that data are too preliminary for release. Given the Nebraska CARA reporting process for birthing hospitals in prenatal exposure cases this might be expected at this time. Due to the recency of the reporting policy change and the lack of available data, it is too early to make conclusions about the potential impact of CARA reporting requirement on the Hotline.

Recommendations:

- Create a weekly report of CARA-related intakes for management review. This new report and regular analysis of CARA-related trends will allow management to remain appraised of the situation, detect whether there are any unexpected spikes in call volume, and act swiftly if state response is needed.
- Develop a CARA decision-making and process map, based on Nebraska's CARA Implementation Plan, to be shared with birthing hospitals, stakeholders, and Hotline staff.

Appendix A: TSG Reports/Data Requests

Request 1:

General Resources:

1. Copy of the PIP
2. Summary table of SDM tools – "Overview of SDM Assessments"
3. NCCD written report on hotline case review
4. Department annual data book/report

Data Request:

Please provide the last two complete fiscal years and current fiscal year to date.

1. Hotline intakes broken out by reporter type, allegation type, region.
2. Of hotline intakes, what was the disposition? (How many were screened out vs. sent for investigation.)
3. Of hotline intakes screened out, any further information about the subject or categorization.
4. Monthly Hotline QA Report
5. Of intakes that are accepted, disposition: by region
6. For cases closed at the end of the 30 days (no in home or out of home), how many were closed by region and also reason codes for closure.
7. Data on Fidelity of Safety Assessment
8. Analysis of FSNA data related to assessment of child well-being
9. Of in-home cases closed where the child is safe but with high or very high risk:
   - Provide the number by region
   - Any data on case closure (i.e., parent refuses services)
   - For this group of cases, what were the recidivism and maltreatment rates, also by region?
10. For all in-home cases where the child is safe but with high or very high risk:
    - In what number/percent of cases does the family consent to services?
    - In what number/percent of cases does the family complete services?
11. How many out-of-home cases are open past the point where a Reunification Assessment indicates the child is ready to go home
12. How many in-home cases are open past the point where a Safety Re-Assessment says can be closed?
13. Generally, do you have data on where there have been "over-rides" based on what a tool has recommended?
    - Are these over-rides due to staff or the courts?
    - We are open to how you can pull this data.
14. Of children who have not achieved permanency, what number/percent have "Safety Threat #12" checked?
15. Of families with open in-home cases, what number/percent have "Safety Threat #12" checked?

16. Any data on completion and timeliness rates of the tools by staff, by region, including:
    - Initial safety assessment - % timely within 24 hours
    - Risk assessment - % timely within 30 days
    - FSNA – timeliness based on 6 month update schedule
    - Percent of closed in-home cases where Safety Re-assessment was performed prior to closure (or conversely, how many cases are closed where the tool is not used)?
    - Percent of out-of-home cases where Reunification assessment is performed prior to closure?

Request 2:

General Resources:

5. Annual # and rate of removals (statewide average) from FY2011 – present (want to pre-date implementation of the SDM tools which we understand to be FY2012 – if that is incorrect, please adjust the timeline).
6. # / % of Hotline Intakes that are not accepted (so no full investigation occurs), where there is another Intake within 12 months.
7. Rate of closed cases that are re-opened within 12 months after one of the SDM tools (i.e., the Safety Re-Assessment, Reunification Assessment) indicated case closure was warranted, for:
   - In-home Cases
   - Out-of-home Cases (re-entry after reunification)
8. Unsubstantiated cases, where a new allegation of maltreatment occurs within 12 months