


Nebraska Health and Human Services

Common Sense Solutions for a Healthy Nebraska



A Report to Governor E. Benjamin Nelson and the Nebraska Legislature

December 1, 1996





December 1, 1996

Dear Governor Nelson and Members of the Nebraska Legislature:

We are pleased to present this report of the Nebraska Partnership for Health and Human Services, as required in LB 1044, the Nebraska Partnership Act. This report represents many months of effort by people who are committed to designing a unified Health and Human Services System for Nebraska. Already, the Nebraska Partnership has drawn national attention for its broad scope, participative design, and accelerated timeframe. The result is a system that will provide better services, be simple and efficient, be based on common sense, realize cost savings, and be accountable for achieving results.

We would like to take this opportunity to thank the hundreds of community and citizen volunteers and state employees who have contributed their enormous talents and energy through their participation in this effort. Citizens who provided valuable input at public forums and meetings are to be commended for taking the time to be involved in this important process.

We would also like to thank Lt. Governor Kim Robak for her vision and leadership, during the past three years, as we have undertaken this reform effort. Likewise, we thank several of our peers for their dedication and foresight: Bob Lange, Director of the Department of Insurance; Mary Dean Harvey, former Director of the Nebraska Department of Social Services; Jessie Rasmussen, former Director of the Governor's Children and Family Policy Office and currently Deputy Director of the Nebraska Department of Social Services; and Jean Lovell, Director of the Governor's Policy Research Office.

We also wish to acknowledge the special contributions of Dale B. Johnson, our friend, colleague and director of the Department of Public Institutions, who passed away this year. Dale had a vision for the Partnership that helped guide us all. He was an inspiration to us and we dedicate this report to him.

In many respects, the work of change is just beginning. This report provides a powerful foundation for the future that will be enhanced as we implement the new Health and Human Services System through the months and years ahead. Thank you for allowing us to be part of this historic effort. We look forward to and anticipate the challenge of providing common sense solutions for a healthy Nebraska.

Sincerely,
Members of the Transition Policy Cabinet


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Jon R. Hill, Director
Office of Juvenile Services



Dedicated to the memory of

Dale B. Johnson

1948 to 1996

*A true public servant who was committed to ensuring
that fairness and quality be maintained for those we serve.*

*We thank him for his vision, inspiration, and leadership
in support of a new Nebraska Health & Human Services System.*



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Executive Summary

December 1, 1996

Nebraska Health and Human Services System: Common Sense Solutions for a Healthy Nebraska

On April 3, 1996, Governor E. Benjamin Nelson signed into law Legislative Bill 1044, the Nebraska Partnership for Health and Human Services Act. This landmark legislation is the most far-reaching government reorganization project ever undertaken in Nebraska. The effort began two years earlier when Lt. Governor Kim Robak and state agency directors set a course for health and human services reform.

Nebraska's effort has drawn national recognition for its broad scope, a participative design process that has involved hundreds of committed Nebraskans, and an accelerated time-frame. Throughout the process, the Nebraska Partnership has kept true to the guiding vision, mission, and set of ten principles and values that have served as a beacon.

Effective January 1, 1997, the Partnership Act sunsets five state agencies — the Departments of Social Services, Public Institutions, and Health, the Department on Aging, and the Office of Juvenile Services in the Department of Correctional Services — and creates a unified Health and Human Services System of three agencies that are consumer-driven, functionally organized, and results-based. The three new agencies are the Department of Health and Human Services, the Department of Health and Human Services Regulation and Licensure, and the Department of Health and Human Services Finance and Support. A Policy Cabinet, consisting of the three agency directors and a Policy Secretary, governs the new System. A public advisory body, the Partnership Council, will advise and assist the Policy Cabinet.

The comprehensive redesign work directed by the Partnership Act culminates in this December 1, 1996 report to the Governor and the Legislature. It includes accomplishments-to-date and sets forth a foundation for the System, including an implementation plan in three phases, a set of nineteen system outcomes and preliminary indicators, a new model for community/state relationships, a plan for maximizing prevention strategies, a performance accountability system linked to strategic planning, an integrated financial management plan that addresses streamlining and cost savings, a proposal for the sharing of confidential information within the System, and a coordinated legislative package. Changes in the way the state agencies work with each other, with citizens, and with communities are becoming reality and examples of successful activities are included in the body of the report.

Redesign and Participation

Participation and involvement lie at the heart of this comprehensive change. Hundreds of citizen volunteers and state employees contributed their enormous talents and energy to this plan. Work emerged around three major areas: restructuring the organization, re-engineering current work processes, and redesigning the System to include new concepts such as performance accountability and community/state partnerships.

Three Redesign Steering Committees, one for each of the three new agencies were created to guide this work. Each Redesign Steering Committee established Work Teams to focus on specific work products. Both the Redesign Steering



Committees and Work Teams engaged experts within and external to state government as members. Attention was paid to integrate the work across the three Redesign Steering Committees and to view their work in the context of a unified System. The results of this work is available in report form.

While this intense work was progressing, a parallel process of broad-based participation was also being undertaken. Valuable information was received through a well planned "dialogue" process taken to communities and state employees across the state; input was solicited from boards, commissions, and associations related to the five sunseting agencies; and a monthly newsletter with periodic surveys was mailed to over 14,000 individuals. Most importantly, this input and feedback was carefully documented and immediately given to the Redesign Steering Committees and Work Teams for their consideration and further action.

The accomplishments of the Nebraska Partnership's redesign and participation phase have set the state firmly on the road toward implementation of a clear and consistent vision for a new Health and Human Services System. The implementation has three phases: an Implementation/Transition Planning Phase (September 1996 - December 1996); an Implementation Initiation Phase (January 1997 - June 1997); and an Implementation Completion Phase (July 1997 - July 1999).

Operating as a System

The Nebraska Health and Human Services System (the three new agencies, the Policy Cabinet, and advisory Partnership Council) are responsible to ensure that the three key elements in the system change model are realized: that policy is driven by outcomes, that work processes are designed to better achieve outcomes, and that community/state partnerships are working to help achieve outcomes.

The System will be supported through the creation of "crosscutting" teams to manage key functions across the three agencies. Five initial crosscutting teams will begin early in 1997. Health Policy, Safety Policy, and Self-Sufficiency Policy crosscutting teams will manage policy development and policy steering related to the new System outcome areas. A Strategic Planning crosscutting team will develop the System's plan for achieving outcomes through strategy development, priority-setting, and the alignment of System resources. A Community/State Partnerships crosscutting team will ensure that the new outcome-based relationships between the state and communities are fully developed and adequately supported.

Accountable for Outcomes

Under a new performance accountability system, the Nebraska Health and Human Services System will be focused on achieving a set of statewide outcomes that will be measured through a set of corresponding indicators. The state's new partnership with communities will create a way to collaboratively identify and achieve outcomes of mutual interest.

Nineteen System level outcomes are clustered in four broad categories: Nebraska residents are safe, Nebraska residents are healthy, Nebraska residents are self-sufficient, and Nebraska residents have opportunities for maximum participation.

The performance accountability system provides a framework for measuring performance of strategies, services, or programs — not merely the processes or workloads — to determine efficiency, quality, and effectiveness. The assessment will provide input to the System's strategic planning and budgeting processes.

The performance accountability system and analysis process will generate infor-

mation so policymakers, community governance authorities, program managers, service recipients, and others can continuously evaluate and improve the Health and Human Services System.

Partnerships with Communities

A new partnership relationship between the state and communities, including public and private sectors, is an important element to realizing a unified Health and Human Services System.

Communities have expressed the desire to be more involved in prioritizing their own needs and a willingness to accept greater responsibility for achieving outcomes. As a partner with communities, the state is willing to support the development of local service networks to organize services and funding in a more integrated way at the local level.

Through a new partnership relationship and formal agreement between the state and communities, their combined resources can be applied to achieving agreed upon outcomes. Accountability for achieving measurable results and fiscal accountability for public funds is shared. Local governance entities will take time to mature. The state maintains its responsibility to make sure that federal and state resources are expended appropriately and that eligible populations are served.

To test the process of forging partnership agreements through negotiations with communities, the state is working with three "learning lab" communities. Each had previously brought together local interests around health and human services issues. The three communities, which provide diverse experiences, include the Omaha metropolitan area, the eleven counties of the Panhandle in western Nebraska, and South Sioux City/Dakota County in northeast Nebraska. Additional communities will have the opportunity to become involved as state resources, focused on community support, are consolidated in the new Services agency.

Department of Health and Human Services

The Services agency is organized around outcomes to be achieved and aligns intervention, prevention, and community support focuses. Work is structured so that decisions can be made as closely as possible to where the work is done.

The work of the Services agency falls into four areas:

- *Individual and Community Services* focuses on intervention services, with work organized around a Veterans' Homes division and four outcome groupings. The outcome groupings are: Maximizing Independence and Long Term Care, Self-Sufficiency and Economic Assistance, Protection and Safety, and Health and Well Being.
- *Preventive Health and Public Wellness* takes a preventive approach, with work organized around three population-based outcome groupings: Healthy Populations, Population Safety, and Population Self-Sufficiency.
- *Community Support and Service Management Areas* is responsible for the local delivery of services statewide, provision of technical assistance and support to communities, and building community/state partnerships.

- *Administration* provides management support and an organizational "home" for key support functions within the Services agency.

Historically, the four Partnership agencies have operated separately, often causing a confusing maze of services for clients. The new alignment of services into one agency has highlighted the need for a single definition and model for services coordination. The new Service Coordination model unifies multiple community access points for entering the System, emphasizes a client locus rather than a program-centered approach, and proposes that most clients have only one service coordinator who can assess their strengths and needs and help identify gaps or barriers in service delivery.

No area has more potential than prevention to profoundly affect the benefits that result from the new Health and Human Services System. Effective prevention programs contribute to cost savings as a result of reduced demand for services, contribute to earlier and more appropriate use of services, and maximize the health of all Nebraskans. Prevention will have a clear and visible presence in the new Services agency.

In order to attend to immediate issues surrounding youth services, the Nebraska Partnership for Health and Human Services has made possible an early merger of staff from the Office of Juvenile Services and the Department of Social Services' Child Welfare unit to become part of the Services agency. This represents a first step in eliminating a fragmented services system for children, youth, and families in Nebraska. A structured planning process is in place to address issues such as critical policy and practice issues, organizational management, resource development strategies, and development of appropriate supports.

Department of Regulation and Licensure

The Regulation and Licensure agency is responsible for evaluation, certification and licensure, regulatory, technical assistance, and performance accountability activities. The agency is organized around five divisions:

- *The Performance Accountability Management Division* is responsible for recommendations on outcomes and indicators; how data is organized, interpreted, and communicated; and how standards are identified and reports are drafted.
- *The Regulatory Analysis/Integration Division* manages and analyzes the system-wide rules and regulations process and identifies streamlining opportunities.
- *The Credentialing Division* determines initial and continuing eligibility for licensure, certification, approval, etc., of health and human services facilities, practitioners, and programs.
- *The Investigations Division* sets standards for investigation and enforcement activities to ensure compliance with federal and state law, provides oversight and consistency to avoid duplication, provides for quality assurance, and conducts investigations.
- *The Public Health Assessment Division* conducts core public health assessment activities regarding health and environment, and designs and implements public health interventions.

Regulation and Licensure facilitators will assist citizens in accessing regulation and licensure services.

Partnership activities can point to early accomplishments. Study areas include Emergency Medical Services; Unlicensed Assistive Personnel; Credentialing of Providers, Programs, and Facilities; Inspecting Programs and Facilities; and Re-engineering the Process for Credentialing. Each study resulted in specific recommendations to improve services to Nebraskans.

Department of Finance and Support

The Finance & Support agency is responsible for aligning human resources, financial resources, and information needs for the Nebraska Health and Human Services System that efficiently allow for flexibility, information flow, quality services, and accountability. Through consolidation in one agency, the current resources can be more strategically managed to ensure consistency throughout the new System. The activities are grouped into eight divisions:

- *The Human Resources Division* includes employee recruitment and selection, labor relations, classification and compensation, affirmative action, supervisory support, human resource analysis and planning, and payroll processing.
- *The Staff and Partnership Development Division* includes organizational development, employee training, career development, and technical assistance.
- *The Financial Services Division* includes accounting, budget administration, claims processing, audit activities, and revenue collection.
- *The Computer Systems and Technology Division* includes applications development and maintenance, data processing operations, project management, and planning and analysis.
- *The Public Information Division* includes public information and outreach, media relations, public education resources, social marketing message development, and legislative liaison activities.
- *The Support Services Division* includes records management, vital statistics, material management, facilities and engineering, administrative support services, and investigations.
- *The Medicaid Division* is the designated Title XIX (Medicaid) agency responsible for provider enrollment activities.
- *The Strategic and Financial Planning Division* includes policy analysis support, strategic planning, resource alignment, research, and data analysis and utilization.

Contracting and granting procedures is a key area in which the current five agencies differ. There is a need for a consistent and streamlined process and contracting period across the System. Central to the vision of the Partnership will be a new focus on contracts and grants management. Partnership accomplishments include recommendations to improve and standardize these processes and tie them to results-based performance.

Results-based budgeting is another area where Partnership planning has begun. The Partnership offers the opportunity for the Nebraska Health and

Human Services System to be a leader in the development of a new relationship between policy-related outcomes and a budget process based on results. Both administrative and legislative policymakers and personnel will need to agree on the concepts pursued.

In determining how quality legal services can best be provided to support the new System, core expectations were balanced with responsible professional practice. Based on the nature of the attorney-client relationship, in the context of agency representation, it was decided that a core legal support for the Policy Cabinet will reside in Finance and Support, and that a legal services function will reside within each of the three new agencies.

A System Advocate will be located in the Finance & Support agency and will report to the Policy Secretary. The System Advocate will respond to issues specifically related to the transition of the five agencies to three, including questions, concerns, and complaints from consumers, service providers, elected officials, and interested citizens.

Integrated Financial Plan

An integrated financial plan for the three new agencies is significant in realizing a unified Health and Human Services System. The financial plan for the 1997-1999 biennium consolidates the budgets for the five Partnership agencies into a System budget based on the distribution of functions across the three new agencies.

This integrated financial plan responsibly addresses the Legislature's directive in the Partnership Act to reduce operating costs. This is done through cost savings, cost containment, and cost management strategies. The request for agency operations funding reflects a decrease of 4.5% over current year funding levels for the same operations. Additional cost reductions are likely to be identified beyond the proposals already included in the 1997-1999 Budget Request.

An important focus of the Partnership has been the development of strategies to constrain the rising costs of Medicaid, a joint federal-state program which pays medical bills for certain low-income people. Within the financial plan, Medicaid expenditures are projected to increase 6% annually, substantially less than the double-digit rise experienced over the last decade. Re-engineering efforts currently underway should help to achieve the savings in Medicaid, including the Senior Care Option Program, the Managed Care Long Term Care Project, the Behavioral Health Partnership, and the statewide implementation of Medicaid managed care.

Staffing changes will naturally result from activities such as restructuring and streamlining efforts, service coordination, and reducing temporary employees and consultants. These changes take into account that the majority of staff in the Health and Human Services System provide direct care or service coordination; fewer than 6% serve in administrative, professional, or managerial positions. The financial plan recognizes a reduction of 400 authorized positions to be accomplished over the course of the 1997-1999 biennium, for a savings of \$22.9 million. As agreed in the Letter of Understanding between labor and management, the reduction will occur first through attrition, reassignment, and retraining, prior to consideration of a reduction in force.

An integrated financial plan will enable the new Health and Human Services System to better manage the fiscal impact of new federal and state require-

ments such as in the area of welfare reform. The impact of recent federal welfare reform changes on the System budget must be more fully analyzed.

Information Management

Services provided by the Health and Human Services System are dependent on several major computer systems. The information systems of the five Partnership agencies are widely diverse and must be integrated in order to manage information across programs and functions. The five Partnership agencies collaborated on an Information Technology Plan for the 1997-1999 Biennium and will work with the Department of Administrative Services to develop a priority plan for the System's information and technology management.

The redesign of the Health and Human Services System presented a unique challenge with respect to balancing the exchange of information between the three agencies with protecting the privacy of individuals served by the System. Appropriate use of confidential information will be part of the Finance and Support agency's internal audit procedures. Legislation is proposed to allow agencies to develop policies regarding confidential information within prescribed guidelines.

Employees and the Transition

Managing the human resources of the new System more effectively and efficiently is a high priority. Short term activities, such as an integrated internal posting of vacant positions, and long term activities, such as developing a human resources system that standardizes and compresses job classifications and considers a corresponding compensation plan, are underway. Opportunities for compressing levels of management and increasing training opportunities are being explored.

A Transition Management Plan has been developed to incorporate the human side of the transition as employees move into their roles in the new Health and Human Services System. Services are being put in place to help employees deal with the uncertainties inherent in reorganization. The new workplace culture needed for successful System operations will also be defined and implemented.

Conclusion

Participation, involvement, and communication continue to be integral to the Partnership transition and implementation. Activities to communicate the efforts, benefits, and value of a unified Health and Human Services System will continue throughout the implementation process.

The Nebraska Partnership's approach will result in a Health and Human Services System that provides better services for Nebraskans, is simple and efficient, is based on common sense, realizes cost savings, and is accountable to Nebraskans. It is based on common sense solutions for a healthy Nebraska.

The realization of this unified system will not occur overnight. New competencies must be built at both the state and community levels. Alignment of human resources, financial systems, and information systems will take time to develop. Even the most ambitious and well thought-out plans will take time to implement in a thoughtful and meaningful way. The work done to date is a significant milestone along the continuum of system change that will be ongoing for many years.

IMPLEMENTATION REPORT OF THE NEBRASKA PARTNERSHIP FOR HEALTH & HUMAN SERVICES

December 1, 1996

I. Introduction

On April 3, 1996, Governor E. Benjamin Nelson signed into law Legislative Bill 1044, the Nebraska Partnership for Health and Human Services Act ("Partnership Act"). For two years prior, Lieutenant Governor Kim Robak worked with five state agency directors on how to better coordinate health and human services statewide. As a result of the combined efforts of the Lieutenant Governor, the agency directors, state employees, service providers, consumers, advocates, business representatives, educators, health care professionals, and community representatives, the most far-reaching government reorganization project ever undertaken in Nebraska began. Effective January 1, 1997, the Partnership Act sunsets five state agencies — the Departments of Social Services, Public Institutions, and Health, the Department on Aging, and the Office of Juvenile Services in the Department of Correctional Services — and creates a new Health and Human Services System.



This new System will consist of three agencies — the Department of Health and Human Services ("Services"), the Department of Health and Human Services Regulation and Licensure ("Regulation & Licensure"), and the Department of Health and Human Services Finance and Support ("Finance & Support") — governed by a Policy Cabinet consisting of the directors of the three new agencies and a Policy Secretary. The Policy Secretary chairs the Cabinet as well as a new public advisory body known as the Partnership Council.

This landmark legislation set the State of Nebraska on a course of reforming the state's health and human services agencies into a "unified" system to better meet the needs of its citizens. The Legislature put into place a skeletal framework for the new system, and asked the agency directors to involve the public, as well as agency employees, in a comprehensive redesign process, culminating in a report to the Governor and the Legislature by December 1, 1996. The Nebraska Partnership for Health and Human Services ("Nebraska Partnership") has drawn national attention for its broad scope, participative design, and accelerated time-frame.

Accomplishments and Collaborations

This report sets forth the Nebraska Partnership's significant accomplishments during its eight month redesign and participation phase, involving hundreds of citizens across the state. These accomplishments address all the areas required

by the Partnership Act. The Legislature asked that the December 1 report include, but not be limited to, the following:

- (1) *"A transition plan describing in detail the actions, methods, steps, and timelines necessary to implement redesign of the agencies by January 1, 1997, and the format of the structure, including who shall have access to confidential information at each level, the procedures, accounting mechanisms, funding streams, public accessibility of services by geographic area, and lines of authority that will exist during each phase of the transition....;"*

ACCOMPLISHED: Five agencies restructured into three, a new Health and Human Services governance structure organized to become effective on January 1, 1997, and an implementation plan in three phases designed to ensure a smooth transition;

- (2) *"A set of outcomes desired to form the basis for accountability of the health and human services system at state and community levels;"*

ACCOMPLISHED: A set of nineteen outcomes and a preliminary list of corresponding indicators developed to focus the new Health and Human Services System on achieving measurable results for Nebraska's citizens;

- (3) *"A plan for support of local service networks that will foster determination of community services consistent with the identified outcomes;"*

ACCOMPLISHED: A new model for community/state partnerships, three "learning lab" communities testing the model, and recommendations for broader implementation of a new way of partnering with communities to provide health and human services to Nebraskans;

- (4) *"A long-term plan for developing effective preventive strategies that reduce the need for more intensive intervention services;"*

ACCOMPLISHED: A plan for maximizing the use of prevention strategies to improve health and human services outcomes in the new system;

- (5) *"A plan for evaluating the health and human services system performance to be used for annual reports to the Governor and the Legislature;"*

ACCOMPLISHED: A performance accountability system linked to strategic planning and other management processes, recommendations for start-up and future reporting, and a preliminary status report issued;

- (6) *"A plan to reduce operation costs as a result of combining the agencies involved;"*

ACCOMPLISHED: An integrated health and human services financial management plan that addresses cost savings and strategies for slowing the growth in public expenditures, including the streamlining of government work

processes, a reduction in authorized positions over the course of thirty months, and consideration given to privatization;

- (7) *"Coordination and exchange among the departments of financial and programmatic information, including, but not limited to, medical records, client records, vital records, and other documents or data otherwise confidential; and"*

ACCOMPLISHED: A plan for the exchange of necessary information across the new departments that respects the need for privacy and confidentiality.

