

Nebraska Department of Children and Family Services

Assessment of Outsource Model in Nebraska's Eastern Service Area:

Findings and Recommendations

PREPARED BY:

THE STEPHEN GROUP
814 Elm Street, Suite 309
Manchester, NH, 03102
Main: (603)419-9592
www.stephengroupinc.com

May 2019

Final Report

Table of Contents

1. Executive Summary	5
1.1. Background	5
1.2. Why Outsource?	5
1.3. Key Findings	5
1.4. Other Findings	7
1.5. Path Forward	8
2. Scope and Objectives	12
3. Review of Past Audits, Studies, and Reports.....	13
4. Methodology	15
5. Assessment of Child Welfare Performance Outcomes	16
5.1. Child and Family Services Reviews (CFSR) Measures	18
5.2. Child And Family Services Reviews (CFSR) Round III Measures	24
5.3. Other Child Safety Outcomes	28
5.4. Other Permanency Outcomes.....	30
5.5. Well-Being Outcomes	35
5.6. Outcomes Related to In-Home Cases.....	39
6. Financial Review – Cost Per Case	41
6.1. State Program Reimbursement under the Vendor Contract	41
6.2. Other Sources of Revenue.....	42
6.3. PromiseShip Cost Structure	43
6.4. Administrative Costs	44
6.5. PromiseShip Costs to Include in the Cost per Case Assessment	46
6.6. Additional Costs for Comparability with Other Regions.....	46
6.7. Date of Costs Included	48
6.8. Costs Not Included	48
6.9. Total Costs Used in the Cost per Case Calculation.....	49
6.10. Cases.....	49
6.11. Reconciling Case Counts Between State and PromiseShip	50
6.12. Cases Over Time	51
6.13. Case Counts in Other Service Areas	52
6.14. Cost per Case.....	54
6.15. Findings from Case Cost Assessment	57
6.16. Summary Findings from Financial Review	59

7. Stakeholder Assessment	62
7.1. 2018 PromiseShip Annual Survey	62
7.2. TSG Stakeholder Feedback.....	63
8. Observations about Partnership Between DCFS and ESA vendor.....	65
8.1. Collaboration not Competition.....	66
8.2. Lack of Clearly Articulated Vision	72
8.3. Instability.....	73
8.4. Summary	74
9. Contracts and Contract Monitoring Review	75
9.1. Contract Between the State and Vendor	75
9.2. History.....	75
9.3. Contract Provisions	78
9.4. Performance Standards and Outcomes.....	81
9.5. Specific Findings Related to the Actual Contract	83
9.6. Contract Monitoring and Oversight	85
10. Continuous Quality Improvement.....	89
10.1. State CQI Program	89
10.2. PromiseShip CQI Program.....	89
10.3. TSG’s findings	91
10.4. Utilization Management.....	92
11. Vendor Process Findings.....	94
11.1. Service Array.....	94
11.2. Alignment with Requirements of Family First Prevention Services Act (FFPSA)	97
12. Review of PromiseShip Caseworker Processes	111
12.1. Hotline Intake Process.....	112
12.2. In-Home Case Transfer Process Map.....	113
12.3. Out-of-Home Case Transfer Process Map	113
12.4. Process Mapping Findings	117
12.5. Opportunity to Expand AR, Community Referrals, and Voluntary Non-Court Cases. .	118
13. Path Forward	123
13.1. Vision	124
13.2. Performance-Based Contract.....	125
13.3. Contract Oversight	126
13.4. FFPSA Compliance.....	131
13.5. Improve Coordination With Medicaid	133

14. Appendix A: Complete Review of Prior Audits and reports	136
14.1. State Auditor of Internal Accounts, 2018.....	136
14.2. Letter to Senator Merv Riepe	138
14.3. Letter to Patrick O’Donnell, Clerk of the Legislature.....	139
14.4. Letter to Patrick O’Donnell, Clerk of the Legislature.....	140
14.5. Nebraska Child Welfare Blueprint Report March 2017.....	140
14.6. OIG Annual Report, 2016-2017	144
14.7. Hornby Zeller, 2014	145
14.8. Digital Commons, University of Nebraska	146
14.9. Hornby Zeller, 2012	149
14.10. Platt Institute, 2012.....	151
14.11. DHHS Report to the Legislature: Legislative Resolution 37 (2011): Review, Investigation and Assessment of Child Welfare Reform	151
15. Appendix B: Performance on CFSR Round II Measures	153
16. Appendix C: Additional Financial Analysis Beyond Cost Per Case	156
16.1. Provider Payment Structure	156
16.2. Description of Provider Base and Payments	158
16.3. Caseloads.....	165
16.4. Caseloads Compared to Federal Standard.....	171
16.5. Turnover	171
17. Appendix D: Florida Required Collaborations.....	176

1. EXECUTIVE SUMMARY

1.1. Background

Currently, the Eastern Service Area (ESA) region of Nebraska for the Department of Health and Human Services (DHHS), Division of Children and Family Services (DCFS), which comprises Douglas and Sarpy Counties, utilizes an outsourced vendor for the provision of children and family services. This vendor, a non-profit entity called PromiseShip (formerly Nebraska Families Collaborative), holds a contract through 2019.

DHHS contracted with The Stephen Group (TSG) to help it determine an appropriate path forward should it should continue forward with the outsource model, to ascertain if the model has been effective to date and how it could be made more effective if the state were to move forward with the outsource model. This assessment comes after numerous meetings with the state, the vendor and numerous stakeholders, as well as rigorous financial and performance analysis, and a review of past audits and assessments.

1.2. Why Outsource?

Nebraska is neither the only nor the first state to outsource children and family services. States have chosen this model, as it allows for flexibility to innovate new solutions that reduce costs and improve services, provides the ability to rapidly adapt to new circumstances and adjust to local considerations, and promotes greater community engagement to improve connectedness and deliver better outcomes.

Maintaining an effective outsource model, however, requires a shared vision and strong collaboration between the vendor and the state. This demands trust, strong communication, accountability and stability to ensure that the practice ultimately produces better results.

1.3. Key Findings

1.3.1. Cost and Outcomes

Fundamentally, the outsource vendor in the ESA has cost, performance and outcome measures similar to those of the other four insourced regions. While some regions performed better in some areas, the outsource vendor produced better in others.

There were no areas in terms of cost or outcomes in which the vendor was an outlier from overall state results. The areas in which outcomes are improving for the vendor match those areas where similar outcomes are improving on a statewide basis. For example, the ESA represents 43% of the state's case count and approximately 43% of the state's expenditure on children and family services.

Producing results mirroring insourced regions was not, however, the reason the state chose to utilize the outsource model – the goal was to develop innovation and best practice models that would lower costs, improve outcomes, or both. The lack of collaboration in the past between the vendor and DCFS has unfortunately hamstrung those efforts.

1.3.2. Vision

Through the years of the contract with the vendor, the lack of a shared vision for outsourcing generally, and between the vendor and the state specifically, has undermined the opportunity to capture the value of the outsource model. The lack of flexibility has also undermined the prospect of innovation that could improve service for children and families across Nebraska. The lack of stability has led to short-term thinking that undercuts a critical component of outsourcing.

The absence of a shared vision of outsource services has led to a breakdown in meaningful collaboration. This has resulted in missed learning opportunities for best practice development, unproductive competition and forcing each party to work to solve problems without the benefit of the experience and insight of the other party. Additionally, with staff and leadership changes at DCFS, it has led to evolving expectations and interpretations of the goals of the outsource model.

1.3.3. Contract Management

While the existing contract structurally contains provisions that would allow for viable management, TSG found a lack of structured and accountable oversight, an absence of performance focus and very few financial incentives that states use to maximize the value proposition of outsourcing. There are no meaningful incentives or consequences to drive performance and, the contract does not allow flexibility for innovation, thereby eliminating some of the best reasons for outsourcing.

Moreover, the ongoing short-term nature of extensions has confounded the vendor's ability to innovate, retain staff, invest in facilities or attempt long-term programming changes.

1.3.4. Data and Financial Reporting

For any partnership to work for an outsourcing model, there must be consistent, accurate and timely performance, outcome and financial data, so there is a shared understanding of how the vendor is delivering services. The ESA vendor relationship, however, has been marked by ongoing struggles between the vendor and DCFS to agree on financial and outcome data, an obstacle that exists to this day and makes understanding the effectiveness of the outsource model a challenge.

1.3.5. Stakeholder Support

Across the ESA, stakeholders were generally supportive of the outsource model, supporting the concept that it delivers strong community backing. There was also concern that moving back to an insourced model would put children and families through a difficult and unhelpful transition that could risk destabilizing existing programming.

