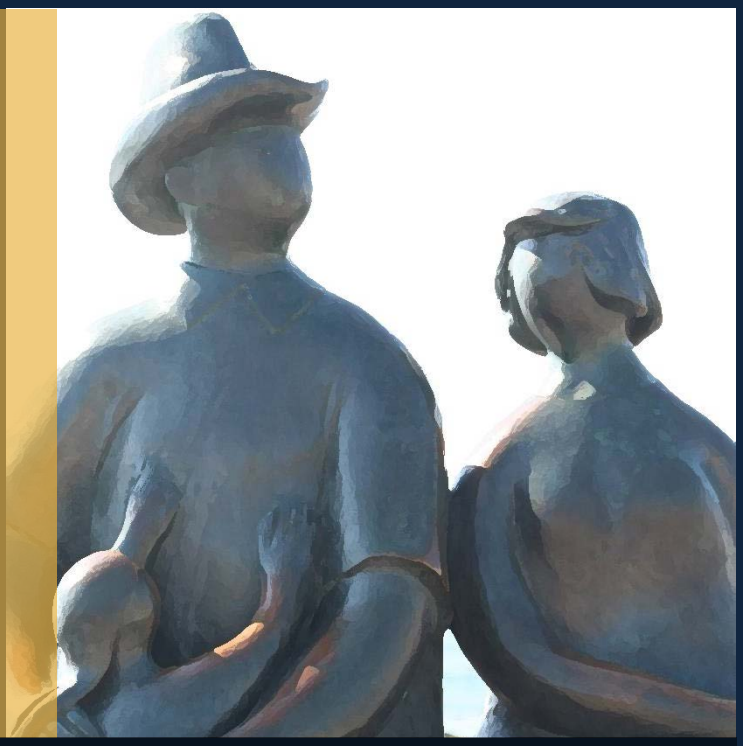

An Assessment of Child Welfare Privatization in Nebraska

Final Report

Prepared for the
Legislative Council

by
Hornby Zeller Associates, Inc.
New York · Maine · Arkansas · Pennsylvania

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Executive Summary

The recent history of child welfare reform in Nebraska, leading to the current study of privatization, can be viewed in four phases. The first represents the period of 2002 to 2007 when various efforts both internal and external to the state agency responsible for child welfare were undertaken, largely in response to shortcomings found in the first federal Child and Family Services Review (CFSR). The second was the period from 2007 to 2009 when the state agency began growing the array of services available to families and giving the providers of these services a more expansive role. The third, from 2009 to 2010, saw the State contracting large portions of services to "lead agencies" who would be responsible for expanding the service array through sub-contracts and paying for the services with a predetermined lump sum rate regardless of the number needing service or their presenting problems. The fourth, from 2011 to the present, represented the transfer of both case management and service delivery functions to the remaining lead agencies in the largest service areas only, using both a fixed monthly rate and a daily rate based on the number of children and families served.

The history is important because it places this entire study in a context. *Child welfare privatization in Nebraska is the result of an evolution, not a revolution.* The challenge in evaluating an evolved service model is that few agree on what it should look like or what it should achieve.

By legislation, the evaluation of the pilot project is to include a 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; an 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; and an update to the information and data from the 2012 Assessment of Child Welfare Services in Nebraska report.

Arguments for and Against Privatization

As various states have attempted to use privatization as a means of improving the performance of their child welfare systems, theorists have articulated arguments both for and against this strategy. Some of the key points in that literature are summarized below.

Child Protection as a Community Problem

Pro: One of the long-standing criticisms of child welfare agencies is their insularity. Child welfare agencies often act in secrecy and take it upon themselves to solve all the problems of families. Many have said that child protection is a community problem. One way to involve the community is for non-governmental agencies to play a larger role in planning and/or delivering the services that children and families receive. Privatized child welfare services, employing the federal definition of delegating case management, is in theory the ultimate

way to transfer responsibility—at least for the service planning and provision—to the community. As one national group pointed out, "When privatization occurs, the private organizations that take over child welfare case management responsibilities are typically local agencies. These employees are often 'better at building relationships, and have the trust of the community.'"[1]

Con: It is sometimes difficult for families to distinguish public from private workers when they are essentially performing the same function. While the initial assessment of wrongdoing has great potential for creating an adversarial relationship between parties, this phase is still performed by the public agency. Once the decision is made to refer the case for services the private ongoing worker is acting *in loco* state worker and has the same requirements of going to court, seeking removals, and enforcing court orders, making the distinction between public and private difficult.

Ability to Produce Effective Services and Reduce Costs through Competition

Pro: The primary argument in favor of privatization is that by opening government services to the private marketplace, the services will decrease in price and will increase in efficiency and quality. Theoretically, because multiple agencies exist that can provide the same or similar services, each agency must find ways to cut costs by increasing efficiency.[2] The competition of the private marketplace replacing the monopoly of the government will drive costs down. Moreover, the smaller agencies may be less burdened with overhead costs or bureaucratic mandates which cost money to implement.

Con: After reviewing six states and counties which privatized at least a portion of child welfare services, Freundlich and Gerstenzang[3] conclude that "communities embarking on privatization initiatives should not expect to save money…" The chief Operating Officer of Alliance, an agency that provides case management services for Topeka, Kansas, said, "States have to be motivated by the desire to pay for better quality and more efficient services that create meaningful change for children and families, not by short-term fiscal benefit. In fact, some states have had to increase their spending after privatizing, a testament to what we already knew: the system, in general, is grossly underfunded."[4]

Ability to Innovate and Respond Flexibly to Family Needs

Pro: Efficiency and quality are also impacted by the increased flexibility of private organizations over state agencies. Because private organizations are smaller than the "alienating megastructures"[5] of government agencies, they can adjust to individual and

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[1] The Center for Public Policy Priorities, & Casey Family Programs. (2008). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX.
[2] Winston, P., Burwick, A., McConnell, S., & Roper, R. (2002). *Privatization of Welfare Services: A Review of the Literature*. Washington, DC: Mathematica Policy Research, Inc.
[3] Freundlich, M., & Gerstenzang, S. (2003). *An Assessment of the Privatization of Child Welfare Services*. Washington, DC: Child Welfare League of America Press.
[4] The Privatization of Child Welfare: Shared Decision Making Between Private and Public Entities is Critical for Success. (2011). *The Alliance for Children and Families Magazine, (3),* 7-10.
[5] Freundlich, M., & Gerstenzang, S. (2003). *Op cit*.

consumer needs more quickly and easily than state programs.[6] Proponents of privatization contend that state agencies are inflexible simply because they are so large. Private organizations that take over case management duties in child welfare are more likely to be small, local agencies that can quickly respond to youth and family needs. This flexibility, in turn, allows for the individualization of services for families and youth, which increases service quality and efficiency.

Con: Private agencies acting in place of public agencies have the same set of federal and state mandates unless explicitly waived. Following the same mandates with generally the same funding level and service array impeded the ability to respond flexibly.

Case Management Performance

To determine the extent to which privatization of child welfare in Nebraska has fulfilled the promises articulated in the arguments for it, this assessment of privatization's success at improving case management focuses on three issues: compliance with state and federal standards, engagement of families and achievement of child and family outcomes. For all three areas the question is one of relative performance: Does privatization of case management provide better performance than public case management?

Compliance

Case Assessments and Planning

Initial case plans (and the assessments on which they are based) are to be completed within 60 days of each child's entry into custody. In each of the months of the first half of calendar year 2014, NFC outperformed the State as a whole on this measure. While the standard for this measure is 100 percent, NFC achieved more than 90 percent compliance in four out of the six months, while that level was never achieved by the State as a whole and only once each by the Southeast, Central and Northern Service Areas.

NFC also outperforms the publicly managed Service Areas when it comes to involving families in assessments and planning, although neither group approaches the federally established standard of 95 percent. DHHS data show that NFC involved families in case plans in 69 percent of the cases during the period from April 2013 through April 2014, compared to a statewide figure of 57 percent.

NFC shows strong performance in relation to Family Team Meetings but so, generally, does the rest of the State. These meetings are required to occur at least every 90 days and are designed to contribute to the assessment and planning process, whether at the beginning of the case or later. The standard is 100 percent compliance. NFC, during the first six months of 2014, consistently showed compliance rates at or above 99 percent. Among the other Service Areas, performance on this measure was always above 90 percent, except in the Central Service Area in June.

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[6] The Center for Public Policy Priorities, & Casey Family Programs. (2008, August). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX.

Based on the information HZA obtained from reading 200 cases, the more frequent involvement of families by NFC does not, however, translate into better assessments or plans. The reviewers found that both NFC and DHHS identify all the strengths and supports that can help resolve the family issues as well as the risk factors and needs of the families and children in more than 90 percent of the cases, but that DHHS does so slightly more often.

The differences are clearer in relation to assessments. DHHS workers tend to consider each of the relevant domains, including the physical, cognitive and emotional level of development of family members; the family's history of abuse and neglect; any special conditions that would require a particular type of service and likely permanency options for the children, more frequently than do NFC workers, sometimes by substantial margins.

Case Contacts and Family Visits

Face-to-face caseworker contacts with both parents and children are required by both state and federal rules. The federal government requires regular reporting of face-to-face contacts with children in foster care, while contacts with parents and with children regardless of placement status are monitored through the federal CFSR. For all groups the standard is that 95 percent have a monthly contact. All Services Areas achieved the 95 percent standard for children in placement during the last half of the state fiscal year. In fact, during June every Service Area showed a compliance level of 98 percent or greater.

The picture on contacts with the child changes substantially when the quality of the contacts is considered. For the most recent Continuous Quality Improvement (CQI) period (April 2013-April 2014), counting only quality contacts drops the level of compliance from over 95 percent to 72 percent of the cases Statewide. NFC showed a slightly higher percentage (75 percent) than the State as a whole, largely because the Central Service Area had a precipitous drop in performance, with only 50 percent of the cases meeting the requirement. Across the rest of the State, DHHS had scores equal to or better than NFC's.

Perhaps the most important performance measurement related to caseworker contacts has to do with contacts with parents. Most of the children in state custody are there not because of their own needs or behaviors but because of the behaviors of the parents, and failure on the part of caseworkers to have regular, substantive interactions with the parents inevitably results in longer lengths of stay. While NFC's performance on this measure is clearly better than that of DHHS, neither organization is anywhere close to the standard. During the most recent CQI period of April 2013 to April 2014, NFC had (or worked diligently to have) sufficiently frequent and substantive face-to-face meetings with the parents in only 39 percent of the cases. The statewide figure was 28 percent.

Family Engagement

Public child welfare agencies, almost by their very nature, are often viewed by families as adversaries. Private agencies do not carry the same stigma. One of the arguments for privatization which could have great persuasive power is that a privatized entity has at least the opportunity to do a better job of engaging families.

Family team meetings are one of the mechanisms developed over the past couple of decades to give families a greater stake in protecting their children by involving the family, their friends and community members they identify in planning for the child's care and safety. For both DHHS and NFC the meetings are generally attended by members of the case management agency, by other service providers and by one adult member of the family. They are also frequently attended by attorneys, because many of the meetings take place immediately prior to a court hearing. No plan is developed at the meeting. Instead, the caseworker comes in with the plan already drafted. The only difference the case reviewers could identify between the family team meetings held by DHHS and those held by NFC was that NFC tended to have more service providers involved, not more family members.

Outcomes

Whether one agency performs better than the other on compliance issues or is better at engaging families, the ultimate criterion has to lie with the agencies' achievement of positive outcomes for children and families. The discussion of outcomes here is broken down into five categories: child safety, reunification, adoption, stability and well-being measures.

Child Safety

The most recent CQI review indicated that, against a target of 95 percent, all Service Areas except Northern showed 100 percent compliance with the requirement to provide services to keep children safe and prevent removal from their homes. The Northern performance was 93 percent, not quite meeting the standard but close.

COMPASS measures actual repeat maltreatment rather than the delivery of services to prevent a recurrence. The federally established standard is 94.6 percent, *i.e.,* that percentage of child victims of substantiated maltreatment should be free of a repeat incident for at least six months.

During the period October 2013 through September 2014, the Eastern and Northern Services Areas met the maltreatment standard every month, and, largely as a result, the State as a whole did so for 10 of the 12 months. The Central Service Area met the standard in eight of the 12 months and the Southeast and Western Areas in five each. During the most recent month, September, the Eastern and Northern Service Areas had the best scores and the Western the worst.

In contrast to all of the other measures to be examined and despite the terms of NFC's contract with DHHS, the Eastern Service Area results are not solely attributable to NFC. All victim children are used as the denominator for the calculation of repeat maltreatment, but not all families of victim children are opened as ongoing services cases. For some families, a DHHS initial assessment worker is the only caseworker they will meet. Whether maltreatment recurs will be due at least partially to the quality of the decision the initial assessment workers make about the family's need for services.

Reunification

The indicators relevant to reunification both appear in COMPASS. The first measures the percentage of children reunified with their families (including discharge to non-parental relatives) within 12 months of their first entry into foster care. The federal standard requires that the percentage be no less than 48.4 percent. The second indicator focuses on children who have been reunified and measures the percentage of children who return to foster care within 12 months of their reunification. No more than 9.9 percent should do so.

During no month in FFY 2014 did Nebraska achieve the standard for reunification. In fact only the Northern Service Area achieved it at any time and that was only for one month. During the last two months of that period NFC showed a lower performance than any other Service Area, except for Central. The last two months of the year have also seen significant improvements in the Southeast, Northern and Western Service Areas.

The story on re-entry is quite different. NFC, Southeast and Northern all met the national standard in every single month, as did the State as a whole. Central and Western, on the other hand, did so in only seven of the 12 months. The re-entry percentages for each of the Areas in September, ranked from best to worst, were the following.

- Southeast: 4.9%
- Northern: 5.3%
- Eastern (NFC): 6.0%
- Central: 10.8%
- Western: 11.2%

The statewide percentage during September was 7.3 percent.

NFC's performance is roughly in line with that of the Department on both reunification and re-entry. When the Department meets the national standard, so does NFC; when the Department does not, neither does NFC.

Adoption

While the measures to be considered here do not all relate directly to adoption, they do all relate to children who have been in care for substantial periods of time. There are five such measures:

1) the percentage of children who have been in care two or more years who are discharged to a permanent home within 12 months;
2) the percentage of children who are free for adoption at the start of the year who are discharged to a permanent home within 12 months;
3) the percentage of children who are free for adoption who get adopted within 12 months;
4) the percentage of children who have been in care 17 months or more who get adopted within 12 months;

5) the percentage of children who have been in care 17 months or more who become free for adoption within six months.

The one indicator on which NFC shows a somewhat better performance than does any other Service Area is the last one, *i.e.,* the percentage of children who have been in care 17 or more months who get freed for adoption within six months. On all other measures, NFC produces neither the best nor the worst results. Several of the Service Areas, including NFC met the established standard, albeit a low one in some instances, on three of the other four measures.

Stability

The federal outcome indicators related to stability all measure the percentages of children who have experienced two or fewer placement settings during their time in care. For those in care 12 or fewer months, the standard is 86.0 percent; for those in care 12 to 24 months 65.4 percent; and for those in care more than 24 months 41.8 percent.

In general, Nebraska's child welfare system is able to provide a reasonable degree of placement stability for children during their first two years in care, and the more recent scores are better than the record for the entire year would initially suggest. There has been a far greater emphasis on involving relatives which may account for this success. Also, DHHS' initiative to remove or at least limit shelter care as an option removes a placement move for those children who stayed in care after the initial placement. After the first two years, however, the record falls well below the national standard. NFC's record follows the general pattern across the State, neither better nor worse.

Well-being

The CFSR and CQI processes measure children's well-being in relation to three topics: education, physical health and mental/behavioral health. During the most recent review, all Service Areas except Central showed 100 percent of the cases meeting the educational requirements, and even Central met the national standard of 95 percent.

In relation to physical health, the record was almost reversed. No Service Area, including NFC, met the standard of 95 percent. The Central Service Area scored highest at 87 percent, with NFC at 81 and the other Service Areas ranging from 68 (Southeast) to 77 (Western).

In relation to providing appropriate mental/behavioral health services, the Northern, Southeast and Western Service Areas all scored at 100 percent. NFC met the standard at 95 percent, while Central lagged with an 89 percent rate.

Summary

The key argument in favor of privatization of case management in child welfare services is that private providers are able to achieve better outcomes at a lower cost.

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.

Comparison of Child Welfare Costs in the ESA to the Rest of the State

Total Costs

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.

Because the DHHS figure is about one-third higher than NFC's, it is important to understand where the additional money is going. The components of these total costs we examined were: 1) case management, based on the salaries and numbers of casework staff and supervisors; 2) service costs, based on the amount each agency pays to contractors; and 3) administrative costs, based on the administrative components of Program 265 for DHHS and the administrative salaries of NFC which are reported separately from case management salaries in their spreadsheets. The only thing omitted from the component analyses, as far as we could determine, was operational costs, and we did not have a good source for those costs for DHHS, largely because it is so much larger and complex that it necessarily operates differently. The results of the component comparison are shown below.

Cost Per Case Per Day By Agency and Component		
Cost Component	DHHS	NFC
Case Management (workers)	$10.73	$17.42
Contracted Services	$74.17	$48.10
Administration	$1.68	$2.57
Total	$86.58	$68.09

Put simply, DHHS pays more for contracted services, while NFC pays more for case management (line staff) and for administration. However, because DHHS and NFC pay their case managers and supervisors similar salaries and are subject to the same caseload standards, all we are relatively certain of in relation to case management costs is that DHHS does not spend more on staff, when measured on a case by case basis, than does NFC. Much the same applies to administrative costs.

The services costs are driven by the amounts paid for in-home supports and out-of-home care. DHHS has over 100 categories of service costs, but we used only those we deemed comparable to NFC categories. It is using this conservative view of DHHS' services costs which produces the cost per client per day for DHHS of $74.17, compared to NFC's $48.10.

One factor which almost certainly explains at least part of the lower NFC cost is the difference in policies regarding the client's role in payment. DHHS does not seek client payments for services while NFC does, based on a sliding scale, when the client is not eligible for Medicaid. The fact that the sliding fees are used for clients who are not Medicaid eligible (or perhaps also for services Medicaid does not reimburse) suggests that NFC actually has two ways to reduce its services costs. The first is to get Medicaid to pay for it; the second is to get the client to pay all or part of the cost. This is in addition to private insurance, where applicable. It is our assumption that DHHS also attempts to get Medicaid to pay for services, but it was well beyond the scope of this study to determine whether NFC or DHHS is more effective in that regard.

Federal Funds

Anyone knowledgeable about child welfare issues in Nebraska is aware of the federal disallowances of Title IV-E funds, over $20 million, which resulted from the structure of the privatization contracts where fixed payments were not linked to individual children and families. The disallowances do not, however, exhaust the full range of federal funding issues related to child welfare. The questions that have to be answered here are: What can be done to increase federal reimbursement for Nebraska's child welfare system? and: How, if at all, does the privatization of case management affect what needs to be done?

Based on a report by Child Trends,[7] Nebraska is the *second lowest state in the country* (third, counting Puerto Rico) in the proportion of federal funds it receives in payment for child welfare services (2012 data). This represents all federal funds, not just Title IV-E, which suggests the problem is larger than Title IV-E.

While the Title IV-E Waiver received by DHHS restores most of the level of funding the State previously received, it also limits what the State can receive. Specifically, anything classified as either maintenance (room, board and supervision for foster children) or administration (including case management costs) falls under the cap. What does not fall under the cap are expenditures for a SACWIS (N-FOCUS) and for training. Both are eligible for enhanced rates of reimbursement and Nebraska is losing out on each, in part due to technicalities associated with privatization such as the way providers are paid and how training contracts are structured.

The huge federal disallowance was perhaps the largest state cost associated with privatization. Once the Title IV-E Waiver expires, the entire system will have to conform to normal Title IV-E rules, and while that can clearly be accomplished with a privatized case management system, it is likely to require a more complex set of processes than would a

[7] Child Trends, Casey Family Programs, The Annie E. Casey Foundation, "Federal State and Local Spending to Address Child Abuse and Neglect in SFY 2012," 2014, p. 13.

non-privatized system. In addition, the ongoing reimbursement issues for SACWIS and training need to be addressed which will require changes not only on the part of DHHS but also in the way NFC operates.

Directions for the Future

Privatization of child welfare in Nebraska, as in several of the other states, began as part of an effort to reform a system viewed as failing in important ways. Unfortunately, the State is still not experiencing any measurable benefits. While compliance with the rules and regulations governing casework with families and children tends to be somewhat better in the private agency than in DHHS, there is no measurable difference in the outcomes for children and families. The federal disallowances generated the major cost impact. The current cost-per-case savings appear to be a result largely of shifting costs to the clients and to Medicaid, where they impact the State budget but do not get counted as child welfare costs.

Privatization has caused disruption and dissension among the parties and within the community without obvious benefits to children and families. What is less clear is what direction the State should take today. We recognize the potential benefits from various courses of action as well as the costs likely to be incurred with each one. In what follows we present three options: staying the course, reversing course and choosing a new model entirely. The first two are obvious choices; the third perhaps less so.

Option 1: Stay the Course

Staying the course would mean simply leaving the basic division of labor as it is now, *i.e.,* DHHS would have case management responsibility for all cases outside of Douglas and Sarpy counties, while NFC would continue, with oversight from DHHS, to manage the cases in those two counties. This is perhaps the easiest of the options to understand because the way work is done with children and families would not change. Staying the course may be the path of least resistance.

Features and Issues

Staying the course was the recommendation we made in our report on this subject two years ago. That recommendation grew out of our dismay at the level of disruption the privatization effort had caused, and it rested on a belief that further change in any direction whatsoever was only likely to make things worse. It also rested, however, on an assumption that, if our recommendation was accepted, both sides would cooperate to make the system work better for children and families. That did not happen.

Despite the continuing institutional struggle, there are reasons to maintain the current division of labor. Perhaps most notable among them is that, as a group, the judges in Douglas and Sarpy do not want to go back. There does not appear to be a consensus among them that the current situation is better than that which existed pre-privatization, but they tend to express the same concern that led to our earlier recommendation: undoing privatization in these counties would cause unnecessary disruption.

A second reason has to do with staffing. It appears that only recently has NFC's staffing situation settled down so that turnover has been reduced and caseload standards are close to being met. Another shift of staff from one agency to the other, or the termination of NFC workers who have learned the job and their replacement by entirely different workers at DHHS is likely to do more to hinder the achievement of positive outcomes for children and families than to help it.

A third consideration is the progress that has already been made on some of the things that will need to be fixed under any alternative. The most important of these are the steps needed to repair Nebraska's Title IV-E reimbursement. Some of the work done in this regard has been undertaken by NFC and assumes NFC will be part of the equation.

In sum, the basic reasons for staying the course all come down either to it being simpler because the system is already on this path or to any other option threatening further disruption to a system which has already experienced significant upheaval. Whether these are particularly good reasons or not, staying the course can work and, more specifically, it can work in ways that benefit children and families. For that to occur, however, a number of things are going to have to happen.

Prerequisites for Success

The most important thing is that the struggle for organizational dominance must stop. The DHHS administration has to treat NFC differently than it treats other contractors, in much the same way that managing supervisors is different than supervising line workers. NFC, on the other hand, will have to acknowledge that it is not a public agency with the same authority and responsibility as DHHS. It must also stop lobbying against the public agency.

Closely related to ending the struggle, DHHS needs to develop mechanisms for holding NFC accountable, and both the Legislature and the Governor's Office need to provide DHHS strong support in the implementation of those mechanisms. While there are many reports comparing NFC's performance to that of the rest of the State, there have never been any consequences, positive or negative, when NFC meets or fails to meet its performance targets. In particular, the rate changes and the *ad hoc* payments compensating for some of NFC's losses have never been tied to performance. Instead, with the exception of adjustments to fit the revised foster care rate, they have been the result of political pressure, which circumvents any standardized accountability. Because DHHS intends to introduce performance-based contracting into its system, the rate for NFC should probably also contain a component based on performance, representing the accountability mechanism discussed above.

Third, the issues with Title IV-E reimbursement have to be fixed. The current DHHS administration, which inherited those issues, has spent an enormous amount of time dealing with those issues and has achieved significant progress in fixing the problems, including obtaining a waiver from the federal government which allows more flexible use of Title IV-E. The waiver provides some breathing room for the State, a five-year period in which to prepare for the restoration of the normal IV-E restrictions.

DHHS needs to create a system for establishing NFC's rates that is based on allowable expenditures and not on political decision making. The fixed portion of the payment is the most obvious issue here, but the variable payments are a problem as well, because they are not tied to the actual cost of serving individual clients.

Finally, NFC needs to examine its family engagement practices, introduce more comprehensive assessments and involve family members in meaningful decision-making.