- (8) *"All legislation, in draft form, necessary to grant authority to implement the recommendations, plans, and changes in existing programs, policies, and funding streams."*

ACCOMPLISHED: A coordinated legislative package reflecting the changes needed to ensure a smooth transition to a single unified system.

Changes Are Happening

The work of the Nebraska Partnership has been likened to "changing the tires on a car moving 70 miles per hour." The work of the agencies has not stopped while the work of redesign has progressed. In fact, changes consistent with the principles of the Nebraska Partnership are already in evidence. Some initiatives were in progress when the Nebraska Partnership began and have moved ahead with strong support from the Partnership. Many demonstrate the service benefits and cost savings that can result from the agencies working together. Examples include:

- Collaboration between the Department of Social Services' Child Welfare Division and the Office of Juvenile Services has resulted in integration of *community-based services for juveniles and their families*;
- *Preadmission screening for nursing home clients* has been jointly implemented by the Departments on Aging and of Social Services, resulting in a more user-friendly system for clients and savings for Nebraska taxpayers.
- Staff from the Departments of *Health, Public Institutions, Social Services, and the Department on Aging* are collaborating on a *joint study of long-term managed care* issues with the goals of containment of Medicaid costs and improved access to appropriate, quality services;
- A *redesign of the state's behavioral health programs* to incorporate managed care principles and prevention strategies is underway involving the Departments of Public Institutions, Social Services, and Health;
- The piloting of the state's successful *welfare reform* initiative, Employment First, is moving to statewide implementation; and
- The functions of the *Governor's Children and Family Policy Office*

have been integrated into the five Partnership agencies and policy direction in these areas will be assumed by the Policy Cabinet.

Why Reform Now

Nebraska's initiative to reform its Health and Human Services System is a bold response to an increasingly dynamic set of political and economic realities. The current system of service delivery must change in order to be prepared to face the challenges of the next century. The reduction of entitlements in federal funding, a growing need for services, the public's demand for efficiency in the use of taxpayer dollars, and consumer difficulty in accessing and coordinating services, all convinced Nebraska's policymakers that strong actions needed to be taken.



Transition Plans

Preparation for the January 1, 1997 implementation of the new agency structures have been underway for several months, using teams comprised of appropriate staff from all five sunseting agencies. Key areas of focus in this pre-transition planning have been:

- Ensuring that employees have *access to information* about the Nebraska Health and Human Services System — what it is, why it is being done, how it will affect them, who they can go to for information, and what they can expect in terms of support during the transition;
- Addressing *critical human resource areas*, such as classification, payroll and record keeping, performance evaluations, recruitment and selection, human resource management and policy, to ensure fairness and equity as employees in the five agencies transition to the new Health and Human Services System;
- Collecting *data on employee concerns* about the pending transition and making services available to assist them in dealing with the uncertainties and stresses attendant to the change process;
- Preparing an *integrated budget and information technology plan* for the new Health and Human Services System for the 1997-1999 biennium for submission to the Governor and the Legislature; and
- Preparing *amendments* to the Partnership Act that will complete the transfer of existing statutory responsibilities to the new agencies.

Throughout this process, hundreds of citizen volunteers and state employees are contributing their enormous talent and energy to develop Nebraska's plan. State employees of the five sunseting agencies, both those who served on Partnership

teams as well as those who did not, are to be commended for ensuring the day-to-day responsibilities of the five agencies are performed and agency services are not disrupted despite the additional requirements for participation in Nebraska Partnership activities. Frontline employee participation was facilitated by the Letter of Understanding that was entered into in January 1996, with the Nebraska Association of Public Employees/Association of Federal, State, County, and Municipal Employees (NAPE/AFSCME) labor union. Regular meetings were held to address issues of concern.

While this report represents an important threshold in Nebraska's reform work to date, in many respects, the work is just beginning.

Establishing a Common Vision

The Partnership Act set forth clear vision and mission statements that have guided and will continue to guide the work of the new Nebraska for Health and Human Services System. These statements have served as beacons, illuminating the work of those who set out to create the best possible system for Nebraska during the redesign and participation process.

The Vision of the Nebraska Partnership for Health and Human Services:

"Each Nebraskan will have a quality of life that reflects safety, self-sufficiency, respect, health and well-being, and opportunities for maximum participation through new partnerships between the state and local communities."

The Mission of the Nebraska Partnership for Health and Human Services:

"To create and sustain a unified, accessible, accountable, caring, and competent health and human services system for each Nebraskan that maximizes local determination to achieve measurable outcomes. To this end, the state will work in partnership with communities and their public and private sector entities."

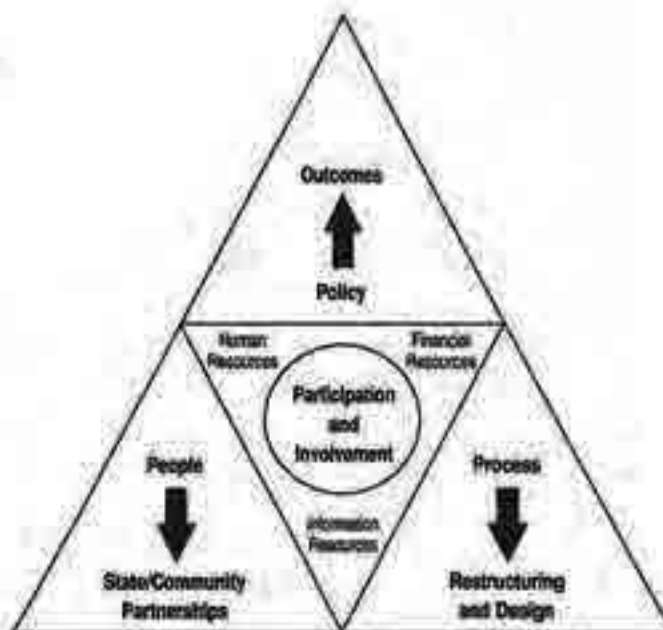
From the outset, the Nebraska Partnership has been consistently grounded in a set of ten principles and values that serve to describe how the new system will look. The system will be:

- *Preventive* by making wise investments in strategies that promote safety and well-being;
- *Integrated* to assure that supports and services are coordinated, understandable, and efficient;
- *Comprehensive and balanced* in its responsiveness to a range of needs from wellness to crisis;
- *Family-centered* and caring by building on the strengths of family relationships as a context for services;
- *Community-based* by forging community/state partnerships that encourage flexible service delivery while assuring high levels of accountability;
- *Accessible* in the form of information and services available to Nebraskans locally, financially, culturally, and conveniently;
- *Outcome-based* to assure that measurable results are achieved and reported by a well-informed management system;
- *Fiscally-sound* by ensuring that financial and human resources are sufficiently invested and responsibly managed to assure progress on the outcomes in a unified and efficient system of care;

- *Protective* of vulnerable individuals and families as needed to assure their well-being and safety; and
- *Strength-based* using the assets of individuals, families, and communities as the basis for service.

Undertaking Fundamental Systems Change

To create the health and human services system described above, the Nebraska Partnership has been about much more than reconfiguring five state agencies into three, although that work alone would have been substantial. The job of restructuring five agencies, currently organized by programs and driven by segregated funding streams, into a unified system of three agencies that are consumer-driven, functionally organized, and outcome-based, governed by a Cabinet structure, is about fundamental systems change. Indeed, it is about a major shift in the way state government does business.



Three key elements define the Nebraska Partnership's approach to systems change:

- Policy will be driven by outcomes;
- The processes of government will be restructured and redesigned to be more efficient and more effective at producing improved outcomes; and
- New relationships will be forged between the state and communities to achieve mutually desired outcomes.

These three elements are the cornerstones of the redesign process undertaken by the Nebraska Partnership. They also serve to frame the Policy Cabinet's work as that new body assumes the responsibility of ensuring that the Nebraska Health and Human Services System operates in an integrated, effective, and efficient manner.

The new System must be supported by human, financial, and information resources that are realigned to create the appropriate incentives and needed supports. Finally,

participation and involvement lie at the heart of the system change model in order to ensure the System is meeting the needs of all Nebraskans.

In order to meet these challenges, Lieutenant Governor Kim Robak set forth five criteria for the Nebraska Partnership to meet as it went about its work of designing a comprehensive Health and Human Services System. They are:

- *Better services* must be provided for Nebraskans;
- Services must be *simple and efficient*;
- Services must be based on *common sense*, and understandable to someone coming into the system for the first time;
- The redesign must realize *cost savings*; and
- Nebraskans must know who is *accountable for achieving results*.
The public wants to get its dollar's worth, with increased decision-making at the local level.

Redesign and Participation Phase Completed

Once the Partnership Act was enacted, the Transition Policy Cabinet, made up of the directors of the five sunseting agencies, joined by the director of the Governor's Policy Research Office, embarked on an ambitious eight month redesign and participation process. In April 1996, the Transition Policy Cabinet created three Redesign Steering Committees, one corresponding to each of the three new agencies — Services, Regulation & Licensure, and Finance & Support. These three committees, comprised of representatives from across the state, both internal and external to state government, were primarily responsible for designing the operational framework for their agency that would function in relationship to the new Health and Human Services System. The Transition Policy Cabinet took responsibility for developing the operational design at the system level, including the new Policy Cabinet and Partnership Council.

At a kickoff meeting in late April 1996, the Redesign Steering Committees were charged with dividing their work into three major areas:

- *Restructuring* the organization — physically organizing the work of five agencies into three, with new organization charts as the work product;
- *Reengineering* work processes — analyzing how targeted work processes could be more effectively and efficiently performed, with recommendations for streamlining being the work product; and
- *Redesigning* the system — identifying how new design concepts such as performance accountability, community/state partnerships, and reinvestment strategies could become operational in the new system, with new system models as the work product.
See Appendix A for a glossary of terms.

To maintain a system-wide linkage, Cabinet members served as sponsors to the Redesign Steering Committees to reconnect the work of the Steering Committees to the Cabinet. Each Redesign Steering Committee sponsored Redesign Work Teams consisting of individuals, internal and external to state government, who had expertise in the particular area assigned to that work team. Certain areas of work were identified early on as needing an integrated approach across the three Redesign Steering Committees. Three Combination Work Teams, made up of representatives from all three Redesign Steering Committees, were created to address the crosscutting issues of restructuring, performance accountability, and community/state partnerships. A Partnership Integration Team made up of the

- Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has.

- Margaret Mead

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By January 1, 1997, Implementation/Transition Planning activities include:

- Initial proposed cost savings, due to a reduction in authorized positions over a thirty-month period, identified;
- The ongoing work of the five sunseting agencies will continue uninterrupted as the new structure is put into effect. Any changes in policy and procedure will be specifically communicated;
- Current five agencies are sunsetted and the new system, with its Policy Cabinet, Partnership Council, and three new agencies, officially comes into existence;
- Policy Cabinet and Partnership Council appointments submitted for legislative approval and other key leadership positions appointed and/or filled;
- Coordinated legislative package drafted and submitted to the Unicameral on behalf of the new Health and Human Services System;
- Integrated budget and information technology plan submitted to the Governor and the Legislature for the 1997-1999 biennium;
- Employees in the Partnership agencies notified of their new agency assignments and provided with all relevant personnel-related information;
- A "System Advocate" and a toll-free number in place to facilitate questions, concerns, and complaints about the new system;
- Initial Cabinet-sponsored crosscutting teams created;
- Partnership agreements negotiated with three community/state "learning labs"; and
- Discussion begun for state service management areas and operations pending results of public input.

By June 30, 1997, at the end of the Implementation Initiation Phase, the following milestones will be achieved:

- 1997 legislation passed to ensure the smooth implementation of the new System and appointments confirmed;
- Implementation of initial redesign recommendations (streamlining, service coordination, etc.) underway;
- Training designed to orient employees to the new System design, operations, and culture change underway;
- Opportunities expanded for communities to enter into partnership agreements with the state;
- Capacity-building needs of communities assessed and technical assistance strategies developed;
- System-level outcomes and preliminary indicators validated with the Legislature and through a public process;
- Plans for the creation of the data collection and analysis capability to support outcome evaluation at the state and/or local level begun;
- Additional reengineering of work processes initiated;
- Organizational structure and lines of authority to the work unit level established;
- Human resource policies and procedures fully integrated;
- State service management areas aligned based upon local input;
- First integrated strategic plan for the new Health and Human Services System initiated; and
- Initial reduction of authorized positions realized.

By June 30, 1999, the end of the biennium, the Implementation Completion Phase will see the following:

- Cost savings fully realized from implementation of restructuring and redesign recommendations;
- Interim report to the Legislature on implementation and cost savings submitted;
- New state classification system piloted in Nebraska Health and Human Services System;
- Reports to the Governor and Legislature on the status of health and human services indicators issued annually;
- Aligning funding streams around outcomes (results-based budgeting) piloted in collaboration with the Legislature;
- Community/state partnership agreements in place across the state, and an increasing number of communities with the capability to manage resources systemically and be held accountable for outcomes. Some communities realizing savings which may be reinvested into preventive strategies;
- State local service management in the field is effectively supporting communities with technical assistance and accessible services;

II. Operating As a Unified Health and Human Services System

Organizing Around Functions

The Departments of Social Services, Health, and Public Institutions, the Department on Aging, and the Office of Juvenile Services currently employ approximately 6,000 people and oversee a combined budget of approximately \$1.4 billion. In sheer size, they consist of approximately one-half of state government, excluding the college and university system. These agencies were not created as a unified system and, consequently, have not operated as one. They evolved as a series of independent programs added to agencies by Congress and the State Legislature over time.

Collectively, their work impacts the lives of virtually every Nebraskan. These agencies administer health and human services programs as diverse as Medicaid managed care, child support enforcement, child care, foster care, child and adult protective services, juvenile justice services, nursing home inspections and licensing, community-based services for the elderly, food stamps, welfare reform, drinking water safety, maternal and child health, developmental disabilities, assistance to the visually impaired, and mental health and substance abuse. These agencies are also responsible for state-operated facilities such as the veterans homes, regional centers for behavioral health and developmentally disabled, and youth rehabilitation and treatment centers.

On January 1, 1997, the current five agencies will be replaced by a Policy Cabinet and three new agencies that are functionally based. Each new agency's functions are focused on a unique perspective of the total system. The Services agency will be responsible for the quality of state-delivered and state-supported services in ways that matter to Nebraskans. The Regulation & Licensure agency will be responsible for protection and quality assurance achieved through regulation and licensure of service providers, as well as system evaluation. The Finance & Support agency will be responsible for the quality of human, financial, and information resources and administrative

"Services to children and families need to merge. It isn't really a matter of overlaps or gaps, but rather of joining to be a total system."

- State employee

services provided to support the work of the three agencies, ensuring the efficient operation of the System as a whole.

The decision to structure the three new agencies around functional expertise (as opposed to around outcomes or identifiable populations) was roundly debated and continues to be controversial. It was the best judgment of the agencies and the Legislature that System effectiveness, efficiency, and quality would be best served by consolidating similar functions across the five agencies into three agencies as one System. Additional refinements and adjustments may be needed as experience with the new System is gained.

Governance of the New Health and Human Services System

The three agencies of the System will be governed by a newly created Policy Cabinet, chaired by a Policy Secretary. The Policy Cabinet is made up of the directors of the three new agencies and the Policy Secretary. A public advisory body known as the Partnership Council will be created to advise the Policy Cabinet. The Policy Secretary will also chair the Partnership Council. The new Nebraska Health and Human Services System is depicted in the chart on page 12:

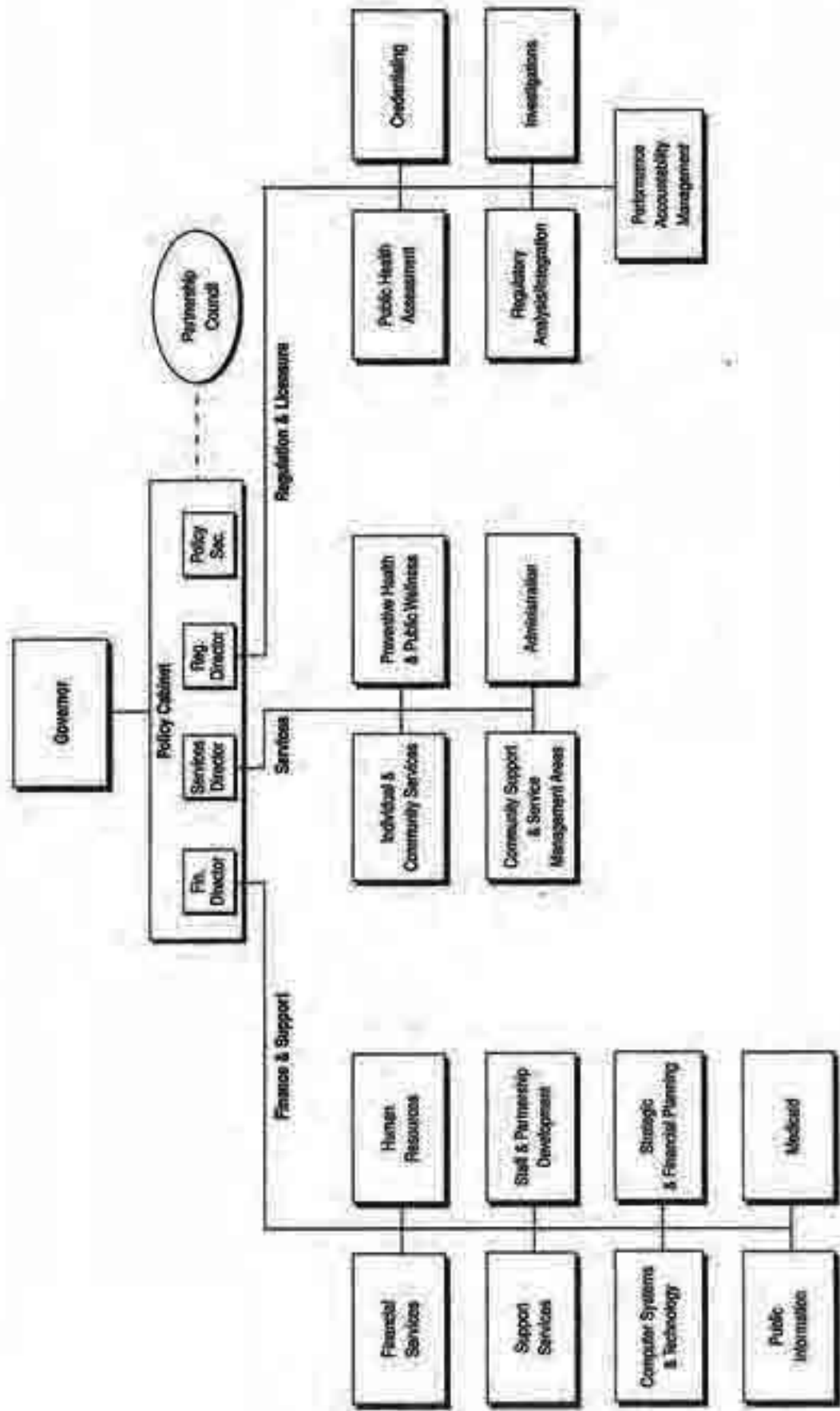
The Policy Secretary and the Policy Cabinet

Primary responsibility for "steering" at the System level rests with the Policy Cabinet, comprised of the three new agency Directors and the Policy Secretary, all of whom are appointed by and serve at the pleasure of the Governor upon confirmation by the Legislature. As defined in the Partnership Act, the Policy Secretary's role is to:

- *"Encourage and direct initiatives and collaboration in the health and human services system;*
- *Facilitate joint planning initiatives in the health and human services system;*
- *Coordinate budget, research, and data collection efforts to insure effectiveness of the health and human services system;*
- *Ensure that the Appropriations Committee of the Legislature is provided any information the committee requires to make funding determinations and budget recommendations to the Legislature, including, but not limited to, specific program budgets, internal budget requests, fiscal reports, and appearances by department, division, program, and subprogram directors before the committee to present department, division, program, and subprogram budget requests; and*
- *Recommend to the Legislature and the Governor legislation he or she deems necessary or appropriate."*

The Policy Secretary is not the only member of the Policy Cabinet that maintains a System perspective. The agency directors wear two hats — one as the head of their respective agency, and the second as a leader of the integrated System. As a Policy Cabinet member, they must manage their agency fully cognizant that it operates as one of the three agencies that make up the complete System. Since virtually every program involves functions that reside across the three new agencies, the directors have the responsibility for ensuring that their employees work in close collaboration with colleagues from the other two agencies in the normal course of their work.

Nebraska's Health and Human Services System



Under the Partnership Act, the Policy Cabinet has the responsibility:

"to achieve policy outcomes through development of policy objectives and strategic plans, to prepare and recommend budgets, to develop and establish consistent priorities and policies for allocation and distribution of resources, to establish procedures to promote and support collaborative community efforts or local service networks, to integrate the services of the departments, to evaluate that outcomes are achieved, and to make health and human services system improvements in accordance with the intent and purposes of the Nebraska Partnership for Health and Human Services Act."