1.3.6. Improving Collaboration

DCFS, PromiseShip and stakeholders all agreed that recent efforts between the state and vendor to improve collaboration were encouraging and are beginning to create an environment that will allow children and families to see the benefit of the outsource model.

1.4. Other Findings

1.4.1. Service Array

The ESA has a larger array of services than those offered in other regions. Some of these services are innovative and close the gap between children and families and providers. Despite these additional services, the outcomes for children are similar to those in other parts of the state, leading to the question as to whether they are truly adding additional value, or whether the contract is not allowing enough flexibility to allow the vendor to capture the maximum value from the programming.

1.4.2. Preparing for Family First Prevention Services Act (FFPSA)

DCFS is currently preparing for implementation of the federal Family First Prevention Services Act (FFPSA), which passed in February 2018, allowing states the opportunity to draw federal funding for qualified prevention services for children and parents. DCFS is aware of the impact that this legislation will have on the entire state and, in particular, is rightly concerned about the ability of the ESA vendor to assure that state-wide prevention programming is meeting the criteria necessary for obtaining these funds, mainly because of the provider capacity of the ESA.

Currently, the vendor has a small percentage of its funding (3.63%) used for prevention and only a small number of its interventions meet the current federal standards and are likely to be approved for federal reimbursement. FFPSA also places a heavy emphasis on placing children in licensed relative fosters, while today only 17% of kinship/relative foster homes are licensed. Thus, more work needs to be done to improve the readiness of the ESA, including the vendor for FFPSA implementation.

1.4.3. Case Management Differentiation

While the operations manual requires the vendor to follow all DHHS regulations for treatment of cases and requires that training content and decision-making must mirror state processes, the

vendor has implemented several innovations in training strategy, organization tools and technology to improve performance.

1.4.4. Case Transfer

Both the state and vendor identified case transfer as a place where problems can occur during “hand-offs.” This is one area where the lack of collaboration has resulted in consternation by both parties, with DCFS expressing concerns about timely reporting of abuse and neglect after the transfer and about accessing services before the transfer and the vendor concerned about the state not completing the case transfer checklist ensuring that communications loops are closed during the transfer process.

TSG identified ambiguity regarding the decision to transfer an in-home case. This should be a protocol that is clearly established, especially with a vendor that has had so many years of experience working with the state. This is particularly true to ensure the case is transferred appropriately, given the increase in non-court/voluntary cases, which go to the vendor, and Alternative Response cases, which don’t receive case management from the vendor.

1.4.5. Summary of Findings

With no clear vision, historically poor collaboration, confused and inadequate incentives and consequences, a lack of flexibility and analysis, as well as ongoing uncertainty about the outsource model, this creates a difficult environment for any vendor to be successful. If the state wants to succeed in maximizing the value proposition of outsourcing, substantial changes must happen to improve how the state works with vendors to achieve success.

1.5. Path Forward

Based on what the existing vendor has been able to achieve and despite the obstacles that have emerged in the current outsource model, TSG recommends that should Nebraska continue to use an outsource model in the ESA, DCFS should make some important changes in the manner in which it manages the vendor relationship, which could allow the state to realize the benefits of outsourcing more fully.

1.5.1. A Clear Vision

For an outsource model to work, there needs to be a clear, shared vision that defines success, fosters collaboration and demands accountability from both the state and vendor. This vision should eliminate competition, promote innovation and substantially improve communication. The partnership should ensure that both parties are consistently working together to improve quality and efficiency of services.

This vision should lay out well-defined terms of how both parties will work to achieve the goals of the vision, including laying out clear-cut mechanisms for measuring and managing important

factors such as improving outcomes and reducing cost. It should also establish a process to encourage flexibility that would limit the number of areas of strict adherence and collaborate on other areas to deliver better results.

1.5.2. Making any Outsourced Contract Performance-Based

Once the state and vendor have established a vision and standards for accountability, DCFS must work to ensure the vendor delivers what is agreed to and expected. This will set performance objectives, metrics for outcomes and costs and then solidifies these with financial incentives and penalties around the vendor's performance. The partners will then both have a strong interest in consistent, robust collaboration to hold each other accountable.

This contract must also include provisions that improve data sharing for financial and outcome data, so that DCFS can develop dashboards to measure performance in real time and share these with the vendor. The goal should be to ensure that both parties can identify problems and find solutions together quickly and with shared understanding. This should transfer to the public as well, with these dashboards published on the DCFS website to offer transparency to the public.

1.5.3. Delivering Oversight that Works

Ensuring that accountability is daily priority begins with real oversight with the vendor. This starts with DCFS creating a Quality Assurance Team from resources across the Department, including agency leadership, finance, CQI staff and contract monitors that meets regularly (at least monthly) to share financial and performance data and discuss operational and strategic matters with the vendor.

This team must have sufficient resources and leadership commitment to maintain fidelity to the mission and will need to work to build a quality assurance tool to take the performance and financial dashboard to build a scorecard, so that the vendor can readily identify problems and improvement areas.

The goal of this effort is to change the nature of oversight from a compliance-based effort to a collaborative, performance-based approach that leads to continuously improving results.

1.5.4. If Outsourced, Include Case Supervision in New Contract

DCFS has already begun the process of identifying families that need services, but not ongoing case management. Utilizing full case management services is unnecessary and costly.

Should DCFS move forward in an outsourced environment, the agency should include in the new contract a second level of case oversight – case supervision – that can provide support for families who need direct services, but minimal case management. This would be supported by two rates to the vendor, which would reflect the level of service demands required. DCFS can

establish Utilization Management controls to ensure that families are getting the appropriate level of case involvement, while reducing overall costs to the state.

This new system would need to include important protocols for when a case would be elevated from case supervision to case management, and vice versa. Clearly, this would require strong coordination and collaboration with the vendor and an ongoing discussion about fine tuning the handoffs.

1.5.5. Building a Culture of Innovation

Nationally, the strength of the outsource model is its ability to adapt rapidly to utilize new technology, new training techniques and new interventions to deliver better outcomes and lower costs. Should DCFS continue with the outsource model, the next contract should loosen the rigid parameters that constrain this innovation and instead collaborate directly with the vendor to encourage this innovation and build a culture of exploring best practices to find solutions that enhance quality and efficiency.

To get there, the vendor and DCFS must discuss new service delivery models and agree in advance on how they should be implemented. This means including baseline standards in the contract and allowing change after the vendor submits an approved plan. This should also include incentives to the vendor to reward innovation, to ensure that it becomes a priority. In turn, DCFS can take the successful strategies, develop them into best practices and deploy them in other Service Areas.

1.5.6. Engaging Stakeholders

As the state moves to performance-based contracting, getting feedback from stakeholders will be essential to ensuring that one of the other major benefits of outsourcing – community engagement and connectedness – remains strong.

To do this, DCFS should begin meetings in the Eastern Service Area to discuss the new vision and renewed goals of the outsource model and take feedback to see how the program is functioning. This should be a consistent process that maintains after the contract is procured and develops into regular feedback process in collaboration with DCFS and the vendor.

1.5.7. Maximizing the Opportunity of FFPSA

DCFS must require any outsourced vendor to develop a comprehensive array of strong, evidence-based services that meet the approval criteria of FFPSA. This fidelity to the federal law must be an important metric connected to contract monitoring and performance management.

For services by the vendor that to meet existing standard of Evidence-Based Treatments under FFPSA, DCFS should work to identify if they meet the standards of innovation and performance,

and if so, should work with the FFPSA Clearinghouse to seek approval. For those that do not meet FFPSA standards and do not advance innovation and performance, DCFS should work with the vendor to transition into new models that are aligned with the federal law and the outsource vision, building a roadmap for these services and providing the resources for success.

DCFS and the vendor must also work with subcontractors to utilize FFPSA approved treatments when possible through provider agreements and offer training and operational resources to transition to these treatments.

Finally, DCFS and the vendor should collaborate with stakeholders to increase the licensing of relatives providing foster care. This could require a review of state licensing and policies, as well as active outreach and training, to move more of these foster families into FFPSA compliance, which will also benefit the children in care.

1.5.8. Improving Coordination with Medicaid

Ensuring coordinated health care will result in better outcomes and help children and families who are often in trying circumstances avoid confusion when passing through complex systems of care.

To deliver this improvement, the state should create an on-going Child Welfare Leadership Team from across DHHS (including DCFS, DM & LTC, DBH and DDD) to plan the services around children and families. This will require an integration of care for future managed care contracts that includes care coordination for high needs/high risk children and youth, a responsibility for manage care providers for finding accessible and timely services, development of behavioral health evidence-based practices and developing an electronic case record for children receiving DCFS services like the Texas Health Passport.

DHHS must work to improve data sharing between DM & LTC and DCFS to focus on meaningful outcomes. Presently, there are limitations that make it difficult to analyze data or create meaningful dashboards.