Option 2: Reverse Course

Features and Issues

Reversing the course means ending DHHS' contract with NFC and returning all of the contracted functions, most notably, case management, to the Department. The motivation for such a move seems obvious. Privatization promised better outcomes at a lower cost, and that has not happened. It was, perhaps, a worthy experiment, but it has failed.

There can be little doubt that ending the privatization experiment would simplify repairing the Title IV-E reimbursement problems. In addition to cost considerations, however, there are programmatic reasons for returning to a system in which all case management is carried out by the Department. One of the mechanisms privatization was supposed to utilize to produce better outcomes was competition. Clearly, there is no competition among private providers in the current system. To the extent that there is competition, it is between NFC and DHHS. If a decision is made, however, to continue with privatization in its current form, the motivation of both agencies to show that their performance is better vanishes. In other words, the competition can only be effective, if at all, within the context of a pilot program.

The lack of effective competition is a serious issue in this system. It raises NFC to a level roughly equivalent to the Department's. It can determine how to structure its work and demand the public resources necessary to cover the costs it chooses to incur. That limits DHHS' ability to control its own budget and even to decide what it is paying for.

Perhaps the strongest programmatic reason to return case management in the Eastern Service Area to DHHS is that involuntary services are inherently a public function. No state privatizes child maltreatment investigations. In Nebraska, the situation is even clearer. Even DHHS cannot remove a child from his or her home; only law enforcement is empowered to take that action. Yet, the decision to remove and the decision to return a child to his or her family should be made on the same criterion: can the child be maintained safely in the family? Keeping a child away from his or her family is no different than removing a child.

In theory, DHHS, even in the Eastern Service Area, has the responsibility for determining when to ask the court to return a child. In practice, however, that decision lies with NFC, as long as NFC is the agency with all the information about the child and the family. DHHS' options are limited by the information NFC provides, and that information in turn is based on NFC's judgments. DHHS retains legal responsibility for the child, but it does not have a full array of tools with which to exercise that responsibility.

Prerequisites for Success

Two things will have to happen if NFC's functions in the Eastern Service Area are to be returned to DHHS. The first is that the entire public sector, including the Legislature, the Governor's Office and the judiciary, will have to support the move. There will be political pressure exerted against the decision, and it will have to be met with a united front. If that front cannot be constructed and maintained, this option has no chance of success.

The second prerequisite is that the change occur gradually and as seamlessly as possible. The main argument against returning NFC's functions to DHHS is the converse of the main argument for staying the course: too much disruption. There is, however, no need to make the transfer on a single day.

A gradual transition should have three components. First, existing cases should not be transferred. DHHS should become responsible for new cases in the Eastern Service Area, but NFC should continue to handle the cases for which it is currently responsible. Second, every NFC caseworker and supervisor should be guaranteed an equivalent job at DHHS. Third, during the transition, NFC's costs need to be covered at public expense.

Option 3: Re-tooling for Reform

Features and Issues

Privatization started as a mechanism for reforming the child welfare system and producing better results for the children and families who become known to that system. Through many changes that have occurred since then, the focus has shifted from child welfare reform towards simply defining the respective roles of the public and private sectors. If the change originally envisioned is to occur, *i.e.,* to increase the proportion of children being served in their own homes by enlisting the help of their families and supporting them in that effort, the primary focus has to be on ***what*** is required to achieve that goal, not on ***who*** can do it best.

In addition to moving the system towards more fundamental goals, this option provides a new role for NFC, focusing on three of its key strengths: its connections to service providers, its community organization talents and its management talents.

In the examination we have just completed, the largest gap we found in the system has to do with family engagement. There are two essential ingredients to meaningful engagement with families: shifting more of the decision-making to families as envisioned in the original model of family group conferencing and assuring ready availability and accessibility of informal as well as formal supports. The dearth of current supports for families being served in-home is perhaps best illustrated by NFC's report to us that 90 percent of its service expenditures are devoted to out-of-home cases; our analysis of DHHS' costs produced similar results. The present system cannot reform, at least in part, because it does not have the necessary service infrastructure specifically to support families with children in their home. While the Title IV-E Waiver obtained by DHHS includes an Alternative Response

component, that program has a broad list of exclusionary criteria and does not encompass Douglas County.

That infrastructure should consist of three parts: formal services directly addressing the family issues threatening the safety of children known to DHHS including clinical, behavioral and concrete supports; paraprofessional services designed to assist, support and guide parents often by teaming them with others who have had similar experiences; and each family's own private sources of informal support.

The first of these, the formal services, should be the easiest to develop because both public and private agencies are most comfortable with formal, structured services. For formal services to be useful in preventing removals of children, however, they have to be aimed at controlling safety threats, not simply at reducing the risk of repeat maltreatment. Providers also need to know how to access concrete supports related to housing, jobs and food support.

Paraprofessional services often use adults who have had experiences similar to those of the client families to guide the latter towards effective parenting of their children. Structured properly, paraprofessional services can be much more flexible than traditional services, with the paraprofessionals able to respond to a family's crisis on a 24-7 basis. In that sense, they can supplement, or for families who are quite socially isolated, even replace the family's own informal support systems.

Private, informal supports can come from family, friends and community members who play specific, agreed-upon roles in helping the children and parents.

If formal, paraprofessional and private informal resources represent the components of the infrastructure needed to keep more children at home, the question remains of how to develop that infrastructure. We believe this is a role which can best be played by the private sector.

Although the image of the desired structure should be relatively clear, it will require a process to achieve. Neither the courts nor DHHS is likely to change its decision-making about removals just because an agency has hired its first paraprofessional. This is where NFC can play a key role. NFC, through a contract with DHHS, should take a lead agency role in relation to in-home services. This does not mean case managing in-home services cases or even having anything to do with individual cases. Rather, the lead agency role should focus on the creation, expansion and ongoing maintenance of an array of in-home services and supports adequate to support realistic alternatives to foster care placement. This part of the role may have been implicit in the original model, but it never got implemented.

We envision that under its contract with DHHS NFC would:

1) identify formal, paraprofessional and informal support models from around the country which are specifically designed to provide means of keeping children safely in their own homes;
2) seek and obtain start-up funds for some of these services;
3) assist private service providers currently focused on out-of-home services to implement the models for which NFC has secured start-up funds by providing training and technical assistance and passing to them the start-up funds for those services;
4) serve as the fiscal manager for all of DHHS' purchases of in-home services in the Service Area, including ensuring that DHHS only pays for services which are both authorized and actually delivered (and that it pays for all services meeting those criteria); and
5) conduct quality assurance reviews of the providers in the Service Area, using instruments approved by DHHS.

In summary this function involves assuming DHHS' contract management and payment functions for in-home services while also being responsible for generating an adequate supply of services (including high-end, intensive services as well as concrete supports) designed to keep children out of care or allow them to be returned home.

Focusing on resource development and management might prove attractive because it can potentially be expanded to other Service Areas without creating the upheaval that accompanied the transfer of service coordination and then of case management. The rural areas of the State were the ones most strongly affected by the loss of service resources during the collapse of privatization outside of the Omaha area, and even if some of those losses may have been recovered in the meantime, resources are nearly always scarcer in rural areas. Paying an organization, be it NFC or someone else wanting to provide the same set of services, to develop, organize, nurture and monitor a reasonable service array in the rural parts of the State could potentially represent a major step forward.

Prerequisites for Success

The most basic prerequisite for the success of the kind of lead agency model suggested here is that services not be paid on the basis of fixed payments regardless of volume. That model never made sense as a start-up strategy.

A second condition for success is the same as one for reversing the course. As the case management function reverts to DHHS, it needs to be done in a gradual way and NFC needs to be fully reimbursed for all its costs during the transition.

Similarly, the third prerequisite is a variation of what has been said about the other two options: each organization has to be both willing and able to accept its role, both the places where that role expands and the places where that role contracts.

Re-tooling for reform will work only if there is in fact a shift, ultimately visible in the fiscal ledger, from out-of-home services to in-home services. That shift has to be reflected not only in the services available but also in the decision making of DHHS case managers. It will also require cooperation from the judiciary and we believe that the chances of success will increase substantially with the addition of a pilot reform project affecting judicial processes. The Nebraska court system represents a hybrid of two systems the American Bar Association has characterized as the prosecutorial and representative models. The prosecutorial model necessarily depends on proving the family at fault as a basis for its mandate to follow judicial orders. This model counters the very premise of a system which recognizes parents as the primary protectors of their children. Further, it is premised on the wrongdoing of the parents rather than the safety of the children.

We recommend that a pilot court project be initiated which would eliminate the prosecutorial component of court proceedings and move instead to a family support model. The county attorney would not be needed and the role of the judge would change. A crucial component of the pilot court would be to use the Family Group Conferences started in 2006 by the Through the Eyes of the Child Initiative and now managed by the regional mediation centers under the Nebraska Judicial Branch. Family members decide who will attend to support them in addition to the professionals. The focus of the meeting should be ways to maintain the child at home or return the child home. Conference attendees develop the child's safety plan, identify the range of formal and informal supports needed and, where possible, identify who will provide the informal supports. If families, neighbors and friends are not available, the paraprofessional services developed by NFC can be invoked. The court will approve or modify the safety plan after hearing DHHS's viewpoint and will monitor the in-home service plan.

The use of Family Group Conferences has declined in Nebraska from its high of 364 in 2006 to a low of 120 last year which some attribute to shifting the program's administration from DHHS to the Nebraska Judicial Branch. The model did not appear anywhere within the 200 cases we read for this study. If a more family-driven system is to be effective, it will need to be used in every case in which family members are still involved.

Recommendation

Each of the above options has been presented with a set of conditions we believe necessary for it to be successful. If those conditions are met, any of the options can represent a reasonable structure for a functioning child welfare system. However, while each of the options could result in better service delivery and improved results, only one is inherently focused on anything that might be called a reform of the system. The only real argument for maintaining the privatized structure in Douglas and Sarpy counties is the need to avoid further disruption to the system. The main argument for returning all the functions to DHHS is that the experiment has not produced what it promised to produce, eliminating any reason to continue allowing a private organization to impose involuntary services on Nebraska's families and children. Only the third option, a division of labor which transfers some of the infrastructure functions to the private sector, focuses on expanding the resources needed to help families keep their children safely at home and to ensure that they are well cared for when they cannot be kept at home through an expanded in-home support structure.

Purpose and Scope of the Assessment

How Did We Get Here? The Promise of Privatization in Nebraska

The recent history of child welfare reform in Nebraska, leading to the current study of privatization, can be viewed in four phases. The first represents the period of 2002 to 2007 when various efforts both internal and external to the state agency responsible for child welfare were undertaken, largely in response to the first federal Child and Family Services Review (CFSR). The second was the period from 2007 to 2009 when the state agency began growing the array of services available to families and giving the providers of these services a more expansive role. The third, from 2009 to 2010, saw the State contracting large portions of services to "lead agencies" who would be responsible for expanding the service array through sub-contracts and paying for the services with a predetermined lump sum rate regardless of the number needing service or their presenting problems. The fourth, from 2011 to the present, represented the transfer of both case management and service delivery functions to the remaining lead agencies in the largest service areas only, using both a fixed monthly rate and a daily rate based on the number of children and families served. In 2012 one of those agencies, KVC Health Systems, surrendered its lead agency status and the Nebraska Families Collaborative (NFC) remained as the only privatization contractor, focusing exclusively on the Eastern Service Area.

The history is important because it places this entire study in a context. *Child welfare privatization in Nebraska is the result of an evolution, not a revolution.* The aftermath of a revolution is a set of principles or written constitution generated by the victors which represents a mandate for the future. Evolutions do not produce constitutions. They yield the fittest structures which have managed to survive through adjustment, intelligence, and resources. The challenge in evaluating an evolved service model is that few agree on what it should look like or what it should achieve.

Phase 1: 2002 to 2007: Federal Review and its Aftermath

The recent history of child welfare reform in Nebraska essentially began in September 2002 after the first federal Child and Family Services Review. While no states achieved substantial conformity on all seven of the safety, permanency and well-being outcomes, Nebraska did not achieve the standard on any of them. Although the State was not alone in that situation, the result spearheaded a series of studies, bills and reforms whose reverberations are being felt to this day. During the last two gubernatorial administrations, not counting the newly elected one, the first phase of reforms included adding funds for 120 additional social workers (2004); developing the Supreme Court Commission on Children in the Courts to ensure maximum state court responsiveness to children in the court system (2005);[8] inaugurating the Through the Eyes of the Child Initiative (2006); restructuring three agencies into the Department of Health and Human Services (DHHS) and creating the Division of

[8] The purpose of the commission is to study and recommend appropriate steps for the judicial system to undertake to insure that the courts are as responsive as possible for children who interact with, or are directly affected by the courts.

Children and Family Services within the department (2007); and initiating a new social services safety model designed to improve safety decisions, provide clarity of purpose for family assessments and improve the ability to support decisions in a professional manner (2007).

Phase 2: 2007 to 2009: Increased Centralization of Support Services

The next reform phase, leading to the current privatization efforts, began in 2007 when Governor Heineman appointed Todd Landry, then CEO of the Child Saving Institute in Omaha, to head the newly created division. Mr. Landry was charged, among other things, with reducing the number of children in foster care and reducing the number of times they moved from home to home.

At that time the State started preparing for the next round of federal reviews using a self-assessment process which all states are required to undertake. Mr. Landry appointed a Partners Council to monitor outcomes and program improvements while the Legislature established the Children's Behavioral Health Task Force. One of the reforms identified as needed was a "true continuum of services" to aid children at the right level of care in the right setting for the right amount of time (2007). A few months later DHHS announced a request for bids from private agencies to provide a continuum of safety and in-home services for at risk children (2008). The request for bids was part of a larger strategy in the State's Program Improvement Plan developed for the federal review to better coordinate the delivery of services through increased centralization. When DHHS signed contracts with six lead agencies to provide comprehensive safety and in-home services to DHHS clients, it began the trajectory leading to privatization today.

Phase 3: 2009 to 2010: Creation of Lead Agencies Statewide

After the second federal review, DHHS released a framework to reform foster care built on the safety and in-home services framework already begun. Central to the framework was that contracted service agencies *would provide both the services themselves and service coordination* (lead agency function) while DHHS would maintain case management and thus critical decisions such as whether to recommend that a child be placed in foster care. After holding a series of public forums in which many provider organizations vocalized concerns about the financial risk to potential lead agencies under the planned contracts, DHHS released a revised framework that described in greater detail the duties and case coordination roles between DHHS case managers and the service contractors. By 2009 Mr. Landry had left the State for a job in Texas while the last of six agencies contracts was signed, with the agencies now responsible to coordinate child welfare and juvenile services. The agencies agreed to develop infrastructure, staffing and programs necessary to provide service coordination under one set of funding, $7 million, and ultimately to begin operations late in 2009 and be fully implemented by April 2010 as both service coordinators and service providers.

The six lead agencies were to subcontract with other private providers to flesh out the needed continuum of services. One of the leads was NFC whose founding partners are Boys Town, Child Saving Institute, Heartland Family Service, Omni Behavioral Health and Nebraska Family Support Network. The service contract agreements replaced the previous

fee-for-service method of compensation with a risk-based payment system. Instead of billing a set amount for each specific service, each contractor received a flat monthly fee regardless of the amount or value of services provided. This payment model did not bode well for capturing federal Title IV-E reimbursement whereby costs have to be linked to specific children.

Early on, the providers began predicting that the capped service contracts would not be sufficient to pay their costs and one of the six agencies, the Alliance for Children and Families serving the Central Service Area, opted out before it began. While the lead agencies met their 2010 service initiation deadline, Cedars Youth Services announced its decision to withdraw within days due to inadequate reimbursement from the State. A week later Visinet filed for bankruptcy and DHHS took over cases in the Eastern and Southeast Service Areas. One of the alleged problems leading to the shortfalls was undercounting the number of children who would need to be served as well as the level of services needed. Over the next several years DHHS reimbursed several of the agencies for funds they had lost but in essence the damage to statewide privatization of the lead agency function had been done. A third agency lost its contract due to problems with both management and financing, leaving KVC and NFC.

According to the Legislative Fiscal Office report (October, 2011) the model was not viable for several reasons. The lead agencies maintained that the costs were higher than projected at the time they signed their contracts, driven largely by the number and expense of youth in foster care, the number of non-court involved cases and treatment costs ordered by the courts and not covered by Medicaid. The "no reject, no eject" provisions in the contracts meant the agencies had to serve everyone. Perhaps most importantly, the lead agencies lacked decision making authority until early in 2011. They had to pay for services that were planned by others. By then, however, only two lead agencies remained and one of them would stop functioning as such just over a year later. By all accounts this were a period of great turmoil and confusion about roles and responsibilities. In addition, instead of creating more service options for families it caused many of the existing services in the rural parts of the State to disappear.

Phase 4: 2011 to the Present: Fully Privatized Services

In January of 2011, the remaining two agencies, NFC and KVC, were given case management responsibility for the cases in the areas where they had previously provided service coordination. The two agencies shared responsibility for the Eastern Service Area, while KVC also managed cases in the Southeast. DHHS eliminated 77 FTEs as a result of the transfer of case management. On March 1, 2012, KVC ended its case management contract, ceding its Eastern Service Area cases to NFC and its Southeast Service Area cases to DHHS.

In 2012 the Legislature required DHHS to maintain case management in most places but to continue privatized services in the Eastern Service Area encompassing Douglas and Sarpy counties. Together these counties represent about 40 to 42 percent of the child welfare caseload. NFC's contract (called the Service Delivery, Coordination and Case Management Master Agreement) was amended many times to accommodate the changes in responsibility

and payment. The major changes began July 1, 2012 and initially ran until June 30, 2014. In March 2014 the legislature (LB660) authorized the pilot project to continue in the Eastern Service Area and provided for an evaluation to be conducted. DHHS entered into a contract with NFC which now runs until June 30, 2015 with a 12-month budget not to exceed $59,951,000. The budget includes a fixed monthly payment and variable payments based on the number served and whether or not the case is court supervised.

Summary

What can we glean from this history as the impetus for child welfare reform efforts in general and privatization of services as a solution in particular? What was it trying to achieve? Because history evolves, it is fair to say that there is no one consistent goal or standard for the whole privatization movement. At the beginning the efforts were geared to improving Nebraska's performance on the federal measures used in the Child and Family Services Review. In the next phase it focused in particular on reducing the number of children in foster care (not in itself a federal measure), serving them instead in their own homes and reducing the number of times children move from home to home, a result that has been shown to cause serious harm to children's well-being. Indeed, the graph below shows improvement in reducing the number of children in state custody on a given day, whether in home or out, between 2009 and 2013 by 15 percent. However, that reduction seems to have been less the result of new in-home services and more the result of a reduction in the number of child maltreatment victims.[9]

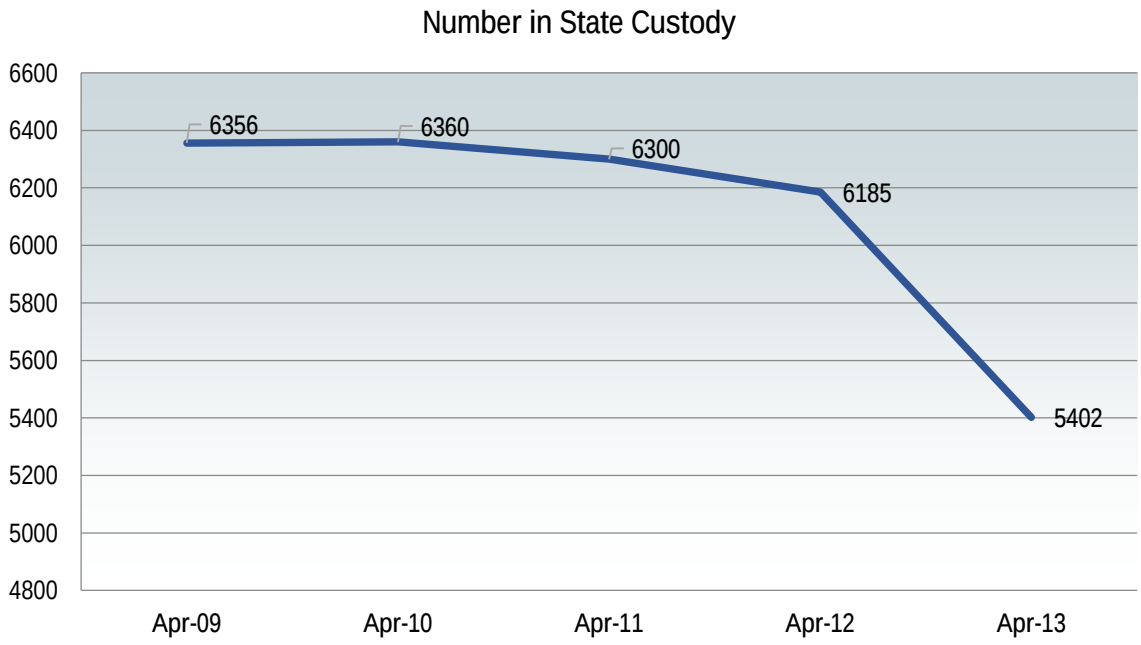

Table 1 shows that the decline in the number of wards has continued into 2014, but the proportions between in-home and out-of-home cases have not changed, a result consistent

[9] DHHS' Child Abuse or Neglect 2013 Annual Data Report (page 7) shows the number of victim children declining during this period from 5437 to 4657, a reduction of 15 percent.

with attributing the reduction in foster children in part to the decline in child victims. The proportion residing out of the home has increased by three percentage points while the proportion in the home has decreased by the same amount.[10]

Table 1. Children in State Custody[11]					
	Total	Out-of-home		In-home	
		Number	Percent	Number	Percent
April 2009	6356	4511	71	1845	29
April 2010	6360	4561	72	1799	28
April 2011	6300	4306	68	1994	32
April 2012	6185	4344	70	1841	30
April 2013	5416	3796	70	1620	30
April 2014	4625	3435	74	1190	26

The changes reflected in the table do not take into account the movement of juveniles from child welfare to probation since that occurred after April 2014, the last date reflected.

In the second phase of the reform efforts, the focus was on increasing the array of services available to children (and presumably families) and, due to the way the contracts were structured, on saving money. That is, for the six lead agencies the contracts were based on fixed amounts rather than fee-for-service. At this same time the concept of "managed care" was spreading throughout the health field and then the residential care and human services field. The lead agency contracts can be viewed as a version of managed care, shifting the burden to the provider to live within the amount given, whether to "profit" or to lose. In this instance, the result was a loss. The lack of services to support families in their homes and the lack of a structured process for deciding which children can safely remain at home made it difficult if not impossible to reshape the system to one which serves more families at home.

There is another aspect of the loss, however, which has not been addressed much in prior studies but which is equally devastating; that is, the State's loss of federal revenue under the newly structured contracts. Federal Title IV-E funding is based on a cost reimbursement system, with costs tied to individual, eligible children. By paying fixed reimbursements to the providers regardless of who they served, the State lost its ability to claim Title IV-E funds in a proper way, particularly for case management. This led to the federal exceptions and penalties from which the State is still suffering today. In addition, although DHHS now has a Title IV-E Waiver, the underlying billing and payment issues have yet to be resolved and will certainly come back to haunt the State when the waiver period of five years is over.

[10] The table reflects only children who are wards of the State. The information we have on non-wards is limited and counted only in terms of families not children. NFC's variable payment is also made on the basis of out-of-home children and in-home families and, as of November of 2014, out-of-home children constituted 77 percent of all "cases" and in-home families 23 percent.

[11] The figures for years prior to 2012 come from Performance Audit Committee, Nebraska State Legislature, *DHHS Privatization of Child Welfare and Juvenile Services*, November 2011, p. 30, while the remaining figures come from DHHS' Point-in-Time reports.

Many people interviewed believe that privatization, to the extent it has been sold, has been promoted on the premise that it would improve services through sheer competition, increase overall program effectiveness, allow for innovative practices and program flexibility and reduce cost. In fact the mandate of the remaining privatized agency, NFC, as reflected in its service contract, is to "provide an individualized system of care for families and their children and youth who are wards of the State of Nebraska involved in the Child Welfare or Juvenile Services System…" The provisions under the Statement of Work make it clear that NFC is required to abide by all policy requirements and operations that the State itself must follow, which makes sense since it is acting as an arm of the State in its largest service area but much less sense if it is to be flexible and innovative. It must perform service coordination and case management functions. It must perform child placement functions; follow the provisions of the Multi-ethnic Placement Act as well as the Indian Child Welfare Act; its staff must attend court hearings and comply with all court orders; and it must provide Independent Living services for eligible children.

NFC's contract also lays out the performance standards to which it must adhere, consistent with the federal measures for safety, permanency and well-being that state workers must follow. NFC's employees are required to have a bachelor's degree in social work, psychology, counseling, human development, education, criminal justice or other closely related area or another bachelor's degree with equivalent case management experience. NFC must also perform contract monitoring and quality assurance functions.