These constitute a set of functions that must be carried out at the System level in order to ensure consistency and integration across the three new agencies.

System Level Functions and Crosscutting Teams

The responsibility is placed squarely on the Policy Cabinet to ensure that policy is driven by outcomes, that work processes are designed to better achieve outcomes, and that community/state partnerships are working to help achieve outcomes — the three key elements in the Nebraska Partnership's system-change model (see diagram on page 6).

Integrated Health and Human Services System



To ensure integration across the System, the Policy Cabinet will create "crosscutting teams" to manage key System level functions. Five initial crosscutting teams will start up early in January 1997:

- *Health Policy, Safety Policy, and Self-Sufficiency Policy* crosscutting teams will manage policy development and do the policy steering related to the new Health and Human Services System outcome areas.
- A *Strategic Planning* crosscutting team will develop the System's plan for the achievement of outcomes through strategy development, priority-setting, and the alignment of System resources.
- A *Community/State Partnerships* crosscutting team will be responsible for ensuring that these new relationships designed to better achieve outcomes are fully developed and adequately supported.

Each crosscutting team will report to the Policy Cabinet and will be linked operationally to the Cabinet through an agency director sponsor. Staff from the three agencies will support the Policy Cabinet in these System level functional areas. The Cabinet and crosscutting teams will also be supported by a new performance accountability system established in the Regulation & Licensure agency that will define, monitor, and evaluate outcomes to ensure System accountability.

Strategic Planning Crosscutting Team

One example of a crosscutting team is in the critical area of strategic planning. Strategic planning is a System level function that will support the Policy Cabinet in setting priorities for the System, providing policy direction for the System, and in aligning System resources with approval by the Governor. The result is a Health and Human Services Strategic Plan that addresses four basic questions: (1) What System outcomes are the priorities to be addressed? (2) What strategies will the System use to achieve these outcomes? (3) How will the agencies and various programs collaborate in carrying out those strategies? (4) How will the System resources be aligned in support of the strategies and collaborations? The Health and Human Services Strategic Plan becomes the context in which management, program, and operations planning will take place.

The Strategic Planning crosscutting team will have responsibility for oversight and coordination of the strategic planning process, as follows:

- Design and implement a Health and Human Services strategic planning process, in collaboration with the Policy Cabinet and the Governor's office, that provides for Partnership Council participation;
- Identify trends/issues that need to be addressed in the strategic planning process;
- Identify and oversee policy analysis and research needed to support the strategic planning process;
- Frame strategic planning decisions for the Policy Cabinet, including providing a context for understanding and decision-making.

- Oversee the development, publication, dissemination, and revision of the Nebraska Health and Human Services Strategic Plan; and
- Keep the Policy Cabinet informed on the alignment of System activities (policy development, planning, resource allocation, etc.) with the Nebraska Health and Human Services Strategic Plan.

The Partnership Council

The purpose of the Partnership Council is to advise and assist the Policy Cabinet in the development of policy objectives and desired outcomes. The Partnership Council will participate in the review and evaluation of the achievement of outcomes and shall make recommendations to the Policy Cabinet for Health and Human Services System improvements.



The Partnership Act specifically charges the Partnership Council with the following responsibilities:

- (1) *"Obtain community perspective and participation as appropriate by holding public hearings, forming ad hoc advisory groups, or using other methods;*
- (2) *Facilitate communication between broad-based community coalitions and the health and human services system;*
- (3) *Serve as a link to community and local service networks and the health and human services system; and*
- (4) *Perform such other specific duties as may be assigned by the Policy Cabinet."*

The Partnership Council will be established effective January 1, 1997. It will consist of not less than seven nor more than fifteen members who are all appointed by the Governor, with the consent of a majority of the Legislature. The Policy Secretary will serve as the chairperson of the Partnership Council. Based upon the important role that the Partnership Council will play in Nebraska's new Health and Human Services System, selection criteria should be established to seek out the most qualified candidates. The following selection criteria are recommended:

- Representative of Nebraska in terms of geography and demography;
- Persons with broad-based knowledge and expertise in health and human services with a systems perspective;
- Persons with expertise in local government affairs, provider issues, working with community groups, and/or advocacy concerns;
- Persons with capabilities specific to the Partnership Council roles and responsibilities, and ability to successfully meet required purposes; and
- Consumers of health and human services, including primary consumers and family members.

Boards and Commissions

The current five agencies have over seventy boards and commissions which perform many important functions. These include: providing professional expertise necessary to regulate health professions; providing advocacy, consumer, provider, community, and intergovernmental expertise to the health and human services system; providing direction and feedback to state health and human services agencies; providing communication to constituencies; making decisions on the allocation of funds; and executing responsibility for statutorily-mandated functions. By January 1, 1997, the current boards and commissions will be assigned to the three new agencies. Where boards have overlapping statutory or administrative obligations, they will be assigned to a lead agency, with additional secondary responsibility to another agency (or agencies).

Beginning in the summer of 1997, a participative process for reviewing the advisory needs of the new agencies will be initiated, calling for recommendations by the end of 1997. Boards which credential health professionals will not be included in this process because they will be reviewed as part of the larger redesign of credentialing under the auspices of the new Regulation & Licensure agency.

III. A System Accountable for Outcomes

Under a new performance accountability system, the Nebraska Health and Human Services System will be focused on the achievement of a set of statewide outcomes. Accountability will be based on measurement of a set of corresponding indicators. The efficiency, quality, and effectiveness of a service, program, or strategy at the state and/or local level will be assessed. This assessment will provide input to the System's strategic planning and budgeting processes. Community/state partnership agreements will create a means by which the state and communities can work collaboratively to achieve outcomes of mutual interest.

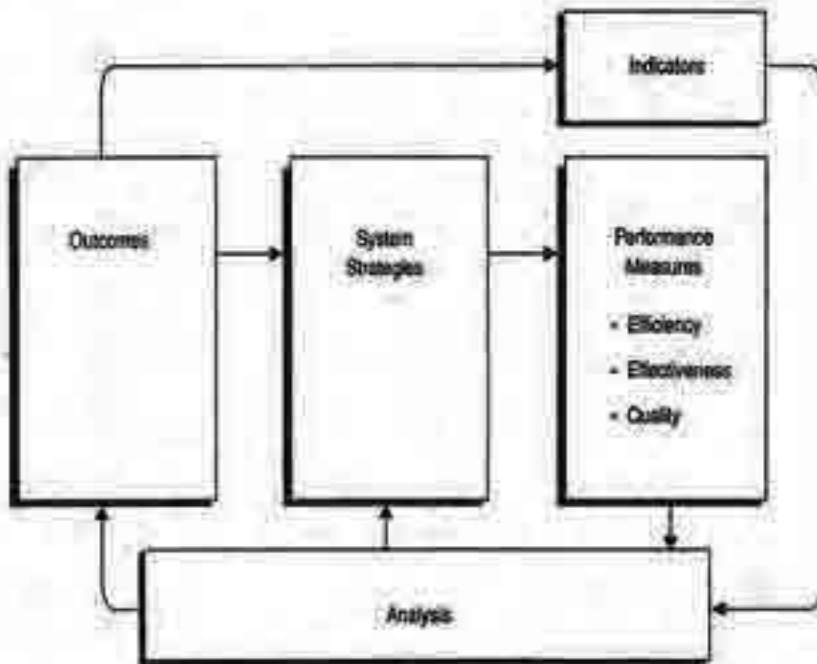
Actions/Recommendations:

To operationalize a new performance accountability system, the Health and Human Services System will:

- Establish a Division of Performance Accountability Management within the Department of Regulation & Licensure;
- Validate system-level outcomes and indicators;
- Create the capability within Finance & Support to collect data needed for outcome evaluation;
- Issue annual reports to the Governor, the Legislature, and the public on the status of health and human services outcomes and indicators in Nebraska;
- Develop and implement a process for outcome-based performance evaluations as part of the system's new performance management process;
- Assist in building capacity in communities around outcome accountability in preparation for entering into partnership agreements with the state; and
- Support outcome-based, crosscutting policy teams at the Cabinet level to utilize performance accountability data as the

basis for strategic planning and budgeting and resource allocation.

Performance Accountability System



Outcomes and Indicators

A set of clearly stated outcomes describing the desired well-being of Nebraskans are always the starting point for the performance accountability process. Nineteen System level outcomes have been developed in the following four broad categories or "clusters":

Nebraska residents are safe:

- Nebraska residents are free from unintentional injury.
- Nebraska residents are free from juvenile crime.
- Nebraska residents are free from abuse, neglect, and exploitation.
- Nebraska residents work in a safe environment.
- Nebraska residents do not experience death/disability/disease due to unsafe or unhealthy conditions from natural environments or those impacted by human intervention.

Nebraska residents are healthy:

- Nebraska residents are free from preventable disease.
- Nebraska residents are free from substance abuse.
- Nebraska residents choose healthy life-styles.
- Nebraska residents experience healthy pregnancies and births.
- Nebraska residents do not experience death/disability/disease related to lack of appropriate treatment.
- Nebraska residents are appropriately nourished.
- Nebraska residents are free of physical and psychosocial conditions which interfere with learning.

Nebraska residents are self-sufficient:

- Nebraska residents have the opportunity to work.
- Nebraska residents live as independently as possible.
- Nebraska's families are stable.
- Families and individuals have the resources needed to achieve self-sufficiency.
- Nebraska residents have adequate personal income (earned & unearned).

Nebraska residents have opportunities for maximum participation:

- Nebraska residents are treated with respect and dignity.
- Nebraska residents are able to participate in and contribute to the political, economic, and cultural life of the community.

A preliminary set of indicators has been developed for each System-level outcome. They are included in Appendix D. The indicators will be the means by which progress toward achieving the outcomes is measured.

Efficiency, Quality, and Effectiveness

The performance accountability system is designed to provide a framework for measuring the performance of strategies, services, or programs — not merely the processes or workloads. The measurement of performance will focus on three perspectives: efficiency, quality, and effectiveness. As with the other steps in the performance accountability system, development of performance measures will be done through a collaborative approach involving communities, service providers, and service recipients.



Continuous Analysis for Results

Key to the success of the performance accountability system is the process of analysis. System indicators focus the collection of information relevant to the system outcomes; performance measures collect information relevant to the performance of state and community services, and the system strategies as a whole. The analysis process will generate a variety of user-defined reports and organize information, so it can be used effectively by policymakers, community governance authorities, program managers, service recipients, and other key stakeholders to evaluate and support the continuous improvement of the Health and Human Services System.

IV. Working in Partnership With Communities

At Partnership community dialogue forums across the state, greater community self-determination and enhanced capacity to integrate service delivery at the local level ranked as high priorities. Communities expressed a desire to have a louder voice in prioritizing their own needs and a willingness to take greater responsibility for achieving meaningful outcomes with the resources they have. The state was cautioned, however, to avoid unfunded mandates and to ensure equity and fairness in the distribution of services.

• "Services which are comprehensive and collaborative need to be also coordinated with the public and private sectors."

- Omaha community forum

In its ongoing relationship with communities, the state has a responsibility to ensure that federal resources allocated to the state, as well as the state's own dollars, are expended in a manner that supports policy objectives set forth in law. Through a new partnership relationship between the state and communities, the combined resources of the state and communities, public and private, can be applied to achieving mutually desirable outcomes through integrated service delivery networks at the local level.

Actions/Recommendations:

- Establish an area for Community Support and Service Management Areas within the new Department of Health and Human Services with responsibility for providing technical assistance to communities;
- Continue working with three "learning lab" communities to implement partnership agreements;
- Expand partnership opportunities to additional communities across the state during 1997;
- Initiate capacity building to develop the competencies of state employees and communities for new partnership agreements.

A new partnership relationship between the state and communities is an important element to realizing a Health and Human Services System that is more accountable for achieving results that matter to Nebraska's citizens. A new community/state partnership is based on the parties entering into a "partnership agreement" to achieve mutually agreed upon outcomes based upon a new set of parameters. Those parameters are:

- *Accountability for outcomes*, as well as fiscal accountability;
- Organization of *local service delivery networks* that coordinate services through collaborative action to achieve outcomes;
- Capacity for *local governance* that agrees to be held accountable for achieving the agreed upon outcomes and organizing the local service delivery network;
- State's willingness to explore opportunities for approaching *funding streams* in new ways that leverage public and private dollars and create incentives for outcome achievement;

Accountability for Outcomes

The state will reach agreement with a partnership community on a set of outcomes they want to work together to achieve and a set of indicators by which achievement of those outcomes will be measured. Accountability for achieving measurable results is shared. Fiscal accountability will be ensured for any public funds made available pursuant to a community/state partnership agreement. A partnership agreement does not change the state's responsibility in ensuring eligible populations are served nor the communities' ongoing fiscal accountability for the funds with which they are entrusted.

Local Service Networks

As a partner with communities, the state will support "local service networks" to organize services in a more integrated way. The state recognizes that integration of services for purposes of improving outcomes, including the coordination of the public and private sectors, will be accomplished most effectively and efficiently at the local level. Under the new partnership, the state will work to support local service networks by removing those barriers

• "Rural communities need to have their needs met in their communities — services are often 50 to 100 miles away."

• North Platte community form

• "The state should stop planning local programs and initiatives — put some control back on local levels based on needs identified locally."

— *Norfolk community forum*

that may be standing in the way of improved integration. Unnecessary state rules and requirements that are tied to maintaining categorical funding streams will be addressed. To the extent barriers result from federal rules or requirements, the state will pursue federal waivers to facilitate achievement of the partnership outcomes.

Local Governance Entities

The state will enter into a partnership agreement with a "local governance entity" that assumes the fiscal and outcome responsibilities. Local governance is *not* synonymous with local government. On behalf of the community, local governance engages both the public and private sectors in taking responsibility for ensuring that available resources are used to maximum advantage for achieving desired outcomes.

Local governance entities will take time to mature. Because of the developmental nature of successful new governance, initial partnership agreements may include the community's plan to develop its local governance over time as it assumes responsibility for a growing set of partnership responsibilities.

While the composition of local governance entities will likely vary from community to community, there are certain minimum principles that local governance entities must reflect:

- The decision-making boards of local governance entities should not have providers or vendors in the majority;
- Public officials will have representation on such boards;
- Consumers and citizens will be represented on such boards;
- Boards will be culturally competent and reflective of the diversity within their communities.

Safeguards such as public notice, opportunity for public discussion, venues for resource/appeal, and conflict of interest rules will be required to ensure all community interests have an opportunity to participate in the local governance structure.

Flexibility and Creativity In Funding

The Health and Human Services System will work with communities to explore how funds might be clustered to enable savings, for example, reductions in out-of-home care, and be reinvested in prevention, such as family preservation and support activities. This clustering of funds approach was the basis for Iowa's "decategorization" program that has been successful in emerging new state/local partnerships. Savings from merger of services, economy of scale, or other service delivery improvements may also be a source of monies for reinvestment into preventive strategies.

Capacity Building

A key to the success of new community/state partnerships will be the building of capacity at both the state and local levels, particularly in the area of local governance and outcome evaluation. The new area of Community Support and Service Management Areas within the Services agency will be responsible for providing support to local communities and negotiating partnership agreements. They will be able to draw upon expertise from the other departments of the System for assistance.

Testing Partnership With Three Learning Lab Communities

The state is working with three "learning lab" communities to test the process of forging partnership agreements through negotiations. The three communities are the Omaha metropolitan area, the eleven counties of the Panhandle in western Nebraska, and South Sioux City/Dakota County in northeast Nebraska.

In mid-September 1996, representatives from the three communities were invited to participate in a workshop designed to simulate the partnership agreement negotiation process under compressed time conditions. Negotiations are proceeding with a goal of entering into signed partnership agreements with the three learning lab communities. Their early experiences have helped to inform the decisions reflected in this report. Additional communities will have the opportunity to enter into partnership agreements with the state in 1997 as state resources, focused on community support, are consolidated in the new Services agency.

V. Department of Health and Human Services

Organized To Achieve Outcomes

Mission

The mission of the Department of Health and Human Services is:

"To create and sustain a unified, accessible, caring, and competent health and human services system for each Nebraskan that maximizes local determination to achieve measurable outcomes. To this end, the state will work in partnership with communities and their public and private sector entities."

Functions

The functions and duties of the Services agency as defined in the Partnership Act are to:

"...manage all Health and Human Services programs, whether contracted or delivered directly by the state, with responsibility to:

- a. provide services in accordance with established policies, desired outcomes and goals;*
- b. identify strategies jointly with communities for accomplishing identified goals and outcomes;*
- c. deliver services directly or by contract or grant to achieve stated vision;*
- d. work in partnership with communities and other public and private sector entities to support current best practices, integrate services and functions when possible, and find solutions that emphasize responsibility and local determination;*
- e. promote the development of community partnerships to ensure needed services are available across Nebraska;*
- f. assure services coordination and access through public education and information, community resource development, technical assistance, and coordinated service management; and*
- g. develop a health and human services system focused on achieving outcomes based on needs of Nebraskans and accountable to Nebraskans."*

"Lack of communication and access to services is causing duplication."

- North Platte community forum

• "The gap often is not only in services, but in the lack of shared philosophy."

- State employee

Organizing Principles

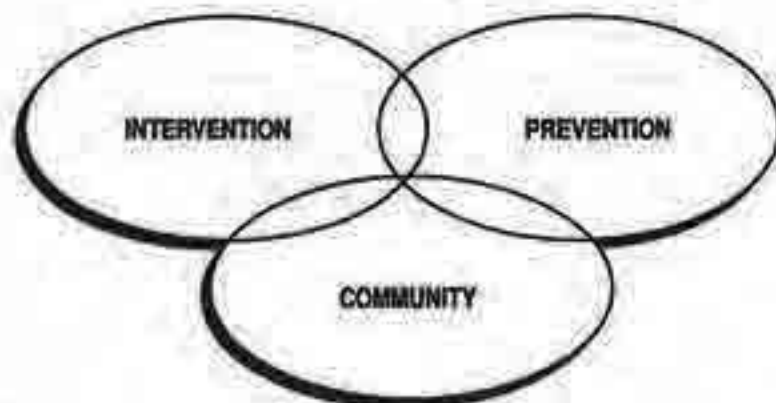
The Services agency in the new Health and Human Services System is large and complex. It brings together the service responsibilities from the five Partnership agencies — the Departments of Health, Public Institutions, Social Services, the Department on Aging, and the Office of Juvenile Services — into one agency. These responsibilities involve over 5,000 employees. The alignment of the five different sets of responsibilities, policies, philosophies, and cultures into one agency is a key change in creating the new system. This change creates the opportunity to examine and pursue unified program strategies, policy analysis, consistency of purpose, work, and process streamlining. It is the foundation for the new Health and Human Services System.

The initial structure for the Services agency is based on the organizational model developed by the Services System Model Work Team. The key principles in this model are:

- *Organization around outcomes*—work is oriented toward outcomes to create accountability based on results;
- *Focus on intervention and prevention*—the clusters of outcome oriented work contain both prevention and intervention activities; and
- *Responsibility Decentralized*—service management area leaders are members of the agency management team; decisions are made as close to where the work is done as possible.

The work of the Services agency falls primarily into three key components: Intervention, provided through the area of Individual and Community Services; Prevention, provided through the area of Preventive Health and Public Wellness; and Community Support, provided through the area of Community Support and Service Management Areas. The Community Support component, comprised of field staff organized into State Service Management areas, draws upon the Prevention and Intervention components for outcome-focused program and policy expertise needed for effective and efficient service delivery and community capacity building. The work is coordinated through interagency and intra-agency crosscutting teams and supported by an administration area.

Key Components of HHS Agency



From Five Agencies To One

The alignment of the full range of health and human services from five agencies to one will result in benefits to recipients of services, those who deliver services, and those who develop the service programs. For example, the policies, programs, and services for persons with disabilities currently in five agencies, will now be in one agency. The people who develop the programs, deliver the services, and receive the services can now come together to create a unified focus in what should be done and how it should be done. In addition, the links with programs for employment, job readiness, protective services, and prevention are ready-made within one agency. Walls between agencies that have made these connections and common visions difficult are coming down. From the client's perspective, one service coordination worker can provide access to the services that in the past might have required multiple trips, multiple applications, and resulted in two, three, four, or even five different caseworkers to keep informed and advised of family/individual needs and changes on an ongoing basis. The service coordinator for the person with disabilities can access employment readiness or other self-sufficiency services for that person within the same agency. From the worker's view, five manuals on disabilities can become one.

Outcomes

Organizing the Services agency around outcomes creates the most significant long-range change in the service system. Public health and human services are often focused on the processes used — the number of checks issued, the number of people seen, served, or contacted — to demonstrate their accountability. The focus on outcomes answers the question — "and so what?" It changes the view to look for results people can see. What difference did the services make? Did they improve the level of independence, self-sufficiency, safety, or health and well-being of the client, community, or population? With the outcome agreed upon, only the available services that help get to the outcome need be used — no more, and no less. This outcome orientation changes several dimensions of services — success, satisfaction, costs, and closure.

The outcomes create the framework to define when the service has been completed and to make the choices on how to get there. It addresses the question, "If you don't know where you're going, how will you know when you get there?" It is then the basis for knowing closure — when the work, the service, or the case, is done. For example, Child Protective Services will know the outcome of safety is reached when a child is safe today and abuse is not repeated. If the outcome is independence, it is reached when the person has the maximum level of independence for their physical or mental health and functioning circumstances. Outcome achievement can be evaluated by clients, communities, caseworkers, management, the public and the legislature. This is the new accountability for the Services agency.