DCFS should also consider shortening the timeframe for a child getting a medical examination with two weeks of a removal down to 72-hours to ensure that child is getting appropriate care quickly.

2. SCOPE AND OBJECTIVES

The Nebraska Department of Health and Human Services (DHHS) Department of Children and Family Services (DCFS) contracted with The Stephen Group (TSG) to perform an assessment of the current outsourcing of in-and out-of-home case management and service delivery in the Easter Service Area (ESA), and to recommend an appropriate path forward, should DCFS continue to outsource the ESA region. DHHS has amended the contract of the current vendor, Nebraska Families Collaborative (PromiseShip), through December 31, 2019 to enable time for this assessment to occur so that TSG's analysis can inform its decision on the release a Request for Proposal (RFP) and any changes that need to be made.

TSG's primary charge is to conduct an insource vs. outsource feasibility study of the ESA. TSG is also tasked with:

- Evaluating the existing service delivery system for services in the ESA and recommend a future state model;
- Define the outsourced service delivery vision; and,
- Conduct impact analysis and provide recommendations for decision framework.

For the final item, TSG was directed to identify clear, actionable recommendations to assist the Department in improving the implementation of the next contract or in transitioning to the state-provision of case management in the ESA.

TSG's task is to determine whether the outsource model has been or can be successful with modifications made to its execution, or whether there is evidence that a vendor cannot be successful, and the state should assume responsibility for case management. This report is not meant to be a validation of whether the current vendor has been successful or not, but rather what the vendor's performance reveals about the success or failure of the outsource model itself.

In arriving at this recommendation, TSG will consider the following objectives:

- Has the vendor been able to achieve improved performance outcomes?
- Has the outsourced model been more cost-effective than state-provided care?
- Did the state achieve its vision in outsourcing case management?
- Did the contract/model allow for innovation in case management and the development of services?

3. REVIEW OF PAST AUDITS, STUDIES, AND REPORTS

TSG reviewed prior audits, studies, and reports on the Nebraska child welfare system and the outsource in the ESA. **Appendix A** summarizes TSG’s complete review of these past audits, studies, and reports, including:

- State Auditor of Internal Accounts, 2018
- Letter to Senator Merv Riepe
- Letters to Patrick O’Donnell, Clerk of the Legislature
- Nebraska Child Welfare Blueprint Report March 2017
- OIG Annual Report, 2016-2017
- Hornby Zeller, 2014
- Digital Commons, University of Nebraska
- Hornby Zeller, 2012
- Platte Institute, 2012
- DHHS Report to the Legislature: Legislative Resolution 37 (2011): Review, Investigation and Assessment of Child Welfare Reform

In reviewing these reports, TSG did not find any reports that gave a favorable review concerning Nebraska’s outsourcing of child protective services. The State Auditor found major fault with financial controls. The 2014 Hornby Zeller report is hopeful, but only if the State makes major changes to the method of managing the relationship. Digital Commons argued philosophically that privatization can never save money and goes on to demonstrate its going-in assumption.

These reports also indicate that outsourcing has not been especially effective for DCFS:

- The objectives of outsourcing were not clearly spelled out in advance, so it is difficult to say there have been achieved.
- Outcomes, though improved, are not especially better than the rest of the state.
- Cost controls are weak, though Hornby Zeller’s 2014 report says costs are lower.

TSG noted a common thread through all the audits and reports: DCFS failed to create a functional outsourcing model. Objectives were not clear; contracts and organizational relationships were not structured correctly, and the relationship was not managed well. Even DCFS predicted that poorly implemented outsourcing would fail to address the situation better than “in-sourcing”. Yet DCFS proceeded with weak outsourcing model and implementation.

These reports agree that that child protection outsourcing has not been “proven” or “disproven” by Nebraska’s experience to date—rather that the administration of the outsourcing is inadequate. Prior to the TSG assessment, reports and audits could not determine whether it could have been effective or not or how it might be improved. Each of the reports call for the same thing: better management.

Across nearly a decade of reporting and audits, the message is clear. Privatization has been assessed as initially ill-conceived and poorly managed. None of the reports suggest that privatization has achieved significant improvement. Thus, the stage was set for TSG's assessment.

Rather than repeat the work of these past audits, TSG seeks to target its review to provide DCFS and policy makers with critical information at this juncture, including their need to know:

- What are reasonable objectives from privatization (outsourcing)?
- How best to arrange the relationship for high performance?
- What has been the performance to date?
- How best to respond: whether in- or out-source and how to improve performance in each scenario.
- How to create on-going management and reporting practices so that the benefits (and challenges) of privatized services are more transparent and adaptable.

4. METHODOLOGY

Upon completion of a thorough review of prior research and analysis on the Nebraska child welfare system and the outsourced ESA, TSG designed a comprehensive review to collect information using the following approaches:

- Review of the existing contract, extensions, and amendments in Nebraska
- Review of other state best practices in child welfare contracting
- Requests of multiple rounds of data, including from DCFS and PromiseShip
- Review and reconciliation of the financial data from DCFS and PromiseShip, which required additional meetings and data requests
- Review of operational and performance outcomes (for in- and out-of-home cases).
- Meetings with DCFS and PromiseShip:
 - DCFS state office contract management and continuous quality improvement staff
 - DCFS ESA regional staff
 - PromiseShip: Administrators, internal management across key functional areas, supervisors and FSR caseworkers
- Meeting with the DHHS Division of Behavioral Health.
- Focus groups, process mapping, and analysis of the case transition process with DCFS and PromiseShip administrative, supervisory, and frontline caseworker staff from Douglas and Sarpy Counties.
- Meetings with key stakeholders, including the following:
 - Inspector General
 - Judges (Sarpy and Douglas County)
 - Juvenile County Attorney and assistant county attorneys (Douglas County)
 - State Executive Leadership for CASA, as well as CASA leadership in Sarpy and Douglas counties
 - Guardians ad litem
 - Foster Care Review Board
 - Nebraska Family Support Network
 - Project Harmony
 - Conducted a provider call with providers operating in both State and ESA
 - Individual Service Providers: Nebraska Children’s Home Society, Capstone BH Services, Cedars

5. ASSESSMENT OF CHILD WELFARE PERFORMANCE OUTCOMES

As noted in TSG’s review of other Nebraska child welfare reports and assessments, in 2014, Hornby Zeller, found “...nearly three full years since the privatization of case management, it is clear that the outcomes achieved for families and children by NFC are no better than those produced by DHHS. Neither are they any worse.”

Four years later, TSG performed a similar review in order to determine if there is compelling evidence to either continue to outsource or to in-source case management in the ESA. TSG finds that generally, outcomes have improved significantly statewide (including in state-run and PromiseShip Service Areas) over the last several years. There are some measures where ESA performs better and others where it performs worse than other Service Areas. However, the outcomes analysis does not suggest that the decision to outsource has been wildly successful or a failure for the state.

In analyzing this data, TSG took a two-pronged approach, which includes analyzing current performance in the ESA compared to historical performance and performance compared to other DCFS Service Areas.

In meetings with PromiseShip leadership as well as stakeholders in the ESA, TSG was cautioned to compare the performance of Nebraska regions due to unique factors of the ESA such as the population size, diversity and acuity, increased availability of placements and providers, and differences in the judicial system. While TSG agrees that these differences are substantial, because TSG is interested in assessing the question of whether DCFS should continue to outsource case management in the ESA, the ability of a vendor to improve performance as well as the performance of the other regions are both relevant.

TSG requested data on the level of care of the children in care (out-of-home cases) to put the performance differences and similarities in context. The following data are a snapshot from December 2016.

Table 1: Children in Out-of-Home Care, by Service Area, December 2018

Level Of Parenting	CENTRAL	EASTERN	NORTHERN	SOUTHEAST	WESTERN	TOTAL
Enhanced	82	450	119	156	69	876
Essential	153	685	209	240	238	1,525
Intensive	31	208	24	67	19	349
No NCR Completed	28	82	31	20	26	187
Grand Total	294	1,425	383	483	352	2,937

Source: DHHS, December 2018.

Notes: Excludes the YRTC youth and tribal youth. Intensive is highest acuity (shown lowest to highest).

Table 2: Share of Children by Level of Care, December 2018

	CENTRAL	EASTERN	NORTHERN	SOUTHEAST	WESTERN
Enhanced	9.4%	51.4%	13.6%	17.8%	7.9%
Essential	10.0%	44.9%	13.7%	15.7%	15.6%
Intensive	8.9%	59.6%	6.9%	19.2%	5.4%
No NCR Completed	15.0%	43.9%	16.6%	10.7%	13.9%
Grand Total	10.0%	48.5%	13.0%	16.4%	12.0%

Source: DHHS, December 2018.