One may ask: if NFC is expected to perform the same functions and operate under the same constraints, with generally a proportionate amount of the funding that DHHS itself receives, why would one expect a significantly different outcome? In some ways this set of circumstances is as much a set-up for NFC as it is for anyone else.

So we have three sources for identifying the goals of the privatization effort. One is the history of privatization in Nebraska. Here the goals are improving the service array, improving service access, particularly in rural areas, and reducing costs, all suggested in the initial efforts to cap the costs and generate competition through a statewide request for bid process. By implication, the goal is also to increase service effectiveness as represented by the desire to reduce the foster care population and placement moves and increase the ratio of children served in their homes. Service innovation is not addressed directly in the history.

The second is the views of key stakeholders in Nebraska, interviewed for this study. They point to improving services through competition, increasing overall program effectiveness, allowing for innovative practices and flexibility and reducing cost.

The third is the NFC contract which essentially cites the federal measures for safety, permanency and well-being to which the State must also adhere.

In approving continuation of the pilot project in the Eastern Service Area the Legislature has asked that the evaluation focus specifically on the case management function since that is the essential purpose of the contract. Before we do that, we would like to make a global observation.

The Nebraska child welfare system has made significant progress, both programmatically and fiscally, since the last review of privatization two years ago. Foster parent reimbursements have been increased and standardized. The use of shelter care has been drastically reduced. DHHS has introduced Structured Decision Making (SDM) to make casework decisions more consistent and more rational. The federal funding situation has been stabilized due to negotiations and granting of the Title IV-E Waiver. The Continuous Quality Improvement process has been brought to the field through periodic meetings to review findings and discuss improvements. The population of children in placement has declined. NFC has stabilized its workforce and nearly achieved caseload standards. NFC also has won a competitive federal grant to improve home finding for difficult-to-place children awaiting adoption. Thus, it is not that no progress has been made. Rather, the progress has been made without regard to the issue of privatized case management, and that issue continues to inspire significant conflict within Nebraska's child welfare community.

Report Purpose

By legislation, the evaluation of the pilot project is to include the following.

1) A comparison of the performance of case management by a private entity under contract with the department in the Eastern Service Area of the department as designated pursuant to section 81-3116 to the performance of employees of the department in all other services areas designated pursuant to such section utilizing the outcome measurements from the Department of Health and Human Services Child and Family Protection and Safety Continuous Quality Improvement (CQI) goals and the Children's Outcome Measured in Protection and Safety Statistics (COMPASS).

2) An analysis of whether case management should be a duty of the Department of Health & Human Services (a) performed by employees of the department and not subject to contract with a private contractor or (b) 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.

3) An update to the information and data from the 2012 Assessment of Child Welfare Services in Nebraska report, as it relates to items 1 and 2 above.

What Others Have Said about Privatization

While many people have defined the word privatization, the federal government's definition comes closest to Nebraska's evolved system: The privatization of child welfare refers to the "contracting out of the case management function with the result that contractors [private

agencies] make the day-to-day decisions regarding the child and family's case."[12] Since this report evaluates case management functions within a privatized context we will use this definition.

Referencing both the literature on privatization and the people interviewed for this study who held diverse views about its potential and its current practice, this section discusses the various aspects of privatization and what professionals and scholars across the country see as the virtues and drawbacks. These include: the potential to involve the whole community in supporting families; the potential to use competition as a way of improving service effectiveness and reducing costs; and the ability to innovate and respond flexibly to family needs. Other issues of debate are the propriety of delegating a coercive government function to a private group; and the advantage private groups have in advocating for public resources.

This discussion of pros and cons illustrates that many of the issues confronting Nebraska have not only occurred elsewhere but have been analyzed and addressed in the literature.

Child Protection as a Community Problem

Pro: One of the long-standing criticisms of child welfare agencies is their insularity. Child welfare agencies often act in secrecy and take it upon themselves to solve all the problems of families. Privatization can help to overcome that.

Many have said that child protection is a community problem. One tangible way that thought has been institutionalized is through mandatory reporting laws. While virtually all states require *professionals* to report, Nebraska is one of only 18 that requires *everyone* to report. Thus, in this respect Nebraska has already brought protection to the community.

Another is through community diversion. Alternative Response, which Nebraska has initiated through its Title IV-E Waiver, is a way to direct families to community agencies for support rather than to the public child welfare agency for supervision. Nebraska is piloting that model outside of the privatization effort. In doing so in one of the Eastern Service Area counties, Sarpy, DHHS is in effect removing some low risk cases that may have been referred at least for in-home services away from NFC's caseload and diverting them farther into the community.

Another way to make child protection a community problem once a family is engaged in the system is to open individual planning sessions not only to family members but to other supports the family identifies. Family group conferencing is an example of this approach.[13]

A fourth way is for non-governmental agencies to play a larger role in planning and/or delivering the services that children and families receive. Privatized child welfare services, employing the federal definition of delegating case management, is the ultimate way, in

[12] U.S. Department of Health and Human Services. (2008). Child Welfare Privatization Initiatives—Assessing Their Implications for the Child Welfare Field and for Federal Child Welfare Programs: *Evolving Roles of Public and Private Agencies in Privatized Child Welfare Systems*. Washington, DC.
[13] Nebraska's Family Team Meetings generally do not include support members identified by the family.

theory, to transfer responsibility, at least for the service planning and provision, to the community. As one national group pointed out, "When privatization occurs, the private organizations that take over child welfare case management responsibilities are typically local agencies. These employees are often 'better at building relationships, and have the trust of the community.'"[14]

Con: It is sometimes difficult for families to distinguish public from private workers when they are essentially performing the same function. While the initial assessment of wrongdoing has great potential for creating an adversarial relationship between parties, this phase is still performed by the public agency. Once the decision is made to refer the case for services the private ongoing worker (in the Eastern Service Area called the Family Permanency Specialist) is acting *in loco* state worker and has the same requirements of going to court, seeking removals, and enforcing court orders. Often the families do not distinguish the public/private difference. Another aspect of community is being in and from the community. Because Omaha is such a large city, NFC has centralized its operation, no doubt for efficiency. Whereas DHHS used to have an office presence in Sarpy county near the court, for example, the NFC workers serving Sarpy are now located in Omaha.

Ability to Produce Effective Services and Reduce Costs through Competition

Pro: The primary argument in favor of privatization is that by opening government services to the private marketplace, the services will decrease in price and will increase in efficiency and quality. Theoretically, because multiple agencies exist that can provide the same or similar services, each agency must find ways to cut costs by increasing efficiency.[15] The competition of the private marketplace replacing the monopoly of the government will drive costs down. Moreover, the smaller agencies may be less burdened with overhead costs or bureaucratic mandates which cost money to implement.

In addition, because profits are directly tied to customer satisfaction, private organizations work to be as flexible and responsive to individual consumer needs as possible. At the governmental level, this is impossible, largely because the bureaucracy of state agencies makes them inflexible, regardless of individual needs.[16]

Because private providers of case management responsibilities can be replaced due to consumer disappointment, these agencies are more likely to strive to provide superior services. To support this theoretical assertion, Reed notes that private organizations outperform state agencies in a number of social services, including alcohol and drug abuse treatment and vocational training for welfare recipients.[17] Florida has had a number of

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[14] The Center for Public Policy Priorities, & Casey Family Programs. (2008). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX.
[15] Winston, P., Burwick, A., McConnell, S., & Roper, R. (2002). *Privatization of Welfare Services: A Review of the Literature*. Washington, DC: Mathematica Policy Research, Inc.
[16] Freundlich, M., & Gerstenzang, S. (2003). *An Assessment of the Privatization of Child Welfare Services*. Washington, DC: Child Welfare League of America Press.
[17] Reed, L. (2001). *Privatization works for social services too.* Midland, MI: Mackinac Center for Public Policy.

positive outcomes for youth in care since the system privatized,[18] which suggests that service quality has improved under the direction of private agencies.

Con: After reviewing six states and counties which privatized at least a portion of child welfare services, Freundlich and Gerstenzang conclude that "communities embarking on privatization initiatives should not expect to save money…"[19] The Chief Operating Officer of Alliance, an agency that provides case management services for Topeka, Kansas, said, "States have to be motivated by the desire to pay for better quality and more efficient services that create meaningful change for children and families, not by short-term fiscal benefit. In fact, some states have had to increase their spending after privatizing, a testament to what we already knew: the system, in general, is grossly underfunded."[20] These conclusions are supported by a number of other studies.[21,22]

An agency may win the contract with a low bid but later find that by underbidding the competition, it is unable to provide the contractually agreed upon services to families and youth at the rate being paid. In this situation, the state faces two poor options: either allow service quality to suffer or subsidize the organization and pay considerably more than was anticipated.[23]

An argument that relates to both competition and cost is that if a state fully privatizes with an agency, as is now the case in Nebraska, that agency also exerts significant control over the relationship, and thus over the State. For example, when the State first enters into a contract with a private agency and the agency contributes the funds for the startup costs, it is probable that the State will decrease its own capacity (by laying off staff who are no longer needed for case management duties) to perform case management services.

With the lack of competition, costs generally do not decrease and may actually increase due to start-up costs or duplication of administrative functions. Examples are the creation or purchase of an information technology system, the training of new staff and investing in a wide array of direct service providers to name a few.[24] In situations where these costs are incurred by the agency, as was the case in Kansas,[25] the number of agencies that are able to provide the services may decrease, thus decreasing competition. In other words, although

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[18] Child Welfare League of America. (2005). *Child Welfare Consent Decrees: Analysis of 35 Court Actions from 1995-2005* (National Child Welfare Resource Center on Legal and Judicial Issues, Comp.).
[19] Freundlich, M., & Gerstenzang, S. (2003). *An Assessment of the Privatization of Child Welfare Services*. Washington, DC: Child Welfare League of America Press.
[20] The Privatization of Child Welfare: Shared Decision Making Between Private and Public Entities is Critical for Success. (2011). *The Alliance for Children and Families Magazine*, (3), 7-10.
[21] Child Welfare League of America. (1999). *CWLA Managed Care and Privatization Child Welfare Tracking Project: 1998 state and county survey results.* Washington, DC: Author.
[22] McCullough, C., & Schmitt, B. (2002). *2000-2001 Management, finance, and contracting survey final report.* Washington, DC: Child Welfare League of America Press.
[23] The Center for Public Policy Priorities, & Casey Family Programs. (2008, August). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX.
[24] O'Brien, M. (2005). *Performance Based Contracting (PBC) in Child Welfare.* National Child Welfare Resource Center for Organizational Improvement.
[25] The Privatization of Child Welfare: Shared Decision Making Between Private and Public Entities is Critical for Success. (2011). *Op. cit*.

passing start-up costs to private agencies will save the state money, it will simultaneously decrease the number of private agencies providing services.[26]

The State has little to bargain with; it is likely that other private agencies have been pushed out of the market due to the high startup costs and because the other private agency has cornered the market. Further, because the State decreased its capacity, it can no longer provide the services required of families and youth. In this way, the private agency, free from competition from other agencies or the State, can set the "going rate" for these services.[27]

Ability to Innovate and Respond Flexibly to Family Needs

Pro: Efficiency and quality are also impacted by the increased flexibility of private organizations over state agencies. Because private organizations are smaller than the "alienating megastructures"[28] of government agencies, they can adjust to individual and consumer needs more quickly and easily than state programs.[29] Proponents of privatization contend that state agencies are inflexible simply because they are so large. Changes to the status quo require multiple levels of approval and happen slowly, when they happen at all. Alternatively, private organizations that take over case management duties in child welfare are more likely to be small, local agencies that can quickly respond to youth and family needs. This flexibility, in turn, allows for the individualization of services for families and youth, which increases service quality and efficiency.

Con: Private agencies acting in place of public agencies have the same set of federal and state mandates unless explicitly waived. In Nebraska's situation NFC's contract specifically requires it to follow state rules and produce comparable results. NFC does not have a mandate to innovate, quite the opposite. Further, following the rules is time-consuming and all-encompassing, no matter who does it. Moreover, NFC is not a small community agency with large amounts of flexibility.

Other Issues Raised by Privatization

Conflict of Interest

When agencies are paid to provide governmental services to vulnerable groups, the possibility exists that service provision decisions will be influenced by budgetary considerations as well as by the needs of families and youth. This issue is considerably more pronounced when services are provided by for-profit organizations, which have a legal responsibility to maximize profits for stakeholders. An example is organizations running private prisons which may decrease the quality of services or supplies to cut costs. These measures, however, are typically detrimental to the prisoners who receive these services.

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[26] Freundlich, M., & Gerstenzang, S. (2003). *An Assessment of the Privatization of Child Welfare Services*. Washington, DC: Child Welfare League of America Press.
Quality Improvement Center on the Privatization of Child Welfare Services. (2006). *Literature Review on the Privatization of Child Welfare Services*.
[27] The Center for Public Policy Priorities, & Casey Family Programs. (2008). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX.
[28] Freundlich, M., & Gerstenzang, S. (2003). *Op. cit*.
[29] The Center for Public Policy Priorities, & Casey Family Programs. (2008). *Op. cit*.

Although non-profits do not have the same monetary obligations, budgetary constraints still exist, especially when payment is made through a fixed amount. For example, if agencies are paid a fixed fee regardless of the number served, there is an incentive to serve fewer people or, in the case of "no reject, no eject" contracts, to provide fewer services per client. Likewise, if an agency is paid more to serve a certain classification of people, such as state wards or children in placement, there may be an incentive to move more cases into that classification. Although the needs of the family are generally paramount, the financial requirements of the organization may factor into the decision.[30]

Ability to Lobby

The privatization of child welfare services can influence governmental spending priorities in the Legislature. Unlike administrative arms of government, private organizations may lobby for continued and even increased spending for specific child welfare services. Because government money is a limited commodity, any money that goes to child welfare services is money that cannot be spent in alternative programming that may preserve families.

Propriety of Delegating Authority

No state in the country has privatized the function of investigating abuse and neglect. This suggests that the public is not entirely comfortable with allowing private agencies to have decision making powers to act in coercive ways towards the public. However, in allowing private caseworkers to make the primary recommendations on removal and to make daily decisions that impact when or if reunification will occur people have transferred these public responsibilities to the private agencies.

Police are another group with state sanctioned authority to act in coercive ways against the citizenry when required. There are a host of mechanisms to monitor the use of this power: community police boards, Constitutional Rights and protections, elected commissioners who serve at the pleasure of the public. The public has largely chosen not to privatize police forces, however.

The decision to remove a child from the home is a coercive governmental responsibility which in Nebraska is played by the police. State employees, and more directly, state agencies are required to respect the civil rights of the public, including those families involved in the child welfare system. These requirements do not always extend to private entities contracting government work.[31] Although private agency caseworkers are required to go through the court for approval of coercive actions, as well as to have a state employee overseeing their decisions, their role is in fact to make recommendations to the court as to how the case should proceed, including recommendations either to reunify a family or to keep them separated. Because the private agency representative has more direct information about the client than others, he or she tends to control decision-making.

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[30] The Center for Public Policy Priorities, & Casey Family Programs. (2008). *Drawing the Line between Public and Private Responsibility in Child Welfare: The Texas Debate*. Austin, TX.
[31] *Ibid.*

Assessment Criteria

To carry out this assessment, HZA compared DHHS and NFC on four domains of child welfare case management: compliance with laws and policy, family engagement, outcomes and cost. The first two represent process measures: each agency's performance on basic case management requirements, as articulated in state and federal policy; and the efforts and successes of each agency at engaging families in the casework process. Although family engagement can be viewed as a part of the case management requirements, the criteria by which it is assessed are less concrete than those applicable to other standards and its significance in contributing to positive outcomes for children and families is greater.

For the assessment of outcomes, we examined DHHS' reports on each agency's achievement of national standards on relevant indicators from the CFSR. Finally, the cost comparison seeks to determine whether the claim that privatization can provide the same or better services at lower cost is in fact justified, at least for Nebraska's child welfare system. The standards used to make the comparisons between DHHS and NFC in each of these four perspectives are described below.

Compliance with Case Management Principles

The most basic question in any assessment is: Do the agencies follow the rules? In this instance, to measure compliance we drew on several sources for those rules, including: Nebraska's own guidebook for case management services,[32] the Operations Manual for the State,[33] and the Protection and Safety Time Frames for Case Management Processes.[34] We also incorporated child welfare practice standards articulated by the Child Welfare League of America (CWLA)[35] in the construction of the case review instrument and interview protocols used in the data collection in the Southeast and Central Services Areas, as well as for NFC. The specific topics and standards are as follows.

Assessments and Structured Decision-Making

Family assessments and decision-making are ongoing processes. The initial assessment should be completed within the first 30 days of case opening and should be reassessed every 90 days thereafter, or more frequently if needed. The assessment should identify the following.

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[32] Case Management for Child Abuse, Neglect and Dependency. (2013). http://dhhs.ne.gov/children_family_services/Guidebooks/Case%20management%20for%20Child%20Abuse,%20Neglect%20and%20Dependency%20Guidebook.pdf.

[33] State Operations Manual, May 2014.

[34] Protection and Safety Time Frames for Case Management Processes. (2013). http://dhhs.ne.gov/children_family_services/Training/Documents/Protection%20and%20Safety%20Time%20Frames%20for%20Case%20Management%20Processes.pdf.

[35] Child Welfare League of America (1995). *Standards of Excellence for Family Foster Care Services*, Revised Edition.

1) the strengths of the family and support systems for the family,
2) the service needs of the family,
3) the family's current level of functioning,
4) the risk factors or presenting problem identified during the initial assessment,
5) the current risk of maltreatment to the children and
6) the effects of maltreatment or presenting problem on the children and family.

To complete a comprehensive assessment of the family, caseworkers are guided to:

1) consider all factors within the family that impact the child and family;
2) identify current issues, functioning, strengths and problems; and
3) examine individual and family history, culture and life experiences.[36,37]

Case Plans and Service Provision

Case plans must be developed for all families within 30 days of case assignment but no later than 60 days after the initial custody date for out-of-home cases. The plan should be formally reviewed, at a minimum, once every 90 days.

The case plan should address six specific topics:

1) outcomes—positive results which, when achieved, reduce risk of maltreatment or alleviate the presenting problem;
2) goals—behaviorally stated actions that the family and caseworker hope to accomplish which will move the family toward their individual outcome;
3) the evaluation method or measure of goal achievement;
4) services—those actions implemented by the agency which will assist families in accomplishing specific goals;
5) time limitations—indications of how often and for how long services will be provided, when goals are to be reached, and when review of progress will occur; and
6) the permanency objective—for children in out-of-home care, the permanency objective and the projected date by which the permanency objective is going to be attained.[38,39]

[36] Case Management for Child Abuse, Neglect and Dependency. (2013). http://dhhs.ne.gov/children_family_services/Guidebooks/Case%20management%20for%20Child%20Abuse,%20Neglect%20and%20Dependency%20Guidebook.pdf.
[37] Protection and Safety Time Frames for Case Management Processes. (2013). http://dhhs.ne.gov/children_family_services/Training/Documents/Protection%20and%20Safety%20Time%20Frames%20for%20Case%20Management%20Processes.pdf.
[38] Case Management for Child Abuse, Neglect and Dependency. (2013). *Op. cit.*
[39] Protection and Safety Time Frames for Case Management Processes. (2013). *Op. cit.*

Case Worker Contacts

1) All family members must be visited in-person every month.
2) Discussions during the visits must address both the child's safety and the appropriateness of the care the child is receiving.
3) Every contact must be documented to show:
    a) the type of contact (*e.g.,* face-to-face, phone, etc.),
    b) the location,
    c) who was present,
    d) information the caseworker obtained,
    e) information the caseworker provided to those present and
    f) any action needed.[40]

Family Visits

Written visitation plans must be developed for each child placed out of the home and will include the following:

1) dates, times and locations of visits;
2) how arrangement will be made for visits;
3) who will be present at the visits;
4) arrangements for monitoring the visits, if any;
5) a plan for handling emergency situations that occur during visits; and
6) procedures for handling problems with visitation.[41]

Placements

Caseworkers should consider each of the following when selecting placements for youth in out-of-home care.

1) The placement is with a relative when possible.
2) The placement is the least restrictive.
3) The placement provider is able to meet the needs of the child, including any special needs as well as cultural and religious needs.
4) The placement is as close to the biological parents as possible so that visitation can occur.
5) The placement allows the child to be placed with siblings or close enough for visits to occur with siblings.

[40] Case Management for Child Abuse, Neglect and Dependency. (2013). http://dhhs.ne.gov/children_family_services/Guidebooks/Case%20management%20for%20Child%20Abuse,%20Neglect%20and%20Dependency%20Guidebook.pdf.
[41] *Ibid.*

6) The placement does not require the child to changes schools or move to a new community.[42,43]

Staffings

Periodic reviews of cases with children in out-of-home care should be held every six months and should include discussion of the following:

1) the safety of the child,
2) the continuing need for and appropriateness of the child's placement,
3) the extent of the child's and family's compliance with the case plan,
4) the extent of progress made to alleviate the need for out-of-home placement and
5) the projected date by which permanency is expected.[44]

Family Engagement

While either organization, DHHS or NFC, may be in compliance with the case management standards described above, if the family is not engaged in the casework process, success at ensuring the child's safety and permanency is far less likely. Because family members, both nuclear and extended, represent potential resources as well as potential sources of information, the professional consensus is that all available family members need to be engaged in the entire process from the initial assessment of strengths and needs to the identification of goals and services to choosing providers, identifying placement homes if the child truly needs to be removed and making long-term permanency decisions. Just as importantly, it is the case management agency's responsibility to ensure this involvement.

Therefore, in this assessment we attempted to determine not only whether the caseworkers engaged the family (*e.g.,* the extent to which family members were involved in the creation of the case plan) but also the extent to which caseworkers made significant efforts to draw the family into the process and ensure that the services being provided were those the family needed and wanted.

Child and Family Outcomes

In assessing the performance of NFC and DHHS in achieving outcomes, we relied heavily on the federal CFSR measures, excluding several for a variety of reasons. Most prominently, we did not use the permanency "composite" scores although these are part of the contract between DHHS and NFC. Some of the measures contained in the composites create perverse incentives for casework and have now been dropped by the federal government for

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[42] Out-of-home Placement and Payment Guidebook. (2002). http://dhhs.ne.gov/children_family_services/Guidebooks/Out%20of%20Home%20Placement%20and%20Payment%20Guidebook.pdf.

[43] Child Welfare League of America (1995). *Standards of Excellence for Family Foster Care Services, Revised Edition, 2.29*.

[44] Case Management for Child Abuse, Neglect and Dependency. (2013). http://dhhs.ne.gov/children_family_services/Guidebooks/Case%20management%20for%20Child%20Abuse,%20Neglect%20and%20Dependency%20Guidebook.pdf.

future reviews. For instance, if a child was reunified with his or her parents after 13 months in foster care or was adopted after 25 months in care, the case counted against the agency, whereas if the child remained in care he or she was simply excluded from the calculations.

Aside from placement stability, this report uses "prospective" measures; these examine cohorts of children all starting at some defined point and track what happens to them from that point forward. To take some simple examples, children entering care during a given period are tracked forward to determine what percentage of them are reunified within 12 months, and children who are reunified are tracked into the future to determine what percentage of them return to foster care within a year. This approach not only limits the focus to the quality of casework at the present time, it allows the agencies to see exactly what they are doing well and where they need improvement, something that gets hidden in the multiplicity of measures contained in each composite.

When we refer to the federal standards for the measures we use, we are referring to the 75th percentile among all states. The Administration for Children and Families (ACF) does not establish standards for the individual measures in the composites, but since this is the standards for the composites it makes sense to use it for the individual measures, as well. This is also consistent with the way DHHS publishes the results.

In addition to excluding the permanency composites, HZA omitted the federal indicator for maltreatment of children in foster care. Again, this is included in NFC's contract and is reported in the COMPASS measures for every Service Area. However, the calculation the federal government used is invalid and has been corrected in the recently released federal measures.