Prevention and Intervention

Locating prevention and intervention services in one agency allows examination of programs and program strategies from both perspectives. Prevention actions can increase personal self-sufficiency and decrease later needs for high intensity intervention services. For example, early and ongoing access to prenatal health care increases healthy births and decreases the incidence of developmental disabilities. Immediate treatment for issues detected in the newborn testing program can prevent serious health problems later in life. The knowledge and perspectives of child protective services and juvenile services come together with

"I believe that prevention saves dollars in all things, whether it be changing the oil in your car and car maintenance, exercise diet and health maintenance, or assessing needs and implementing measures before extensive services are needed within the Partnership."

- Lincoln community forum

prevention perspectives to develop services that prevent child abuse and neglect and juvenile crimes, and also deal with risk avoidance behaviors when the child enters the intervention service system.

Organizational Structure

True to their assigned task, the Work Team designed the Services organization of the future. The organization chart on page 25 begins implementation of that design in 1997—the alignment of the work of over 5,000 employees that serve an estimated 350,000-400,000 people through intervention services and serve all residents of the state, over 1.7 million people, through the population-based prevention services. The work has been grouped into four areas for initial implementation:

- Individual and Community Services
- Community Support & Service Management Areas
- Preventive Health and Public Wellness
- Administration

The listings of programs and activities displayed on the chart and discussed in this text are representative rather than exhaustive of all possible work and activities. No programs or service responsibilities have been eliminated during this restructuring. The work of examining programs and processes for streamlining will begin with the implementation of the Service Coordination Model (see section on page 29). This examination of the nearly 100 program areas will involve the people who do the work as the Services agency structure is implemented and people and work come together in new teams.

An explanation of those services that fall under each of the four areas within Services follows:

• Individual and Community Services

This area develops, coordinates, and establishes standards and program policy for state provided and supported services. Individual and Community Services supports the Health and Human Services Service Management Areas and the communities. The programs reflect the state or federal authority assigned to the agency. Current work located in this area includes program development based on federal or state law authorizations and requirements, and technical assistance or policy interpretation arising from the programs. Cross agency teams will maintain connections to focus on the interests of populations such as the elderly, disabled, or children and families and the needs of populations that cross multiple outcome areas.

Individual and Community Services also includes 24-hour inpatient services—Beatrice State Developmental Center, two Youth Rehabilitation and Treatment Centers and the planned Youth Secure Confinement Facility, and also the three Regional Centers. These services have responsibilities that intersect locally, regionally, and statewide.

Veterans Home Division includes four state veterans homes located in Scottsbluff, Grand Island, Norfolk, and Omaha. These homes provide nursing home and domiciliary care for Veterans.

Within the area of Individual and Community Services, work will be organized around the Veterans' Homes and the following four outcome groupings:

Maximizing Independence and Long Term Care includes Rehabilitation

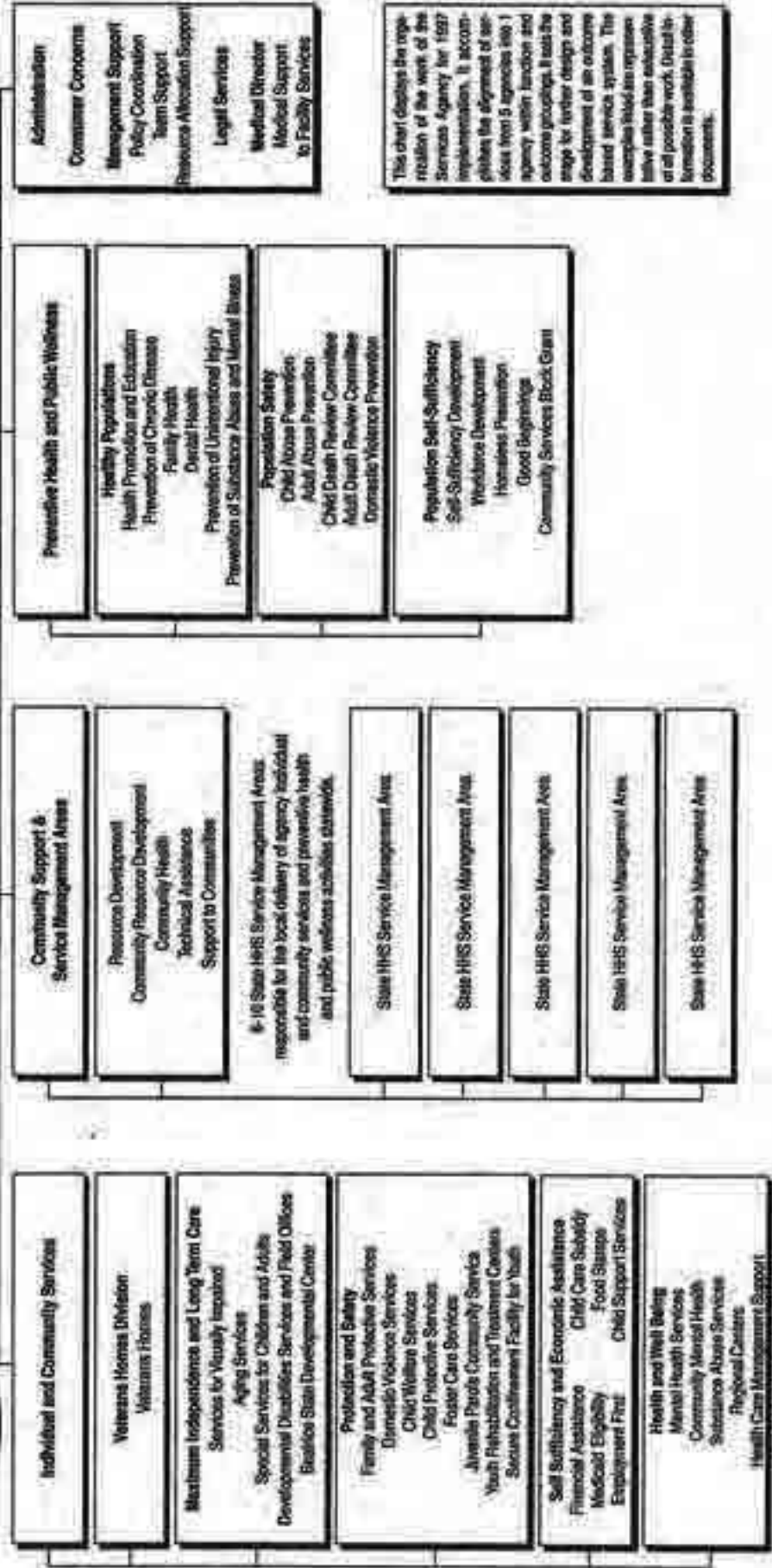
• *"Individuals with multiple disabilities are often not served or bounce from one system to another."*

- *State employee*

Department of Health and Human Services Services Agency Structure for 1997

Key Principles
 One Agency Home
 Outcome Focused
 Decentralized
 Intervention and Prevention
 Team Based

Services Agency Director



This chart displays the organization of the work of the Services Agency for 1997 implementation. It accomplishes the alignment of services from 5 agencies into 1 agency within function and outcome groupings. It sets the stage for further design and development of an outcome based service system. The examples listed are representative rather than exhaustive of all possible work. Detail information is available in other documents.

Services for the Visually Impaired, Aging Services, Special Services for Children and Adults including the Medically Handicapped Children's program, Disabled Persons and Family Support, the Medicaid Waiver services for Aged and Disabled, Early Intervention program, Medicaid in Public Schools (MIPS) and services for people with Developmental Disabilities and the Beatrice State Developmental Center.

Self-sufficiency and Economic Assistance includes services such as Public Assistance, Employment First, Supplemental payments for Aged, Blind and Disabled, related Medicaid eligibility programs, and Food Stamps. Child Care Subsidy and Child Support are grouped in Self-sufficiency and Economic Assistance.

Protection and Safety includes Adult Protective Services, Child Protective Services, Foster Care, services which help provide permanency such as Children and Family Services that strengthen and support families, Independent Living services for wards of the Health and Human Services agency and the community-based juvenile services including the Youth Rehabilitation and Treatment Centers in Kearney and Geneva.

Health and Well Being includes the Community Mental Health services, Mental Health and Substance Abuse services, and the services of the three Regional Centers in Hastings, Lincoln, and Norfolk. This area also includes health care management support.

There are several Medicaid related functions and responsibilities within the Services agency. Medicaid is also the funding source for many services developed and delivered in the Services agency, such as the Aged and Disabled Waiver services provided to support people to live as independently as possible outside of the nursing home. The design and development of such services that are funded by Medicaid as well as the criteria for client eligibility for Medicaid coverage will be done in partnership with Regulation & Licensure and Finance & Support, the designated Medicaid agency for federal policy requirements. Each of the three Health and Human Services agencies have responsibilities related to Medicaid and they each bring needed perspectives for the systemic management of the service, coverage, and standards associated with its effective and efficient administration. The full structure of the agency roles and responsibilities in this area will develop during implementation of the Health and Human Services System.

• "We need a change in philosophy from sickness to wellness."

• Omaha community forum

• ***Preventive Health and Public Wellness***

This area takes a preventive approach to health and human service issues. This function is placed clearly and visibly in the Services agency to demonstrate a commitment to the use of population-based and preventive strategies in promoting the health of all Nebraskans. (See discussion on Maximizing Prevention Strategies on page 33). This area includes both broad population-based preventive programs and services targeted to certain populations.

Within the Preventive Health and Public Wellness area, work will be organized around three population-based outcome groupings:

Healthy Populations includes current prevention programs focused on chronic diseases such as breast and cervical cancer prevention through Every Woman Matters, diabetes control, and AIDS; family health programs such as Newborn Screening and Genetics, School and Adolescent Health, Commodity Supplemental Food and the WIC Supplemental Nutrition Program to provide health education information and prevent health problems related to inadequate nutrition, Health Promotion and Education programs focused on preventing injury, cardiovascular disease, and tobacco related illness and deaths.

Population Safety includes programs to prevent child abuse and adult abuse and domestic violence.

Population Self-Sufficiency includes Homeless Prevention, Community Services Block Grant programs to prevent poverty, and the Good Beginnings Program.

• **Community Support & Service Management Areas**

The Community Support and Service Management Areas is responsible for the local delivery of services statewide. Geographic boundaries are relevant to the Services agency from two different perspectives. Administrative boundaries are necessary for the management of the agency's work. Six to ten state Service Management Areas will be used for the organization of the local service delivery work. Current geographic management areas in use by the five agencies will be used until these boundaries are set. A single set of geographic boundaries for service management will be in place by the summer of 1997. This area will be providing technical assistance and support to community capacity building. Current activities focused on this responsibility are Resource Development, Community Resource Development and the Community Health Program activities.

Defining boundaries from the community perspective for governance purposes raises issues different from state management. A plan to address regional governing boundaries will be developed in 1997. Appropriate participation, communication, and dialogue and feedback will be included in the planning process.

• **Administration**

The Administration area provides specific connections within the Services agency and among the Services, Finance & Support, and Regulation & Licensure agencies. It provides management support and facilitates policy coordination directed toward outcomes and the service change and innovation needed to achieve outcomes. It also provides an organizational "home" for special key support functions in the Services agency such as Legal Services and Medical Director support for facility services.

Operations

The operations of the Services agency is based on strong horizontal communications across the agency. Team-based work provides a tool to connect the necessary sets of skills, information and talent to the work at hand.

• *"Technical assistance is a must."*

• *Kearney community forum*

- "Service gaps frequently exist often related to "turf" issues that hinder agency delivery."

- State employee

The Management Team for the agency will have a statewide perspective and statewide representation. Leaders of the Service Management Areas will be members of the agency Management Team. The creation of Service Management Areas and the leaders for the teams within the areas distributes the power and decision-making across the state and through the organization. It moves it out of the traditional governmental central office. As the agency structure is implemented and the new groupings of work in the Individual and Community Services and the Preventive Health and Public Wellness areas are established, program support staff will be decentralized and located in the Service Management Area offices, to be closer to the work they support.

Regional support teams will be created to support communities in the Community/State Partnerships. These regional support teams will include the technical support for the agency and community delivered services. The members of these teams will be employees of the HHS agencies.

Implementation Plan

There is much work to be done to operationalize the new Services agency structure. Early implementation is evidenced by the successful merger of the Office of Juvenile Services and the Child Welfare unit of the Department of Social Services. (See pages 5-36 for more details).

By January 1, 1997:

- Agency leadership assignments are made; and
- Current work, supervisory relationships, and geographic locations continue until specific changes to the work are designed and communicated.

By June 30, 1997:

- Complete orientation and training of employees to the new department and the new Health and Human Services System;
- Engage all Health and Human Services field employees in team building, joint planning, and program redesign activities;
- Define work responsibilities of Health and Human Services state service management area leaders;
- Define process and timeline to define state service management areas by July 1, 1997;
- Begin implementation plan specific to major areas of work: Prevention, Service Coordination, Community/State Partnerships, and Service System;
- Continue work in existing priority redesign areas: Welfare Reform, Long Term Care Project, Behavioral Health, Child Welfare and Juvenile Services Merger;
- Complete planning for organization and staffing in Central Office components; and
- Develop structure and working relationships regarding Medicaid related functions and responsibilities among the three agencies.

By June 30, 1999:

- Implement structure revisions and unified program strategies as they are completed; and

- Develop and implement plan to address existing statutory regional boundaries.

Improving Client Access Through Service Coordination

Unifying Multiple Service Approaches

By design, the current five Partnership agencies have operated separately. Clients entering the system for the first time have found themselves wading through a maze of seemingly unconnected agencies and programs searching for the services they need. Some clients currently have service coordinators in more than one of the five Partnership agencies. Some clients are required to have a service coordinator in order to access other services. Some clients are able to coordinate their own services, but there is no mechanism to allow or support this.

The new alignment of services into one agency has highlighted the existence of different definitions, worker names, service coordination/policies/procedures and program regulations focused on similar outcomes. Further, it has made it more apparent that, in some situations, multiple workers have been serving the same client/family.

To address the disparities and duplication, the Service Coordination Work Team developed a single definition and model for the new Services agency that will provide for a unified, consistent approach to ensuring that Nebraskans have access to the services they need. The new Service Coordination definition and model will result in:

- **More effective services:** Programs will be unified to focus on clients achieving outcomes. There will be a unified program of disability services, for example, rather than five or six different programs with conflicting manuals, processes, requirements, and policy focuses.
- **More accountable services:** Services will be judged by outcome achievement rather than only measurements of processes of clients served or not served, applications taken, or number of cases per worker.
- **More efficient services:** Only the services that contribute to achieving the outcomes are needed. Processes are streamlined and work is organized to achieve outcomes.
- **Cost savings:** There will be only one service coordinator for each client/family; client participation in service planning will ensure only needed services are provided.



• "Duplication exists because clients are working with two or three caseworkers from various agencies."

• State employee

"Case management seems essential for many individuals. Has there been any thought to individuals having one case manager who would work with them for a length of time and help them access all the services they need."

Lincoln community forum

- *Services that make common sense:* Preventive strategies will be incorporated into service plans to prevent recurring crises and minimize the need for other intervention services.
- The state will work in partnership with communities to provide outcome-focused services.

Service Coordination Model

The system-wide definition of Service Coordination reads *"Service Coordination is an individualized, negotiated, goal-oriented process which accesses and coordinates services to meet client needs. Service Coordination is based on client choices that make the best use of available resources to achieve the agreed-upon outcomes. It includes an individualized determination of strengths, priorities and resources, to assist with planning, connecting with needed services, advocacy, and monitoring."* This model provides for flexibility and variation in service intensity to respond to client differences. Each client's capacities and needs are individual and service plans will adjust to changes in client needs and capacities over time.

Service Coordination is a process that assures clients and families receive the needed services in a supportive, efficient, and cost-effective manner, while working toward self-direction and empowerment. For many clients/families, a self-directed approach will afford them maximum control and choice in performing their own service coordination functions. Clients/families may also receive services through a "Fast Track" process which bypasses formal Service Coordination and allows them to directly access needed services.

(See the Service Coordination Flow Chart on page 31)

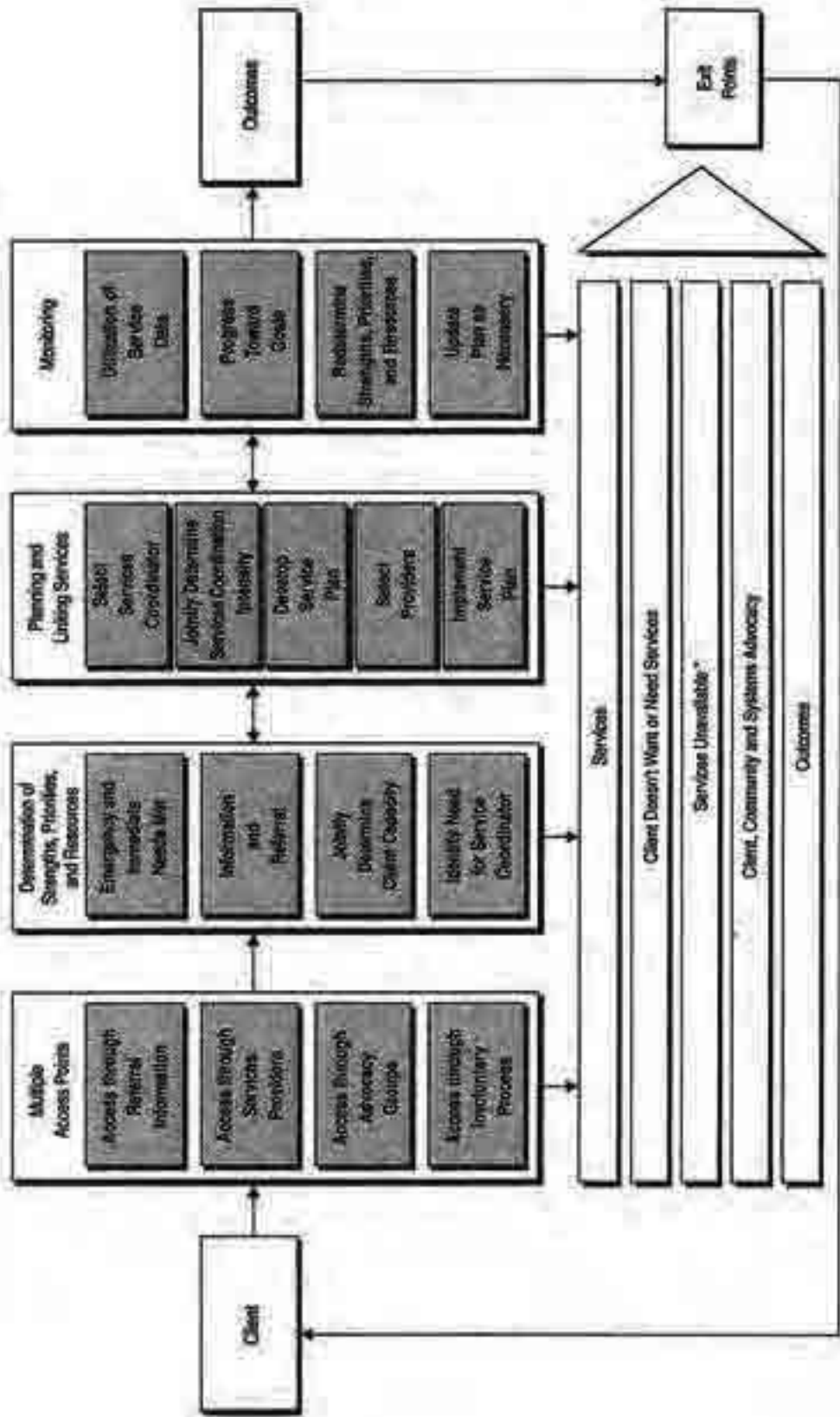
How Service Coordination Will Work

To streamline client access and agency intake processes, the Service Coordination model allows for multiple community access points to enter the system. A client/family can access the system through information and/or referral, through a current services provider, a current Service Coordinator, or through advocacy groups. These multiple access points build on the current pathways in community systems. The planning and linking of services utilizes the client/families support system and promotes the assumption that client/families are equal partners and decision makers. The emphasis on coordination, communication, and outcome measurements are key to the efficiency and effectiveness of Service Coordination.

The new Service Coordination model shifts from the program/agency-centered approach to one which emphasizes client/family direction in all aspects of planning and services delivery. Client/family values and preferences strongly influence the timing, duration, and intensity of Service Coordination, provider services rendered, and the setting in which services are delivered. Clients/families are encouraged to direct their own services. However, in situations where clients/families enter the system through involuntary processes such as child and adult protection, court-ordered wardship/commitment, or mental health board commitments, the client/family choices are made within prescribed constraints.

Under this model, the client/family will have only one Service Coordinator. After meeting initially with the client/family, the Service Coordinator will consult with an eligibility expert to determine eligibility for the service program(s). The Service Coordinator for that client/family will authorize and access the services needed to achieve improved outcomes.

Service Coordination Flow Chart



The Service Coordination process will identify gaps and overlays in services and barriers or duplications to receipt of services. The information will be used to develop a plan for improved services, and to evaluate program effectiveness.