This figure demonstrates that while the ESA has 48.5% of the state’s population of children and youth in care, it has a slightly greater share of the state’s children/youth with the Intensive level of care. Note: This is December 2018 data and captures the children in out-of-home placement. This differs from TSG’s estimate that the ESA vendor has 43% of total cases.

Table 3: Case Mix by Service Area, December 2018

	CENTRAL	EASTERN	NORTHERN	SOUTHEAST	WESTERN	TOTAL
Enhanced	27.9%	31.6%	31.1%	32.3%	19.6%	29.8%
Essential	52.0%	48.1%	54.6%	49.7%	67.6%	51.9%
Intensive	10.5%	14.6%	6.3%	13.9%	5.4%	11.9%
No NCR Completed	9.5%	5.8%	8.1%	4.1%	7.4%	6.4%

Source: DHHS, December 2018.

This figure demonstrates the share of cases within each Service Area, and statewide, by level of care. The ESA is carrying the greatest share of the state’s total of “Intensive” children (59.6% of

all “Intensive” children are in the ESA) and children with an “Intensive” level of care make up a greater share of the case mix in the ESA than and in other regions (14.6% compared to state average of 11.9%). While it is not possible to determine how this distribution affects each individual measure based on the data provided to TSG, this is important contextual information for evaluating the outcomes in the ESA, including permanency outcomes, as well as cost of care.

5.1. Child and Family Services Reviews (CFSR) Measures

The federal Administration for Children and Families Children's Bureau uses established measures to assess and compare the performance of state child welfare systems with key Title IV-B and IV-E requirements.¹ These measures focus on the out-of-home cases (children in the state's care).

5.1.1. Round II Measures

TSG reviewed performance of all of the Nebraska Service Areas for the following CFSR Round II measures to assess whether there are significant differences in performance:

- Absence of maltreatment recurrence (over 6-month, calculated over rolling 12 months)
- Absence of maltreatment in foster care
- Timeliness and permanency of reunification
- Timeliness of adoption
- Placement stability
- Permanency for children in foster care

Historically, all Nebraska Service Areas performed poorly on these measures (with the exception of the measure on permanency for children in foster care which the state has always been in compliance and is not included in the charts below)² but under the state and PromiseShip's leadership, achieved significant improvement between 2012 – 2016. The following five figures prepared by DHHS illustrate the historical improvement achieved statewide and in all Nebraska Service Areas. **Appendix B** provides more detailed data by Service Area.

¹ ACF, “Child and Family Services Review Technical Bulletin #7 Announcement of the next round of reviews, changes to the review process and information on the scheduling of reviews.” March 2014.
https://www.acf.hhs.gov/sites/default/files/cb/cfsr_tb7.pdf.

² Per Doug Beran email 12/12/18.

Figure 1: Absence of Maltreatment Recurrence

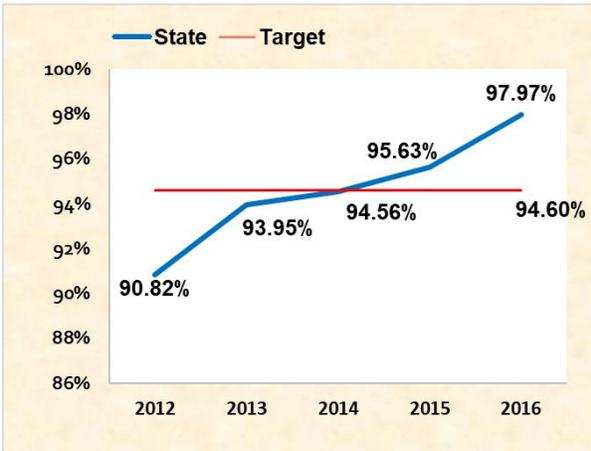


Figure 2: Timeliness of Adoption

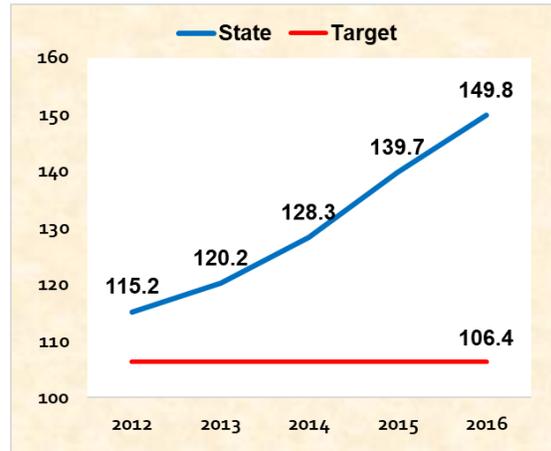


Figure 3: Absence of Maltreatment in Foster Care

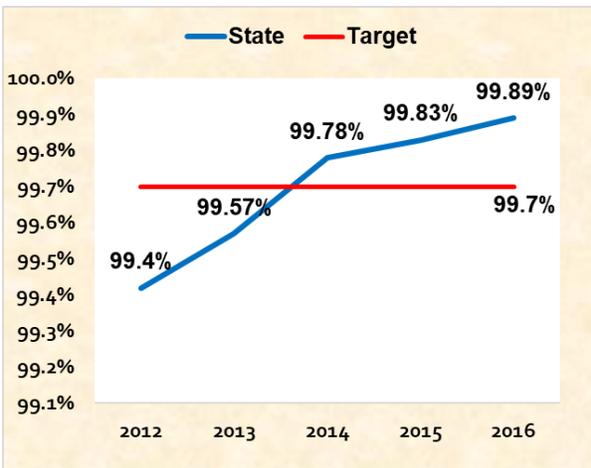


Figure 4: Placement Stability

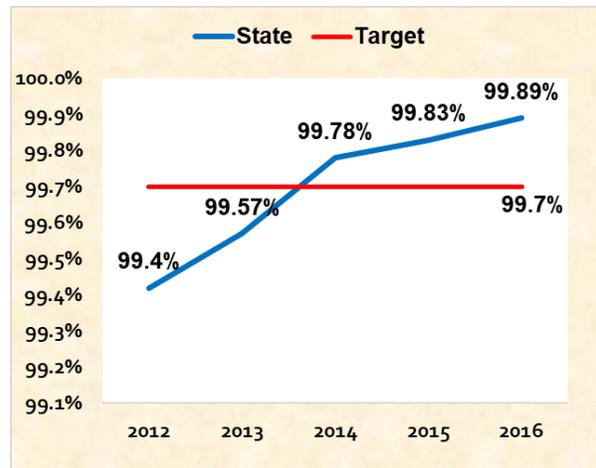
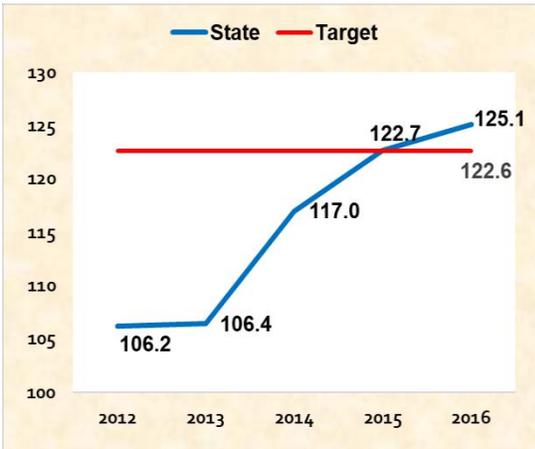


Figure 5: Timeliness and Permanency of Reunification

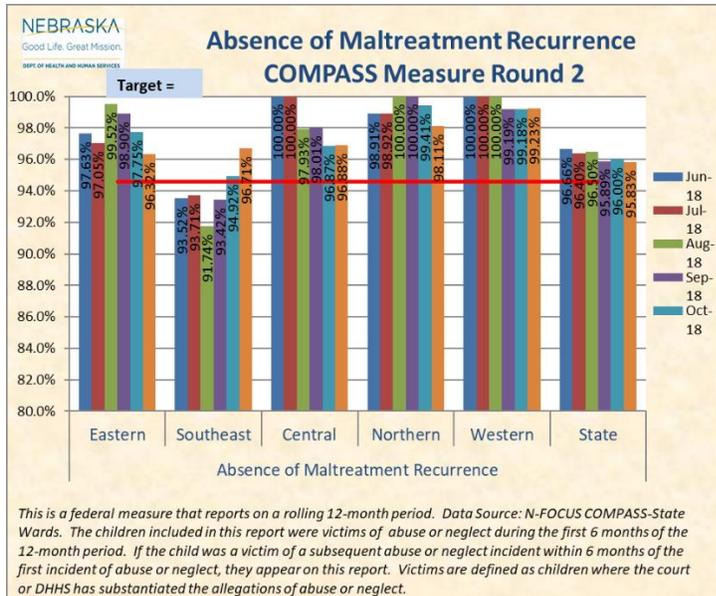


According to DHHS staff, performance has plateaued since 2016, with most Service Areas continuing to meet these measures on an ongoing basis, such that these measures are not ways to differentiate performance.