The resulting outcomes examined include the following:

a) Absence of recurrence of maltreatment: What percentage of children who were victims of substantiated abuse or neglect during the first six months of a 12 month period, did not experience repeat maltreatment within six months?
b) Reunification: What percentage of children discharged from foster care within a 12 month period were reunified in less than 12 months of the first entry into care?
c) Re-entry: What percentage of children discharged from care to reunification, re-entered foster care in less than 12 months of the date of discharge?
d) Discharge to permanency after two or more years: What percentage of children in care for more than 24 months were discharged to a permanent home by the last day of a 12 month period and prior to their 18th birthday?
e) Legally free and discharged to permanency: What percentage of children who were legally free for adoption at the time of discharge were discharged to a permanent home by the end of the year and prior to their 18th birthday?

f) Legally free and adopted: What percentage of children who became legally free for adoption at the start of the year were adopted by the end of the year?
g) Adopted after 17 months: What percentage of children who had been in foster care for 17 or more continuous months on the first day of the year experienced an adoption finalization by the last day of the year?
h) Freed for adoption after 17 months: What percentage of children who had been in foster care for 17 or more continuous months on the first day of the year and who were not legally free for adoption became legally free for adoption during the first six months of the year?
i) Stability less than 12 months: Of all children who were in foster care during the year, who were in care for at least eight days, but less than 12 months, what percent had two or fewer placement settings?
j) Stability 12 to 24 months: Of all children who were in foster care during the year, who were in care for at least 12 months but less than 24 months, what percent had two or fewer placement settings?
k) Stability 24 months or more: Of all children who were in foster care during the year, who were in care for at least 24 months, what percent had two or fewer placement settings?

Cost Comparison

Unlike the other standards laid out above, the cost component of the assessment, has no external standard. Instead, the standard is the lesser of the two costs of case management measured both in aggregate and by its component parts. The overall judgment rests on the comparison of costs to the overall comparison of achievement. Higher costs may be warranted for superior results on the other measures.

Methodology

HZA's approach to this project included five components: a review of the literature on privatization of government functions; a review of case management practice standards; interviews with many of those involved in child welfare in Nebraska; a case reading encompassing 200 cases; and review of an extensive array of documents, including web-based documents, produced by DHHS, NFC, the Legislature and others.

Data-Gathering

Literature Review

This aspect of the review represented an update of work done in our previous evaluation of Nebraska's privatization of child welfare. There has not been a great deal written since that time specifically on the privatization of child welfare, but HZA also examined newer literature that related to privatization of government functions in general. What we gleaned from this review is found most explicitly in the chapter on the Purpose and Scope of the Assessment, but it also helped to frame the way we approached the issues.

Practice Standards

While in the last study we were interested in standards governing network management, the focus of this study was case management. To identify appropriate standards, we examined both DHHS and NFC documents that guide the field in their practice and national standards from CWLA[45]. These standards were used to shape both the interview questions and the case reading tool.

Interviews

There were four relatively separate components to the interviews. First, beginning in July of 2014, HZA met with key legislators and with the administrators of both DHHS Children and Family Services and NFC. The interviews with the legislators were designed to ensure that we had a complete understanding of what was expected from the assessment, as well as to gain a better understanding of the politics of the situation at this point in time. The interviews with the two organizations were designed to explain our methodology and receive updates since the last study on practice and payment issues.

The second group of interviews focused on caseworkers, supervisors and administrators in both DHHS and NFC, as well as judges. All of these interviews involved the Eastern, Southeast and Central Service Areas.

Here, the purpose was to obtain an understanding of the casework process as seen from the point of view of those doing the work. All of the interview questions were open-ended, allowing respondents to elaborate as much as they desired. Some of the questions were factual in nature, *e.g.,* asking how many cases a worker was assigned or for how many

[45] Child Welfare League of America (1995). Standards of Excellence for Family Foster Care Services, Revised Edition.

workers a supervisor was responsible or asking a judge whether he or she has been paired with one or more teams of caseworkers. Other questions were designed to obtain opinions, *e.g.,* asking caseworkers and supervisors whether they thought that children in foster care receive adequate educational, physical health and mental/behavioral health services, or asking a judge whether caseworkers should be specialized to address specific presenting problems.

The third set of interviews was with people who either headed large agencies that serve DHHS families or who had a broad perspective on the child welfare system in their roles as counsel to the legislature, foster care review staff, CASA directors, and inspectors general as examples. They were asked open-ended questions about the quality of case management and both the strengths and concerns they saw regarding privatization.

The fourth set involved people from the general public who had had some contact with the child welfare system. Rather than obtain lists of clients from either of the agencies, HZA arranged for various media outlets to publicize opportunities for people to tell the stories of their involvement with the system. Each respondent was scheduled for a 15-minute discussion with no pre-set questions. Those taking advantage of this opportunity included clients, foster parents and advocates.

Each interview was written up individually, generally constituting three to five pages per interview. All of the interviews were treated as providing qualitative rather than quantitative information. Much of what we gleaned from these processes had to do with caseworkers' and supervisors' attitudes towards their clients, their colleagues and the other organizations with whom they interact; the judges' perspectives on the roles and competencies of staff in cases which come to court; and the perspectives of professionals with a broader perspective on privatization as to whether they perceive differences in case management, what is working well under privatization and what is not. The information we include in this report represents themes which emerged from the interviews, *i.e.,* opinions which emerged repeatedly. The instruments used for caseworkers, supervisors, judges and other members of the professional community are found in the Appendix.

Case Reading

Drawing from cases which were open for services as of June 30, 2014, HZA pulled random samples of 100 cases for NFC and 100 cases from DHHS. The latter were confined to the Southeast and Central Service Areas which we used as our areas of comparison.

Reviewers examined both the N-FOCUS records and the paper records for these cases. The purpose was to obtain information about details of the case handling which was not available in official statistics published by either organization. In particular, we were interested in understanding the extent to which the two agencies make substantive efforts to involve families in the decision making regarding their children, as well as in the thoroughness of the assessments and case plans which get developed. In other words, the purpose was not to call any of the officially published numbers into question but rather to supplement them with information that focused specifically on case management.

Document Reviews

Examination of the various documents relevant to the assessment consumed a large amount of time, primarily because so many documents were available. These included, just as examples, reports from the satisfaction surveys both agencies conduct, reports from the Foster Care Review Board, results of the Title IV-E audits which resulted in disallowances of federal funds, two years' worth of federal claims for Title IV-E reimbursement, the contracts between DHHS and NFC and between NFC and its affiliated providers, the CQI reports published by DHHS, a report published by the Auditor of Public Accounts, the measurement of outcomes displayed in the COMPASS portion of the DHHS website and numerous fiscal documents.

There were three ways in which all of these documents were used. The first was to inform our discussion of the history of the privatization effort in Nebraska. As the previous chapter made clear, this is a complex story with significant levels of ambiguity. It was important for us to understand why privatization was started and what people hoped to achieve through it. That history will almost certainly have some kind of impact on whether and in what form privatization continues in the future.

While understanding the history was important, most of the time spent reviewing the documents related to the key questions of whether privatization improved the performance of the child welfare system and whether it generated cost savings. Each of these is discussed in more detail below.

Data Analysis

Performance Measurement

As suggested in the discussion of assessment criteria in the previous chapter, we measured three broad areas of performance: compliance with agency mandates, family engagement and client outcomes. The data come primarily from three sources: HZA's own case reading, the Department's CQI reports and the Department's COMPASS reports. In addition, the examination of the degree of family engagement also utilizes the results of HZA's interviews and the satisfaction surveys carried out by both NFC and DHHS.

DHHS' CQI reports are based on the on-site review instrument used by the federal government in its CFSRs but are more expansive than the federal assessments. The CQI reviews are published monthly and report on different time periods for different measures. The measures used here come from the July 2014 reviews and represent primarily some of the federal measures from the on-site review. Consistent with the federal procedures, the standards are set at 95 percent, *i.e.,* 95 percent of the cases should be in compliance with each of the measures. Only the most recent results are used in this report, covering the period from April 2013 through April 2014.

The Department's COMPASS reports are published on the agency's website each month and provide information on the performance of the State and each Service Area on the federal statewide indicators. HZA examined the results for the State and each Service Area for each month during federal fiscal year (FFY) 2014, i.e., from October 2013 through September

2014. Comparisons between NFC's and DHHS' performance are made by reporting the number of months during this period when each Service Area achieved the national standards and by showing the latest month's figures, those from September 2014. Because privatization promised to produce better results at a lower cost, the focus of the comparisons is on the question of whether in fact NFC's performance exceeded that of the Department.

We used our case reading data both to confirm some of what was found in the CQI reports and to delve more deeply into the thoroughness of some of the efforts the agencies made. This was particularly important in relation to case planning, which is an essential part of case management, and in relation to family engagement. As noted above, the interviews and satisfaction surveys supplemented some of the more quantitative data we collected on family engagement.

Cost Analysis

The final component of the assessment is the cost analysis, which generally focused on state fiscal year (SFY) 2014, July 1, 2013 through June 30, 2014. This was without any doubt the most difficult aspect of the methodology, because the purpose of the cost analysis was to compare the costs of case management when carried out by each of the agencies, and the ways that DHHS and NFC report their expenditures are necessarily different.

While essentially all of NFC's costs can be attributed to child welfare case management, DHHS, even within Children and Family Services, has a much wider array of responsibilities, and that makes it more difficult to assign the costs it reports to a single function. To take just one example, within child welfare purchased services, DHHS includes juvenile detention, a cost that NFC presumably does not have. While that specific expenditure must be subtracted from DHHS' costs in any valid comparison with NFC, it was not possible to determine with certainty how many of the other purchased services should also be eliminated, but we did make estimates in that regard.[46]

The cost comparison was made on a per client per day basis, *i.e.,* after estimating the amount each agency spent on child welfare services, we divided by the average number of clients served on a given day and then by 365. Estimating the amount of NFC's expenditures was straightforward. We simply used the unaudited spreadsheets of monthly expenditures and revenues provided by NFC, summed across the months of the year and averaged the number of clients shown on those spreadsheets.

For DHHS we combined the purchased service costs shown in three categories within Program 354, namely, 30-IV-E Foster Care, 48-Child Welfare and 52-Adoption and Safe Families, subtracting the amount paid to NFC. To that amount we added the caseworker and administrative costs shown in Program 265, subtracting an amount estimated for workers conducting initial assessments (child maltreatment investigations), since NFC does not have

[46] While juvenile detention has now been shifted out of DHHS, that was not the case during the period studied, and it is not clear how much of the remaining costs are attributable to cases other than child welfare case management cases.

a comparable cost. Case counts were obtained from the Department's Point-in-Time reports, subtracting the clients in the Eastern Service Area.

Once this comparison was made, a clear difference in costs appeared, so we conducted a further exploration to identify the sources of the difference. This analysis focused on three components of the costs: case management, services and administration. It omitted examination of operating costs, such as rent and other overhead. NFC's costs were clear from the spreadsheets, because there were separate lines for each of the three components. For DHHS we used the same figures as above but replaced the Program 265 case management costs with more detailed information from the Caseload Report which is provided periodically to the Legislature. Again, the final comparison was made on a per client per day basis.

While numerous estimates had to be made to create a cost comparison between the two agencies, we believe the results show a generally accurate picture, and, indeed, a picture which conforms to other things we learned during this review.

Case Management Performance

As set out in the previous section, this assessment of privatization's success at improving case management focuses on three issues: compliance with state and federal standards, engagement of families and achievement of child and family outcomes. While the last is clearly the most important, examination of the other two can help provide explanations as to why privatization has or has not improved outcomes. For all three areas the question is one of relative performance: Does privatization of case management provide better performance than public case management?

Compliance

Much of the information about compliance derives from the Department's own ongoing reviews, and these are designed largely to reflect the same issues which get examined in the on-site portion of the federal CFSR. Because the results are broken down by Service Area, comparison of NFC's performance to that of the rest of the State is straightforward. Additional results come from the case reading HZA conducted for this assessment.

Case Assessments and Planning

Case assessments and case plans are required to be completed within specific time frames, with the involvement of the family and with sufficient scope and detail to provide accurate appraisals of the families' situations and reasonable approaches to addressing the issues bringing the family to the agency's attention.

Initial case plans (and the assessments on which they are based) are to be completed within 60 days of each child's entry into custody. In each of the months of the first half of calendar year 2014, NFC outperformed the State as a whole on this measure. While the standard for this measure is 100 percent, at no point was that achieved by any of the Service Areas. However, NFC achieved more than 90 percent compliance in four out of the six months, while that level was never achieved by the State as a whole and only once each by the Southeast, Central and Northern Service Areas.

NFC also outperforms the publicly managed Service Areas when it comes to involving families in assessments and planning, although neither group approaches the federally established standard of 95 percent. DHHS data show that NFC involved families in case plans in 69 percent of the cases during the period from April 2013 through April 2014, compared to a statewide figure of 57 percent. HZA's case reading for this project showed similar figures, 69 and 63 percent, respectively. In addition, the case reading indicated that families were involved in the assessments leading to the case plans 77 percent of the time when NFC was the case manager and 72 percent of the time when DHHS managed the case.

NFC shows strong performance in relation to Family Team Meetings but so, generally, does the rest of the State. These meetings are required to occur at least every 90 days and are designed to contribute to the assessment and planning process, whether at the beginning of the case or later. The requirement comes solely from the State, not from the federal

government, and the standard is 100 percent compliance. NFC, during the first six months of 2014, consistently showed compliance rates at or above 99 percent. Among the other Service Areas, performance on this measure was always above 90 percent, except in the Central Service Area in June.

Based on the information HZA obtained from reading cases, the more frequent involvement of families by NFC does not, however, translate into better assessments or plans. The reviewers found that both NFC and DHHS identify all strengths and needs of the families and children in more than 90 percent of the cases, but that DHHS does so slightly more often than NFC. The differences are clearer in relation to assessments. DHHS workers tend, with one exception, to consider each of the relevant domains more frequently than do NFC workers. Specifically, DHHS's assessments demonstrated consideration of:

1) the appropriateness of the client's level of development in 82 percent of the cases compared to 73 percent for NFC,
2) special conditions requiring specific services 50 percent of the time compared to 19 percent for NFC,
3) the family's history of abuse and neglect in 48 percent of the cases compared to 20 percent for NFC,
4) other family member strengths (*i.e.,* anyone but the target child) for 47 percent of the families compared to 39 percent for NFC and
5) likely permanency options in 33 percent of the cases compared to 21 percent for NFC.

The only area NFC is more likely to consider is the child's strengths, but even there the difference is only 28 percent to 24 percent.

The notion that compliance with regulatory requirements is not correlating to substantive quality in case assessment and planning receives further support from a couple of other findings from the case reading. First, only one-third of the children in out-of-home care under NFC's case management had concurrent goals. For DHHS children the comparable figure was 75 percent. The federal government began requiring concurrent planning more than a decade ago, as a way to shorten lengths of stay in care. In the classic case, a child with a goal of reunification should have a concurrent goal of either adoption or guardianship, with concrete steps being taken to ensure that if and when reunification proves impossible, the agency can move immediately to the concurrent goal. Without a concurrent goal, work on a new permanency goal begins only after the failure of reunification, and that inevitably means the child remains in care longer than he or she should. While concurrent planning is a compliance issue, it clearly has a substantive impact.

The second additional area of concern has to do with visitation plans, *i.e.,* the part of the case plan which sets out the arrangements for visits between a child in placement and his or her parents. Children under the management of NFC are slightly more likely (92 percent) to have a visitation plan in the record than are children managed by DHHS (89 percent). However, the DHHS plans tend to have more detail, more often indicating, for example, the dates, times and locations of the visits; how arrangements will be made; who will be present; and how, if at all, the visits will be supervised. These features were found in nearly

every DHHS visitation plan HZA read but were missing in more than one out of every five of those produced by NFC.

The overall quality of case plans is also assessed by the Foster Care Review Board. In a review of 737 plans statewide and dealing only with children ages zero to five, described in its September 2014 quarterly report,[47] the Board found a substantially smaller percent of "complete" case plans in the Eastern Service Area than anywhere else in the State as shown in Table 2.

Table 2. Completeness of Case Plans
As Measured by the Foster Care Review Board

Plans	ESA	NSA	SESA	CSA	WSA
Complete	47%	72%	91%	88%	99%
Incomplete	47%	21%	4%	6%	0%
Out dated	3%	7%	3%	0%	1%
None	2%	0%	2%	6%	0%
Total	100%	100%	100%	100%	100%

The types of factors the Board saw rendering a plan incomplete included the following.

- The plan or concurrent plan is adoption, but all the goals reflect reunification.
- The plan does not address a non-custodial parent.
- The plan does not address paternity, if not already established.
- The plan does not reflect case changes made prior to the date of the plan.
- A service to address an adjudicated issue is not included in the plan.
- The plan is missing goals, or timeframes, or tasks.
- The plan doesn't include all children who should be in the plan.

Case Contacts and Family Visits

Periodic face-to-face caseworker contacts with both parents and children are required by both state and federal rules. The federal government requires regular reporting of face-to-face contacts with children in foster care, while contacts with parents and with children regardless of in-home/out-of-home status are monitored through the federal CFSR. For all groups the standard is that 95 percent of the cases have a monthly contact. For the contacts with children in out-of-home care, this means that the visits must occur in 95 percent of the months the child is in care. When the measurement is done through the CFSR (and through the Department's Continuous Quality Improvement process, which is based on the CFSR), compliance includes consideration of the quality of the contact; simply seeing the child or the parent is not enough.[48]

[47] The quarterly report does not itself show service area breakdowns on this measure. The information was made available at our request.

[48] Measurement of compliance in relation to parental contacts excludes cases where the parents are not involved and also gives credit to the agency when the effort to make contact was not successful but the agency made diligent efforts.

All Services Areas achieved the 95 percent standard for monthly contact with children in out-of-home care during the first six months of calendar year 2014. In fact, during June every Service Area showed a compliance level of 98 percent or greater. Clearly, any differences between DHHS and NFC were negligible.

Despite still high levels of compliance and small differences between NFC and DHHS, one interesting pattern emerges when the child population is expanded to include all wards and non-wards. In every one of the six months examined, NFC caseworkers see a higher percentage of ward children than is true for the State as a whole, while for non-ward children exactly the opposite is true.

The picture on contacts with the child changes substantially when the quality of the contacts is considered. For the most recent CQI period (April 2013-April 2014), counting only quality contacts drops the level of compliance from over 95 percent to 72 percent of the cases Statewide. NFC showed a slightly higher percentage (75 percent) than the State as a whole, but this was because the Central Service Area had a precipitous drop in performance, with only 50 percent of the cases meeting the requirement. Across the rest of the State, DHHS had scores equal to or better than NFC's.

Perhaps the most important performance measurement related to caseworker contacts has to do with contacts with parents. Most of the children in state custody are there not because of their own needs or behaviors but because of the behaviors of the parents, and failure on the part of caseworkers to have regular, substantive interactions with the parents inevitably results in longer lengths of stay. While NFC's performance on this measure is clearly better than that of DHHS, neither organization is anywhere close to the standard. During the most recent CQI period of April 2013 to April 2014, NFC had (or worked diligently to have) sufficiently frequent and substantive face-to-face meetings with the parents in only 39 percent of the cases. The corresponding figures for the other Service Areas were:

1) 12 percent for Central,
2) 30 percent for Northern,
3) 26 percent for Southeast and
4) 29 percent for Western.

The statewide figure was 28 percent. NFC's performance represents an improvement over the rest of the State of about 40 percent, but it still leaves more than half of the population underserved.

Another significant component of case contact is the visits that children in placement have with their mothers and fathers. This practice is monitored in the reviews of local foster care review board members for both the mother and father. Again, based on the review of 737 cases of children zero to five, the Tables 3 and 4 show visitation by service area for mothers and then fathers.

Visitation between these very young children and their mothers is occurring most often as a percent of cases in the Northern Service Area and least often in the Eastern Service Area and the Central Service Area although the proportions are close for all but the Northern

Service Area. With fathers the lowest percent of visits is in the Eastern Service Area which is considerably lower than the others. The highest, as with the mothers, is the Northern Service Area at 32 percent.

Table 3. Visitation of Children in Care with Mothers						
Visit Status	ESA	NSA	SESA	CSA	WSA	Total
Occurring	39%	47%	41%	39%	40%	294
Not occurring	37%	32%	27%	32%	32%	242
No contact order	1%	0	3%	4%	0	14
Lack of documentation	4%	5%	1%	0	0	20
Not applicable	18%	17%	25%	25%	28%	159
Voluntary–occurring	<1%	0	2%	0	0	4
Voluntary–not occurring	<1%	0	1%	0	0	3

Table 4. Visitation of Children in Care with Fathers						
Visit Status	ESA	NSA	SESA	CSA	WSA	Total
Occurring	18%	32%	24%	24%	29%	164
Not occurring	16%	12%	11%	28%	29%	124
No contact order	1%	0	11%	0	0	25
Lack of documentation	5%	5%	2%	0	3%	27
Not applicable	46%	44%	42%	43%	36%	321
Voluntary–occurring	1%	<1%	3%	0	0	9
Voluntary–not occurring	1%	0	0	0	0	3

Family Engagement

Assessing the differences between the privatized case management of NFC and the public version under DHHS on issues such as the engagement of families is decidedly more difficult than measuring the differences in compliance levels. It is also more important. One of the arguments for privatization which could have great persuasive power is that a privatized entity has at least the opportunity to do a better job of engaging families. Public child welfare agencies, almost by their very nature, are often viewed by families as adversaries. Private agencies do not carry the same stigma. However, in this instance, there is little if any evidence that NFC has utilized the opportunity to take a new approach.

The notion that family engagement is important has at least two very different sources. On the one side is the argument which both DHHS and NFC workers and supervisors repeated

in interview after interview: engaging families in the assessment and decision making processes will get them more committed to following the case plan. On the other side is the presumption that families, not the State, are the primary protectors of their children, a view suggested by only one worker interviewed who said, removing a child from his or her home can be more harmful than the maltreatment.

These two arguments can be viewed, however, as coming from diametrically opposed positions. The first seems to say that the utility of engaging families lies in getting them to agree to do what the agency thinks should be done, and, in fact, in several interviews with workers and supervisors the lack of cooperation from parents was viewed as a reason either to open a case or to remove the child.

The second argument can be seen as taking the opposite point-of-view. The parents need to be involved in assessment and planning because they are generally committed to protecting and nurturing their children and, despite any failures they may have encountered in those efforts, the ideal solution is for them to be able to do so without further state intervention. This argument views parents, then, not as passive objects to be convinced of the right way to do things but rather as active participants of a team focused on children's safety. They want to do what is right and will, with support.

Neither DHHS nor NFC operates according to the second of these beliefs. Nowhere is this clearer than in the way family team meetings are conducted. Family team meetings are one of the mechanisms developed over the past couple of decades to give families a greater stake in freeing themselves from state intervention. They originated in New Zealand as a way to deal with the indigenous population when it came into contact with the child welfare system. Under the New Zealand design, family team meetings were attended only by members of the nuclear and extended families, even including children for at least parts of the meeting. Those families designed plans for protecting the child and then presented them to the child welfare agency. If the agency deemed the plan to be credible, the family was given the opportunity to implement it.

In the time they have been incorporated in this country child welfare agencies have debated whether to let the families meet alone, to have an impartial (*i.e.,* non-agency) facilitator to assist or to have the normal caseworker present. Whichever way the meetings are held, the most important feature is for the family to bring "informal supports" to the meeting so it can be helped to care for the child without relying on paid social services. This means that as many of the family members as possible should attend, along with committed friends, neighbors, clergy and anyone else the family members want.

HZA's case reading for this project showed that family team meetings in Nebraska have none of the characteristics of the model. The meetings here are generally attended by members of the case management agency, by other service providers and by one adult member of the family. They are also frequently attended by attorneys, because many of the meetings take place immediately prior to a court hearing. No plan is developed at the meeting. Instead, the caseworker comes in with the plan already drafted. In fact, the only difference the case reviewers could identify between the family team meetings held by

DHHS and those held by NFC was that NFC tended to have more service providers involved, not more family members.

The major difference that appeared between NFC and DHHS relationships with families relates, at least in part, to service providers. Several informants reported that families are often confused when dealing with NFC because of the multiplicity of workers. Some of that is sequential and some of it is simultaneous. On the sequential side, as a court-involved case transfers from DHHS' initial assessment phase to NFC, there are at least three workers involved: the DHHS worker, the NFC engagement worker and the NFC permanency specialist. The transfer from one NFC worker to another is a function of aligning workers to specific judges; the engagement worker is the one assigned until the agency knows to which court the case will be assigned if it is a ward case. Whatever the motivation, families have at least one extra worker with whom to deal because NFC and the courts find it easier to work with one another under that structure.

Even after the case has been assigned to court, however, families sometimes express confusion. NFC uses more service providers than does DHHS and some families report that they do not know the difference in roles between the NFC case manager and the service provider worker(s). The situation is exacerbated when services begin prior to the end of the initial assessment and a DHHS worker is still involved.

Ultimately, the attitudes towards families and the approaches to family engagement that both case management agencies utilize are perhaps best illustrated by comments from two DHHS staff, one a supervisor and one a relatively newly trained case manager. The supervisor reported that with the new Alternative Response initiative, the agency was beginning to focus its planning on what the family wanted, but that this was not the way "normal" cases were handled. The case manager, when asked about the degree to which families were involved in case assessment and planning, indicated that this was an entirely new idea which he or she had never considered. No one else expressed that view, but it represents a reasonable interpretation of the way families are actually handled.