Achieving outcomes is the driving force behind Service Coordination. Monitoring will occur to determine whether or not the client/family outcomes have been met. Once the outcomes are achieved or the client/family shows capacity to be their own Service Coordinator, the function of Service Coordination will be discontinued. The duration of Service Coordination will vary from a short-term intervention to the maintenance of client/families on a long-term basis. Duration will be a joint decision of the client/family and the Service Coordinator, except in cases where the duration of health and human services intervention is court-ordered.

For the majority of clients/families, the delivery of Service Coordination will employ a generalist approach. When situations are complex and require intensive Service Coordination, a specialist will be available. Areas where specialists may be needed are:

- Elderly or persons with complex needs related to visual or physical disabilities
- Children and adults in need of protection or with acute levels of care or risk
- Court-mandated cases
- Persons with disabilities who have services that must be monitored closely
- Children with special health care needs where no one system (medical or educational) could deal with all aspects of the case
- Persons working toward self-sufficiency outcomes who face multiple barriers to employment
- Persons with complex mental illness and substance abuse situations
- Juvenile offenders

Implementation Plan for Service Coordination

To enable a smooth transition to this new Service Coordination model, the state will phase in implementation as follows, beginning with Disability Services as the initial area of focus:

By January 1, 1997:

- Distribute Service Coordination definition and model to Service agency staff;
- Form interagency implementation planning group under Services leadership;
- Develop Implementation Plan; and
- Identify current clients with multiple service coordinators, identify duplications.

By June 30, 1997:

- Develop criteria for primary Service Coordinator assignments;
- Assign primary Service Coordinators;
- Develop Service Coordinator and Eligibility Consultant qualifications/classifications;
- Review program rules and regulations for consolidation and revision;
- Work with Finance & Support to determine data and information system needs; and

- Work with Finance & Support to develop and provide training for staff, clients, and community members on new Service Coordination processes and self-directed services.

By June 30, 1999:

- Continue implementation of new Service Coordination process; and
- Work with Regulation & Licensure Performance Accountability to establish quality assurance/outcome measures.

Maximizing Prevention Strategies

No area has more potential than prevention to profoundly affect the benefits that result from the services of the new Health and Human Services System. Prevention programs contribute to Medicaid and overall state cost savings as a result of reduced treatment services and reduced institutionalization and incarceration. Effective prevention programs will reduce demand for services, contribute to earlier and more appropriate use of services, and maximize the health of all Nebraskans. Perhaps the greatest benefit that will result from meaningful commitment to prevention will be Nebraskans leading healthier, safer life-styles.

Prevention is recognized as occurring at three levels: *primary, secondary, and tertiary.*

Primary Prevention focuses on reinforcing appropriate behaviors and creating an environment that will deter the development of a problem. Primary prevention, through population-based programs, can reduce the likelihood of needing case-managed services, and can increase the likelihood of self-sufficiency for individuals, families, and communities.

Secondary prevention focuses on individuals and how they react to the onset of a problem, how they seek an expert opinion and how they get appropriate services as early as possible. Screening programs for early detection of treatable conditions are good examples of secondary prevention.

Tertiary prevention ensures treatment and rehabilitation to improve a person's quality of life, given the realities of their current or permanent condition. Preventing a reoccurrence of the problem keeps a person functioning with dignity and self-sufficiency without the need to return to intensive services.

The Health and Human Services System approach will enhance the benefits of prevention by focusing on primary prevention opportunities at *all stages* of the continuum of care.

Enhancing Prevention Effectiveness

Significant changes are planned in the way prevention is viewed. Specific strategies to greatly enhance prevention effectiveness are as follows:

- **Outcome Based Programs** — Prevention programs will be developed with measurable outcomes clearly linked to the problem being addressed. These outcomes are the basis for program evaluation, program revision, and cost-effectiveness;

• "Remember that primary prevention saves money."

• State employee

- **Community Ownership** — Communities are important in the initiation and conduct of prevention programs. Ownership and capacity building are essential to avoid the present situation where many program initiatives at the local level are lost when the state's technical assistance and/or financial support from outside sources ceases.
- **Careful Planning** — Planning is a critical element in the development of all prevention programs. Planning will be based on documented community need. Planning will be comprehensive in nature, acknowledging the need for programs to be inclusive and to link prevention initiatives into a continuum of care that will include prevention, early intervention, treatment, and rehabilitation.
- **Policy Support** — Policies facilitate the linking of prevention initiatives with other initiatives. With coherent support from policy, prevention programs can be sustained and have increased effectiveness. Policy support for prevention can range from legislation at the state level, such as the law requiring the reporting of child abuse, to policy actions taken at the local level, like local youth curfews, to the less formal policies found in the workplace related to things like tobacco use and maternity leave.

Preventive services have a clear and visible presence in the Services agency. Prevention continues its traditional role of enhancing protective factors and reducing risk factors through population-based programs. In addition, once a person is identified as at-risk and enters the Health and Human Services System, a series of new opportunities for prevention can be capitalized upon.

For example, within the Services agency, prevention will become an integral part of Service Coordination. A Service Coordinator working with an adolescent entering the system will be able to reinforce appropriate behaviors and direct the youth to information and skill building resources to reduce risk behaviors such as use of alcohol, tobacco or drugs.

Prevention's Contributions to the New System

Prevention strategies will make these contributions to the new Health and Human Services System:

Better Services for Nebraskans — Prevention will be part of the array of available services (prevention, early intervention, and treatment/rehabilitation). It will also encourage early, appropriate, and complete care.

A Simple, More Efficient System — Well-trained prevention professionals will develop and provide effective prevention programs incorporating recognized best practices.

A System Based on Common Sense — Preventing a problem is more sensible than waiting for it to occur and then correcting it. Encouraging, supporting, educating and changing the physical and social environment can minimize unhealthy practices and reduce the likelihood of many major social and health problems.

A Realization of Cost Savings — Preventing the need for services, encouraging early and appropriate use of services, and reducing the likelihood of someone reentering the service system are each clearly related to cost savings, but they may take time to materialize. In the short term, adequate resources will need to be invested in prevention efforts for those long-term benefits to be realized.

Accountable to Nebraskans—Accountability will be enhanced with outcome-based objectives for all prevention programs.

Implementation Plan for Prevention Strategies

By January 1, 1997:

- Distribute Prevention Strategies report to other Partnership teams and community agencies to acquaint people with the report and help ensure a prevention focus at the policy development level.
- Ensure representation on the Partnership Council with expertise in primary prevention.
- Identify primary prevention specialists to lead technical assistance teams. Identify prevention opportunities in all agency programs.
- Establish organization goals and strategies to create a "prevention culture" throughout the new Health and Human Services System. Establishment of policies and procedures to ensure prevention programs remain coequal with intervention and treatment/rehabilitation programs.

By June 30, 1997:

- Establish prevention domains for focus of prevention services attention.
- Appoint a primary prevention advisor to serve the Policy Cabinet with specific responsibility to ensure that prevention opportunities are fully explored and developed.

By June 30, 1999

- Develop policies and procedures to require preventive focus in all managed care contracts.
- Provide effective in-service training for primary care providers on integrating primary prevention activities into their practices.
- Complete comprehensive inventory of services/programs/initiatives related to selected prevention domains.

OJS / DSS Child Welfare Merger

In order to attend to immediate issues of funding for youth services and the development of needed service capacity, a plan was developed to merge the staff of the Office of Juvenile Services (OJS) with the Department of Social Services (DSS) Child Welfare unit. The merger represents a first step in eliminating a fragmented service system for children, youth, and families in Nebraska by bringing together two entities within the Partnership which serve many of the same types of clients and work with the same support systems (courts, foster care providers, schools, treatment facilities, etc.) to achieve a common outcome of safety and protection for both individuals and communities.

Historically, there has been a substantial inequity in the resources available to the child welfare and juvenile service systems. OJS was created just three years ago to address the needs of troubled youth, yet it has struggled with limited staffing and funding to establish an array of services outside its institutions. In its efforts to get established, OJS has had difficulties in accessing

• "There is a real clash of cultures that must be addressed. We call ourselves "Birkenstocks and Badges."

- OJS/DSS Child Welfare Work Team Member

categorically-defined funding streams and has experienced an upsurge of youth placed in its custody (up almost 18% in the last six months). The merger plan is intended to overcome the current categorical funding barriers; increase service capacity and maximize resources within the two systems; improve overall service delivery; and produce efficiencies in management and operation of an integrated child welfare and juvenile service system.

A structured planning process is in place which involves a significant amount of work by OJS/DSS planning teams to address critical policy and practice issues, organizational structure and management, resource development strategies, communications strategies, and development of appropriate supports in such areas as legal assistance, information systems, and finance. The University of Nebraska Center for Children, Families, and the Law has established a support team to assist OJS and DSS in training and managing change with staff across the state.

Several key decisions relating to the merger include co-location of central office staff as well as co-location of staff in the community where appropriate; equalization of payment rates to foster and group care providers (OJS payment rates have typically been lower); coordination of OJS and DSS resource development initiatives utilizing DSS resource development staff; and alignment of budget resources to serve a common population. The merger will move forward in the coming months as these decisions are implemented and recommendations on the issues described above are developed.

VI. Department of Health and Human Services Regulation & Licensure

Structuring To Serve Customers

Mission

The mission of the Department of Health and Human Services Regulation & Licensure is "to preserve the quality of the health and human services system based on outcomes and performance measures."

Functions

In order to fulfill this mission, the agency was given six general duties under the Partnership Act:

- Develop evaluation measurements and analyze results throughout the Health and Human Services System;
- Certify and license facilities and professionals;
- Evaluate services or programs to determine compliance with state, federal, or other contractual requirements;
- Develop, review, and revise regulations in accordance with established system-wide policies and objectives;
- Coordinate with the Department of Health and Human Services to develop appropriate technical assistance, education, training, and joint problem-solving; and
- Provide a common-sense approach to regulation and licensure that focuses on the outcomes of the Health and Human Services System and assures compliance consistent with those outcomes.

"The process is too cumbersome, complicated, and slow. (We) need to standardize, (be) less autocratic — more supportive and make forms user-friendly."

Community forum participant

Organizational Structure

In order to carry out its statutory duties and to serve its customers effectively, the Regulation & Licensure agency is organized around five divisions.

The work of each division is described below:

- **Performance Accountability Management:** This division staffs and leads the interagency team charged with managing the performance accountability system for the three Health and Human Services agencies. It is responsible for recommendations on outcomes and indicators, how data is organized, interpreted, and communicated, and how standards are identified and reports are drafted. The Performance Accountability Management division manages the process by periodic evaluations of Health and Human Services programs and activities. (The work of this division is discussed in greater detail on pages 16-18.)
- **Regulatory Analysis/Integration:** This division staffs and leads the interagency team charged with managing the system-wide process by which rules and regulations are written and promulgated, including integration with pre-existing regulations. The division also performs analysis of the need for regulatory activities, identifies ways for streamlining them, and provides a "common sense" approach to regulation. The Credentialing Review (LB 407) Program is included in this unit.
- **Credentialing:** This division validates initial and continuing eligibility for credentialing (licensure, certification, approval, etc.) of health and human services facilities, practitioners, and programs. The division is responsible for:
 - Establishing and enforcing requirements for regulation;
 - Approving and conducting examinations;
 - Reviewing applications against requirements (paper review or on-site inspection/survey);
 - Issuing and renewing permits, licenses, provider numbers, Drug Enforcement Administration (DEA) numbers, etc.;
 - Providing technical assistance and education on credentialing process;
 - Identifying when it is necessary to initiate the disciplinary process;
 - Establishing fees (statutory or regulatory definitions);
 - Operating Certificate of Need program;
 - Verification of qualifications; and
 - Intake of complaints, screening of complaints to determine appropriate follow-up, and gathering information to support investigations.
- **Investigations:** This division sets standards for investigation and enforcement activities for the Health and Human Services System to ensure compliance with state and federal laws and regulations. It provides oversight and ensures consistency and coordination to avoid duplication, provides quality assurance for investigation and enforcement activities, and conducts investigations to gather data regarding possible violations of law or regulations or fraudulent activity where the possible penalties include loss or restriction of regulated/approved status.
- **Public Health Assessment:** This division conducts core public health assessment activities of analyzing data regarding health and environ-

• The Department of Health is collaborating with the Department of Social Services, Aging and the federal government in meeting with providers to develop agreed-upon outcomes that will serve as a basis for an examination of the current system of survey processes in long-term care facilities. Developmental Disabilities staff have been meeting with the Department of Public Institutions, the Department of Social Services and providers to look at the survey process in those facilities. Recently, the Department of Health met with the Nebraska Dental Association to discuss beginning an examination of the X-ray equipment inspection process. The purpose is to eliminate duplicative inspections.

• "Licensing and regulation should not be created...without clear consumer demand and assurance of positive outcomes".

- Lincoln community forum

ments, and designs and executes interventions to protect public health. It assesses environments and events that could impact individual or community health and provides recommendations to programs and policymakers regarding needed enhancements in environmental conditions.

Operations

A basic assumption of this organizational structure is that citizens requiring services must be able to access these services simply and quickly. Thus, the divisional structure through which employees are managed is not identical to the service delivery structure through which the public interacts with the agency. Employees work in teams that are customer-based emphasizing integration of functions to ensure quality and consistency of performance and coordination with the other Health and Human Services agencies. The diagram on page 39 illustrates the matrix of relationships in which Regulation & Licensure employees work.

The pyramid on the right of the chart represents the fairly traditional divisional management structure described above. The Regulation & Licensure agency retains the flexibility to present itself to the public through a discrete number of service areas, represented by the middle columns on the above diagram. Examples of persons and interests served through each area are presented at the bottom of the columns.

The four service areas and examples of their customer groups are:

1. Individual providers (individuals regulated by the Health and Human Services System): health care providers.
2. Program and facility providers (facilities and programs regulated by the Health and Human Services System): hospitals, nursing homes, foster care homes.
3. Consumer, safety, and protection (establishments and services selected and used by consumers): child care agencies, food safety, massage, and cosmetology establishments.
4. Environmental health and safety protection (regulatory programs and activities affecting the general population and environment of Nebraska): drinking water systems, radon program.

Activities within the Regulation & Licensure agency are coordinated within each of these service areas to ensure that the needs of their respective customers are met. This horizontal management structure provides for a high degree of flexibility in assigning staff to meet customer needs and in allocating other resources wisely. It also offers the greatest opportunity to avoid overlap and duplication of responsibilities.

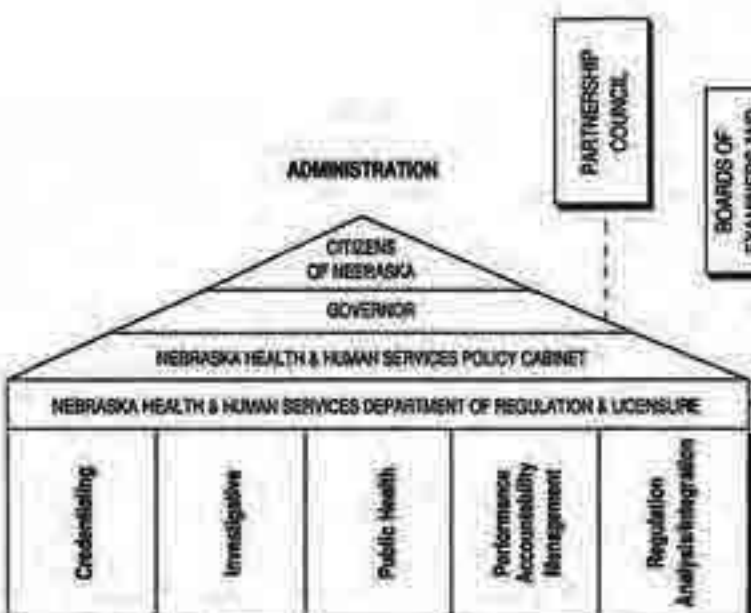
Regulation and Licensure Facilitators

To assist citizens requiring regulation and licensure services in accessing the new Health and Human Services System, *regulation and licensure facilitators* will be designated. Regulation & Licensure employees throughout Nebraska will be called upon to fulfill these roles. They will assist the customer in defining their needs from the System and in linking them with appropriate parts of the System to satisfy those needs. Regulation and licensure facilitators might not be needed for relatively simple and direct transactions; many customers would be comfortable going

Department of Health and Human Services Regulation and Licensure

SERVICE DELIVERY STRUCTURE

NEBRASKA HEALTH & HUMAN SERVICES		CITIZENS OF NEBRASKA		
Inter-Agency Team Leaders		Areas of Service Coordinated by State Regulation & Licensure Facilitators		
Regulation and Licensure staff serve on interagency teams in areas requiring expertise from two or more HHS agencies. In addition to Performance and Regulatory Analysis and Integration, teams are planned to address activities such as Strategic Planning and Community Services. Other Teams will likely be organized. Some of these teams would be permanent and others temporary.	Individual Providers	Program & Facility Providers	Consumer Safety & Protection	Environmental Health & Safety Protection
	<p>Customers: Citizens of Nebraska Nebraska Communities Individuals regulated (licensed, certified, approved, etc.) by ISIS Systems. Health Care Practitioners Hospitals Nursing Homes Ambulatory Care Facilities</p>	<p>Customers: Citizens of Nebraska Nebraska Communities Facilities and Programs Regulated (licensed, certified, approved, etc.) by HHS System. Ambulatory Care Facilities Out-Patient Services In-Patient Services QAS Facilities/Programs Nursing Homes Therapeutic Communities Donorkey-Boarding Homes</p>	<p>Customers: Citizens of Nebraska Nebraska Communities Establishments and services selected and used by consumers Health Care Practitioners Mobile Home Parks Food Safety Massage Est. Cosmetology Est. Swimming Pools Funeral Est.</p>	<p>Customers: Citizens of Nebraska Nebraska Communities Regulatory Programs and Activities Affecting the General Population and Environment of Nebraska Health Care Practitioners Drinking Water Systems Radiology Services Air Quality Radon Programs</p>



directly to the part of the System they need to access. However, for more complex needs, facilitators will be responsible for ensuring that customers have all the information they need to complete the transaction successfully.

An example is a physician seeking to set up practice in Nebraska and needing a medical license, DEA number, Medicaid provider number, radiology certificate, physician assistant protocol, etc. For such complex transactions, the facilitator might put customers in touch directly with the person(s) who could meet their needs, provide customers with a checklist identifying necessary steps and indicating a starting point, or quickly organize a team to work with the customers directly. The facilitator may also serve as an exit point from the system, according to the customers' needs. Facilitators will offer a follow-up to ensure that all necessary services have been provided. In these respects, the facilitator functions as an advocate for regulation and licensure customers.

Coordination with the Health and Human Services System

Other parts of the Health and Human Services System, as well as other agencies of Nebraska state government, are customers of the Regulation & Licensure agency, as shown by the column at the left of the diagram on page 39. Regulation & Licensure staff will serve on interagency teams in areas requiring expertise from or coordination among two or more Health and Human Services agencies. Examples might be in areas such as strategic planning, regulations development, and budget development. Some of these teams will be permanent and others temporary.

Implementation Plan

By January 1, 1997:

- Agency leadership assignments made;
- Service Area coordinators and Regulation & Licensure facilitators designated;
- Team leaders for ongoing redesign work identified; and
- Regulation & Licensure employees will be notified of their divisional assignments.

By June 30, 1997:

- Orientation and training of employees to the new agency and new System will be completed; and
- Organizational design and staffing work within divisional units and planning for implementation will be completed.

Streamlining the Way Work Gets Done

Both customers and state employees find it difficult to wade through the maze of regulatory and licensing requirements that resulted from the current process of adding more regulatory programs rather than looking at how the entire system should function. The Partnership Act states that the Department of Health and Human Services Regulation & Licensure is to preserve the quality of the Health and Human Services System based on outcomes and performance measures, with responsibility to: ...

"Provide a common sense approach to regulation and licensure that focuses on the outcomes of the health and human services system and assures compliance consistent with those outcomes."

*"We need to
simplify rules
and regulations."*

- State employee

The following five regulatory and licensing areas were studied:

Study Area #1 — Emergency Medical Services (EMS)

• **Reducing Certification Categories**

The regulatory program which licenses and supports emergency medical service providers has evolved over more than twenty-five years. The pattern had been to respond to new technology by creating separate licensing categories. When advanced emergency medical care (such as paramedics) came into existence, another board and separate set of regulations were created. Thus, the current system for certifying emergency medical services personnel and for licensing emergency medical services both have eleven different categories.



Action/Recommendation:

- Introduce legislation in January 1997, to reduce the number of categories for EMS certification of personnel from eleven to five and simplify the list of categories for EMS licensing services from eleven to four. The new set of licensing services categories would be: Ambulance Services; Intermediate Services; Paramedic Services; and Approved Training Agencies.

A task force, led by State Senator Bob Wickersham, evaluated the licensing system. The task force proposal recommended replacing regulations of the Nebraska Department of Health by placing responsibility with the local physician medical director to determine the type of services the ambulance or first responder service would provide. The local physician medical director would be supported by a set of model protocols to use as the basis for working with their first responder and ambulance services. Similarly, the EMS training agencies would be responsible for evaluating instructors.