The following five charts, prepared by DHHS in December 2018, provide the state and each Service Area's performance over the past six months for these measures. Most of the Service Areas and the state are in compliance with all of the targets for this time period. Exceptions include:

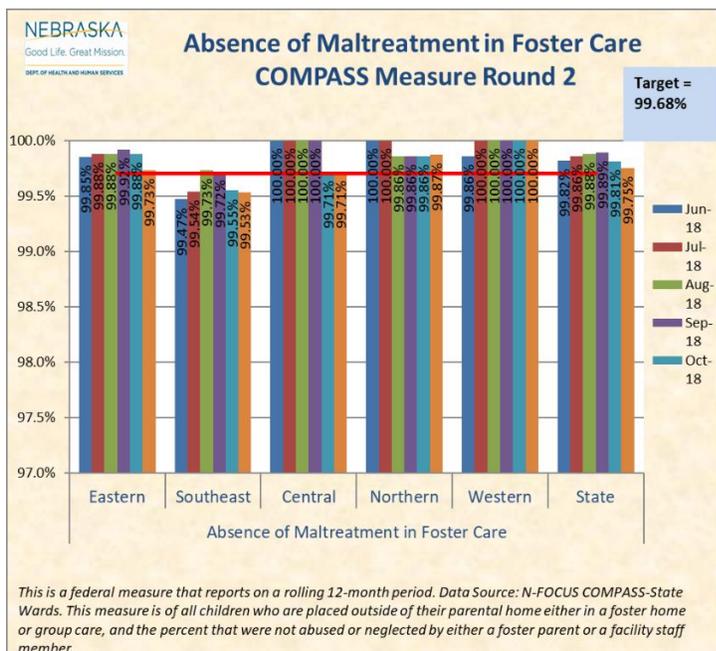
- For the Absence of Maltreatment Recurrence measure, the Southeast Service Area did not meet the target for several months over the past six months, but performance has improved to a passing level in the most recent month.
- For the Maltreatment in Foster Care measure, the Southeast Service Area has been out of compliance for four of the last six months and as of November 2018 was not passing.
- For the Timeliness and Permanency of Reunification measure, four Service Areas and the state overall did not have a passing score in November 2018 including the Eastern, Northern, Southeast, and Western Service Areas. The Eastern and Northern Service Areas did not reach the target for any of the last six months.

Figure 6: Absence of Maltreatment Recurrence, June – October 2018.



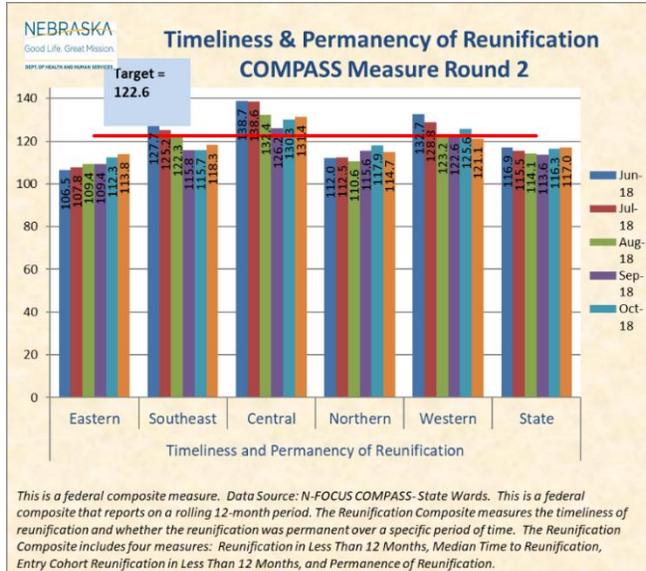
Source: DHHS, December 2018.

Figure 7: Absence of Maltreatment in Foster Care, June – October 2018.



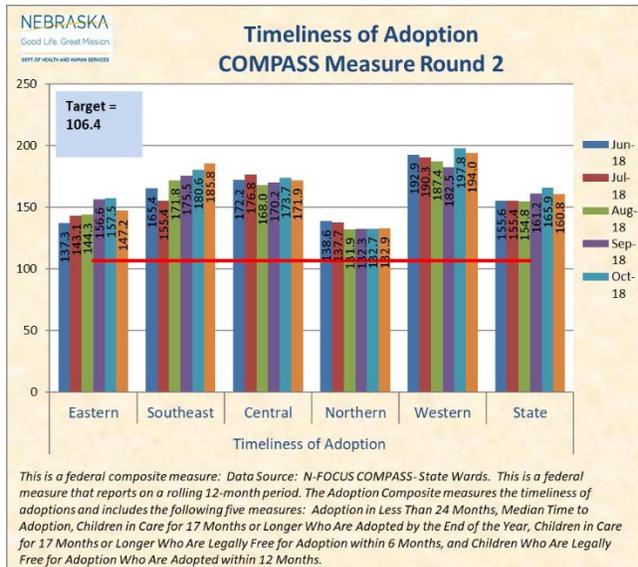
Source: DHHS, December 2018.

Figure 8: Timeliness and Permanency of Reunification, June – October 2018.



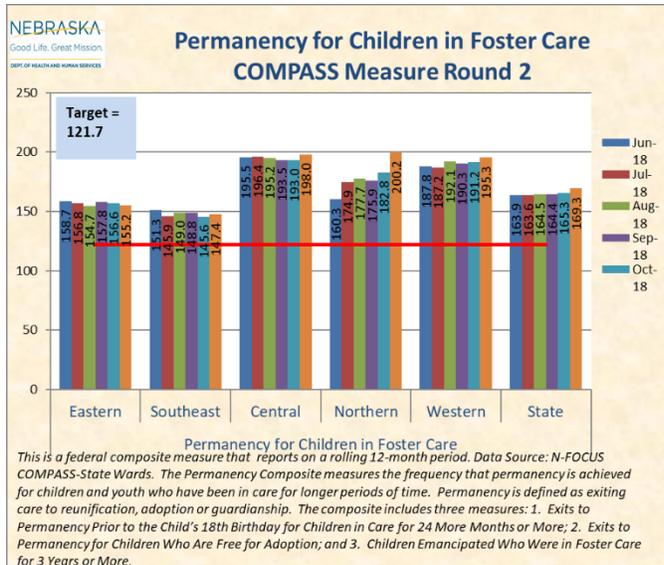
Source: DHHS, December 2018.

Figure 9: Timeliness of Adoption, June – October 2018.



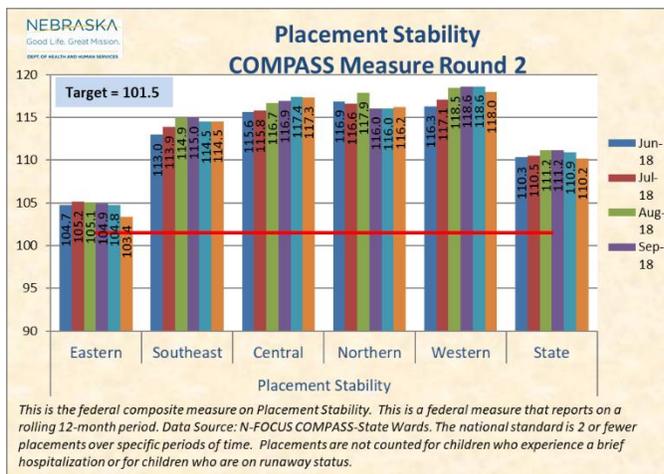
Source: DHHS, December 2018.

Figure 10: Permanency for Children in Foster Care, June – October 2018.



Source: DHHS, December 2018.

Figure 11: Placement Stability, June – October 2018.



Source: DHHS, December 2018.