Outcomes

Whether one agency performs better than the other on compliance issues or is better at engaging families, the ultimate criterion has to lie with the agencies' achievement of positive outcomes for children and families. While both the federal government and DHHS publish a plethora of outcome statistics, for reasons described earlier in this report, HZA's judgment about the agencies' relative performance on outcomes focuses only on two kinds of measures: those which are calculated prospectively and those relating to placement stability. Both are consistent with the changes the federal government is currently making to its CFSR indicators, and the latter represent a reasonable method of measurement to which there are presently few if any alternatives.

The majority of the measures discussed here come from the Department's regularly published COMPASS data, with a couple also drawn from the July 2014 CQI report. The discussion is broken down into five categories: child safety, reunification, adoption, stability and well-being measures.

Child Safety

Two measures are relevant to child safety, one from COMPASS and one from CQI. The COMPASS measure calculates the percentage of children who were victims of maltreatment who were again maltreated within six months. The CQI measure focuses on the question of whether services were provided to protect children from harm and prevent removal.

The most recent CQI review indicated that, against a target of 95 percent, all Service Areas except Northern showed 100 percent compliance with the provision of services. The Northern performance was 93 percent, not quite meeting the standard but close.

The COMPASS measure focuses on actual repeat maltreatment rather than on the delivery of services to prevent a recurrence. The federally established standard is 94.6 percent, i.e., that percentage of child victims of substantiated maltreatment should be free of a repeat incident for at least six months.

During the period October 2013 through September 2014, the Eastern and Northern Services Areas met the maltreatment standard every month, and, largely as a result, the State as a whole did so for ten of the 12 months. The Central Service Area met the standard in eight of the 12 months and the Southeast and Western Areas in five each. During the most recent month, September, the Eastern and Northern Service Areas had the best scores and the Western the worst.

There are at least two important points to be made here. First, there is no direct correlation between the results of the two measures. The Northern Service Area was the only one *not* to meet the standard for providing appropriate services during the last review, but it scored highest, along with the Eastern Service Area, on actually preventing repeat maltreatment.

The second point is that, in contrast to all of the other measures to be examined and despite the terms of NFC's contract with DHHS, the Eastern Service Area results are not solely attributable to NFC. All victim children are used as the denominator for the calculation of repeat maltreatment, but not all families of victim children are opened as ongoing services cases. For some families, a DHHS initial assessment worker is the only caseworker they will meet. Whether maltreatment recurs will be due at least partially to the quality of the decision the initial assessment workers make about the family's need for services.

Although the two measures present slightly different pictures of the situation in different parts of the State, both come to the same conclusion there is not a serious safety issue for children coming into contact with the Nebraska child welfare system. Interestingly enough, that conclusion is contradicted by the new federal measurement. In federal fiscal year 2013, Nebraska failed to meet the new federal measure. Unfortunately, the breakdown by Service Area is not yet available for the new measures.

Reunification

The indicators relevant to reunification both appear in COMPASS. The first measures the percentage of children reunified with their families (including discharge to non-parental relatives) within 12 months of their first entry into foster care. The federal standard requires that the percentage be no less than 48.4 percent. The second indicator focuses on children who have been reunified and measures the percentage who return to foster care within 12 months of their reunification. No more than 9.9 percent should do so.

During no month in FFY 2014 did Nebraska achieve the standard for reunification. In fact only the Northern Service Area achieved it at any time and that was only for one month. During the last two months of that period NFC showed a lower performance than any other Service Area, except for Central, and generally NFC's score has ranged between about 35 and 38 percent, with one month reaching 40 percent. The last two months of the year have also seen significant improvements in the Southeast, Northern and Western Service Areas, with all of those Areas above 42 percent in September.

The story on re-entry is quite different. NFC, Southeast and Northern all met the national standard in every single month, as did the State as a whole. Central and Western, on the other hand, did so in only seven of the 12 months. The re-entry percentages for each of the Areas in September, ranked from best to worst, were the following.

- Southeast: 4.9%
- Northern: 5.3%
- Eastern (NFC): 6.0%
- Central: 10.8%
- Western: 11.2%

The statewide percentage during September was 7.3 percent.

It should be noted that neither the differing performances on reunification and re-entry nor the contrast between the safety performance and reunification are unusual. What is almost certainly reflected in these numbers is a system in which child safety is achieved (and re-entry avoided) by removing a relatively large proportion of children and keeping them for relatively long periods of time. Children are less likely to be maltreated if they are in foster care and they certainly cannot re-enter foster care if they have never been discharged. Nor is this a function solely of agency decision making. Many of those interviewed, including the judges themselves, reported that judges tend to be conservative on the questions of removal and return, generally tending to approve the removal or keeping children in care longer just to be safe.

In relation to the question to be answered in this assessment, NFC's performance is roughly in line with that of the Department on both reunification and re-entry. When the Department meets the national standard, so does NFC; when the Department does not, neither does NFC.

Adoption

While not all the measures to be considered here relate directly to adoption, they do all relate to children who have been in care for substantial periods of time. There are five such measures:

1) the percentage of children who have been in care two or more years who are discharged to a permanent home within 12 months;
2) the percentage of children who are free for adoption at the start of the year who are discharged to a permanent home within 12 months;
3) the percentage of children who are free for adoption who get adopted within 12 months;
4) the percentage of children who have been in care 17 months or more who get adopted within 12 months;
5) the percentage of children who have been in care 17 months or more who become free for adoption within six months.

Tables 5 through 9 show in how many months each Service Area achieved the target figures for each of these measures, as well as each Service Area's score during the final month of the period, *i.e.,* September 2014.

Table 5. In Care 24+ Months and Discharged to Permanency
(National Standard: 29.1%)

Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	7	50.0%	Yes
Eastern	12	42.8%	Yes
Northern	12	35.0%	Yes
Southeast	12	42.5%	Yes
Western	12	59.7%	Yes
State	12	42.4%	Yes

Table 6. Free and Discharged to Permanency
(National Standard: 98.0%)

Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	12	100.0%	Yes
Eastern	7	97.9%	No
Northern	1	89.4%	No
Southeast	12	98.6%	Yes
Western	12	100.0%	Yes
State	7	97.7%	No

Table 7. Free and Adopted (National Standard: 53.7%)			
Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	9	79.5%	Yes
Eastern	12	74.3%	Yes
Northern	7	70.9%	Yes
Southeast	12	70.2%	Yes
Western	12	69.8%	Yes
State	12	72.5%	Yes

Table 8. In Care 17+ Months and Adopted (National Standard: 22.7%)			
Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	5	29.6%	Yes
Eastern	12	28.8%	Yes
Northern	7	22.7%	Yes
Southeast	12	29.9%	Yes
Western	12	34.3%	Yes
State	12	27.6%	Yes

Table 9. In Care 17+ Months and Freed (National Standard: 10.9%)			
Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	2	10.3%	No
Eastern	12	13.8%	Yes
Northern	9	6.8%	No
Southeast	11	9.5%	No
Western	7	12.2%	Yes
State	11	10.7%	No

The one indicator on which NFC shows a somewhat better performance than does any other Service Area is the last one, *i.e.,* the percentage of children who have been in care 17 or more months who get freed for adoption within six months. On all other measures, NFC produces neither the best nor the worst results. Several of the Service Areas, including NFC, met the established standard, albeit a low one in some instances, on three of the other four measures.

Stability

The federal outcome indicators related to stability, from which the Department derives the results published in COMPASS, all measure the percentages of children who have experienced two or fewer placement settings during their time in care. For those in care 12 or fewer months, the standard is 86.0 percent; for those in care 12 to 24 months 65.4 percent; and for those in care more than 24 months 41.8 percent. Tables 10 through 12 show the results.

Table 10. Two or Fewer Placement Settings: In Care Less than 12 Months
(National Standard: 86.0%)

Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	0	85.6%	No
Eastern	12	88.2%	Yes
Northern	12	94.1%	Yes
Southeast	8	89.8%	Yes
Western	12	93.7%	Yes
State	12	89.3%	Yes

Table 11. Two or Fewer Placement Settings: In Care 12 to 24 Months
(National Standard: 65.4%)

Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	10	65.3%	No
Eastern	5	71.2%	Yes
Northern	12	74.9%	Yes
Southeast	8	67.6%	Yes
Western	3	69.4%	Yes
State	12	69.9%	Yes

Table 12. Two or Fewer Placement Settings: In Care 24 Months or Longer
(National Standard: 41.8%)

Service Area	Months Meeting Target	Score September 2014	Meets Target September 2014
Central	8	45.2%	Yes
Eastern	0	35.3%	No
Northern	0	34.4%	No
Southeast	0	30.4%	No
Western	0	37.5%	No
State	0	36.0%	No

In general, Nebraska's child welfare system is able to provide a reasonable degree of placement stability for children during their first two years in care, and the more recent scores are better than the record for the entire year would initially suggest. There has been a far greater emphasis on involving relatives which may account for this success. Also, DHHS' initiative to remove or at least limit shelter care as an option removes a placement move for those children who stayed in care after the initial placement. After the first two years, however, the record falls well below the national standard. NFC's record follows the general pattern across the State, neither better nor worse.

Well-being

The CFSR and CQI processes measure children's well-being in relation to three topics: education, physical health and mental/behavioral health. During the most recent review, all Service Areas except Central showed 100 percent of the cases meeting the educational requirements, and even Central met the national standard of 95 percent.

In relation to physical health, the record was almost reversed. No Service Area, including NFC, met the standard of 95 percent. The Central Service Area scored highest at 87 percent, with NFC at 81 and the other Service Areas ranging from 68 (Southeast) to 77 (Western).

In relation to providing appropriate mental/behavioral health services, the Northern, Southeast and Western Service Areas all scored at 100 percent. NFC met the standard at 95 percent, while Central lagged with an 89 percent rate.

Summary

The key argument in favor of privatization of case management in child welfare services is that private providers are able to achieve better outcomes at a lower cost. As discussed in the section on the history and philosophy of privatization, this claim has met with opposition, including some from private providers who argue that better outcomes can indeed be achieved, but not for lower cost. The earlier discussion also suggested that if the private providers were subject to all of the same constraints as the public agency, there may be no real reason to expect different results.

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.

Understanding why outcomes are not better is important. One indicator comes from the analysis of compliance discussed above, especially in relation to case planning. According to both DHHS' CQI reports and HZA's case reading, NFC showed higher levels of compliance on most of the items related to case planning. When the thoroughness of the plans was inserted into the equation, however, DHHS performed better. HZA's case readers also noted that NFC workers were more likely to copy and paste their descriptions of the case from one document to another without making any updates. In the most egregious instances, this involved describing situations in which children were no longer in the same foster home being described.

During interviews with workers and supervisors from both organizations, HZA also heard that NFC places a great deal of emphasis on having caseworkers complete their paperwork on time, with the records centralized. While this is a laudable goal, one interviewee even reported that some of the turnover at the agency is due precisely to this situation and others reported a good deal of pressure to meet various mandates. NFC's strong management and corporate culture help its staff to achieve compliance with the rules even if it cannot translate those into superior outcomes.

Additional reasons for the absence of any substantial difference in the outcomes were offered by a number of the judges interviewed, even without being told that we thought there was no difference. One simply said that there were good and bad workers in both systems and that there was basically no difference. Another believed that because workers in both systems have become case managers rather than professional social workers, they generally do little thinking about the cases. This view was expressed by others who made the case managers sound more like functionaries who did not see the need to understand underlying problems or establish a helping relationship with the family.

A third judge thought that privatization should have allowed for a better compensated and more experienced work force, as well as for a different and more flexible structure for doing casework. On this judge's view, NFC simply adopted the same model utilized by DHHS, with the same service array, and so it got very similar results. Still another thought that "privatization is an ideology in search of a problem."

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. It is to the question of cost that the next chapter turns.

Cost Comparison

Conducting a comparative analysis of the two agencies' costs proved to be challenging. The operative word is comparative; DHHS and NFC do not use comparable ways of accounting for or displaying their costs. While each organization was cooperative (repeatedly) in providing the information we requested, in the end we had to make some educated guesses as to which costs could reasonably be characterized as comparable. We should also note that costs which do not appear in NFC's budget or in DHHS' child welfare budget, such as Medicaid payments for services and client payments of fees for the services they receive, are not captured here.

This section addresses three questions.

1) How does the current cost of privatization in the Eastern Service Area compare to statewide child welfare costs?
2) To what extent are the losses of federal revenue resulting from privatization likely to continue in the future?
3) Are the differences in costs reasonable given the outcomes or other benefits?

Comparison of Child Welfare Costs in the ESA to the Rest of the State

We used two methods of analyzing and comparing costs. One encompassed the entire budget, excluding budget lines that were not comparable between the two organizations. Because we did find differences, the second method involved breaking the overall case management costs into components to provide a better understanding of the sources of the differences.

When we looked simply at the total costs of serving child welfare cases, using the methodology described previously, 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.

Because the DHHS figure is about one-third higher than the NFC figure, it is important to understand where the additional money is going. The components of these total costs which we examined were: 1) case management, based on the salaries and numbers of casework staff and supervisors; 2) service costs, based on the amount each agency pays to contractors; and 3) administrative costs, based on the administrative components of Program 265 for DHHS as described above and the administrative salaries of NFC which are reported separately from case management salaries in their spreadsheets.

The only thing omitted, as far as we could determine, was operational costs, and we did not have a good source for those costs for DHHS, largely because it is so much larger and complex that it necessarily operates differently. The results of the component comparison are shown in Table 13.

Table 13. Cost Per Case Per Day By Agency and Component		
Cost Component	DHHS	NFC
Case Management (workers)	$10.73	$17.42
Contracted Services	$74.17	$48.10
Administration	$1.68	$2.57
Total	$86.58	$68.09

Put simply, DHHS pays more for contracted services, while NFC pays more for case management (line staff) and for administration. These results merit further exploration.

Case Management Component

Case management costs are driven by the salaries paid and the workload of the staff; that is the number of cases each staff person carries. Again, we need to extrapolate on the DHHS side, because DHHS cases include the Initial Assessment (investigation side of child protection) whereas the NFC caseload does not. Also some caseworkers have a combined caseload of initial assessment and ongoing work.

DHHS and NFC pay their case managers and supervisors similar salaries. Although starting salaries for DHHS workers are somewhat lower than for NFC, due to longevity we calculate the actual average salaries of DHHS caseworkers to be slightly higher ($36,471 *vs* $34,320), while salaries are virtually the same for supervisors ($46,591 *vs* $46, 675). Including fringe benefits (adding, on average, $6.00 per hour which includes benefits and payroll taxes) raises the totals to the amounts shown in Table 14.

Table 14. Average Staff Salaries, DHHS and NFC						
	DHHS		Total	NFC		Total
	Salary	Fringe		Salary	Fringe	
Caseworker	$36,471	$12,699	$49,170	$34,320	$12,355	$46,675
Supervisor	$46,591	$16,223	$62,814	$46,800	$16,640	$63,440

Both FPSs and Supervisors may receive raises of zero to three percent each year based on performance by meeting or exceeding outcomes and goals. The increases are individualized.

DHHS caseworkers do not receive merit increases. For caseworkers and trainees cost of living adjustments are bargained for and for supervisors they are approved by the Legislature. The average length of service in all service areas is 3.57 years for DHHS caseworkers. During that period their pay has increased on average by $953. Staff report to HZA that the lack of merit increases is a problem suggests that the limited sizes of the raises may account for some of DHHS' turnover.

The caseload standard for in-home and out-of-home cases and mixed ongoing cases is equal to or less than one to 17. If a service area is out of compliance it means that the worker has more cases than he or she should which should equate to a lower cost. As of June 30, 2014 the statewide compliance with the caseload standard was 84 percent and compliance in the Eastern Service Area where NFC operates was 79 percent.

NFC accounts for its training costs in its case management budget line. Therefore we have done the same in the component analysis for both agencies. DHHS spent nearly $2.8 million in its contract with the Center on Children, Families and the Law (CCFL) at the University of Nebraska last year plus $1,290,656 in staff costs while in training for a total of $4,014,264.

Many of these costs, including the staff costs while in training, would be eligible for allocation at the enhanced training rate if the proper documentation is used. In addition, NFC spent $447,524 for new worker training and $159,474 for ongoing training. Assuming it is using the same training content as DHHS, its costs are eligible for allocated reimbursement as well.

These data illustrate a comparability in wages and benefits that leaves the disparity in case management costs unexplained. Part of the answer may be that DHHS makes greater use of lower cost trainees, but that cannot explain all of it. It is also possible that our estimates of the costs of initial assessment staff are faulty, but we used essentially the same methodology and assumptions when calculating total cost. At this point, all we are relatively certain of is that DHHS does not spend more on staff, when measured on a case by case basis, than does NFC.

Services Component

The services costs are driven by the amounts paid for in-home supports and out-of-home care. DHHS has over 100 categories of service costs, but we used only those we deemed comparable to NFC categories. It is using this conservative view of DHHS' services costs which produces the cost per client per day for DHHS of $74.17, compared to NFC's $48.10. The top 12 services, each exceeding $1 million per year (excluding NFC's contract itself as a service cost) are shown in Table 15.

Table 15. DHHS Service Costs by Category for Largest Amounts		
7933-AGENCY SUPPORTED FOSTER CARE	$	14,228,068
7360-PARENT SKILLS & VISIT	$	10,514,696
4331-FAMILY SUPPORT SERVICES	$	8,275,888
9795-GROUP HOME CARE	$	7,466,367
4235-OUT OF HOME TREATMENT	$	7,350,440
2061-MOTOR VEHICLE PRIVATE	$	2,645,264
8487-INTENSIVE FAMILY PRESERVATION	$	2,442,531
8641-DRUG SCREENING TESTING	$	2,232,392
1965-COMMERCIAL TRANSPORTATION	$	1,880,173
4880-OUT OF HOME MAINTENANCE	$	1,765,255
2464-TRACKER SERVICES	$	1,169,634
2755-THERAPEUTIC GROUP HOME MAINTENANCE	$	1,060,244

One factor which almost certainly explains at least part of the lower NFC cost is the difference in policies regarding the client's role in payment. DHHS does not seek client payments for services while NFC does, based on a sliding scale, when the client is not eligible for Medicaid. This practice was mentioned repeatedly in our interviews. NFC reports that it does not know how often and how much clients pay for their services because the fees go directly to the providers, but since this limits what NFC then pays the provider, we would think NFC would at least know how much it saves, which should be the same figure as what the clients pay. The only way that number would not be known would be if the referrals to agencies using sliding fee scales resulted in NFC paying nothing for the services.

The fact that the sliding fees are used for clients who are not Medicaid eligible (or perhaps also for services Medicaid does not reimburse) suggests that NFC actually has two ways to reduce its services costs. The first is to get Medicaid to pay for it; the second is to get the client to pay all or part of the cost. It is our assumption that DHHS also attempts to get Medicaid to pay for services, but it was well beyond the scope of this study to determine whether NFC or DHHS is more effective in that regard.

We also hypothesized that DHHS' services costs might be higher because more of them involved foster care placements, rather than family support services. That, however, proved not to be true. DHHS spends over 14 percent of its service budget on in-home safety, family support and intensive family services, compared to nine percent for NFC.

Administration Component

The administration costs for NFC are reflected in its spreadsheet for Administrative salaries, taxes and benefits.[49] Those for DHHS are reflected in three lines in Program 265: Child Welfare Administration, Child Welfare Unit, and CQI/Quality Assurance. Because we excluded overhead costs such as rent and utilities for NFC in the unit cost comparison we did not allocate such costs to DHHS either.

Impact of Child Welfare Reform on Federal Reimbursement

Like any state child welfare agency, DHHS receives funding from multiple sources for child welfare services. These include primarily state general funds and federal funds under a variety of titles of the Social Security Act. An analysis of costs must consider not only what was *expended* in support of child welfare cases but what was *received* in the form of revenue from sources outside of the State General Fund. The question here is what privatization has cost the State in state funding both in total and as a proportion of the budget.

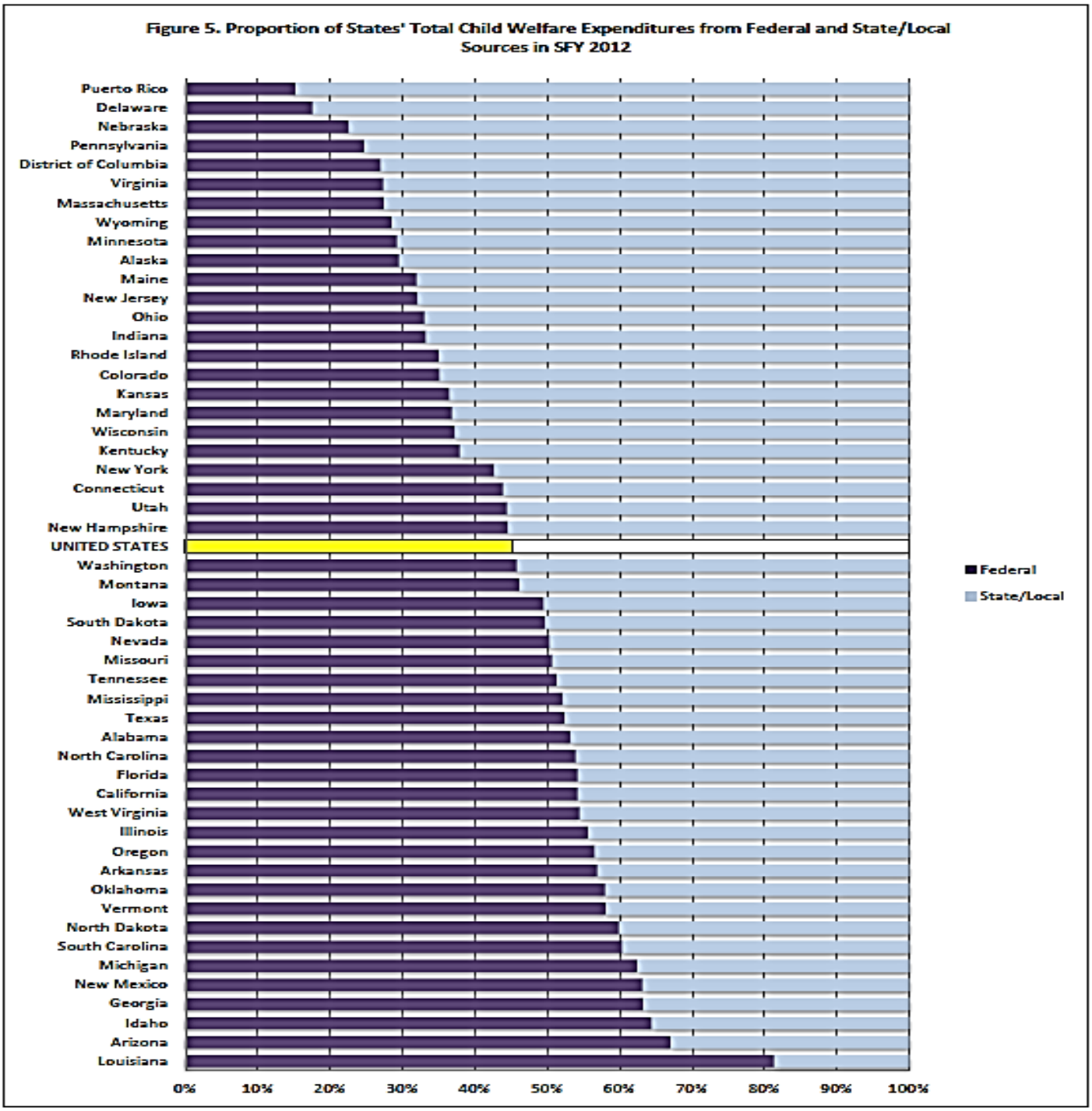
Anyone knowledgeable about child welfare issues in Nebraska is aware of the federal disallowances of Title IV-E funds which resulted from the structure of the privatization contracts. The disallowances do not, however, exhaust either the full range of federal funding issues related to child welfare or even the Title IV-E reimbursement issues facing the State. The questions that have to be answered here are: What can be done to increase federal reimbursement for Nebraska's child welfare system? and: How, if at all, does the privatization of case management affect what needs to be done? As it turns out, these questions are closely related.

Based on a report by Child Trends and as shown in the graph below,[50] Nebraska is the *second lowest state in the country* (third, counting Puerto Rico) in the proportion of federal funds it receives in payment for child welfare services (2012 data). The graph represents all federal funds, not just Title IV-E which suggests the problem is larger than Title IV-E.

[49] We did not include Operating Expenses such as rent and insurance because we do not think those are included in DHHS's costs. However, they are included in the overall cost per day per case at the beginning of this section and constituted $1,802,697 in SFY 2014.