• **Merger of EMS Regulatory Boards**

The administrative structure of the Boards supervising Emergency Medical Services (EMS) has two regulatory boards: Board of Ambulance Advisors with thirteen members, and the Board of Advanced Emergency Medical Care with twelve members. The Board of Ambulance Advisors is responsible for approving regulations governing licensing seven of the eleven categories. The Board of Advanced Emergency Medical Care oversees advanced emergency medical providers.

Action/Recommendation:

- Introduce legislation in January 1997, to create a single Board of Emergency Medical Services.

The new Board of Emergency Medical Services would be responsible for approval of regulations covering training standards, equipment standards, standards for inspections, ambulance design and construction standards, sanitation, operation,

maintenance, and medical direction. It would oversee the credentialing of both services and personnel involved in emergency medical services, as well as training agency approval. The Nebraska Uniform Licensure Law would govern disciplinary actions concerning emergency medical care providers.

Study Area #2 — Unlicensed Assistive Personnel

Not all individuals have the ability to take medications independently. There is a need to define a way to safely assist these individuals in taking their medications in a way that can be used in all settings in a cost effective way. There are different requirements for administering the same medications depending on whether they are given in a nursing home, a halfway house, a day care center, or a school. The requirements are not consistent and create confusion as an individual moves from one setting to another. The existing method also has legal and accountability problems; there is inconsistency in definition of terms and roles of providers, and inequity in educational requirements.

Actions/Recommendations:

- Introduce legislation in January 1997 that addresses:
- The *Medication Assistant Registry* established. The Regulation & Licensure agency should maintain a Registry of persons who have met minimum competency standards to provide medications according to the "Five Rights" (meaning the right person gets the right drug in the right dose via the right route, and at the right time).
- *Competency criteria* defined by the state but competency assessment should be done at the community/provider level.
- *Current statutes and/or regulations* related to Care Staff Members and Medication Assistants repealed to eliminate duplication.

Recommendations based on the following principles:

- If an individual is not able to take medication for themselves, a trained and competent person should be accountable for decisions associated with the taking of medications.
- The method should apply only in situations which are already regulated. An individual's personal home and/or custodial place of residence should not be included. Also excluded are medications provided by family and friends.
- There should be agreement on what is necessary for a person to be recognized as trained and competent. Competent provision of medication should include the "Five Rights." Competency assessment should include the provision of routine medications.

Study Area #3 — Credentialing Providers, Programs, and Facilities

Three of the five Partnership agencies engage in some form of credentialing activities. Credentialing of providers of health and human services encompasses many things. Examples include certification by national associations, organizational credentialing, self-regulating activities, litigation, and market forces.

Actions/Recommendations:

- Implement the One Stop/One Shop model for credentialing.

Under the One Stop/One Shop model, all the processes of licensure and provider approval status are located within the Regulation & Licensure Agency. This includes both initial and renewal/re-enrollment credentialing processing. The "one stop/one shop" model has the following essential components:

1. *Single Resource Centers*— Individuals and facilities/services seeking credentialing services will be able to go to a single location and receive necessary information regarding credentialing services. As the technological capabilities of the state expand, information/application abilities should be made available electronically.
2. *Facilitators* — People will be available to provide technical assistance in working with the credentialing system. They will coordinate the various parts of credentialing and provide a type of "case management" related to the credentialing activities.
3. *Universal Application Form*— There will be a uniform application form for licensing individuals and a separate application form for facilities/services requesting credentialing and any approvals associated with being a provider.
4. *Master Information system*— There will be a master information system so credentialing information is entered once and available to all individuals needing such information to process credentialing.
5. *Unique Identifier*— A unique identifier number will be used to access credentialing records for an individual or a facility/service.
6. *Consistent Credentialing and Practice Standards*. There will be a core set of governmental principles/policies applicable to all credentialing standards and approval processes.
7. *Universal definitions and terms* will be used and applied across the individual professions/occupations as well as facility/ services.
8. *Local Waiver — State Approval*— Minimum uniform standards are to be determined by the state but there will be the opportunity for state waivers compatible with local needs and circumstances. Waivers will be the exception and not the rule, and will be time limited.

Study Area #4 — Inspecting Programs and Facilities

Currently there are several facilities and programs which are inspected by more than one of the Partnership agencies.

Actions/Recommendations:

- The new Health and Human Services agencies continue the internal and external dialogue with staff, providers, and consumers about how inspections are conducted.

- "Instead of the current system, have one stop shopping."

- Norfolk community forum

-
- The Health and Human Services System use the following approaches to conducting inspections in the following ranked order to minimize duplication and reduce the burden on those inspected:

1. *Accreditation*—

When possible, programs that have a history of compliance with regulations and that are accredited by a recognized national or state organization will be inspected only in areas not covered by the accreditation process. This approach is used in hospitals by recognizing the Joint Commission on the Accreditation of Hospitals (JCAH).

2. *Consumer/Provider/Inspector Team*—

Inspections will be conducted by teams which include state inspector(s), consumer/family member(s) and provider(s). This approach is used in licensing Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and for Centers for the Developmentally Disabled (CDD) and is called the Combined Efforts on Outcomes (CEO). This process uses a quality improvement approach rather than traditional inspection/compliance survey. This collaborative approach between regulators and providers is based on shared responsibilities, risks, and teamwork.

3. *Single Inspector*—

A single inspector will be utilized for initial, renewal, and complaint inspections when one individual has the expertise to complete the inspections. Currently Child Care Homes II (fewer than twelve children) are inspected separately by a Child Care Specialist and an Environmental Health Specialist. With the proposed special training, these tasks can be done by a single knowledgeable inspector.

4. *Coordinated Team of Inspectors/Single Report*—

In some instances the knowledge and skills of more than one person are necessary to complete inspections needed to assure quality of a licensed facility or program. In such instances there will be a coordinated inspection process which results in a single integrated report rather than multiple reports.

5. *Coordinated Multiple Inspections*—

When other approaches are not appropriate, multiple inspectors may need to conduct inspections at different times. These will be coordinated so that standards are not in conflict and a single regulatory facilitator will work with the provider, as appropriate.

Study Area #5 — Re-engineering the Process for Credentialing

The regulatory programs established in statute and regulation which govern the Health and Human Services System have been created piecemeal over many decades. The desired outcome is to develop a model credentialing process which contains a clear statement of policy regarding the role of Nebraska state government in credentialing practitioners, facilities, and providers. This more comprehensive look at credentialing will be informed by the work done to date in the four study areas discussed above.

Actions/Recommendations:

- In January 1997, introduce legislation requiring a comprehensive study by the Regulation & Licensure agency to result in a model credentialing process;
- By January 1998, introduce legislation recommending comprehensive changes to the process of credentialing facilities;
- By January 1998, introduce legislation recommending generic changes to the process of credentialing professions and occupations; and
- By January 1999, introduce legislation aligning provisions specific to individual professions and occupations with generic requirements.



VII. Department of Health and Human Services Finance & Support

Structuring To Support the System

Mission

The mission of the Department of Health and Human Services Finance & Support is to provide administrative, financial and management information, and support functions for the Nebraska Health and Human Services System that efficiently allow for flexibility, information flow, quality services, and accountability.

Functions

To support this mission, the Partnership Act outlined the duties of the Department of Health and Human Services Finance & Support as the administrative activities, finance, and information management functions for all three departments of the Health and Human Services System, specifically to:

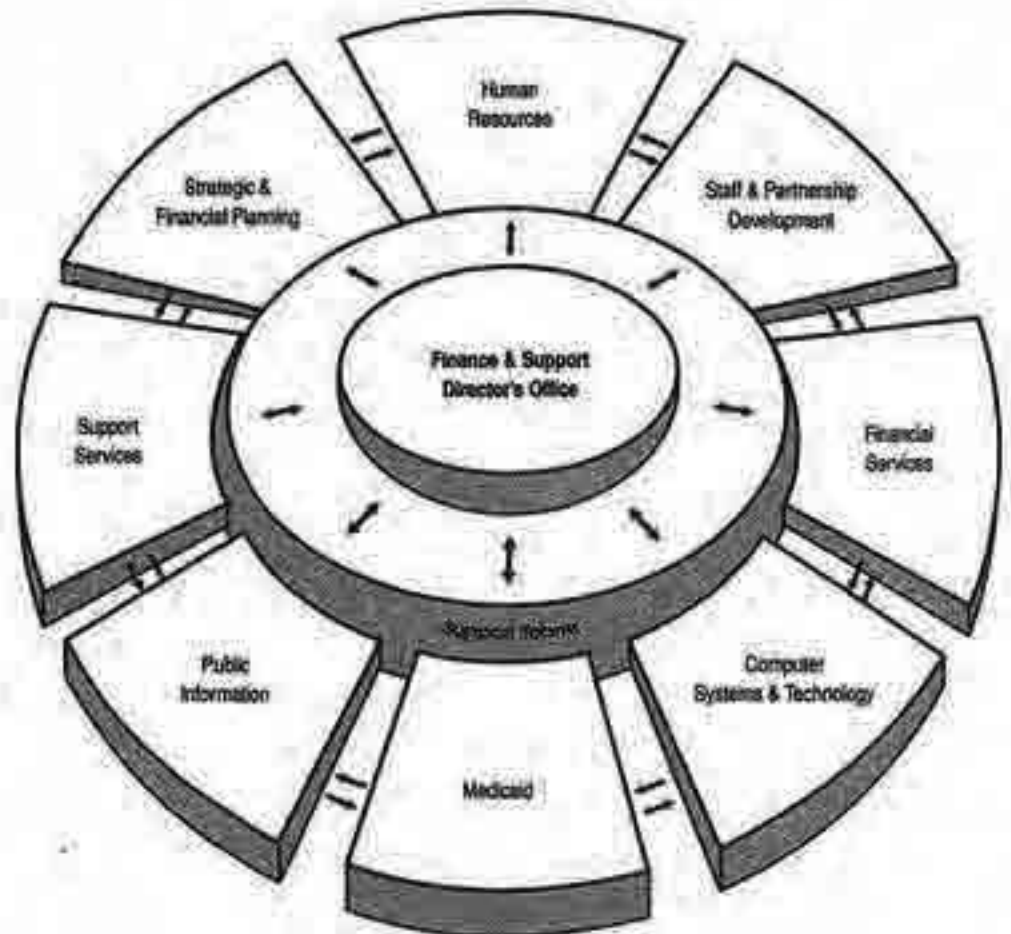
- *Integrate and manage information systems across programs and functions, provide meaningful data to determine whether desired outcomes are achieved, and support policy development;*
- *Consolidate program funds of the departments whenever appropriate to accomplish desired results;*
- *Analyze financial status and impacts for the departments;*
- *Develop and manage a consistent accounting, contracting, disbursement, and fiscal compliance system;*
- *Consolidate operational support services such as budget, information management, purchasing and procurement, personnel, audit, and contract management; and*
- *Act as the primary Medicaid agency (Title XIX).*

"Services need to be common sense driven — consider resources and cost, advocate for what is best as well as cost effective."

- Omaha community forum

Organizational Structure

Department of Health and Human Services Finance and Support



The functions of the Finance & Support agency are grouped into eight divisions: Human Resources, Staff and Partnership Development, Financial Services, Computer Systems and Technology, Public Information, Support Services, Medicaid, and Strategic and Financial Planning.

These eight divisions are arranged around a director's office connected by support teams. This framework reflects the interdependency of these divisions and the fact that the agency's work is accomplished in support teams that draw upon staff from one or more of the divisions. The support teams reflect the responsibility of each division leader to make the entire agency function and to support the other two agencies. The support teams are dynamic and do not reflect a layer of management between the divisions and the director's office. Individuals serving on the support teams are responsible to the other divisions and agencies.

Operations

Finance & Support consolidates the significant resources located within the current five agencies and other state agencies responsible for implementation of policy. This includes health and human services components associated with

Human Resources, Financial Services, Computer Systems and Technology, Staff and Partnership Development, Public Information, Support Services, Medicaid, and Strategic and Financial Planning. Through consolidation into the agency, the current resources can be more strategically managed to ensure consistent implementation of policy throughout the system.

The following table shows the core functions of each of the divisions:

Finance and Support Core Functions

<p style="text-align: center;">HUMAN RESOURCES</p> <ul style="list-style-type: none"> • Recruitment and Selection of Employees • Handling Labor Relations and Grievances for the Partnership • Classification and Compensation Issues • Affirmative Action, EEO, Americans with Disabilities Act • Supervisory Support Such as Work Performance Issues • Strategic HR Analysis and Planning • Payroll processing 	<p style="text-align: center;">COMPUTER SYSTEMS & TECHNOLOGY</p> <ul style="list-style-type: none"> • Applications Development, Maintenance and Consistency • Customer Support • Planning and Research • Coordinate with Staff and Partnership Development for Computer Training • Data Processing Operations • Project Management
<p style="text-align: center;">STRATEGIC & FINANCIAL PLANNING</p> <ul style="list-style-type: none"> • Policy Analysis Support • Strategic Planning • Resource Alignment • Research • Data Analysis/Utilization 	<p style="text-align: center;">SUPPORT SERVICES</p> <ul style="list-style-type: none"> • Records Management • Vital Statistics • Material Management • Facilities and Engineering • Administrative Services • Investigation
<p style="text-align: center;">STAFF & PARTNERSHIP DEVELOPMENT</p> <ul style="list-style-type: none"> • Organizational Development • Training and Development • Career Development • Consultative Services 	<p style="text-align: center;">PUBLIC INFORMATION</p> <ul style="list-style-type: none"> • Public Information/Outreach • Media Relations • Public Education Resources • Social Marketing • Legislative Liaison Services
<p style="text-align: center;">FINANCIAL SERVICES</p> <ul style="list-style-type: none"> • Accounting • Budget Administration • Claims Processing • Audit Activities • Revenue Collection 	<p style="text-align: center;">MEDICAID</p> <ul style="list-style-type: none"> • Title XIX (Medicaid), Provider Enrollment, Education, & Assistance • Retroactive Quality Assurance

Finance & Support provides its expertise to the Policy Cabinet in administering the Health and Human Services System. The new agency structure will provide the opportunity to focus the agency's vision, mission, and functions into specific areas of expertise. This change will incorporate all of the advantages of interdisciplinary teams that are key to successful business and government operations.

• "The same towns and same people (seasoned grant writers) keep getting grant funds, we need a closer relationship with funding sources for technical assistance, and we need technical assistance on outcomes."

• Community forum participant

Implementation Plan

By January 1, 1997:

- Agency leadership assignments made; and
- Finance & Support employees notified of their divisional assignments.

By June 30, 1997

- Orientation and training of employees to new agency and the new System completed;
- Organizational design and staffing work within divisional units and planning for implementation completed; and
- Develop a structure and working relationship regarding Medicaid-related functions and responsibilities among the three agencies.

Streamlining Contract Procedures

Each of the five Partnership agencies has its own processes and procedures for the development and management of contracts and grants. There is a need for a consistent and streamlined contracting and grant-making process. Providers view the current lack of standardization of the contracting period as costly and the common practice of entering into contracts for only one year is costly and burdensome. Many Nebraskans also seem to be concerned about a lack of expertise in grant writing, understanding performance outcomes, and other related topics.

Contracting/granting is a central part of the way in which each of the five Partnership agencies carries out their responsibilities. In addition to the Nebraska Medicaid program which spends more than \$700 million each year, the five Partnership agencies have approximately four hundred other contracts/grants with service providers totaling \$130 million. The Partnership structures for managing operations are, however, still largely oriented to direct services. Central to the vision of the Partnership will be a new focus on contracts and grants management.

Actions/Recommendations:

- A four-step contracting process will be used:
 - General identification of outcomes prior to the request for proposals utilizing the community/state Partnership concepts;
 - Competitive selection;
 - Classification of management expectations; and
 - Evaluation and accountability.
- A single Health and Human Services System contract template developed to streamline and use standardized language where possible.
- The period of contracts lengthened from two to five years, as appropriate;
- Outcomes to be achieved defined in terms of effects on the lives of Nebraskans; and
- Technical assistance provided to community/state partnerships to meet outcomes.

The process through which the state contracts with local entities to provide health and human services to Nebraskans must adhere to the following criteria:

- *Identification of outcomes prior to the request for proposals.* Outcomes must be consistent with overall outcomes of the Health and Human Services System, and be negotiated between contractor and contractee or the community.
- *Competitive selection.* Whenever possible, the process to select a provider or subgrantee should be competitive, contracts and subgrants should not be automatically renewable. Selection criteria must be established and published prior to beginning the competitive selection process. It is recommended that community governance structures award contracts and subgrants using a competitive selection process.
- *Management.* Negotiations leading to the award of a contract should include classification and management expectations, such as expectations for provisions of technical assistance to the provider agency and oversight to enhance performance outcomes and accountability measures. Ability to effectively carry out a contract can be demonstrated through review of history of operation, financial reports, or other means.
- *Evaluation and accountability.* Expectations must set forth regarding methods of program review and performance measurements to be employed. The reporting procedures will be uniform, and comply with governing regulations. An annual, independent fiscal audit and agreed-upon state monitoring procedures will be conducted to support fiscal accountability. Communication will be encouraged to minimize duplication between review activities. A formal program performance review should be conducted by one review team looking at all applicable regulations and performance measures in order to enhance the value of the activity and reduce costs. An evaluation of the process for requesting proposals is necessary to support accountability to the community governance structure and other citizens of Nebraska.

Agencies of the Health and Human Services System will award contracts for a period of two to five years, where appropriate, with a clause that allows cancellation of the contract for any reason with 90 days written notice. Increasing the contracting period will reduce costs for both the contractee and the contractor by:

- Increasing the amount of time between competitive bidding processes: A significant amount of time each year is spent preparing for a successful competitive bid which takes away from resources to provide quality services.
- Reducing the frequency of required performance review activities: Performance review would occur at midterm of the contracting period (as the contract period is increased, these associated costs are lowered).
- Allowing enough time for contractees to "round the learning curve": A one-year contract period may not allow enough time for contractees to make adjustments to meet performance outcomes. This may require additional staff resources to provide assistance which may not actually be needed.

Actions/Recommendations:

The following actions should be taken to begin implementation of a new contracting system:

- Notification to three new Health and Human Services System agencies that it is "business as usual" in working with subgrants and provider agreements until decisions are made to implement recommended changes.
- Identify work teams to begin building processes in follow-up to the Contracting/Granting Work Team recommendations:
 - Identify and assign staff to develop contract process for "business as usual";
 - Identify and assign staff to provide technical assistance to Community Learning Labs negotiating teams; (evaluation, financial, legal, etc.);
 - Identify and assign staff to address database issues and identify all ways data gathered can be used;
 - Identify issues for waiver negotiations of current mandates which may restrict desired outcomes;
 - Develop common terminology and definition of terms in the area of contracts and granting; and
 - Develop an Administrator's Manual; and identify necessary changes to legislation relative to contracting/granting practices.
- Define when a contract is necessary versus some other form of agreement.

Planning for Results-Based Budgeting

Over the past thirty years, the state budget process has remained essentially unchanged. State agencies continue to submit "program" budgets that provide detailed information on historical and proposed spending by "line item account," but do not show the relationship to the broad policy-related outcomes of state government, nor how successful those items are in achieving specific outcomes of a particular program.

Actions/Recommendations:

Take the opportunity provided by the Nebraska Partnership for Health and Human Services to be a leader in the development of a new budget process based on results. This process would emphasize what specific results are achieved through the expenditure of the funds as well as the specifics of how funds are expended.

Preliminary work in this area has shown that while several states have implemented performance measures for the purpose of maintaining agency accountability, these states focus more on performance-based budgeting and not on results-based budgeting. This fact, coupled with the reality that the development of a new process is dependent on other work team products not yet complete, made it difficult to develop a results-based budget process at this time.

Results-based budgeting is a concept that will require time and flexibility during the planning process. Prior to a new budget process being implemented, both administrative and legislative policymakers and personnel must agree on the concepts of results-based budgeting. Developing a budget process requires an understanding of outcome-based planning and results-based budgeting.

New Roles and Relationships

Legal Services

Currently, the legal services function that exists within the five Partnership agencies is handled separately with minimal coordination or communication. There are offices of agency legal counsel in the Departments of Social Services, Health, and Public Institutions. The Department on Aging has no separate office of agency legal counsel and obtains necessary legal support directly from the Attorney General's Office. The Office of Juvenile Services obtains its legal support from the agency counsel within the Department of Correctional Services. The Nebraska Partnership is an opportunity to organize legal services within the new health and human services system in the most efficient and effective manner.



Actions/Recommendations:

- There will be a legal services function in each agency reporting directly to the agency director.
- Legal support to the Policy Secretary/Cabinet will be provided by a separate independent attorney administratively housed in the Finance & Support agency and reporting directly to the Policy Secretary.
- Legal support for personnel matters for all three agencies consolidated within the Finance & Support agency.
- A review will be undertaken in 1987 to determine the feasibility of consolidating the appeal and hearing function within one agency, presumably the Finance & Support agency.

In determining how quality legal services can be provided to support the new System with the greatest efficiency and effectiveness, the core expectations — better services, simplicity, common sense, cost savings, and accountability — were balanced against the legal requirements of responsible professional practice and the desire to preserve the best features of existing representation.

Consideration was given to two major alternatives — having a single legal support function for the system housed within the Finance & Support agency, or having separate legal support functions within each agency. The Partnership Act did not provide direction on how legal services functions should be consolidated in the new organization. Based on the nature of the attorney-client relationship, awareness of the rights and duties flowing from that relationship, and the knowledge that, for a government lawyer, the agency is the client, it was decided that a legal services function will reside within each of the three new agencies.