Taken together, TSG concurs that performance on the Round II measures does not provide a means of differentiating between the Service Areas. All Nebraska Service Areas have made significant progress in improving performance on the Round II measures. The Eastern Service Area has a passing score on all of the measures but one, but that is a measure that four of the

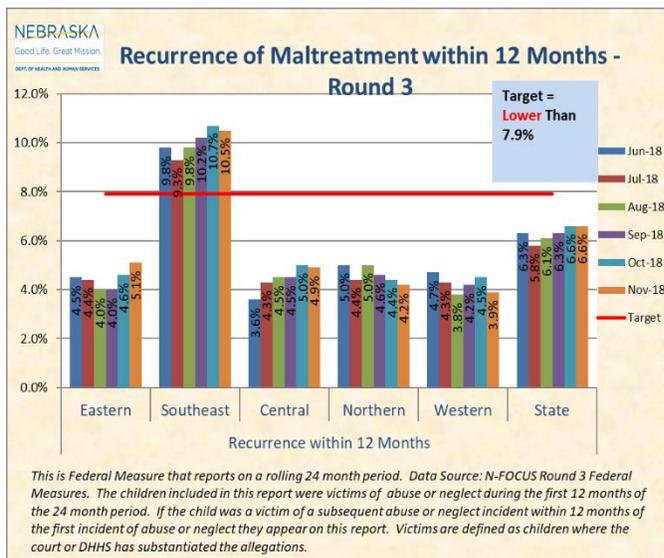
state’s five Service Areas are struggling to meet, which suggests that there are system issues involved and not issues specific to the ESA.

5.2. Child And Family Services Reviews (CFSR) Round III Measures

These measures include some of the same general topics as are addressed in Round II, with some variations in the methodologies for calculating the measures:

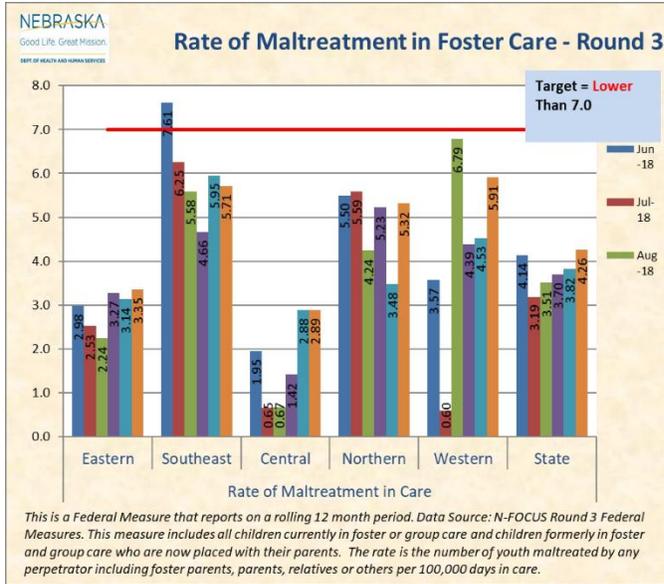
- Absence of maltreatment recurrence (over 12-month, calculated over rolling 24 months)
- Rate of maltreatment in foster care
- Placement stability rate
- Youth Entering Out-of-Home Care - Permanency in 12 Months
- Re-Entries into Care in < 12 Months of Discharge
- Youth in Care 12-23 Months - Permanency in 12 Months
- Youth in Care 24+ Months - Permanency in 12 Months

Figure 12: Recurrence of Maltreatment within 12 Months, June – October 2018.



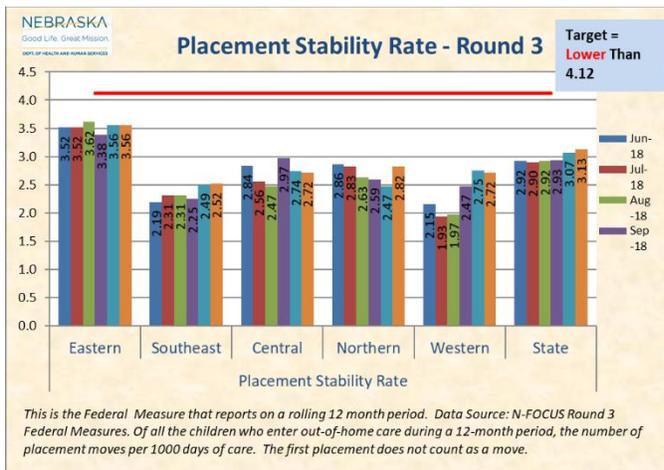
Source: DHHS, December 2018.

Figure 13: Rate of Maltreatment in Foster Care, June – October 2018.



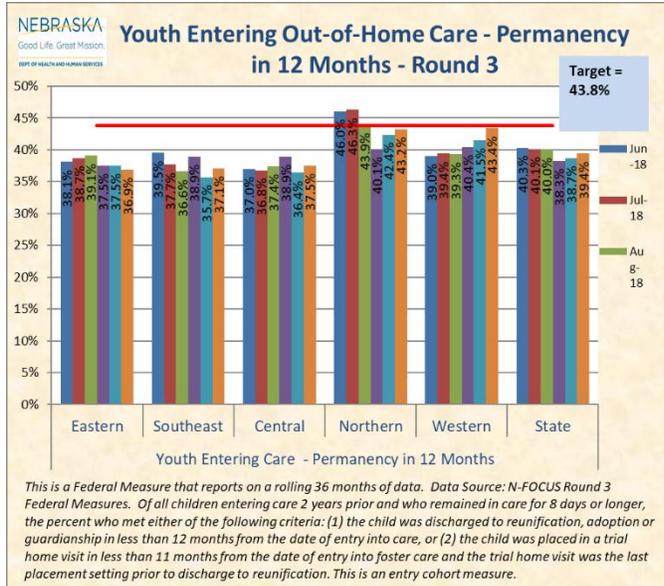
Source: DHHS, December 2018.

Figure 14: Placement Stability, June – October 2018.



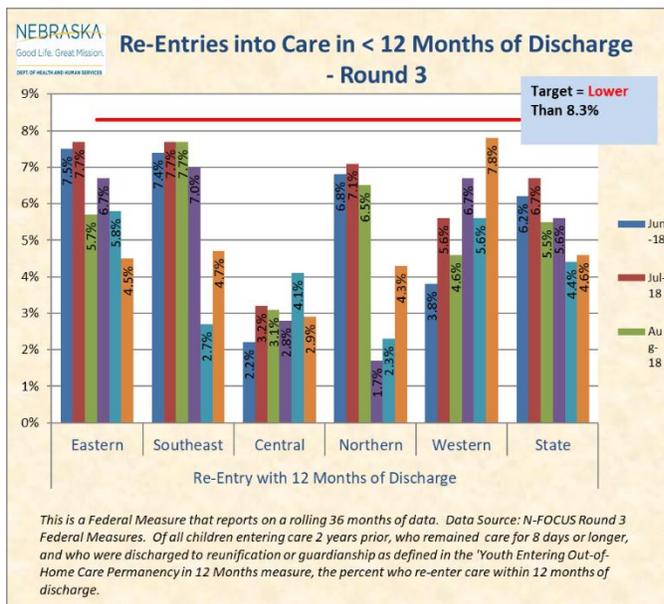
Source: DHHS, December 2018.

Figure 15: Youth Entering Out-of-Home Care, June – October 2018.



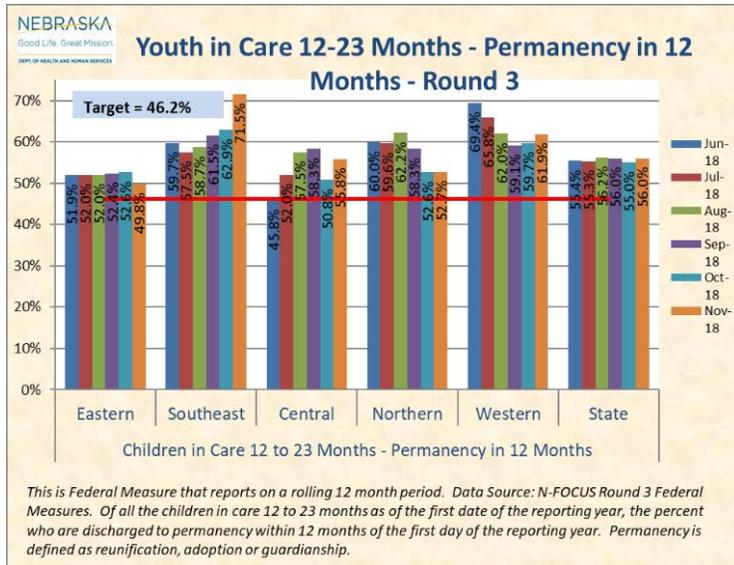
Source: DHHS, December 2018.

Figure 16: Re-Entries into Care Less than 12 Months of Discharge, June – October 2018.