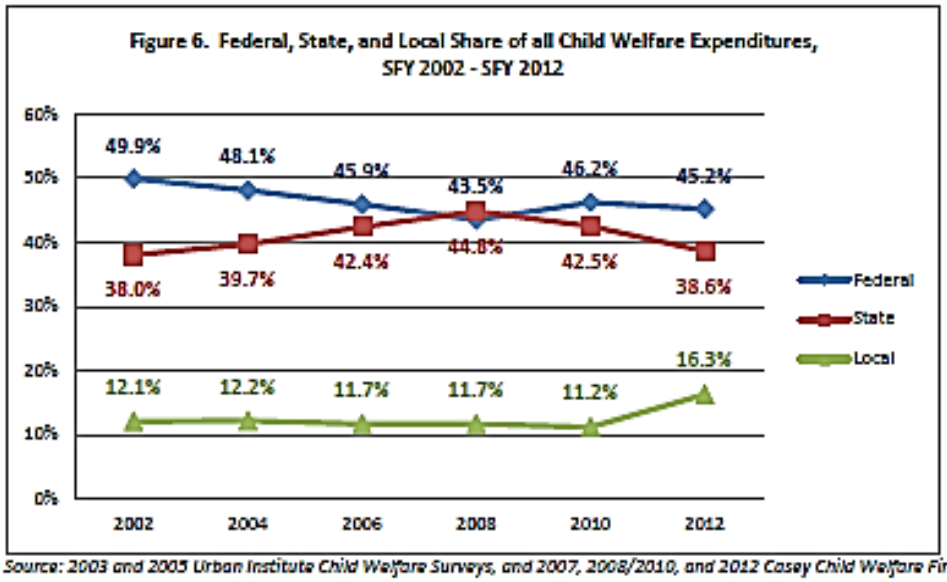
[50] Child Trends, Casey Family Programs, The Annie E. Casey Foundation, "Federal State and Local Spending to Address Child Abuse and Neglect in SFY 2012," 2014, p. 13.

Figure 5. Proportion of States' Total Child Welfare Expenditures from Federal and State/Local Sources in SFY 2012



Note: Excludes Hawaii (no survey for SFY 2012).

The graph below, drawn from an Urban Institute study, shows the proportion of child welfare expenditures that can be attributed to federal, state and local sources nationally. The same report shows that over a ten year period the national average of federal expenditures ranged from a low of 43.5 percent to a high of 49.9 percent. In contrast, the proportion of federal reimbursement for Program 354, Child Welfare Aid, was 12 percent in SFY 2014 in Nebraska as shown in the calculation below.



Source: 2003 and 2005 Urban Institute Child Welfare Surveys, and 2007, 2008/2010, and 2012 Casey Child Welfare Financing Surveys
Note: Number of states providing data varies by year, and the states included or excluded in a given year may impact the analyses. Amounts may not total 100 percent due to rounding.

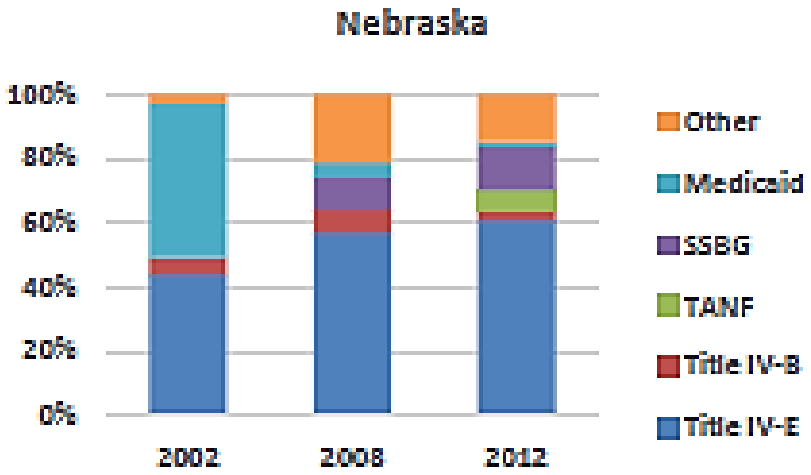
Nebraska's FY 2014 Expenditures for Program 354: Child Welfare Aid, excluding the categories of predisposition detention and OJS transitions is:[51]

General Funds:	$164,621,581
Cash Funds:	$2,734,444
Federal Funds:	$22,863,480
Total:	**$190,219,505**

A similar result was shown by the Auditor for his report of the previous year's expenditures. While Nebraska's privatization drastically reduced its ability to capture Title IV-E reimbursement due to the way the contracts were initially structured, it may be more of a surprise to learn that the proportion of federal funds received from Medicaid for child welfare services in Nebraska has also declined drastically in the past decade, as shown in the graph below.[52]

[51] Source: FY14\finalreports\DivBud0614 provided by DHHS
[52] ChildTrends, op. cit. p. 62.

Breakdown of Federal Funding Sources in Nebraska



Federal funds constitute both fixed allocations and open-ended reimbursement based on expenditures. The table below shows the major federal funding sources for child welfare, whether these sources are "capped" meaning the state gets a fixed allocation which generally has to be matched with state dollars or whether they are open-ended meaning the state can be reimbursed for a portion of its costs if eligible children or families receive eligible services. We are providing this detail because while assessing the entire scope of the issues with federal reimbursement for child welfare lies outside the scope of this study, the Legislature should be aware that the issues are larger than Title IV-E, with some of them even outside the child welfare budget as normally understood.

Table 16. Federal Funding Sources and Conditions of Eligibility

Source of Funding	Eligible Population	Eligible Services or Costs	Type of Funding
CAPPED OR PARTIALLY CAPPED SOURCES			
Title IVB			
Subpart 1	No income-based eligibility criteria	Services to prevent abuse and neglect, preserve and reunite families	Discretionary 75% federal 25% state up to federal allotment
Subpart 2 Promoting Safe and Stable Families	No income-based eligibility criteria	Services for family preservation, family support, time-limited reunification	Capped entitlement and discretionary component 75% federal 25% state up to federal allotment

Table 16. Federal Funding Sources and Conditions of Eligibility			
Source of Funding	Eligible Population	Eligible Services or Costs	Type of Funding
Chafee Foster Care Independence/Education and Training Vouchers (ETV)			
	Chafee: youth who are likely to remain in foster care until 18; youth 18-21 who have aged out; youth who have left for adoption or guardianship 16 or older	Life skills training, job readiness and employment, substance abuse prevention, housing, financial assistance (youth no longer in care)	Chafee: Capped
	ETV: youth eligible for Chafee; youth up to age 23 if they are receiving an ETV at age 21 and are progressing	Up to $5000 per year for post-secondary education or vocational training	ETV: Discretionary 80% federal, 20% state
TANF			
	Families with children in need of assistance as determined by state	Supports and services including those related to child welfare such as supports to keep children at home	Capped No state share but states must meet maintenance of effort
Social Services Block Grant			
	State-specific	Broad range of services including prevention of abuse and neglect, child protection and reunification	Capped 100% federal
OPEN ENDED ENTITLEMENTS			
Title IV-E Foster Care			
Maintenance	Children in placements who were needy in the homes from which they were removed; who entered care through judicial determination or voluntary placement; and who are in licensed or approved placements	Room and board payments to eligible providers for eligible children	Open-ended entitlement Federal share equal to state's FMAP (federal Medicaid Assistance percentage ranging from 50% to 83%)

Table 16. Federal Funding Sources and Conditions of Eligibility			
Source of Funding	Eligible Population	Eligible Services or Costs	Type of Funding
Administration and placement	Children in foster care who are IV-E eligible; children at imminent risk of entering foster care (limited time); children moving from ineligible to eligible placement	Case planning, management and review (including caseworker salaries); licensing, foster parent recruitment, eligibility determination, other overhead required under IV-E.	Open-ended entitlement 50% federal 50% state
Training	Public and private child welfare staff; prospective and current foster parents; court personnel	Training generally limited to individuals who work with IV-E eligible children	Open-ended entitlement 75% federal 25% state
Title IV-E Adoption Assistance			
Adoption payments	Children adopted from foster care with special needs as determined by the state	Recurring payments to adoptive parents not to exceed comparable foster care payments	Open-ended entitlement Federal share equal to state's FMAP (federal Medicaid Assistance percentage ranging from 50% to 83%)
Administration and placement	Children who are adopted or about to be adopted and who have special needs	Placement costs and other administration activities related to adopt; recruitment of adoptive parents	Open-ended entitlement 50% federal 50% state
Training	Public and private child welfare staff; prospective and current adoptive parents; court personnel	Training generally limited to individuals who work with IV-E eligible children	Open-ended entitlement 75% federal 25% state
Guardianship Assistance			
Guardianship payments	Children exiting foster care to guardianship with relatives under various conditions	Recurring payments to relative guardians not to exceed comparable foster care payments	Open-ended entitlement Federal share equal to state's FMAP (federal Medicaid Assistance percentage ranging from 50% to 83%)

Table 16. Federal Funding Sources and Conditions of Eligibility			
Source of Funding	Eligible Population	Eligible Services or Costs	Type of Funding
Administration and placement	Children who are eligible for IV-E guardianship	Placement costs and other administration activities related to guardianship; non-recurring expenses such as court costs, attorney fees	Open-ended entitlement 50% federal 50% state
Training	Public and private child welfare staff; prospective and current guardians; court personnel	Training generally limited to individuals who work with IV-E eligible children	Open-ended entitlement 75% federal 25% state

The major point here is that every dollar in federal reimbursement lost is a dollar of state money spent. Some of the past issues have been addressed through the State's Title IV-E Waiver. Nebraska is the only state in the federal region with a Title IV-E Waiver. States with waivers, which last five years,[53] no longer have to adhere to all the reimbursement rules for Title IV-E. Instead they negotiate a "capped" amount of Title IV-E funding they will receive and can use the funds in innovative ways for the specific, approved initiatives.

Fortunately, the federal agency, ACF calculated the amount Nebraska would receive based on claims from FFY 2007 and 2008 before the controversy began. The FFY 2008 calculated average claim per child was then adjusted for the impact of any maintenance rate changes promulgated in each subsequent FFY from 2009 through 2012, and DHHS is currently working with ACF to raise the CAP. The result so far is shown in the following table, drawn from the Terms and Conditions outlined by ACF.[54]

[53] ACF can close down the waiver after three years if the state has not made significant progress in implementing its approved plan.
[54] Nebraska Terms and Conditions, ACF Waiver Authority, DHHS, no date.

Table 17. Nebraska Title IV-E Foster Care Total Computable Demonstration Project Capped Allocation Payments*							
Demonstration Project Funding Category	Base FFY Amount	FFY 2014 Allocation Cap	FFY 2015 Allocation Cap	FFY 2016 Allocation Cap	FFY 2017 Allocation Cap	FFY 2018 Allocation Cap	FFY 2019 Allocation Cap
Maintenance Payments	$9,492,751	$9,045,372	$12,471,155	$13.662,330	$13,698,768	$15,726,392	$16,994,664
Administration	15,5478,491	$15,374,348	$15,689,522	$15,949,968	$16,085,542	$16,330,043	$16,548,865
All Capped Categories	$25,041,242	$24,419,720	$28,160,677	$29,612,298	$29,784,310	$32,056,435	$33,543,529

*The amounts in the table without application of the contingency factors discussed in Section 4.2.2.1 in each FFY.

While the waiver restores most of the level of funding the State previously received, it also limits to some degree what the State can receive. Specifically, anything classified as either maintenance (room, board and supervision for foster children) or administration (including case management costs) falls under the cap. What does not fall under the cap are expenditures for a SACWIS and for training. On both of these counts, Nebraska seems to be losing out.

ACF has declared that N-FOCUS does not qualify as a SACWIS, in part, as we understand it, because the information DHHS has provided to ACF failed to show that the privatization contractors (including KVC at that time) used N-FOCUS for all case management activities. Because NFC currently does enter case management information into N-FOCUS, we assume that at least part of the issue is that NFC does not pay its providers through N-FOCUS, nor does DHHS pay NFC through that system. Whatever the reason, N-FOCUS not qualifying as a SACWIS means that any expenditures on N-FOCUS get counted, at best, as administration and therefore fall under the cap.

Training is the other opportunity for additional Title IV-E reimbursement, even during the waiver period. Here, again, there are two issues. First, during the first two quarters of calendar year 2014 (the latest claims we have), DHHS claimed nothing on the training line. DHHS reported that this was due to an agreement between the State and ACF that training would be funded at 50 percent instead of the normal 75 percent.

We assume that ACF had discovered some issue with the training claim, *e.g.,* perhaps it did not sufficiently separate Title IV-E eligible training from other kinds of training or perhaps the university contract included costs that were something other than training. The reimbursement at 50 percent, however, would appear to mean that, until that issue is fixed, training will be considered as part of administration and therefore not reimbursable outside the cap. A proper cost allocation plan would presumably repair that situation.

The second issue relates to NFC. None of NFC's training costs are claimed under Title IV-E, even though most of the work it does, and therefore most of the training it provides its workers, relates to foster care. In part, this problem is undoubtedly related to the fixed payments made to NFC, because Title IV-E reimbursements must relate to specific kinds of costs. At a minimum the cost allocation plan NFC has submitted will have to be approved before any of these costs can be claimed, and it may be that additional steps will need to be taken, as well, such as a modification of DHHS' cost allocation plan.

In sum, there are opportunities currently available for increasing the level of federal reimbursement for Nebraska's child welfare system, but to realize the savings in state dollars those opportunities represent will require not only changes on the part of DHHS but also changes in the way NFC operates. Moreover, these are only the issues which should be dealt with immediately. Once the Title IV-E Waiver expires, the entire system will have to conform to normal Title IV-E rules, and while that can clearly be accomplished with a privatized case management system, it is likely to require a more complex set of processes than would a non-privatized system. Discussion of those issues can be found in the final chapter outlining our recommendations.

Reasonableness of Cost of Privatization Given Other Outcomes and Benefits

This report has shown throughout that the outcomes are fairly comparable between DHHS and NFC and the overall costs per case are somewhat higher for DHHS largely due to the services component. That presents a bit of a dilemma. DHHS' costs are far higher even though a smaller percent goes for out-of-home care which is more expensive than in-home services.

Part of the difference may be attributable to NFC's requiring families to pay for their services on a sliding fee scale if they are not eligible for Medicaid. Some of it may be that NFC is more effective at getting Medicaid to pay for the services families need. If the latter is the case, NFC's costs are higher than they appear, because Medicaid costs are captured neither in NFC's budget nor in DHHS' child welfare budget. Yet, those costs are genuine costs to the State.

The administrative costs are about 50 percent higher for NFC than DHHS on a per case basis, but the overall cost of administration is small in both scenarios. At present we have to attribute all of NFC's administrative salaries, taxes and benefits to this program, although as it attains other clients and revenue sources in the future that will not be necessary.

For example, NFC won a federal grant this year from the Administration for Children and Families for $1.5 million over three years to support efforts at finding adoptive homes for hard to place children. Assuming no new administrative staff are needed to manage the grant that would reduce the administrative costs attributable to child welfare case management to some degree.

Aside from the simple comparison of administrative costs, it is clear that privatizing case management has created some duplication in administrative structures. All contracting does. NFC needs people for accounting, CQI and contract management, for example, if it is to manage a $60 million operation properly. Because administrative costs appear relatively low in both organizations, however, any objection to the duplication of administrative structures is probably based more on principle than on practicality.

Even so, one might ask how much DHHS is paying to have NFC as a contractor in what might be considered duplicative costs. NFC's expenditures for administrative salaries (that is, excluding caseworkers and supervisors) is $1,887,756; its costs for rent, insurance and related operating expenses is $1,802,699; further its revenues received from the child welfare and juvenile services contract in excess of expenses last year were $388,251. These three items total $4,078,706.

If DHHS were to regain case management it would incur some additional administrative costs associated with managing over $30 million in purchased services which NFC now controls and housing more than 100 caseworkers, as examples. As this section has illustrated, the largest financial issue associated with privatization is the lost federal revenue not the cost of NFC's contract.

Directions for the Future

Privatization of child welfare in Nebraska, as in several of the other places where it has been tried, began as part of an effort to reform a system viewed as failing in important ways. The extraordinary implosion of the effort during the first two years, however, made simply recovering lost ground the most urgent task, and one to which a great deal of energy would need to be devoted. Progress beyond that point would have to wait.

Unfortunately, the State is still not experiencing any measurable benefits from having privatized child welfare. While compliance with the rules and regulations governing casework with families and children tends to be somewhat better in the private agency than in DHHS, there is no measurable difference in the outcomes for children and families, and the cost savings appear to be a result largely of shifting costs to the clients and to Medicaid, where they impact the State budget but do not get counted as child welfare costs. Savings have been offset by the huge loss in federal funding.

Privatization has caused disruption and dissension among the parties and within the community without obvious benefits to children and families. What is less clear is what direction the State should take today. We recognize the potential benefits from various courses of action as well as the costs likely to be incurred with each one. While we do have a recommended path, it will come with a caveat: our recommendation should be followed only if the conditions we believe to be prerequisites for its success are met. If the State is unable or unwilling to meet those conditions, we believe it would be better to choose a different alternative. Ultimately, the choice of any alternative will only succeed if those involved in the child welfare system, including the Legislature, are realistic about the benefits and willing to accept the costs.

In what follows we present three options: staying the course, reversing course and choosing a new model entirely. The first two are obvious choices; the third perhaps less so.

Option 1: Stay the Course

Staying the course would mean simply leaving the basic division of labor as it is now, *i.e.,* DHHS would have case management responsibility for all cases outside of Douglas and Sarpy counties, while NFC would continue, with oversight from DHHS, to manage the cases in those two counties. This is perhaps the easiest of the options to understand because the way work is done with children and families would not change, except in the ways each agency already tries to improve its efficiency and effectiveness. Staying the course may be the path of least resistance, but that does not imply that it will be either the best alternative or the one which provides the greatest value. In fact, some of the costs of this option may be quite large.

Features and Issues

Staying the course was the recommendation we made in our report on this subject two years ago. That recommendation grew out of our dismay at the level of disruption the privatization effort had caused, and it rested on a belief that further change in any direction whatsoever

was only likely to make things worse. It also rested, however, on an assumption that, if our recommendation was accepted, both sides would cooperate to make the system work better for children and families. That did not happen.

Although we believe relationships between the two agencies are noticeably better at the direct service level, the DHHS administration has made no secret of its contempt for the very notion of privatization, while NFC has challenged DHHS with its political weight in the pursuit not only of continuation but also of higher rates. To paraphrase one of the people we interviewed, the relationship between the two agencies is a competition. Unfortunately, it is not a competition to show who can keep more children safely at home with their families; it is a competition for organizational dominance. DHHS prevents NFC from having meaningful administrative access to data on the clients it manages; NFC lobbies for a re-structuring of the rates so that the rates "incentivize" NFC to keep children out of care.

Despite the continuing institutional struggle, there are reasons to maintain the current division of labor. Perhaps most notable among them is that, as a group, the judges in Douglas and Sarpy do not want to go back. There does not appear to be a consensus among them that the current situation is better than that which existed pre-privatization, but they tend to express the same concern that led to our earlier recommendation: undoing privatization in these counties would cause unnecessary disruption.

A second reason has to do with staffing. It appears that only recently has NFC's staffing situation settled down so that turnover has been reduced and caseload standards are close to being met. Another shift of staff from one agency to the other, or the termination of NFC workers who have learned the job and their replacement by entirely different workers at DHHS is likely to do more to hinder the achievement of positive outcomes for children and families than to help it.

A third consideration is the progress that has already been made on some of the things that will need to be fixed under any alternative. The most important of these are the steps needed to repair Nebraska's Title IV-E reimbursement. Some of the work done in this regard has been undertaken by NFC and assumes NFC will be part of the equation.

In sum, the basic reasons for staying the course all come down either to it being simpler because the system is already on this path or to any other option threatening further disruption to a system which has already experienced significant upheaval. Whether these are particularly good reasons or not, staying the course can work and, more specifically, it can work in ways that benefit children and families. For that to occur, however, a number of changes should occur.

Prerequisites for Success

The most important change if the current structure is maintained is that the struggle for organizational dominance must stop. The DHHS administration will have to acknowledge that it operates on two very different planes in different parts of the State and will need to alter some of its processes and perhaps some of its structures to accommodate those differences. It will have to treat NFC differently than it treats other contractors, in much the

same way that managing supervisors is different than supervising line workers. NFC, on the other hand, will have to acknowledge that it is not a public agency with the same authority and responsibility as DHHS and that it has a shared agenda for the children and families. It must also stop lobbying against the public agency.

Closely related to ending the struggle, DHHS needs to develop mechanisms, for holding NFC accountable, and both the Legislature and the Governor's Office need to provide DHHS strong support in the implementation of those mechanisms. This statement may appear to be somewhat strange to those who regularly examine the various reports coming out of both agencies which measure NFC's performance, both by itself and in comparison to the remainder of the State. While there are many such reports, some of which are cited here, there have never been any consequences, positive or negative, when NFC meets or fails to meet its performance targets. In particular, the rate changes and the *ad hoc* payments compensating for some of NFC's losses have never been tied to performance. Instead, with the exception of adjustments to fit the revised foster care rate, they have been the result of political pressure, which circumvents any standardized accountability.

Third, the issues with Title IV-E reimbursement have to be fixed. The current DHHS administration, which inherited those issues, has spent an enormous amount of time dealing with them and has achieved significant progress in fixing the problems, including obtaining a waiver from the federal government which allows more flexible use of Title IV-E. The Waiver provides some breathing room for the State, a five-year period in which to prepare for the restoration of the normal IV-E restrictions.

There are, however, further actions which can be taken to increase the level of Title IV-E reimbursement even during the waiver period. The most obvious is to address the lack of reimbursement for N-FOCUS and training, both of which can be reimbursed outside of the waiver at enhanced rates. At present, it appears that any costs incurred for either of these functions are being reimbursed, if at all, as administrative costs, which place them under the waiver cap.

We did not spend a great deal of time examining the N-FOCUS issue, but it appears that a prerequisite for obtaining SACWIS funding outside the cap is getting all case management activities, including payments made to NFC and other contractors, recorded in N-FOCUS. If that understanding is correct, steps need to be taken immediately either to modify or replace N-FOCUS so that the DHHS information system can support this function.

Training reimbursement should be simpler to fix. None of the training that NFC provides to its workers is currently reimbursed under Title IV-E and during at least the first two quarters of this calendar year even DHHS' training costs were shifted into the administrative line. Addressing this issue will almost certainly require a modification of DHHS' cost allocation plan and perhaps changes in the cost allocation plan NFC recently submitted, as well. Whatever it takes, focusing attention on obtaining appropriate reimbursement for Title IV-E eligible training is critical to restoring federal fiscal responsibility, especially during the waiver period.

DHHS needs to create a system for establishing NFC's rates that is based on allowable expenditures. This is closely tied to the reimbursement issue, because, unless the federal government is saying it does not care how NFC is reimbursed so long as it does not receive more than its spends, the current reimbursement structure fails to connect the payments DHHS makes to NFC to the work that agency does.[55] The fixed portion of the payment is the most obvious issue here, but the variable payments are a problem as well, because they are not tied to the actual cost of serving individual clients.

One way to express the problem with the current rate structure is that it allows NFC to decide how much it will be reimbursed *given the way it decided to operate.* In any normal rate structure, the agency letting the contract, not the agency receiving it, decides what the rate should be, and it does so by calculating what the costs *should* be for accomplishing the work it wants done. In this instance, that would mean building the case management component of the rate on the caseload standards in the DHHS-NFC contract, allowing for salary and fringe costs equivalent to those incurred by DHHS. It would also mean determining a reasonable level of administrative costs which would be allowed, as well as a realistic estimate of the service costs NFC would incur.

Because DHHS intends to introduce performance based contracting through the Title IV-E Waiver, the rate for NFC should probably also contain a component based on performance, representing the accountability mechanism discussed above. Because Title IV-E reimbursement is tied to individual clients and may represent only reimbursement to NFC, not a profit, care will have to be taken in constructing such a mechanism, but that is likely to be the case with the other contracts, as well.

Finally, NFC needs to examine its family engagement practices, introduce more comprehensive assessments and involve family members in meaningful decision making.

In sum, staying the course will require a great deal of work. Some of that work will need to be accomplished under any alternative, but some of it is specific to this option. If the prerequisites can be met, continuation of the current division of labor can lead to an improved system. If that cannot be met, another alternative needs to be selected.

Option 2: Reverse Course

Features and Issues

Reversing the course means ending DHHS' contract with NFC and returning all of the contracted functions, most notably, case management, to the Department. The motivation for such a move seems obvious. Privatization promised better outcomes at a lower cost, and that has not happened. The outcomes NFC achieves are no better than those DHHS obtains and the costs have been high both in lost federal dollars and in lost service resources. It was, perhaps, a worthy experiment, but it has failed.