System Advocate Role

The Partnership Act requires a position and a toll-free number be established to respond to questions, concerns, and complaints from consumers, service providers, elected officials, and interested citizens related to the transition of the agencies.

services, and programs into the new Health and Human Services System. This position will be called a "System Advocate" and will be in effect, at a minimum, from January 1, 1997 to July 1998.

The System Advocate will be located in the Department of Health and Human Services Finance & Support and will report to the Policy Secretary. Responsibilities include:

- assessing individual questions/concerns/complaints and directing them to the appropriate system area or agency for a response;
- helping the program understand the issues of the individual, if necessary;
- assisting in finding the answer at the closest possible level to the work;
- ensuring that the individual gets an appropriate response;
- reporting system problems to the Policy Cabinet;
- supporting development of the Health and Human Services System to meet the goals of the Partnership Act; and
- making monthly reports to the Governor, Legislature, and Policy Cabinet.

VIII. Integrated Financial and Information Technology Plan

Integrated Financial Plan

An integrated Health and Human Services System financial plan for the 1997-1999 budget biennium has been submitted under separate cover. The financial plan for this next biennium consolidates the budgets for the five Partnership agencies into a Health and Human Services System budget based on the functional distribution of the three new agencies. The principal features of the 1997-1999 financial plan are:

- The request for agency operations funding reflects a decrease of 4.5% over current year funding levels for the same operations. With the inclusion of the new Omaha Youth Security Facility, the overall Operations budget still reflects a decrease of 3.4%.
- Overall staffing levels are reduced by 400 authorized positions resulting in a cost savings of \$22.9 million. The reductions are to be staged over the course of the next biennium ending June 30, 1999.
- Medicaid expenses which comprise almost one half of the entire Health and Human Services System budget are projected to rise 6% annually. This is substantially less than the double-digit rise experienced over the last decade.
- The Blueprint for Developmental Disabilities, which addresses the waiting list for services, is projected at a fully-funded level for the next biennium.
- The budget request does not reflect such actual cost increases as increased rates charged by the Department of Administrative Services or an additional bi-weekly payroll for state institutions that occurs every seven to ten years. These costs will be managed through Operations savings.
- Increased costs pursuant to the statewide implementation of the Employment First Welfare Reform program (including that new, statutorily-defined child care reimbursement rates are funded.)
- Initial strategies to manage long-term care costs including implementation of preadmission screening statewide are provided for.

• "Passing the buck — one agency will pass to another in order to save money."

— State employee

- Costs of managing 24-hour care facilities including drugs, medical services and supplies, household supplies, utilities, and food are included.

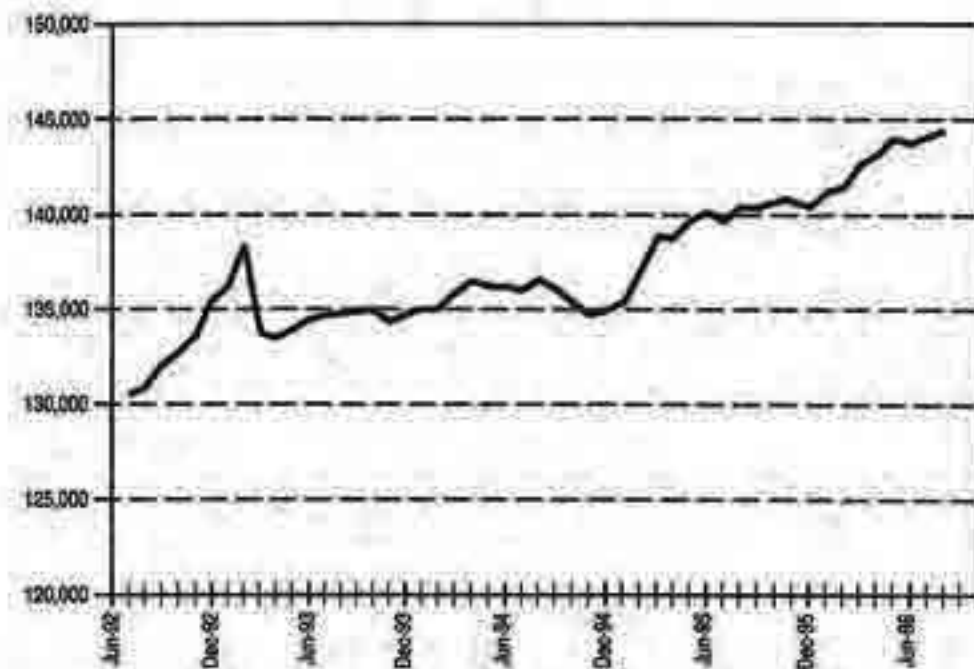
This integrated financial plan responsibly addresses the Legislature's directive in the Partnership Act to reduce operating costs. This will be done through cost savings, cost containment, and cost management strategies. Additional cost reductions will be realized over time.

As the work of the new System continues, additional cost savings are likely to be identified and implemented beyond the proposals already included in the 1997-99 Budget Request.

Managing Medicaid — Strategies for Efficiency

Medicaid is a joint federal-state program which pays medical bills for certain low-income people who cannot afford medical care. The Nebraska Medical Assistance Program (Medicaid) covers services such as inpatient General Hospital Services, Nursing Home Services, Physician Services, Home Health Care, Case Management, Prescription Drugs, and Outpatient Hospital Care.

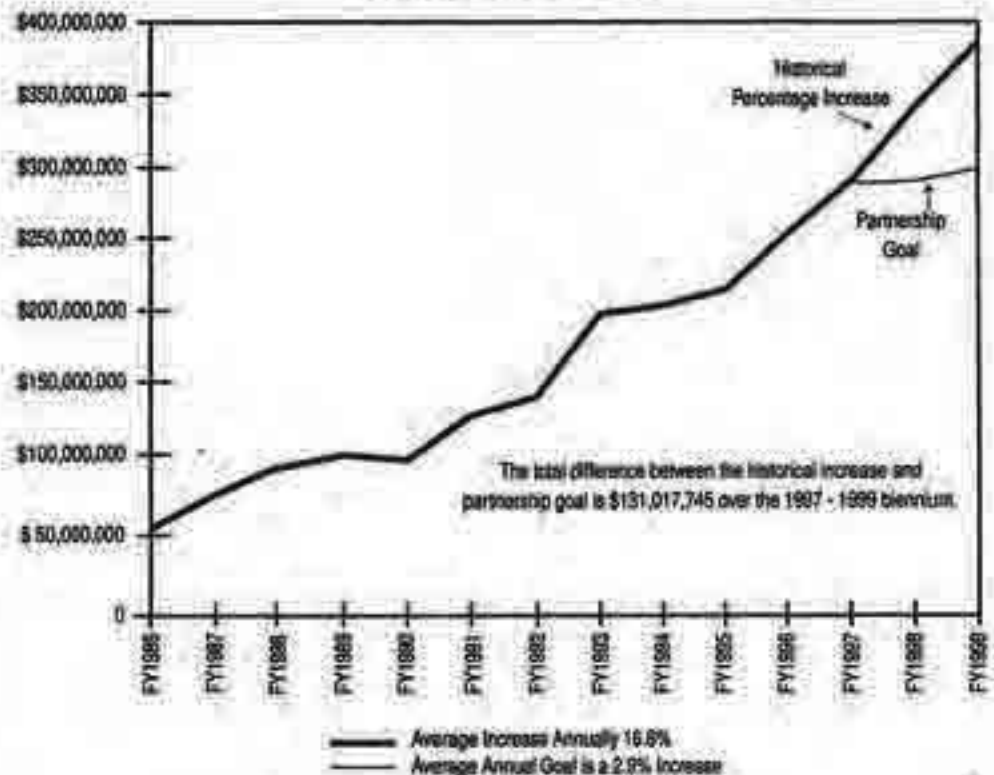
Medicaid Eligibles *July Persons 144,305*



Much of the initial work of the Partnership has included the development of strategies which have the containment of Medicaid costs as their goal. The Nebraska Partnership agencies will use managed care technologies of promoting coordination, cost efficiency, and networking to meet the needs of the state's most vulnerable citizens. The following graph shows the actual trendline for Medicaid growth, and reflects the goal of the Partnership to level-off that increase, beginning in 1997.

• The Diabetes Program, in the Department of Health, and Medicaid Program, in the Department of Social Services, are cooperating on a project to evaluate diabetes care for Medicaid patients. The programs have also been working together on quality assurance for the Medicaid Managed Care plans.

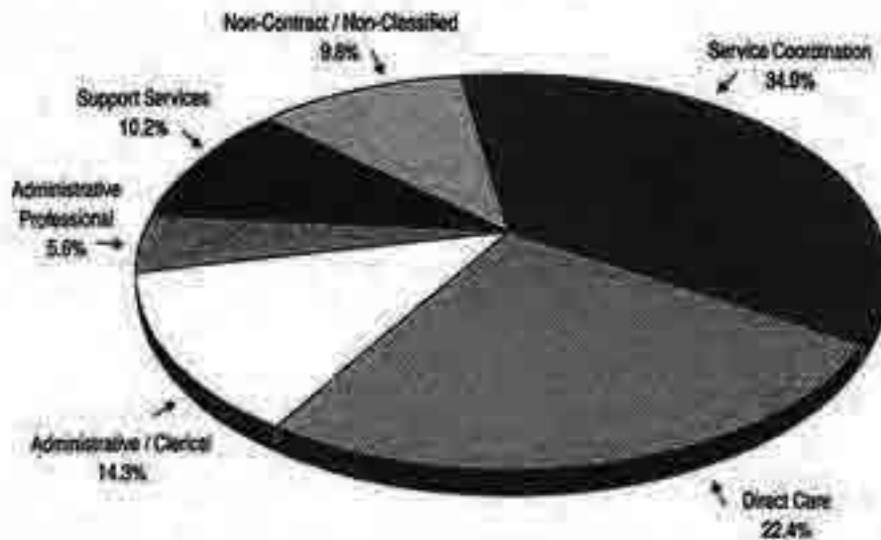
Medicaid General Fund Expenditures (Program 348 and 349)



Reengineering efforts by the Partnership, currently underway, should help to achieve the goal of a manageable six percent annual growth in Medicaid.

- The **Senior Care Options Program** is designed to test various methods of reducing Medicaid long-term costs in Nebraska, primarily through the implementation of preadmission screening for Medicaid-eligible applicants over age 65 desiring nursing facility placement. The Program utilizes the Medicaid Waiver for the Aged and Disabled to finance community services provided to persons diverted from nursing facility placement, if they are eligible for waiver services.
- The **Managed Care Long-Term Care Project** will identify methods to restructure services, in order to make Medicaid Long-Term Care services more effective and efficient in the state. The Project has divided the work among seven work groups (Facility Reimbursement, Case Management, Assessment, Quality Assurance, Medical Estate Planning, Long Term Care System Development, and Long Term Care Insurance) and will produce a recommendation in early 1997.
- The **Behavioral Health Partnership** initiative is designed to serve persons with problems of mental illness and substance abuse in the setting most appropriate to their needs. It is anticipated by realigning monies previously expended in more costly institutional settings, State General Funds can be redirected and matched with federal Medicaid funds to cover less costly community-based services.
- The **statewide implementation of managed care** as a Medicaid financing strategy, initiated in 1995, will show additional savings in the coming biennium.

FTE's by Bargaining Unit



Fewer than 6% of the staff serve in administrative, professional, or managerial positions. Currently, the majority of staff in the Partnership agencies provide direct care or service coordination. It is expected that staffing changes will naturally result from systems change activities, such as:

- *Streamlining service coordination.* Clients will have one Service Coordinator assigned to them, regardless of the number of services they need. This will lead to a more consolidated approach, reducing the need for multiple Service Coordinators in the field.
- *Restructuring and streamlining efforts across the three agencies.* Agency functions which have been duplicated in the past will be consolidated, and fewer administrative staff will be needed to accomplish routine agency operations.
- *Reducing temporary employees and consultants.* Current employees will be retrained to enhance existing expertise already available among Partnership staff. The use of internal expertise will reduce the need for expensive outside contractors.

The reduction of 400 authorized positions in the 1997-99 Biennium Budget will be accomplished over the course of the biennium. Specific positions have not been identified for reduction, at this time, as the detailed organizational structures and redesign of work activities have not been finalized. This measured approach to reductions is being used to ensure that critical services for Nebraskans are not jeopardized. Under the letter of understanding with the NAPE/AFSCME labor union, any reduction in state personnel will occur first through attrition, reassignment, retraining, and then if necessary, through reductions in force. This process will be applied to all state employees in the System, not just those covered by collective bargaining.

Welfare Reform

An integrated financial plan will enable the new Health and Human Services System to better manage the fiscal impact of new federal and state requirements such as in the area of welfare reform.

"We need to be able to help people get back to work without pulling the safety net of health care."

- Kearney community forum

The state's welfare reform initiative entitled "Employment First" is currently operating under federal waivers in Adams, Clay, Lancaster, Nuckolls, and Webster Counties and is slated for statewide implementation in fiscal year 1998. This initiative alters the relationship between Aid to Dependent Children (ADC) clients and the state with the goal of fostering client opportunities for self-sufficiency. Families are assisted in becoming and remaining independent through a combination of limitations on their eligibility for ADC benefits and enhanced case management and expanded job support services, child care assistance, and Medicaid coverage.

State legislation expands cost-shared Child Care assistance to ADC families with income up to 185% of the Federal Poverty Level for up to two years after leaving assistance. Legislation also requires that reimbursement rates to child care providers be adjusted every second year beginning July 1, 1997 based on a current market rate survey.

Recently enacted federal welfare reform legislation will affect the way various public assistance programs are operated and funded, but the specific impact on Nebraska cannot be determined at this time due to insufficient information about the changes. The open-ended federal entitlement for assistance is discontinued and replaced with a block grant covering ADC, Job Support, and Emergency Assistance funding. Significant changes are also made to Child Care, Food Stamps, Supplemental Security Income for Children, Child Support Enforcement, and benefits for legal immigrants. These changes have not been incorporated into the Partnership budget request but will be submitted at a later date.

Information Technology Plan

The services provided by the Health and Human Services System are dependent on several major computer systems to fulfill the agencies' missions. Since the services and information are provided by a variety of providers, both inside and outside the state system, an efficient, effective system for gathering and finding information is key to good management of the overall process.

The current information systems of the five Partnership agencies are widely diverse and will be reviewed in order to integrate and manage information systems across programs and functions; provide meaningful data to determine achievement of outcomes; and to support policy development. The five Partnership agencies collaborated on an Information Technology Plan for the 1997-99 Biennium and will work with the Department of Administrative Services to develop a priority structure for revision of the System's information and technology management.

Ongoing initiatives such as N-FOCUS (an integrated information system designed to decentralize and make eligibility determination more efficient) and the Child Welfare Information System (a collaborative effort across the agencies to manage child welfare information), will be viewed as a strong foundation for further information management and technology revisions.

Enabling Exchange of Information / Protecting Confidentiality

The redesign of Health and Human Services presents a unique challenge with respect to the exchange of information between the three new agencies created by the Partnership Act. In particular, the challenge is how to balance the most efficient provision of services through a unified system with the protection of the privacy of individuals who are either served by the system or for whom confidential information has been collected.

• "Could there be a coordinated application form that individuals complete one time and then this application is utilized to allow the person to access all the services they need."

- Lincoln community forum

• "Make sure that client privileges are maintained, and that confidentiality is addressed and maintained."

- Lincoln Community forum

Actions/Recommendations:

- Introduce legislation in January 1997 to address sharing of confidential information among the Health and Human Services agencies.

The legislation proposed by the Partnership would allow the departments to jointly adopt and promulgate rules, regulations, and policies which prescribe standards and procedures for access to and security of confidential information within each agency and among the departments, including standards for collection, maintenance, and use of information in electronic or other storage media. Procedures for disclosure of confidential information among the agencies shall include a process for a decision by the Policy Cabinet or its designees on whether confidential information should be shared among the agencies. Appropriate use of confidential information will be regularly audited as part of the Finance & Support's internal audit procedures. Such decisions may take the form of interagency agreements. Several factors would be considered including:

- The law governing the collection of the information and the original purpose for which it was collected;
- The potential for harm to an individual if the disclosure is made;
- Whether the disclosure will further the coordination of policy development, service provision, eligibility determination, program management, quality assurance, or financial and support services;
- Whether the information is a trade secret, academic or scientific research work in progress, unpublished and other proprietary or commercial information;
- Any conditions under which the information was received from the original source;
- Whether the proposed use is for a bona fide research project or study, the procedures and methodology of which meet the standards for research in the particular body of knowledge;
- The security of the information, including the scope of access, ongoing security, publication, and disposal of the information at the end of its use; and
- The degree to which summary data may identify an individual whose privacy would otherwise be protected.

The disclosure of any confidential record among the departments shall not be considered a public disclosure or make the record a public record. Any further disclosure may be made only if permitted by the law or department policy governing the originating department. Finally, the legislation proposed that all officials and employees shall receive training on laws, rules and regulations, and policies governing confidential information to which they have access.

IX. Transitioning the System's Human Resources

There are a range of human resource needs in the new System, and the job of managing these resources effectively and efficiently is a high priority. The job of aligning the current human resources system has begun so that it will be ready to meet the needs of our workforce in the new system. Several processes are in place to assist in the Transition Phase such as an integrated internal posting of vacant positions and the expanded ability to donate earned vacation time to an ill co-worker in any of the Partnership agencies. Other initiatives planned include consolidation of human resource policies and an integrated human resource information system.

“There appears to be an awful lot of middle management to go through to get even simple decisions made.”

- State employee

Reinventing Classification

Employees in the new Health and Human Services System must be treated fairly and consistently across the System. In collaboration with the Department of Administrative Services' State Personnel Department, a unified classification system is being developed that standardizes job classifications and defines jobs horizontally within classifications rather than separate titles assigned to each agency. This broad-banded classification system will be automated to better facilitate standardization in evaluation of reclassification requests and reduce the process and file maintenance time. Elements of the classification system serve as a foundation for recruitment/selection based on knowledge, skills and abilities, training needs, and performance management standards and measures tied to duties and responsibilities.



A broad-banded classification system will allow levels of management to be compressed, in conjunction with the development of a corresponding compensation plan. It will also provide for greater flexibility to respond to client's needs.

There will be multiple training opportunities to provide employees with the new skills they need to handle their changing roles. While change is difficult, this is an opportunity for employees to be able to sharpen their skills to potentially position themselves in an area that may better fit their strengths.

X. Supporting Employees In Managing the Transition

Managing the Transition

Leaders in the field of organizational change have recognized the best technical planning will fail unless the human element is incorporated. The attitudes and expectations of employees form the foundation for success or failure of organizational transformation efforts. The Nebraska Partnership's Transition Management Plan is a planned set of services and activities whose purpose is to manage the human side of the transition as state employees move from their five current agency affiliations to their identification with the new Nebraska Health and Human Services System.

Actions/Recommendations:

1. Change will be managed by providing support for managers and employees in dealing with the uncertainties and stresses associated with reorganization;
2. The workplace culture that will enable the Health and Human Services System outcomes and values will be explicitly defined and action taken to implement; and
3. Priority has been placed on the development of two additional human resource management approaches: project contract worker and early retirement. The project contract worker would be an employee hired to manage specific project(s) for a limited

period of time. An early retirement program would create an option for interested employees to elect early retirement from state government to pursue other interests.

Management's Responsibility

The Transition Management Team was formed as a catalyst in bringing together resources needed to support management and employees through the coming changes. Existing managers bear the responsibility of leading employees through the field of change, and that any activities and that services are created are supports and not replacements for the roles of managers.

Managing The Change

- ***Employee Check-ins:*** Periodic interviews are being conducted with a cross section of employees to determine if support services being provided meet their needs. Tracking interviews will continue during the transition to gauge employees' adjustment to the new system.
- ***Administrators' Meetings:*** Several meetings have been held throughout 1996 with the administrators, or senior level managers, from the five agencies to keep them informed during the various phases of the Nebraska Partnership. Administrators' views were solicited and questions/concerns addressed during discussions with the Transition Policy Cabinet.
- ***Employee Assistance Program Services (EAP):*** The Methodist EAP is available to help prepare managers and employees to respond positively to the transition. Training on "dealing with uncertainty" is being provided to administrators, middle management, and frontline supervisors. Counseling services are being provided through the existing EAP contract, and additional information is available to managers and supervisors to encourage their referral of employees who experience stress during the transition.
- ***Opportunity Management Supports:*** These services will assist Partnership employees in self-managing their career opportunities. A diverse array of services are planned to help employees react positively to the changes and see them as opportunities for self-growth. Services that have already been implemented include the *Nebraska Partnership Job Mart*, *Staff Development Opportunities in State Government*, and a *Tuition Assistance Program*.
- ***Local Bridge Teams:*** Local bridge teams, comprised of frontline workers and managers have been organized to facilitate a local approach and quick response capacity. Through local bridge teams close to their own work units, employees have an opportunity to talk about the changes with peers. These teams will serve as a horizontal communication network *bridging* information gaps.
- ***Sunsets and Sunrises:*** A set of activities have been organized to celebrate the valuable services provided by the current agencies and to provide opportunities for Partnership employees to build new relationships through team building activities. The agencies

are being asked to celebrate and recognize the end of their respective identities and to plan activities to recognize the new system taking effect on January 1, 1997.