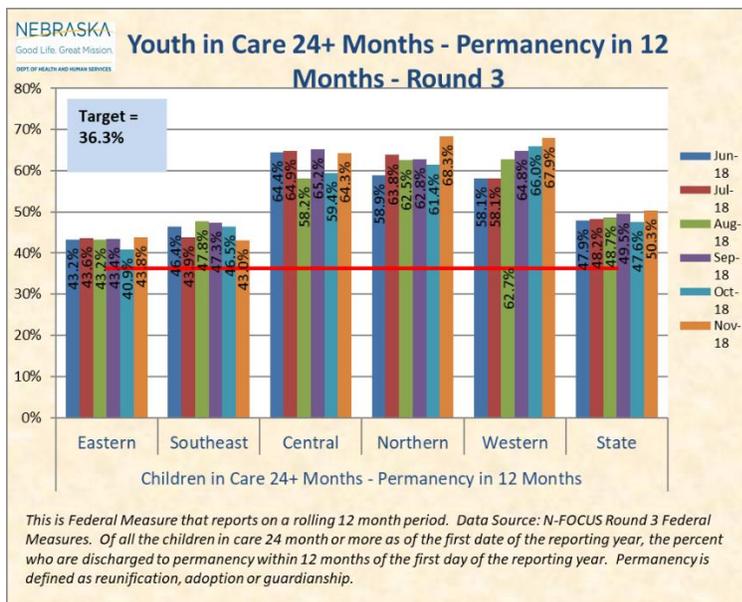
Source: DHHS, December 2018.

Figure 17: Permanency in 12 Months, Youth in Care 12-23 Months, June – October 2018.



Source: DHHS, December 2018.

Figure 18: Permanency in 12 Months, Youth in Care over 24 Months, June – October 2018.



Source: DHHS, December 2018.

As with the Round II measures, most of the Service Areas have consistently met the performance targets for most of the measures. As of November 2018, the State’s performance meets the targets for six out of seven measures. Exceptions include:

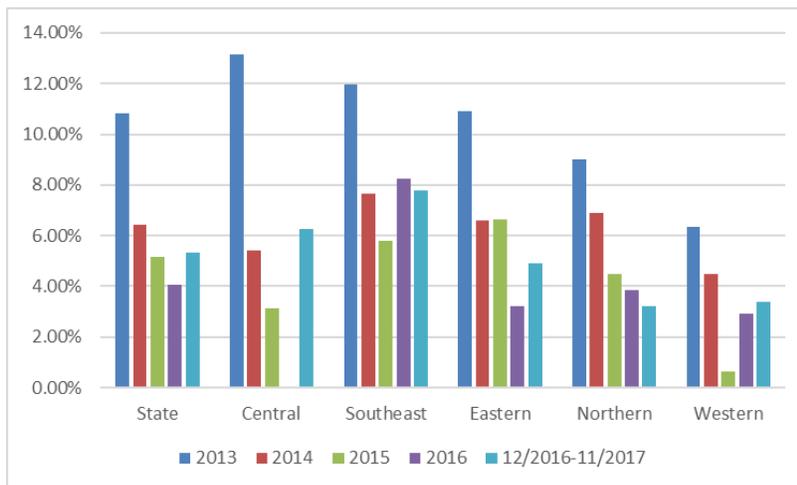
- The Southeast Service Area is not in compliance with the Recurrence of Maltreatment.
- All Service Areas and the state are not in compliance with Youth Entering Care Achieving Permanency in 12 Months.

As with the Round II measures, the Eastern Service Area has a passing score on all of the measures but one, but that is a measure that all five Service Areas are struggling to meet, which suggests that there are system issues involved and not issues unique to the ESA.

5.3. Other Child Safety Outcomes

In addition to the child safety outcomes included in the CFSRs which are for children in care (out-of-home cases), TSG analyzed recidivism (recurrence of maltreatment) for all populations of cases served by DCFS.

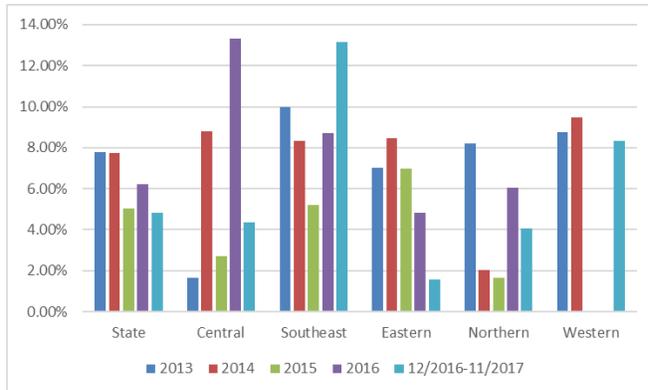
Figure 19: Substantiated Intakes with Active Court Case: 2013 – 2017.



Source: DHHS, December 2018

Notes: This chart reflects the Federal Round 3 12-month Maltreatment measure. Per DHHS, the years represent the year of the first substantiation and include if there was a recurrence within 12 months. The most recent year provided is 12/2016 – 11/2017 to provide for a full 12-month follow-up period.

Figure 20: Substantiated Intakes with Active Non-Court/AR Case, 2013 – 2017.

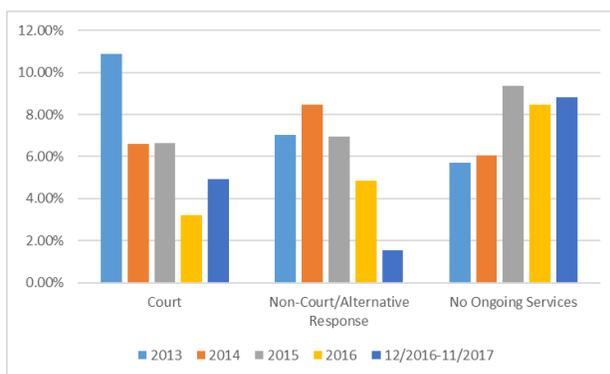


Source: DHHS, December 2018.

This series of charts depicts state-wide 12-month maltreatment recurrence rate by case type (out-of-home, in-home/Alternative Response (AR), and cases in which the family received no ongoing services) and Service Area. Observations from this data include:

Generally, and with exception to 2013, the highest rates of recurrence are among families where no ongoing services were received and there was an increase between 2016 and the time period of 12/2016 – 11/2017. Over the past several years, the rate of maltreatment recurrence alternated in being higher among out-of-home vs. in-home/AR cases, with out-of-home having a higher rate in the most recent year of data available.

Figure 21: Substantiated Intakes in Eastern Service Area with Active Case, by Type, 2013 – 2017.



Source: DHHS, December 2018.

Notes: This chart reflects the Federal Round 3 12-month Maltreatment measure. Per DHHS, the years represent the year of the first substantiation and include if there was a recurrence within 12 months. The most recent year provided is 12/2016 – 11/2017 to provide for a full 12-month follow-up period.

Since 2015, the highest rates of recurrence have been among those with no ongoing services. The rates of recurrence have alternated between being higher for out-of-home and in-home. In the most recent year, the rate of recurrence for in-home/AR was much below that of out-of-home. One issue to keep in mind is that PromiseShip does not provide case management for AR families. However, the relatively small amount of AR cases should not have too great of an impact on this difference.

5.4. Other Permanency Outcomes

Nebraska struggles statewide with a permanency measure in both CFSR Rounds II & III and has many initiatives in place to improve performance. Because it can take many years to improve permanency outcomes, TSG examined additional related measures to assess whether there were any early signs of progress or areas where the ESA outperformed the rest of the state. TSG found this is an area where the state, including the ESA, has made significant progress, though the ESA remains below state performance in some measures. It is also important to consider performance in the context of case mix differences.

Table 4: Reunification rate for children where termination of parental rights does not occur

	Central	Eastern	Northern	Southeast	Western	State
SFY 16	53.1%	62.7%	67.5%	52.0%	55.3%	59.8%
SFY 17	57.5%	65.4%	57.6%	53.5%	54.3%	59.7%
SFY 18	66.3%	60.3%	59.5%	53.8%	67.8%	60.8%

Source: DHHS, November 2018.

For this measure, a higher rate is desirable. The Eastern Service Area out-performed the state average and the performance of multiple regions in 2016 and 2017; in 2018, its performance is close to the state average and above that of the Central, Southeast, and Western Service Areas.

Table 5: Time to permanency: Median Months to Reunification

	Aug-15	Aug-16	Aug-17	Aug-18
Eastern	9.5	8.1	9.7	9.9
Southeast	8.6	9.6	8.1	8.6
Central	7.5	10.4	7.6	8.0
Northern	6.8	7.0	6.2	10.9
Western	7.0	7.6	7.1	8.5
State	8.2	8.0	8.2	9.4

Source: DHHS, November 2018.

This measures the median months to reunification and a lower number is desired. TSG looked at four points in time: in August of 2015 – 2018. TSG found that the Eastern Service Area’s median has exceeded state median over the past four Augusts and has tended to be longer than that of the other Service Areas.