[55] Even if the federal government is now saying that the reimbursement is irrelevant, there is no guarantee that this stance will not change in the future.

There can be little doubt that ending the privatization experiment would simplify repairing the Title IV-E reimbursement problems. Without a sub-grantee (federal terminology), only one cost allocation plan would be needed and its terms would be more straightforward. Obtaining reimbursement for both training and N-FOCUS would probably also be simpler and would lead to additional resources for the child welfare system immediately.

In addition to cost considerations, there are programmatic reasons for returning to a system in which all case management is carried out by the Department. One of the mechanisms privatization was supposed to utilize to produce better outcomes was competition. Clearly, there is no competition among private providers in the current system; no one is vying to replace NFC, even in part. To the extent that there is competition, it is between NFC and DHHS. While there is some evidence that NFC's presence has spurred additional efforts on DHHS' part, those efforts have emerged out of the struggle for organizational dominance. They are part of DHHS' campaign to prove that NFC is not needed and NFC's effort to prove that it is better. If a decision is made, however, to continue with privatization in its current form, the motivation of both agencies to show that their performance is better vanishes. In other words, the competition can only be effective, if at all, within the context of a pilot program.

The lack of effective competition is a serious issue in this system. It raises NFC to a level roughly equivalent to the Department's. It can determine how to structure its work and demand the public resources necessary to cover the costs it chooses to incur. That limits DHHS' ability to control its own budget and even to decide what it is paying for. To take one example, when clients need services in the four Service Areas managed by DHHS, DHHS bears the cost; when they need services in the Eastern Service Area, they are subjected to a sliding fee scale, because that is the way NFC has structured itself. The use of sliding fee scales may or may not be a good idea, but it is not something over which DHHS has any say, even though it remains responsible for the outcomes that result.

Perhaps the strongest programmatic reason to return case management in the Eastern Service Area to DHHS is that involuntary services are inherently a public function. As noted earlier, no state privatizes child maltreatment investigations. In Nebraska, the situation is even clearer. Even DHHS cannot remove a child from his or her home; only law enforcement is empowered to take that action. Yet, the decision to remove and the decision to return a child to his or her family should be made on the same criterion: can the child be maintained safely in the family? Keeping a child away from his or her family is no different than removing a child.

In theory, DHHS, even in the Eastern Service Area, has the responsibility for determining when to ask the court to return a child and has inserted state attorneys in the courts more consistently. In practice, however, that decision lies with NFC, as long as NFC is the agency with all the information about the child and the family. DHHS' options are limited by the information NFC provides, and that information in turn is based on NFC's judgments. DHHS retains legal responsibility for the child, but it does not have a full array of tools with which to exercise that responsibility.

Prerequisites for Success

Two things will have to happen if NFC's functions in the Eastern Service Area are to be returned to DHHS. The first is that the entire public sector, including the Legislature, the Governor's Office and the judiciary, will have to support the move. There will be political pressure exerted against the decision, and it will have to be met with a united front. If that front cannot be constructed and maintained, this option has no chance of success.

The second prerequisite is that the change occur gradually and as seamlessly as possible. The main argument against returning NFC's functions to DHHS is the converse of the main argument for staying the course: too much disruption. There is, however, no need to make the transfer on a single day.

A gradual transition should have three components. First, existing cases should not be transferred. DHHS should become responsible for new cases in the Eastern Service Area, but NFC should continue to handle the cases for which it is currently responsible. When the number of cases becomes so small that maintaining the NFC structure is no longer feasible, *e.g.,* 50 or 100, those can be transferred all at once, with that number decided at the outset of the transition.

Second, every NFC caseworker and supervisor should be guaranteed an equivalent job at DHHS. If this requires a change in the civil service statute, that statute should be amended. At the very end of the process, when the few cases remaining to NFC are transferred, the few remaining workers and supervisors should transfer with their cases.

Third, during the transition, NFC's costs need to be covered at public expense. Returning NFC's functions to DHHS should not be viewed as a kind of punishment; everyone shares responsibility for the issues which have made the privatization experiment controversial. More importantly, the goal is to develop a well-functioning child welfare system, and that requires looking forward rather than backward. Failing to cover NFC's costs during the transition would likely force NFC to make the transition more abrupt than it needs to be.

Option 3: Re-tooling for Reform

Features and Issues

There are at least two sound reasons for exploring some option other than continuing privatization in the Eastern Service Area and returning all functions there to the Department. The first is simply that selecting either of the first two options will be experienced as a complete defeat for one or the other side of this controversy. Because neither organization produces results which are clearly superior, such a decisive blow to either of them seems unjustified, and we suspect either decision would risk creating a strong political backlash and continuing or even intensifying the turf battle that has waged for five years now.

The second reason for considering a third option is, however, more important. Privatization started as a mechanism for reforming the child welfare system and producing better results for the children and families who become known to that system. Through many changes that have occurred since then, the focus has shifted from child welfare reform towards simply defining the respective roles of the public and private sectors. Moreover, the largest improvements which have been made to the system during that period, namely, the introduction of Structured Decision Making (SDM), the limitations imposed on the use of emergency shelter care, and the approval of the Title IV-E Waiver which includes an Alternative Response initiative, have occurred without regard to the question of privatization. If the even more radical change originally envisioned is to occur, *i.e.,* to increase the proportion of children being served in their own homes by enlisting the help of their families and supporting them in that effort, the primary focus has to be on ***what*** is required to achieve that goal, not on ***who*** can do it best.

In addition to moving the system towards more fundamental goals, this option provides a new role for NFC, focusing on three of its key strengths: its connections to service providers, its community organization talents and its management talents.

In the examination we have just completed, the largest gap we found in the system has to do with family engagement. Neither agency demonstrates an understanding that the professional child welfare system cannot replace the family as the primary protector of children. If more children are to be kept safe in their own homes, the first function of the child welfare system must be to support and assist families in doing that job, not to begin working with their parents only after removal.

There are two essential ingredients to meaningful engagement with families: shifting more of the decision making to families as envisioned in the original model of family group conferencing and assuring ready availability and accessibility of informal as well as formal supports. The dearth of current supports for families being served in-home is perhaps best illustrated by NFC's report to us that 90 percent of its service expenditures are devoted to out-of-home cases; our analysis of DHHS' costs produced similar results. The present system cannot reform, at least in part, because it does not have the necessary service infrastructure specifically to support families within their own home. While the Title IV-E Waiver obtained by DHHS includes an Alternative Response component that program has a broad list of exclusionary criteria and does not encompass Douglas County.

In fact, the failure of the lead agency model which initiated privatization in Nebraska was probably due precisely to this lack of infrastructure. Lead agencies were given fixed amounts of funds with the expectation that they could be more flexible in how they used those funds, shifting substantial portions to in-home services rather than out-of-home. At that time, however, neither the decision making processes nor the service and support resources were available to make that shift feasible. It was not so much a matter of DHHS under-estimating the number of clients to be served; it was rather a conflict between the expectation that families could be served more cheaply through alternatives to placement and the reality that the system was simply not equipped to provide those alternatives.

One component of that has now changed. The introduction of Structured Decision Making is changing the way caseworkers decide when removal of the child is necessary. SDM calls for removal from the home only when there is an imminent safety threat which cannot be controlled, not when there is simply a risk of some future maltreatment. While our interviews revealed that the SDM principles have yet to be absorbed by the majority of staff of either DHHS or NFC, the process has begun and the SDM principles can be expected to provide the future direction of the Department.

What remains largely missing, and one barrier to a more robust implementation of SDM, is the service and support infrastructure which would provide concrete, alternative ways to keep children safe without removing them from their homes. That infrastructure should consist of three parts: formal services directly addressing the family issues threatening the safety of children known to DHHS including clinical, behavioral and concrete supports; paraprofessional services designed to assist, support and guide parents often by teaming them with others who have had similar experiences; and each family's own private sources of informal support.

The first of these, the formal services, should be the easiest to develop because both public and private agencies are most comfortable with formal, structured services. For formal services to be useful in preventing removals of children, however, they have to be aimed at controlling safety threats, not simply at reducing the risk of repeat maltreatment. Providers also need to know how to access concrete supports related to housing, jobs and food support. Biweekly parenting classes, weekly or monthly counseling sessions and random drug screens may be useful in reducing the longer-term risks to children, but they are not sufficient to address the imminent threat of harm to a child. For that the services have to be more concrete and more intensive, *e.g.,* child care services during key periods of the day (or evening) to reduce the stresses on parents or daily in-home visits by caseworkers designed both to check on the children's safety and to help parents deal with their daily stresses. One example of the kind of service which might be useful here is the In-home Family Service which Boys Town piloted a couple of years ago. While it focused on acting-out teenagers rather than parents, it used a behavioral approach rather than traditional therapy, and that is probably appropriate for child welfare families, as well.

There are also models of paraprofessional services available which use adults who have had experiences similar to those of the client families to guide the latter towards effective parenting of their children. Here in Nebraska the Right Turn program operating under the aegis of Lutheran Social Services uses people, some with direct experience as adoptive parents, to counsel, support and guide adoptive parents who are having trouble dealing with their adopted children. The Nebraska Federation of Families provides peer support services to families experiencing difficulty with their teenage children in order to prevent families from institutionalizing those children. Further away, in New York City private foster care and prevention agencies hired parent advocates, *i.e.,* parents who had formerly been in the child welfare system, to work with families both to keep children out of care and to return children home who had been removed, while another program, Bridge Builders, trains and hires

parents from the community to go door to door asking families if they need help before their issues become overwhelming.[56]

Structured properly, paraprofessional services can be much more flexible than traditional services, with the paraprofessionals able to respond to a family's crisis on a 24-7 basis. In that sense, they can supplement, or for families who are quite socially isolated, even replace the family's own informal support systems. These latter are, of course, the kinds of supports most likely both to empower families to take more affirmative charge of their lives and to provide an ongoing support structure for protecting children in the community. The grandmother, aunt, uncle, neighbor, clergy or teacher who is committed to the child and familiar with the family dynamics can be a powerful actor in the effort to keep the family intact while also protecting the child. For that to occur, however, the professional child welfare system must give them the room to play that role, even if it helps to structure and guide the family.

If formal, paraprofessional and private informal resources represent the components of the infrastructure needed to keep more children at home, the question remains of how to develop that infrastructure. We believe this is a role which can best be played by the private sector.

It should be clear that reversing the proportions of families served with all their children at home and of families served with one or more children in foster care will have a significant fiscal impact on the private agencies which currently offer out-of-home services. Both to avoid undercutting the financial foundations of those agencies and to enlist their support in reducing the foster care population, they should be given the task of developing and then delivering (and being reimbursed for) the necessary services and supports.

In relation to the formal services, this probably means identifying and implementing modalities, preferably but not necessarily evidence-based, not commonly in use in Nebraska's child welfare system at the present time. For the paraprofessional services it means actively recruiting, training, motivating and monitoring parents and other adults from the community, at least many of whom might have experience with the child welfare system, to help guide, support and advocate for families currently in the system. In other program models such as Family to Family even foster parents have been used as paraprofessional role models for the birth families.[57]

For the private informal supports, the agencies are likely to need something akin to the efforts now going into finding kinship homes for children removed from their parents and then helping families engage those people and show them how they can help. It would not be inconsistent for the model to include some form of stipends for informal support providers.

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[56] Tobis, D. (2013). *From Pariahs to Partners: How Parents and Their Allies Changed New York City's Child Welfare System*, Oxford University Press.

[57] http://www.aecf.org/m/resourcedoc/aecf-ImplementingValuesStrategiesofF2F-2001.pdf

Although the image of the desired structure should be relatively clear, it will require a process to achieve. Neither the courts nor DHHS is likely to change its decision making about removals just because an agency has hired its first paraprofessional. This is where NFC can play a key role. NFC, through a contract with DHHS, should take a lead agency role in relation to in-home services. This does not mean case managing in-home services cases or even having anything to do with individual cases. Rather, the lead agency role in this instance should focus on the creation, expansion and ongoing maintenance of an array of in-home services and supports adequate to support realistic alternatives to foster care placement. This part of the role may have been implicit in the original model, but it never got implemented.

We envision that under its contract with DHHS NFC would:

1) identify formal, paraprofessional and informal support models from around the country which are specifically designed to provide means of keeping children safely in their own homes;
2) seek and obtain start-up funds for some of these services;
3) assist private service providers currently focused on out-of-home services to implement the models for which NFC has secured start-up funds by providing training and technical assistance and passing to them the start-up funds for those services;
4) serve as the fiscal manager for all of DHHS' purchases of in-home services in the Service Area, including ensuring that DHHS only pays for services which are both authorized and actually delivered (and that it pays for all services meeting those criteria); and
5) conduct quality assurance reviews of the providers in the Service Area, using instruments approved by DHHS.

One could summarize this function by saying it involves assuming DHHS' contract management and payment functions for in-home services while also being responsible for generating an adequate supply of services (including high-end, intensive services as well as concrete supports) designed to keep children out of care or allow them to be returned home.

One thing should be clear, however. This is not intended to represent any version of a managed care system, with a pre-determined fix cost or even a capitated rate. A managed care system might work at some point in the future when the service array is more mature, but it is likely to create more problems than it solves if applied to a newly developing system. NFC would pass through to each provider the rate agreed upon by the Department and the provider, earning an administrative fee for doing that as well as for the other functions described above. Because the resource related functions are administrative in nature, they could be paid either as a fixed amount or as an amount to vary by the volume, whether measured as the total amount of contracted services, the number of provider agencies or any number of other non-client related measures.

One major advantage of what might be called "contracting out contract management," is that it would likely improve the way that function is now carried out. The recent report by the State Auditor[58] strongly criticized the Department for its lack of controls over contract payments and information we received during this project indicated that NFC's mechanisms for ensuring appropriate payments are much better. On that count, then, NFC could offer a valuable service in exactly an arena where DHHS is deemed to be weak. To maintain the focus on alternatives to placement, however, we see NFC's contract management function as being limited, at least for the foreseeable future, to the new array of services.

The final reason focusing on resource development and management might prove attractive is that it can potentially be expanded to other Service Areas without creating the upheaval that accompanied the transfer of service coordination and then of case management. The rural areas of the State were the ones most strongly affected by the loss of service resources during the collapse of privatization outside of the Omaha area, and even if some of those losses may have been recovered in the meantime, resources are nearly always scarcer in rural areas. Paying an organization, be it NFC or someone else wanting to provide the same set of services, to develop, organize, nurture and monitor a reasonable service array in the rural parts of the State could potentially represent a major step forward.

Prerequisites for Success

The most basic prerequisite for the success of the kind of lead agency model suggested here has already been mentioned. Services cannot be paid for on the basis of fixed payments regardless of volume. That model never made sense as long as DHHS remained in the case management position and was the one ordering the services, while the lead agencies were the ones having to pay for them. Even after the transfer of case management responsibility, NFC transferred costs to the clients through sliding fee scales and to the State through Medicaid, probably to reduce its excess costs.

Service payments need to be made on a client-specific basis, both to ensure that provider agencies obtain adequate reimbursement and can continue to make their services available and to facilitate receipt of federal reimbursement (post-Title IV-E Wavier) for services outside the strictly clinical realm, which these would be. Administrative functions can be reimbursed in other ways, but services need to be tied to old fashioned fee-for-service payments.

A second condition for success is the same as one of those for reversing the course. As the case management function reverts to DHHS, it needs to be done in a gradual way and NFC needs to be fully reimbursed for all its costs during the transition.

Similarly, the third prerequisite is a variation of what has been said about the other two options: each organization has to be both willing and able to accept its role, both the places where that role expands and the places where that role contracts. It is not clear that DHHS would welcome contracting out some of its contract administration processes, and it may not be ready to develop the new processes it will need to ensure that the lead agency

[58] Auditor of Public Accounts, *Attestation Report of the Department of Health and Human Services, Program 354 Subprogram 48 – Child Welfare, January 1 through December 31, 2013*, Issued September 19, 2014.

contractor is carrying out those functions in the way intended. Similarly, NFC may have to develop new capacities if it is to expand the service array, and it is probably not clear whether it can or would want to do that when the expansions add to the scope of a provider agency rather than to NFC's range. It cannot enter into competition with the other providers, however, if it is to carry out all the other contract administration functions listed above.

Finally, DHHS would need both to be able to require the lead agency to develop and husband, to the extent possible, the services DHHS believes necessary and to be open to contracting for services the private agencies can show might be useful for some families and children. Stated differently, while this option gives most of the directive power of the child welfare system to the public agency, it also requires that the private sector be able to contribute its experience and creativity without being shut out from public funding.

Re-tooling for reform will work only if there is in fact a shift, ultimately visible in the fiscal ledger, from out-of-home services to in-home services. That shift has to be reflected not only in the services available but also in the decision making of DHHS case managers. It will also require cooperation from the judiciary and we believe that the chances of success will increase substantially with the addition of a pilot reform project affecting judicial processes.

The Nebraska court system represents a hybrid of two systems the American Bar Association has characterized as the prosecutorial and representative models. The prosecutorial model necessarily depends on proving the family at fault as a basis for its mandate to follow judicial orders. This model counters the very premise of a system which recognizes parents as the primary protectors of their children. Further, it is premised on the wrongdoing of the parents rather than the safety of the children.

We recommend that a pilot court project be initiated which would eliminate the prosecutorial component of court proceedings and move instead to a family support model. The county attorney would not be needed and the role of the judge would change. A crucial component of the pilot court would be to use the Family Group Conferences started in 2006 by the Through the Eyes of the Child Initiative and now managed by the regional mediation centers under the Nebraska Judicial Branch. Family members decide who will attend to support them in addition to the professionals. The focus of the meeting should be ways to maintain the child at home or return the child home. Conference attendees develop the child's safety plan, identify the range of formal and informal supports needed and, where possible, identify who will provide the informal supports. If families, neighbors and friends are not available, the paraprofessional services developed by NFC can be invoked. The court will approve or modify the safety plan after hearing DHHS's viewpoint and will monitor the in-home service plan.

The use of Family Group Conferences has declined in Nebraska from its high of 364 in 2006 to a low of 120 last year which some attribute to shifting the program's administration from DHHS to the Nebraska Judicial Branch. The model did not appear anywhere within the 200 cases we read for this study. If a more family-driven system is to be effective, it will need to be used in every case in which family members are still involved and that is what we recommend for the pilot court.

Recommendation

Each of the above options has been presented with a set of conditions we believe necessary for it to be successful. If those conditions are met, any of the options can represent a reasonable structure for a functioning child welfare system. However, while each of the options could result in better service delivery and improved results, only one is inherently focused on anything that might be called a reform of the system. The only real argument for maintaining the privatized structure in Douglas and Sarpy counties is the need to avoid further disruption to the system. The main argument for returning all the functions to DHHS is that the experiment has not produced what it promised to produce, eliminating any reason to continue allowing a private organization to impose involuntary services on Nebraska's families and children. Only the third option, a division of labor which transfers some of the infrastructure functions to the private sector, focuses on expanding the resources needed to help families keep their children safely at home and to ensure that they are well cared for when they cannot be kept at home through an expanded in-home support structure.

Increasing the proportion of children served at home will require a much richer array of services to prevent children from being removed and a much greater availability of those services. In Nebraska it seems especially appropriate to ask the private sector to develop those services, because of the long history of private development of services for placement. While several states have private agencies develop and oversee at least some of their foster homes, not many do it as universally as Nebraska. That gives the private sector a powerful incentive to promote placement, and reversing the proportions of children served in and out of their own homes will require providing equally powerful incentives to keep children out of placement.

While we are recommending the third option discussed above, we wish to underscore the importance of fulfilling the prerequisites for its success. If those conditions cannot be met, we believe that one of the other options should be chosen instead. In the end, none of the options represents a turnkey operation leading to a more effective and more efficient child welfare system. The success of any change will depend on the commitment of those working in the system to implement that change to the benefit of children and families, and the decision as to which of the options is most likely to generate that commitment is one that needs to be made through Nebraska's political processes.

Appendix: Research Instruments

Nebraska Privatization Assessment
Case Review Tool

Case Questions

Reviewer Name:	Date of Review: __/__/__	Child ID:
Case ID:	Date Case Opened: __/__/__	Case Closure Date: __/__/__
Date of Removal: __/__/__	Discharge from Care Date: __/__/__	
Service Area: □ ESA □ SESA □ CSA	If ESA: Initial NFC Date: __/__/__	
Case Type: □ In-home □ Out-of-home		

Assessments and Structured Decision Making

Please examine the child assessment as well as the parent assessment. If there are other children in the family, you may find some of the information relevant to the selected child in those children's records. To answer some of the following questions, you may also need to read the case notes, as well as the assessments themselves.

1. Record the date of the most recent assessment: __/__/__
   □ No assessments in the case record *(skip to Question 13)*

2. From the information obtained in the record, were the relevant clients[59] actively involved in conducting the most recent assessment?
   □ All □ Some □ None

   If Some or None, is there evidence in the case record that the caseworker made efforts to locate and actively involve all the relevant clients?
   □ All □ Some □ None

3. From the information obtained in the record, does it appear that the worker identified the significant risk factors/needs relevant for the family?
   □ All □ Some □ None

4. From the information obtained in the record, does it appear that the worker identified the strengths/supports that can help resolve the family issues?
   □ All □ Some □ None

[59] Client is defined as a target child (age-appropriate) and parent or a caregiver that works the case plan towards the reunification with the target child.

5. Did the most recent assessment consider the following areas?

□ The physical, cognitive and emotional level of development

□ Any history of abuse or neglect

□ Strengths of other family members

□ Any special conditions that would call for services or particular type and level of placement

□ The child's special skills, talents or strengths

□ Likely permanency options

6. Record the needs identified in the assessment.

□ Disciplinary methods
□ Appropriate expectations
□ Child behavior
□ Child's special needs
□ Alcohol abuse
□ Drug abuse
□ Physical abuse
□ Sexual abuse
□ Food, clothing, shelter
□ Educational issues
□ Other, Specify:

7. Based on the available documentation, were needs generally determined through utilization of the Structured Decision Making and Needs Assessment?

□ Yes □ No □ UTD □ N/A, no Structured Decision Making and Needs Assessment *(Skip to Question 13)*

8. Record the scores of the most recent Structured Decision Making and Needs Assessment:

Caregiver Questions[60]	P	S	Child Questions[61]	Score
SN 1			CSN 1	
SN 2			CSN 2	
SN 3			CSN 3	
SN 4			CSN 4	
SN 5			CSN 4b	
SN 6			CSN 5	
SN 7			CSN 6	
SN 8			CSN 7	
SN 9			CSN 8	
			CSN 9	
			CSN 10	
			CSN 11	
			CSN 12	

[60] Caregiver question options are a, b, c and d.
[61] Child question options are strength, average, increase need and extraordinary need.

9. For the caregiver items with scores of c or d, answer the following questions from the SDM form. All answers are Y or N.

Item	Is this need related to a safety threat?	Is this need related to other concerns?	Is the caregiver willing to address the need in this domain?	Prioritized for the case plan?
SN __				
SN __				
SN __				

10. For the caregiver items with scores of a or b, answer the following questions from the SDM form. All answers are Y or N.

Item	Is this strength relevant to improving safety?	Is this strength relevant to other concerns?
SN __		
SN __		
SN __		

11. If the case contains a previous assessment conducted during the period under review (July 1, 2013 through June 30, 2014), did the child and parents experience any life events between assessments that might have had an impact on the assessment?
    ◻ Yes ◻ No ◻ N/A, no previous assessment during the review period

12. Is there a difference in the identified needs and strengths between the previous assessment and the most recent?
    ◻ Yes ◻ No ◻ N/A, no previous assessment during the review period

Case Plans

13. Record the date of the most recent case plan: __/__/__
    ◻ No case plans in the case record *(skip to Question 16)*

14. From the information obtained in the record, were the relevant clients[62] actively involved in creating the most recent case plan?
    ◻ All ◻ Some ◻ None

[62] Client is defined as a target child (age-appropriate) and parent or a caregiver that works the case plan towards the reunification with the target child.

If Some or None, is there evidence in the case record that the caseworker made efforts to locate and actively involve all the relevant clients?
□ All □ Some □ None

15. From the information obtained in the record, were any outside agencies, such as service providers involved in creating the most recent case plan?
□ Yes □ No

If yes, please list the agencies involved:

16. What is the most recent primary permanency goal of the child?

□ Remain in the home	□ Reunification	□ Live with other relatives
□ Adoption	□ Long term foster care/APPLA	□ Emancipation
□ Guardianship	□ No goal identified	

17. What is the most recent concurrent permanency goal of the child?

□ Remain in the home	□ Reunification	□ Live with other relatives
□ Adoption	□ Long term foster care/APPLA	□ Emancipation
□ Guardianship	□ No concurrent goal identified	

18. Based on the documentation in the case record, was the child consulted regarding the development of the permanency goal/concurrent goal?
□ Yes □ No □ UTD □ N/A, not appropriate based on child's age or developmental status

19. Based on the documentation in the case record, were the parents consulted regarding the development of the permanency goal/concurrent goal?
□ Yes, all parents involved □ Yes, some parents involved □ No, no parental involvement
□ N/A, TPR has occurred or parents are not involved

20. If the child has been in care for 17 of the most recent 22 months and the primary permanency goal is reunification and no petition has been files for TPR, what is the justification given in the record for continuing the reunification goal and not seeking termination?
□Relative placement
□Agency did not provide parents with needed services
□Parents are making progress, but need more time
□Parents soon to be released from incarceration
□Other, Specify: _____

□ N/A, child not in care 17 of 22 months or goal not reunification

21. If the child's primary permanency goal is not reunification, adoption or guardianship what was the previous permanency goal listed in the case record?