- **Employee Wellness:** As employees face the stresses of change, healthy life-styles are important to ensure mental and physical well-being. The outcomes of the wellness program are to increase employee morale and productivity, support healthy life-style patterns, encourage disease and accident prevention, reduce absenteeism, and lower or stabilize health care costs.

Changing the Culture

- **Baselining the Culture:** Before January 1, 1997, the work cultures operating within the five agencies will be assessed to have a baseline for future comparisons. Characteristics being assessed include: innovation and risk taking; concern about quality in products/services; responsiveness to customer needs; control in decision-making; leadership and vision; and collaboration in problem-solving. Repeat assessments are planned annually to track employees' progress in moving toward a unified work culture.
- **Culture Definition Process:** Based upon the system's vision and principles and the cultural assessment data, a draft set of work culture characteristics will be developed for approval by the Policy Cabinet. These work culture characteristics will form the basis for future activities designed to usher in the new system culture.
- **Incorporation of the Cultural Definition into Human Resource and Staff Development Processes:** The new cultural definition will be incorporated into various human resource processes such as selection criteria for leaders in the new system, performance evaluation criteria, and new employee orientation, etc.
- **Cultural Orientation Workshops:** Workshops for small groups of employees, perhaps twenty or so at a time, will be held to present back to employees the new cultural definition and to help employees interpret how the new culture applies in their day-to-day work.
- **Training:** Based on the definition of the new workplace culture, a core set of skills and competencies expected of employees at various levels will be defined. Training will be developed to support employees in developing these skills and competencies.
- **Leadership Development Institute:** The support and active role-modeling of the new culture will be an essential expectation of leaders in the new system. To help leaders quickly incorporate the cultural values and to assume the special expectations needed to lead the change, individualized leadership assessment and feedback, coaching, specialized training, and long-term dialogue training are being explored. This training will foster the development of new leadership within the system.

XI. Information and Participation are Key to Partnership Success

A meaningful participation process lies at the heart of the Nebraska Partnership. The activities of restructuring and redesigning three new agencies are accomplished through a participative process that affords community representatives, state employees, service providers, consumers, and advocates multiple opportunities to shape the design of the new system, based on a common set of objectives.

Nebraskans interested in the Partnership are able to find out information, be updated, and engage in genuine dialogue about the process through:

- Public meetings and forums;
- *Progress Report* newsletter, mailed to employees and others who either participated in the system redesign or requested to be included on its mailing list;
- Partnership Web Page, e-mail, and toll-free Information Line;
- Partnership news stories and editorials, in both the public media and community advocate newsletters;
- Partnership video library, with taped copies of presentations by facilitators and content experts;
- Speakers Bureau presentations, held throughout the state; and
- Employee Forums, videoconferences, and administrator meetings.

These seven avenues of communication support three of the Partnership's basic premises: working with Nebraskans to forge better services, making services simple and efficient, and basing services on common sense.

Since Nebraskans want — and need — to receive and process information in different ways, this effort supplies a variety of participation windows to allow learning processes to accommodate those individual needs.

As the number of Partnership decisions grows, so have the ever-widening circles of interaction windows available to Nebraskans. While some citizens have been interested in the process since the announcement of the legislation in January, most have become increasingly interested as the Partnership works through processes and programs affecting their own lives.

Communication will play an essential role in helping the System achieve the five criteria of better services for Nebraskans; a simple and efficient system; a system based on common sense; realization of cost savings, and accountability to Nebraskans. Short-term communication goals to bring the Partnership closer to achieving the five criteria include:

- Creating an awareness of the efforts and benefits of a unified Health and Human Services System;
- Promoting the value of the unified system to a variety of constituencies;
- Communicating the new names and general contact points of the new agencies; and
- Fielding questions from constituencies needing more information.

Outreach activities during the transition period include:

- Designing and producing a system-wide employee newsletter to begin early in 1997;

• "Be the change you want to create."

• Gandhi

- Resource guide for employees, listing numbers, names, programs, acronyms, and other useful information, also to be available in January;
- Public service announcements for radio;
- Small print pieces for distribution and pickup at community sites;
- Scheduling guest commentators for both commercial and public broadcasting programs and services; and
- Small display advertisements in Nebraska newspapers and on Nebraska radio; and

These windows of communication will continue to provide Nebraskans of all ages, abilities, and talents the opportunity to stay alert and involved in the participation process.

XII. Conclusion

Now that the redesign phase is complete, the focus will shift to implementation issues scheduled to occur over the next 30-month time-frame. At the end of 1996, the Implementation/Transition Planning Phase (September 1996 - December 31, 1996) will be complete, whereby, the initial foundation will be laid to officially transition to a unified Health and Human Services System. Employees will have been notified of their new agency assignments; a coordinated legislative package will be introduced; an integrated budget and information technology plan submitted; partnership agreements negotiated with pilot communities; and the Policy Cabinet and Partnership Council selected and ready to be submitted to the Legislature for approval. On January 1, 1997, the Implementation Initiation Phase (January 1, 1997 - June 30, 1997) begins with further development of opportunities for communities, validating system level outcomes and indicators, orienting employees to the new System, further refining the organizational structures of the three agencies, and integrating human resource policies and procedures. On July 1, 1997, the Implementation Completion Phase (July 1, 1997 - June 30, 1999) begins where many of the previously proposed activities will become a reality.

The realization of this unified system will not occur overnight. New competencies must be built at both the state and community levels. Alignment of human resources, financial, and information systems will take time to develop. Changes in cultural norms such as collaborative teamwork, focus on consumer-based outcomes, continuous improvement, and participative decision-making will be ongoing. Even the most ambitious and well thought-out plans will take time to implement in a thoughtful and meaningful way. The work done to date is a significant milestone along the continuum of system change that will be ongoing for many years.

The Nebraska Partnership's "common sense" approach will result in a Health and Human Services System with unified and coordinated policy development, service provision, program management, evaluation, financial resources, and support services at the state level. The new structure will ensure accountability for results that matter to the citizens of Nebraska while decentralizing decision-making to promote flexibility, responsiveness, and responsibility at the point where services are being delivered. As a result of these changes, operating costs will be reduced and efficiencies will result in the way the state does its work. This new Nebraska Health and Human Services System provides common sense solutions for a healthy Nebraska. Many individuals have contributed their energy and expertise to the development of this report. Their tireless efforts and willingness to sacrifice many hours of their own time to commit to the work of this worthwhile venture are appreciated.

APPENDIX A

Glossary of Terms:

Certification: A voluntary process that identifies to the public that an individual, facility, or service meets a prescribed set of standards.

Cross-Cutting Teams: Five teams that "cut across" issues relevant to all three new agencies are being formed: Health Policy, Safety Policy, Self-Sufficiency Policy, Strategic Planning and Community/State Partnerships.

Credentialing: A generic term for both licensing and certification. It also applies to commonly used terms such as registration, approval status, and enrollment.

Culture Change: The alignment of workplace values and behaviors that lead to a more open and participative culture.

Finance & Support: One of three new agencies in the Health and Human Services System.

Funding Streams: Funds that are derived from multiple sources.

Indicator: A characteristic or quantitative value that is used to measure an outcome. For example, a high death rate from cigarette smoking is an indicator for an outcome that Nebraska residents choose healthy life-styles.

Learning Labs: Three communities — Metropolitan Omaha, the Panhandle and Dakota County/Sioux City — who volunteered to serve as test sites for a new community/state relationship.

Licensing: A process by which an individual, facility or service applies for and receives legal authority from the state to practice a profession, operate a facility, or to provide health and/or human services.

Local Bridge Team: A group of employees at the work unit level that serve as a bridge between employees and the Policy Cabinet. The Local Bridge Teams will serve as a horizontal communication network to build stronger relationships and enhance communication about the Partnership.

Local Service Networks: Providers of health and human services, either public or private, and other supporting organizations which join together to form a coalition or alliance to better serve a community or communities collaboratively and which are recognized as local partners by the Health and Human Services System.

Medicaid: A joint federal-state program which pays medical bills for certain low-income people who cannot afford medical care.

Medicaid Waiver for the Aged & Disabled: This waiver provides for home- and community-based services (housekeeping, respite, etc.) to be delivered to eligible Nebraskans and paid through Medicaid.

NAPE/AFSCME: The Nebraska Association of Public Employees/Association of Federal, State and County Municipal Employees is the collective bargaining unit for many Partnership agency employees.

Outcome: A condition of well-being for individuals, families or communities which is the ultimate focus and desired result of a set of Health and Human Services programs, activities and/or interventions. For example, "healthy mothers-to-be" might be the desired *outcome* of a public health program.

Partnership Act: The legislation passed in April, 1996, that legally requires the development of a unified Health and Human Services System.

Partnership Council: The Partnership Council advises and assists the Policy Cabinet in the development of policy objectives and desired outcomes. The Council will also participate in the review and evaluation of the achievement of outcomes and shall make recommendations to the Policy Cabinet for Health and Human Services System improvements.

Participative Design: A method for involving people in restructuring their own workplace to be as self-managing as possible. Participative design results in a workforce committed to implementing their own design.

Performance Accountability System: The processes in the Health and Human Services System that defines statewide outcomes to be achieved, establishes corresponding indicators for measuring progress and assesses the performance of services and programs at the state and/or local level based on their effectiveness, efficiency, and quality. This assessment provides input to the Systems strategic planning and ongoing processes.

Policy Cabinet: The Policy Cabinet is comprised of the three new agency directors and the Policy Secretary. All of these positions are appointed by and serve at the pleasure of the Governor and are confirmed by the Legislature.

Policy Secretary: The Policy Secretary chairs the Partnership Council and serves as a member of the Policy Cabinet, along with the three agency directors. This position is appointed by and serves at the pleasure of the Governor and is confirmed by the Legislature.

Redesign Steering Committee: A committee of state and community members appointed by the Transition Policy Cabinet to make recommendations regarding the structure and operational design of each of the three new agencies of the Health and Human Services System. These three committees concluded work in November, 1996.

Regulation & Licensure: One of three new agencies in the Health and Human Services System.

Regulation & Licensure Facilitators: Regulation & Licensure staff who assist customers in defining their needs from the System and linking them with the appropriate parts of the System to satisfy those needs.

Regulation & Licensure Service Area: One of four areas of service in the Regulation & Licensure agency directed out individual providers; program and facility providers; consumer, safety and protection; and environmental health and safety protection.

Results-Based Budgeting: An approach to budgeting which focuses on established outcomes. Results-based budgeting uses outcomes defined for children, individuals, families and communities and works backward to incorporate more traditional budget concepts. Results-based budgeting is a tool which when used in

conjunction with Strategic Planning and Performance Accountability, insures that resources are aligned in the system.

Services: One of three new agencies in the Health and Human Services system.

State Service Management Areas: The geographically based management areas within the Department of Health and Human Services responsible for the local delivery of individual and community services, preventive health, and public wellness activities statewide.

Sunrises/Sunsets: Many employees need ritual good-byes to their current agency in order to fully embrace a new agency and a new identity. Sunrise (beginnings) and sunset (endings) events serve to meet those needs.

System Advocate: Required by LB 1044, this position — and an accompanying toll-free number — will serve as response centers for questions, concerns and complaints from consumers, service providers, elected officials and interested citizens. The position will be in effect, at a minimum, from January 1, 1997 to July, 1998.

Transition Policy Cabinet: The directors of the Departments of Social Services, Health and Public Institutions, Department on Aging and the Office of Juvenile Services in the Department of Correctional Services, along with the director of the Governor's Policy Research Office.

Waivers: A request to be excepted from federal government regulations that interfere with achievement of Partnership outcomes. For example, a waiver could be addressed to the elimination of categorical federal funding streams. See also: Medicaid Waiver.

Work Teams: Teams created by Redesign Steering Committees, consisting of individuals both internal and external to state government, who had expertise in the particular area assigned to that work team. Ultimately, all products of the teams were integrated into the work of the Redesign Steering Committees and formulated into recommendations for approval by the Transition Policy Cabinet.

APPENDIX B

List of Partnership Work Products

To receive copies of any of the following work products, please call 471-9109 in Lincoln or 1-800-254-4202 outstate.

Finance & Support —

Department of Health and Human Services Finance & Support Organizational Structure: dated November 21, 1996.

Ongoing Budget Process Work Team Report: dated September 16, 1996, presented and approved by TPC, November 5, 1996.

Contracting/Granting Work Team Final Report: dated October 15, 1996, presented and approved by the TPC, November 5, 1996.

Report of the Combination Team on Restructuring

Regulation & Licensure —

Summary of the Regulation & Licensure Redesign Steering Committee Work on Streamlining Regulatory and Credentialing Processes: November 15, 1996. This summarizes five areas of study: *Simplification of Emergency Medical Services Regulations; Unlicensed Assistive Personnel, Providing Medication; Credentialing Providers, Programs, and Facilities; Re-engineering the Process for Credentialing.*

Health & Human Services System Outcomes and Suggested Indicators: approved by the TPC, October 29, 1996.

Performance Accountability System: approved by the TPC, September 17, 1996.

Proposed Organization Structure: approved by the TPC, October 4, 1996.

Regulation & Licensure Redesign Steering Committee: Streamlining Inspections presented to TPC, October 29, 1996.

Regulation & Licensure Redesign Steering Committee: Re-engineering the Credentialing Process: presented to TPC September 24, 1996.

Regulation & Licensure Redesign Steering Committee: Unlicensed Assistive Personnel (UAP)-Medication Provision: presented to TPC, October 29, 1996.

Services —

Proposed State/Community Partnership Model: presented to the TPC, August 27, 1996.

Readiness Criteria for Local Governance: November 1, 1996.

Proposed Youth Services Delivery System Plan: Transition Toward

Partnerships: prepared by the Office of Juvenile Services and the Department of Social Services; approved by TPC, September 3, 1996.

Services Coordination Work Team Final Report: October 8, 1996.
Approved by the TPC, October 15, 1996.

Service System Model Report: October 15, 1996, approved by the TPC, October 22, 1996.

Prevention Strategies Work Team Report: October 22, 1996, approved by the TPC, October 22, 1996.

Others —

Nebraska Partnership for Health and Human Services Progress Report: September 16, 1996.

Nebraska Health and Human Services Indicators: A Preliminary Report, September 16, 1996.

Legal Team Report: dated October 22, 1996, presented to and approved with modifications by TPC, October 22, 1996.

APPENDIX C

- * Denotes Team Leader
- ** Denotes Team Sponsor

Services Redesign Steering Committee

Jessie Rasmussen, Team Leader	Jon Hill, Committee Sponsor
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APPENDIX D

System Outcomes and Preliminary Indicators

Cluster Area: Safety

Nebraska residents are free from unintentional injury (HHS System Outcome #1)

Preliminary Indicators:

- Rate of unintentional injury deaths
- Rate of hospital emergency room admissions for unintentional injury
- Rate of motor vehicle unintentional injuries and deaths
- Rate of water related unintentional injuries and deaths

Nebraska residents are free from juvenile crime (HHS System Outcome #2)

Preliminary Indicators:

- Juvenile arrest rate (total)
- Arrest rate for personal crime
- Arrest rate for property crime
- Arrest rate for other (public order) crime

Nebraska residents are free from abuse, neglect, and exploitation (HHS System Outcome #3)

Preliminary Indicators:

- Number of children hospitalized because of abuse or neglect
- Number of children who are the victims in substantiated Child Protective Service (CPS) cases
- Number of older adults who are the victims in substantiated Adult Protective Service (APS) cases
- Number of disabled adults who are the victims in substantiated Adult Protective Service (APS) cases
- Number of persons who are victims in substantiated cases of abuse or neglect in institutions
- Number of children or adults who are victims after intervention
- Incidence of domestic violence
(Recommend development of indicator(s) for exploitation)

Nebraska residents work in a safe environment (HHS System Outcome #4)

Preliminary Indicators:

- Rate of persons injured while at work
- Incidence of occupational disease

Nebraska residents do not experience death, disease, injury due to unsafe or unhealthy conditions from natural environments or those impacted by human intervention. (HHS System Outcome #5)

Preliminary Indicators:

- Rate of poisoning
- Incidence of elevated blood lead levels in children
- Incidence of illness caused by contamination of public water supplies
- Incidence of hospital admissions for asthma and other respiratory diseases
- Incidence of illness caused by contamination of the food chain

Cluster Area: Health and Well-Being

Nebraska residents are free from preventable disease (HHS System Outcome #6)

Preliminary Indicators:

- Incidence of sexually transmitted disease
- Incidence of HIV infection
- Incidence of cardiovascular disease
- Incidence of cancer
- Incidence of Type II diabetes
- Incidence of vaccine preventable disease
- Incidence of tobacco related deaths

Nebraska residents are free from substance abuse (HHS System Outcome #7)

Preliminary Indicators:

- Percent of teens who report binge drinking (Behavioral Risk Study)
- Percent of adults who report binge drinking (Behavioral Risk Study)
- Percent of teens who report substance abuse (Behavioral Risk Study)
- Percent of adults who report substance abuse (Behavioral Risk Study)
- Percent of teens using tobacco
- Percent of adults using tobacco
- Number of deaths and injuries related to alcohol use
- Number of deaths and injuries related to substance abuse

Nebraska residents choose healthy lifestyles (HHS System Outcome #8)

Preliminary Indicators:

- Percent of teens who report being overweight (Behavioral Risk Study)
- Percent of adults who report being overweight (Behavioral Risk Study)
- Percent of teens who report little or no exercise (Behavioral Risk Study)
- Percent of adults who report little or no exercise (Behavioral Risk Study)
- Percent of teens who are sexually active
- Percent of sexually active teens participating in safe sex practices.

Nebraska residents experience healthy pregnancies and births (HHS System Outcome #9)

Preliminary Indicators:

- Percent of mothers who receive prenatal care in the first trimester

- Infant death rate (also: fetal death rate, neonatal death rate)
- Percent of low birthweight babies (< 2500 grams)
- Percent of babies born with birth defects
- Teen pregnancy rate
- Percent of women who smoke or drink during pregnancy

Nebraska residents do not experience death, disease, injury related to lack of appropriate treatment (HHS System Outcome #10)

Preliminary Indicators:

- Percent of residents who reside in medically underserved areas
- Percent of deaths due to lack of emergency treatment

Nebraska residents are appropriately nourished (HHS System Outcome #11)

Preliminary Indicators:

- Percent of children who are the appropriate weight for their height
- Percent of adults who are the appropriate weight for their height

Nebraska residents are free of physical and psychosocial conditions which interfere with learning (HHS System Outcome #12)

Preliminary Indicators:

- Percent of children who are the victims of substantiated CPS cases
- Percent of children who are homeless
- Percent of children with sensory, behavioral, physical, and cognitive disabilities not diagnosed prior to pre-kindergarten physical

Cluster Area: Self-Sufficiency

Nebraska residents have the opportunity to work (HHS System Outcome #13)

Preliminary Indicators:

- Unemployment rate
- Percent of employed persons who are underemployed
- Number of employees with employer benefit plans (real jobs) (Develop a training or retraining indicator(s) specifically for older and persons with disabilities)

Nebraska residents live as independently as possible (HHS System Outcome #14)

Preliminary Indicators:

- Percent of persons living in institutional settings (i.e., nursing homes, state hospitals, the Beatrice State Developmental Center) (Note: Numbers alone may not tell if living as independently as possible. This indicator needs more work.)
- Percent of older persons with self-care limitations, mobility limitations, or both, living independently

- Percent of older adults living in their own homes
- Percent of persons with disabilities living in their own homes
- Percent of older Nebraska residents receiving "in-home" services
- Percent of Nebraska residents with access to transportation (indicators need to be developed)

Nebraska families are stable (HHS System Outcome #15)

Preliminary Indicators:

- Divorce rate
- Rate of children removed from their homes (out-of-home placements)
- Families living in homeless shelters
- Number of runaways

Families and individuals have the resources needed to achieve self-sufficiency (HHS System Outcome #16)

Preliminary indicators:

- Percent of families using food pantries
- Percent of persons with disabilities affecting their ability to perform daily living activities
- Number of high school dropouts
- Number of persons without health insurance (Medicaid, Medicare, private, etc.)

Nebraska residents have adequate personal income (earned and unearned) (HHS System Outcome #17)

Preliminary Indicators:

- Percent of population below 200% of poverty level
- Percent of persons receiving public assistance
- Rent as a percent of personal income
- Per capita income

Cluster Area: Opportunities for Maximum Participation

Nebraska residents are treated with respect and dignity (HHS System Outcome #18)

Preliminary Indicators:

- Percent of discrimination reports filed
- Number of persons on waiting lists for admissions at nursing homes for a Medicaid bed
- Number of physician/health care facilities serving minority, persons with disabilities, aged, rural, populations
- Number of substantiated complaints related to unfair program applications

Nebraska residents are able to participate in and contribute to the political, economic, and cultural life of the community (HHS System Outcome #19)

Preliminary Indicators:

- Number of Rehabilitation Act and ADA complaints
- Number and location of TDDs in the state
- Number and location of interpreters (e.g., sign, bi/multi-language) available
- Percent of adults who are functionally impaired because they cannot read
- Percent of adults who do not speak English
- Number of persons registered to vote through HHS programs.