□ Remain in the home	□ Reunification	□ Live with other relatives
□ Adoption	□ Long term foster care/APPLA	□ Emancipation
□ Guardianship	□ No goal identified	□ N/A, goal is reunification, adoption or guardianship

22. If the child's primary permanency goal is not reunification, adoption or guardianship has TPR been granted for each parent?

Mother	□ Yes	□ No
Father	□ Yes	□ No

23. If the case contains a previous case plan created during the period under review (July 1, 2013 through June 30, 2014), did the child and parents experience any life events that might have had an impact on the case plan?

□ Yes □ No □ N/A, no previous case plan during the review period

24. Is there a difference in the identified services and plans between the previous case plan and the most recent?

□ Yes □ No □ N/A, no previous case plan during the review period

Service Provision and Placements

25. Based on the information in the most recent case plan and case notes, what services were recommended for the family and which were provided? If indicated, write in the anticipated or actual provider of the service.

Service	Recommended	Provided	Service Provider
Parenting Education	□ Yes □ No	□ Yes □ No	
Substance Abuse Treatment	□ Yes □ No	□ Yes □ No	
Basic Needs Assistance	□ Yes □ No	□ Yes □ No	
Counseling	□ Yes □ No	□ Yes □ No	
Anger Management	□ Yes □ No	□ Yes □ No	

Service	Recommended	Provided	Service Provider
Sexual Abuse Treatment (Victim)	□ Yes □ No	□ Yes □ No	
Sexual Abuse Treatment (Perpetrator)	□ Yes □ No	□ Yes □ No	
Educational Assistance	□ Yes □ No	□ Yes □ No	
Other (Specify)	□ Yes □ No	□ Yes □ No	

26. Please indicate the child's most recent placement type
□ Relative Placement □ Foster Care □ Therapeutic Foster Care
□ Pre-adoptive Placement □ Group Home □ Institution (Child Welfare)
□ Institution (Psychiatric) □ Juvenile Facility □ Other (Specify)
□ Runaway □ Supervised Independent Living
□ N/A Child is not in out-of-home care *(Skip to Question 32)*

27. Please indicate how long the child has been in the most recent placement setting (in months).
DROP DOWN OF NUMBERS

28. Based on the information in the case record, was the child consulted and his or her preferences considered prior to being placed in the most recent placement setting?
□ Yes □ No □ UTD
□ N/A, child is under age 12 or not developmentally able to provide preferences

29. Based on the information in the case record, were the parents consulted and their preferences considered prior to being placed in the most recent placement setting?
□ Yes, all parents □ Yes, some parents □ No □ UTD
□ N/A, parents are not involved in the case

30. Please indicate in which ways the child's current placement setting is appropriate for the child.

Placement is close enough for child to visit with parents	□ Yes □ No □ UTD □ N/A
Placement allows child to be placed with siblings	□ Yes □ No □ UTD □ N/A
Placement is close enough for child to visits with siblings	□ Yes □ No □ UTD □ N/A
Placement is with a relative	□ Yes □ No □ UTD □ N/A
Placement did not require the child to change schools	□ Yes □ No □ UTD □ N/A

Placement did not require the child to move to a new community	◻ Yes ◻ No ◻ UTD ◻ N/A
Placement provider is able to meet the child's needs (emotional, physical, medical)	◻ Yes ◻ No ◻ UTD ◻ N/A
Placement provider is able to meet the child's cultural and religious needs	◻ Yes ◻ No ◻ UTD ◻ N/A
Other, Specify:	◻ Yes ◻ No ◻ UTD ◻ N/A

31. Please indicate how may placement settings the child has experienced during the period under review (July 1, 2013 through June 30, 2014), including the current placement setting.
DROP DOWN OF NUMBERS

Caseworker Contacts

32. Please indicate the number of contacts the caseworker had with the child (out-of-home cases) or the family (in-home cases) during the last six months of the review period as well as:
    - the date of the contact
    - who was present for the contact,
    - where the contact occurred and
    - whether the visits were in conjunction with a case activity such as a court date or development of the case plan

◻ N/A, no visits listed in the record *(Skip to Question 35)*

Visit	Date	Participants	Location	In Conjunction?
1		◻ Mom ◻ Dad ◻ Siblings ◻ Other, Specify	◻ Office ◻ Home ◻ Court ◻ Community Location ◻ Other, Specify	◻ Yes ◻ No
2		◻ Mom ◻ Dad ◻ Siblings ◻ Other, Specify	◻ Office ◻ Home ◻ Court ◻ Community Location ◻ Other, Specify	◻ Yes ◻ No

33. For each visits listed above, please identify whether the documentation of the visits included the following:

Visit	Documented?	
1	The physical condition of the child, including signs of maltreatment	◻ Yes ◻ No ◻ N/A
	The emotional status of the child, including mannerisms, signs of fear, and development status	◻ Yes ◻ No ◻ N/A
	The reactions of the parents to the Department's concerns	◻ Yes ◻ No ◻ N/A

	The emotional and behavioral status of the parents during the visit including levels of denial and resistance, and use of defense mechanisms	◻ Yes ◻ No ◻ N/A
	Interactions among the family members	◻ Yes ◻ No ◻ N/A
2	The physical condition of the child, including signs of maltreatment	◻ Yes ◻ No ◻ N/A
	The emotional status of the child, including mannerisms, signs of fear, and development status	◻ Yes ◻ No ◻ N/A
	The reactions of the parents to the Department's concerns	◻ Yes ◻ No ◻ N/A
	The emotional and behavioral status of the parents during the visit including levels of denial and resistance, and use of defense mechanisms	◻ Yes ◻ No ◻ N/A
	Interactions among the family members	◻ Yes ◻ No ◻ N/A

34. Based on the information in the case record, did the caseworker attempt to conduct contacts during the most convenient time with the family by making inquiries into their daily schedule?
◻ Always ◻ Sometimes ◻ Rarely ◻ Never ◻ UTD

Family Visits

35. Please indicate the number of visits the child has had with his or her parents during the last six months of the review period as well as:
- who was present for the visit,
- where the visits occurred
- whether the visits were in conjunction with a case activity such as a court date or development of the case plan and
- whether the record contains substantive content of the visit.

◻ N/A, parents are not involved in the case

Visit	Participants	Location	In Conjunction?	Substantive Content?
1	◻ Mom ◻ Dad ◻ Siblings ◻ Other, Specify	◻ Office ◻ Home ◻ Court ◻ Community Location ◻ Other, Specify	◻ Yes ◻ No	◻ Yes ◻ No
2	◻ Mom ◻ Dad ◻ Siblings ◻ Other, Specify	◻ Office ◻ Home ◻ Court ◻ Community Location ◻ Other, Specify	◻ Yes ◻ No	◻ Yes ◻ No

36. Did the case record contain a visitation plan, also known as the Parenting Time Plan, which identified each participant's role and responsibility in terms of ensuring that visitation is successful?
□ Yes □ No □ N/A, no family to warrant plan

If yes, does the plan address the following items?

Dates, times and location of visits	□ Yes □ No
How arrangements for visits will be made	□ Yes □ No
Who will be present at the visits	□ Yes □ No
Arrangements for monitoring or supervision, if needed	□ Yes □ No □ N/A
Plan for handling of emergency situations	□ Yes □ No
Procedures for handling problems with visitation	□ Yes □ No

Case Staffings/Supervision

37. Based on the information in the case record, please indicate the date of each staffing/supervision which occurred during the period under review as well as the purpose for each staffing/supervision. If no staffings or supervision are documented in the case record, enter 12/31/55 for the first date and skip to question 38.

Date	Purpose	
___/___/___	The appropriateness of and necessity services.	□ Yes □ No
	The appropriateness of and necessity for the current foster care placement.	□ Yes □ No □ N/A
	The extent of compliance with the case plan.	□ Yes □ No □ N/A
	The extent of progress toward alleviating or mitigating the difficulties that initiated case opening/child removal	□ Yes □ No □ N/A
	The services necessary to facilitate achievement of the permanency plan.	□ Yes □ No □ N/A
	The likely date by which the permanency plan or case plan is to be achieved.	□ Yes □ No □ N/A
___/___/___	The appropriateness of and necessity services.	□ Yes □ No
	The appropriateness of and necessity for the current foster care placement.	□ Yes □ No □ N/A
	The extent of compliance with the case plan.	□ Yes □ No □ N/A

Date	Purpose	
	The extent of progress toward alleviating or mitigating the difficulties that initiated case opening/child removal	◻ Yes ◻ No ◻ N/A
	The services necessary to facilitate achievement of the permanency plan.	◻ Yes ◻ No ◻ N/A
	The likely date by which the permanency plan or case plan is to be achieved.	◻ Yes ◻ No ◻ N/A

Case Summary

38. After reviewing all possible case documentation, to what degree does the case management reflect effective concern with the following?

Child's Needs	Fully	Mostly	Barely	Not	N/A
Safety					
Basic care					
Permanence					
Intervention and treatment to reduce risk of maltreatment and its effects					
Security and continuity in valued relationships, environments and community					
Support (emotional and physical)					
Respect					
Closure					
Family's Needs	**Fully**	**Mostly**	**Barely**	**Not**	**N/A**
Explanation and understanding of issues					
Supportive services, such as, in-home services, family therapy, etc.					
Appropriate assessment, planning and services					
Respect					

39. Please use the text box below to identify any noteworthy elements, positive or negative, characterizing the handling of the case.

Nebraska Privatization Assessment
Service Area Administrator Interview

Name:	Date:
County:	Interviewer:

General

1) How long have you held your current position? How long have you worked for DHHS? Has all of that time been in this position?

2) Please describe what your position entails, including programs you oversee, daily duties and responsibilities.

3) How many caseworkers does the Area employ at this time? How many supervisors? How many county supervisors? Do you have any vacancies at this time?

4) Please explain what factors (organization, resources, policy) allow you to perform your work duties well. What barriers exist?

Administration

5) How would you describe the Area's caseworker, supervisor, and county supervisor turnover rate? What impact does this have on the organization?

6) How often do you meet formally with individual caseworkers, supervisors and county supervisors? How often are you in large meeting with multiple caseworkers, supervisors and county supervisors?

7) What accountability mechanisms are in place in your Service Area?

8) What kinds of support do you get from the Central Office in your role as a Service Area Administrator?

Assessments and Plans

9) What trends do you see in the type of cases coming into your Area? *(Try to get specifics on client characteristics, allegations, service needs.*) To what extent, if any, are the trends different from those seen in other areas?

10) Prior to opening a case, do workers make efforts to connect the family to services or supports and avoid case opening? Why or why not?

11) What are the criteria workers in this Service Area use to determine whether a case should be opened? Is this different from other areas? Can you identify any trends in reasons for removals?

12) Prior to removing a child, what efforts do workers in this Service Area make to find alternatives to the removal? Are there other strategies or resources that might reduce the need for removals and placement into foster care?

13) What are the criteria workers in this Service Area use to determine whether a child should be removed from the home? Is this different in other areas?

14) When children are removed, what efforts are made to place them with appropriate relative foster parents and what efforts are made to match the needs of children as they are removed with the placement resources?

15) What efforts are made in your area to encourage family visitation?

16) What are the criteria workers in this Service Area use to determine whether a child should be returned home from foster care? Are there any mechanisms in place to support families upon the return of a child to his or her home?

17) What are the criteria workers in this Service Area use to determine whether a case should be closed? Do these relate to the criteria for opening cases?

Service Provisions and Resources

18) Can you comment on the educational, physical and mental health services available to children and families in your area: how adequate are they in types, quality and availability? What gaps in services are there? What strategies could improving access and utilization?

19) Does the availability of services (or lack thereof) affect the length of time cases stay open or children stay in care?

20) Describe DCFS's relationship with service providers. How effective is the collaboration among the agencies? What barriers exist? Are there any strategies that you would recommend to increase collaboration?

21) Does your Area have an adequate number of placement resources in terms of foster homes? How does the number of available homes affect the number of placement changes children experience? How about the length of time they spend in care?

22) What efforts are made to recruit more foster homes? How successful are those efforts? Can anything else be done?

Court and Law Enforcement Role

23) How would you describe the agency's relationship with the various courts? What do you do to foster a good relationship within the judicial system? Is there anything that you would recommend to other Service Area Administrators?

24) How often do the courts take DCFS' recommendations into consideration when making decisions in terms of placements? How about for returning children home? How about for case closures? Who is primarily responsible for the recommendations the agency makes to the court? The supervisor, the worker, the attorneys?

25) Can you describe, from your perspective, the agency's relationship with law enforcement, the courts and other professionals in the community? What do you do to foster a good relationship? Are there any strategies that you would recommend to other Service Area Administrators?

Summary

26) Is there anything else you would like for us to know about the case management process? Do you have suggestions for improving the process?

Nebraska Privatization Assessment
Supervisor Interview

Name: Date:
County: Interviewer:

General

1) How long have you held your current position? How long have you worked for DHHS? Has all of that time been in this position?

2) Please describe what your position entails, including program, daily duties and responsibilities.

3) Please explain what factors (organization, resources, policy) allow you to perform your work duties well. What barriers exist?

Caseload

4) In addition to supervising staff, are you carrying a caseload? If so, how many cases are you currently handling?

5) *If the supervisor's unit carries a mixed caseload* - What proportion of the cases assigned to your unit are investigative vs. in-home vs. foster care cases? Among in-home cases, what proportion consists of wards? Has that changed much in the past year?

6) Do you have administrative responsibilities in addition to supervising caseworkers? If so, what are those?

Supervising Caseworkers

7) How many caseworkers are you currently supervising? Has that changed substantially in the last year or so?

8) How much time do your caseworkers get to spend with the average case? How much does that vary? *If not an investigative supervisor only* - Is it different for in-home and for foster care cases?

9) How would describe your relationship with your workers? How often do they come to you with case-related questions or asking for advice?

10) Aside from the times workers come to you with questions or asking for advice, how often do you meet formally with each of your staff to discuss individual cases?

11) Are you aware of the performance measures DHHS has established, such as, reducing multiple placements? If so, how do you learn about these? What impact do these measures have on your decisions, if any?

12) How well does your team get along? Do they talk to each other about work-related issues? Do they talk to each other about their own lives?

Permanency and Well-being

13) What are the largest challenges you face in regard to achieving permanency for children? Are there specific types of family issues that make achieving permanency more difficult?

14) Do you believe that children in foster care have adequate access to educational, physical and mental health services? If not, what barriers prevent access? What would improve their access?

Assessments and Plans

15) When caseworkers conduct a child assessment (as opposed to an investigation of maltreatment), what factors should they take into account? Do they take all of those factors into account?

16) When caseworkers conduct a parent assessment, what factors should they take into account? Do they take all of those factors into account?

17) To what extent should families be involved in case planning? To what extent should the child be involved in case planning? Do your caseworkers actually involve the families and children?

18) When caseworkers create a service plan, to what extent should it contain specific details such as specific goals that should be met at specific time points or services provided by specific institutions? Do their service plans usually contain specific details?

19) Do they usually create service plans that can be accomplished within the given amount of time?

20) Do they actively revise service plans when they feel that they are not effective or appropriate? If yes, how often?

21) Does this revision process occur with or without the family? How important do you believe it is that the family be present?

Service Provision

22) To what types are services are families typically referred?
    a. Are they able to receive those services?
    b. If no, why not?

23) Are there services families are often unable to access? Why are the families unable to access these services?

24) What is your process for accessing services which are under contract for your client families? Are these easier to access than other community services?

25) What strategies do you think would be successful in improving access to and utilization of services?

Court Hearings

26) How involved are families in the court reviews/hearings? How important do you believe it is to have the families present at the reviews and hearings?

Out-of-home Placements

27) When a child is placed in foster care, what is the process for identifying an appropriate placement? Is that working well, i.e., are the placements stable?

28) What should the caseworkers discuss with the child before or after they have a placement change? Do you believe that they discuss these things?

Summary

29) Is there anything else you would like for us to know about the case management process and your role in it? Do you have suggestions for improving the process?

Nebraska Privatization Assessment
Ongoing Caseworker Interview

Name: Date:
County: Interviewer:

General

2) How long have you held your current position? How long have you worked for this agency? Has all of that time been in this position? (If the worker is an FPS with NFC, ask whether he/she worked for DHHS previously.)

3) Please describe what your position entails, including program, daily duties and responsibilities.

4) Do you have a mixed caseload? What proportion of your cases are in-home vs. foster care cases? What proportion of the in-home cases are wards? Has any of that changed much in the past year?

5) Please explain what factors (organization, resources, policy) help you to perform your work duties well. What barriers exist?

Contact with Children and Families

6) What is your caseload size at this time? Has it increased or decreased noticeably in the last year or so?

7) When you meet with a child, how much time do you usually spend with him or her? What kinds of things do you discuss with the child?

8) When you meet with parents, is there much difference in the amount of time you spend based on whether there is a child in out-of-home care? What difference is there in the topics you discuss?

Permanency and Well-Being

9) What are the largest challenges you face in regard to achieving permanency for children? Are there specific types of family issues that make achieving permanency more difficult?

10) Do you believe that children in foster care have adequate access to educational, physical and mental health services? If not, what barriers prevent access? What would improve their access?

Assessments and Plans

11) To what extent are families involved in assessment and planning? To what extent is the child involved? How important is it for parents and children to be involved in assessment and planning? What are the ways you have found most effective in gaining active participation?

12) What are the most typical needs families have that caused them to become involved in the child welfare system?

13) To what kinds of services do you most often refer families? Are they typically able to access those services? When they cannot access them, what are the reasons?

14) What is your process for accessing services which are under contract for your client families? Are these easier to access than other community services?

15) Are there specific providers you tend to use more often than others? If so, why?

16) Please describe your relationship with law enforcement, the judicial system and other professionals in the community. How often do you collaborate with these groups?

Court Hearings

17) How involved are your families in the court reviews/hearings? How important is it for them to be involved?

18) What percentage of your time is spent in court or preparing for court hearings?

19) Do you find that the court generally follows your recommendations?

Out-of-home Placements

20) When a child is placed in foster care, what is the process for identifying an appropriate placement? Is that working well, i.e., are the placements stable?

21) What should you ideally discuss with the child before or after they have a placement change? Are you generally able to discuss these things with the child?

22) Are you aware of the performance measures DHHS has established, such as, reducing multiple placements? If so, how do you learn about these? What impact do these measures have on your practice, if any?

23) Do you have to use more than one data system in your work? If so, how does that affect what you do?

Summary

24) Is there anything else you would like for us to know about the case management process and your role in it? Do you have suggestions for improving the process?

Nebraska Privatization Assessment
Initial Assessment Staff Interview

Name:	Date:
County:	Interviewer:

General

1) How long have you held your current position? How long have you worked for DHHS? Has all of that time been in this position?

2) Please describe what your position entails, including program, daily duties and responsibilities.

Investigations

3) When you become involved in the removal of a child from his or her home, is that likely to be upon the first contact after a report is received, or is it likely to be later? Can you describe a typical situation?

4) At what point, if any, during the removal process do you (or someone else) involve the ongoing/NFC worker? Can you describe that process for me?

5) How much interaction do you have with the ongoing worker at this point? (*Be sure to distinguish between the DHHS/NFC worker and any other agency worker who might be involved. We are only talking about the case manager, i.e., the DHHS/NFC worker.*)

6) When a child is not removed from the home after you receive a report (or at least not removed immediately), how often do you open a case for services prior to completion of the investigation? When that happens, is an ongoing/NFC worker involved? Can you describe that process for me?

7) What criteria do you use to decide whether to open a case prior to the end of the investigation? Do you use the SDM assessment? How?

8) In these circumstances, how likely are you to seek court involvement in the case? What are the criteria for deciding that?

9) When you open a case prior to the end of the investigation, how are responsibilities divided between you and the ongoing/NFC worker? How often are the two of you likely to communicate about those cases?

Post-investigation Transfers

10) Assuming the investigation has been completed and not already been opened for service, what criteria do you use to decide whether the case should be opened and transferred to ongoing? How is that decision affected by the SDM assessment?

11) How do you decide whether to obtain court involvement in this kind of case? What are the criteria? Do those criteria relate in any way to the results of the SDM assessment?

12) Can you describe the transfer process? For instance, is there a face-to-face meeting between you and the ongoing/NFC worker? Does the client family attend? What documentation is shared?

13) How soon after the end of the investigation is this transfer process likely to take?

14) Do you experience difficulties in making the transfer to ongoing/NFC very frequently? If so, what kind?

15) If a child has been removed from his or her home, is there a formal process of any kind when you finish the investigation and the ongoing/NFC worker has sole responsibility for the case? Can you describe that?

16) *For those who have been investigators and experienced both privatization and DHHS responsibility for case management:* Have you experienced any differences in relation to your own work when DHHS has case management responsibility and when a private agency does? If so, how would you describe those differences?

17) Overall, how would you describe your relationship with the ongoing/NFC workers and units with whom you work?

18) Is there anything else we should know about case management and its relationship with the work you do?

Nebraska Privatization Assessment
CFOM Interview

Name:	Date:
County:	Interviewer:

General

1) How long have you held your current position? How long have you worked for DHHS? Has all of that time been in this position?

2) Please describe what your position entails.

3) Please explain what factors (organization, resources, policy) help you to perform your work duties well. What barriers exist?

Case Monitoring

4) How many cases are you currently monitoring?
    a. Has that changed substantially in the last year or so? If so, how?

5) How many case decisions or recommendations do you usually review in a day?
    a. What types of decisions are those (e.g., placement changes, case closures, medical consent, etc.)?

6) In making your decisions, do you review specific documents?
    a. If so, what types (e.g., court reports, case plans, assessments, etc.)?
    b. Do you also routinely talk to the FPS making the recommendation?

7) What proportion of these recommendations do you approve without making any changes to them?
    a. What are the most common points of disagreement?
    b. How do you resolve those disagreements?
    c. How long does the process usually take?

8) Are you aware of the performance measures DHHS has established, such as, reducing multiple placements? If so, how do you learn about these? What impact do these measures have on your decisions, if any?

9) How would you characterize your relationship with the FPSs?
    a. What things make the relationship easy?
    b. What things make it difficult?

Assessments and Plans

10) When FPSs conduct a child assessment (as opposed to an investigation of maltreatment), what factors should they take into account? Do they take all of those factors into account?

11) When FPSs conduct a parent assessment, what factors should they take into account? Do they take all of those factors into account?

12) To what extent should families be involved in case planning? To what extent should the child be involved in case planning? Do the FPSs actually involve the families and children?

13) When FPSs create a service plan, to what extent should it contain specific details such as specific goals that should be met at specific time points or services provided by specific institutions? Do their service plans usually contain specific details?

14) Do they usually create service plans that can be accomplished within the given amount of time?

15) Do they actively revise service plans when they determine that they are not effective/appropriate?

16) Do the FPSs submit these revised service plans to you for approval? If yes, how often?

17) Does this revision process occur with or without the family? How important do you believe it is that the family be involved?

Service Provision

18) To what types are services are families typically referred?
    a. Are they able to receive those services?
    b. If no, why not?

19) Are there services families are often unable to access? Why are the families unable to access these services?

20) What strategies do you think would be successful in improving access to and utilization of services?

Court Hearings

21) How involved are families in the court reviews/hearings? How important do you believe it is to have the families present at the reviews and hearings?

22) Do you have any suggestions for increasing family participation?

23) How often do you go to court and what is your role?

24) Describe your relationship with local law enforcement, the judicial system and other community professionals.

Out-of-home Placements

25) Are you aware of how NFC identifies placements for children? If so, can you explain?
   a. Are there ways in which this process could be improved?
   b. What are the barriers to finding appropriate placements for children?

26) If you ever have to override placement decisions made by FPSs, what are the reasons you typically override the decision?

27) Do you believe that children whose cases are managed by NFC have adequate access to educational, physical and mental health services?
   c. If not, what barriers prevent access?
   d. Is there anything that either NFC or DHHS could do to improve their access?

Summary

28) Is there anything else you would like for us to know about the case management process and your role in it? Do you have suggestions for improving the process?