Table 6: Adoption rate for children where termination of parental rights does occur

Children Legally Free for Adoption and Adopted in < 12 Months: Trend for the last five years										
	Sep-13	Mar-14	Sep-14	Mar-15	Sep-15	Mar-16	Sep-16	Mar-17	Sep-17	Mar-18
State	65.10%	70.30%	71.10%	74.00%	73.70%	73.80%	77.70%	74.20%	67.40%	73.40%
Central	46.40%	56.00%	79.50%	89.70%	75.00%	74.60%	84.70%	81.00%	74.70%	80.30%
Eastern	59.80%	70.30%	72.40%	72.60%	72.40%	74.90%	75.10%	69.60%	61.50%	69.10%
Northern	48.10%	52.70%	68.40%	84.90%	82.90%	61.50%	65.60%	71.90%	64.20%	65.30%
Southeast	74.30%	76.40%	70.20%	70.40%	70.30%	74.80%	82.90%	77.90%	74.80%	84.90%
Western	93.60%	77.60%	66.70%	63.90%	80.00%	82.10%	78.60%	76.40%	65.20%	63.00%

Source: DHHS, November 2018.

This is a measure where a higher percentage is desired. The State has improved its performance in this area by 8.3% over the last five years. Along with the State, performance in the Eastern Service Area has also improved over that time period (by 9.3%), though the Eastern Service Area’s overall performance is below the State’s. Although the Eastern Service Area has trended below the other Service Areas, as of March 2018, its performance is in the middle of the Service Areas.

Table 7: Time to permanency: adoption

Median Months in Care: Trend for the last five years										
	Sep-13	Mar-14	Sep-14	Mar-15	Sep-15	Mar-16	Sep-16	Mar-17	Sep-17	Mar-18
State	30.6	30.1	31.7	32.8	30.6	27.9	26.8	27.6	27.6	27.7
Central	28.3	30.0	32.3	34	33.4	28.3	26.2	26.2	27.6	27.7
Eastern	34.8	31.3	30.7	33.5	31.8	28.8	29.9	30.9	29.9	28.4
Northern	23.0	24.4	35.5	36.9	32	25.2	27.1	29.5	28.1	32.0
Southeast	28.1	31.8	33.1	29.1	26.3	26.2	24.9	25.8	25.9	27.3
Western	26.0	26.3	28.1	32.3	31.3	29.5	23.8	24.9	26.8	23.3

Source: DHHS, November 2018.

This is a measure where a lower number of months is desired. Over the last five years, the state has reduced the median months in care by 2.9. Although the ESA's median months in care exceeds the state's, it has reduced the time to permanency by 6.4 months since 2013 and is now outperforming one region and achieving comparable performance to several other regions.

Table 8: Rate of exit to relative guardianship

	Central	Eastern	Northern	Southeast	Western	State
SFY 16	11.1%	6.6%	11.4%	8.0%	18.1%	9.5%
SFY 17	7.2%	5.9%	12.2%	9.8%	18.7%	9.3%
SFY 18	6.7%	8.0%	10.3%	11.4%	9.5%	9.0%

Source: DHHS, November 2018.

This measure should be considered in the context of other rates of exit. This is a measure in which the state's rate of exit to guardianship has been declining over the past three years. The ESA's rate of exist decreased between 2016-17 but then increased between 2017-18.

Table 9: Percent of youth are aging out of care

	Central	Eastern	Northern	Southeast	Western	State
SFY 16	5.3%	6.7%	4.6%	7.8%	3.4%	6.0%
SFY 17	3.8%	6.5%	5.4%	7.7%	3.0%	5.8%
SFY 18	3.0%	5.0%	4.7%	5.6%	0.9%	4.3%

Source: DHHS, November 2018

This is a measure where a lower rate is desired. The state's rate has been declining over the past three years, as has the ESAs rate, even though the ESA's rate has exceeded the state's each year.

5.4.1. Average Number of Placement Moves for Children Exiting Care:

Table 10: Reunification

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	120	569	295	234	131	1349
Average # of Placements	1.80	1.76	1.62	1.87	1.54	1.73
SFY 17						
Number of Children	184	652	245	229	145	1455
Average # of Placements	1.70	1.87	1.60	1.42	1.37	1.68
SFY 18						
Number of Children	177	612	203	221	229	1442
Average # of Placements	1.58	1.92	1.58	1.51	1.45	1.69

Source: DHHS, November 2018

A lower number of moves is desired. The state's average number has trended down overall between 2016-2018, while the ESA's number has trended up and is the worst among the Service Areas.

Table 11: Adoption

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	62	206	58	139	39	504
Average # of Placements	2.13	2.48	1.88	2.87	1.72	2.42
SFY 17						
Number of Children	97	190	69	116	58	530
Average # of Placements	1.87	2.69	2.17	2.29	2.31	2.34
SFY 18						
Number of Children	62	253	57	116	68	556
Average # of Placements	1.90	2.36	2.68	2.42	1.78	2.29

Source: DHHS, November 2018

The state's average has trended down between 2016-2018, while the ESA's number has increased and decreased. The Eastern and Southeast Service Area's performance are the worst among the Service Areas.

Table 12: Emancipation

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	12	61	20	35	8	136
Average # of Placements	9.08	9.21	6.70	10.71	6.00	9.03
SFY 17						
Number of Children	12	65	23	33	8	141
Average # of Placements	5.42	7.66	4.22	10.82	2.38	7.35
SFY 18						
Number of Children	8	51	16	23	3	101
Average # of Placements	7.63	6.86	6.25	6.91	4.33	6.76

Source: DHHS, November 2018

Note that the ESA has approximately half of the state's youth that are emancipating in a given year. A lower number of moves is desired. The state's average number has trended down overall between 2016-2018, as has the ESA's. In the most recent year, the ESA's performance was in the middle of the other Service Areas on this measure.

Table 13: Guardianship

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Number of Children	25	60	50	36	43	214
Average # of Placements	1.92	2.25	2.06	2.61	1.93	2.16
SFY 17						
Number of Children	23	59	52	42	50	226
Average # of Placements	1.74	2.03	1.85	2.40	1.80	1.98
SFY 18						
Number of Children	18	81	35	47	32	213
Average # of Placements	1.89	1.96	2.74	2.85	2.25	2.32

Source: DHHS, November 2018

A lower number of moves is desired. The state and ESA's average number has trended down overall between 2016-2018 and in the current year, the ESA performed in the middle of its peers.

5.5. Well-Being Outcomes

Generally, TSG finds that the ESA has done well in terms of reducing congregate care, increasing relative placement, placing children within 25-30 miles of home, and maintaining school connections.

Table 14: Rate of congregate care use vs. foster home settings for children in out of home

SFY 16

Facility Type	Central	Eastern	Northern	Southeast	Western	State
Kinship Foster Care	11.1%	13.3%	13.4%	12.3%	21.7%	13.6%
Medical Facility	1.4%	2.5%	2.0%	2.9%	1.2%	2.3%
Non-Relative Foster Care	30.7%	36.8%	31.0%	35.2%	30.4%	34.4%
Relative Foster Care	28.1%	37.1%	41.2%	32.1%	37.0%	35.4%
Residential	24.7%	6.4%	8.0%	13.2%	6.2%	10.4%
Therapeutic	4.1%	3.8%	4.4%	4.2%	3.6%	4.0%

SFY 17

Facility Type	Central	Eastern	Northern	Southeast	Western	State
Kinship Foster Care	13.1%	14.9%	15.5%	12.0%	27.9%	15.3%
Medical Facility	1.8%	3.5%	2.4%	3.3%	1.2%	2.9%
Non-Relative Foster Care	38.5%	40.3%	38.2%	36.9%	34.6%	38.6%
Relative Foster Care	32.5%	42.0%	46.7%	40.3%	58.2%	42.4%
Residential	24.5%	6.4%	7.4%	11.0%	6.6%	9.9%
Therapeutic	4.3%	3.6%	3.3%	3.8%	5.1%	3.9%

SFY 18

Facility Type	Central	Eastern	Northern	Southeast	Western	State
Kinship Foster Care	10.0%	14.6%	12.7%	12.7%	23.0%	14.1%
Medical Facility	1.4%	3.5%	2.2%	1.9%	2.5%	2.6%
Non-Relative Foster Care	33.1%	36.5%	33.4%	33.5%	31.9%	34.7%
Relative Foster Care	27.7%	38.8%	36.8%	34.0%	56.5%	37.7%
Residential	19.9%	5.3%	5.4%	8.6%	4.4%	7.9%
Therapeutic	4.8%	3.4%	4.4%	2.6%	5.4%	3.7%

Source: DHHS, November 2018

This is a measure for which increased use of kinship and relative foster care is desired, as well as a general use of either kinship or foster care over congregate settings and institutions. In reviewing the last three years of data, the ESA has been able to increase use of kinship foster care and relative foster care overall between 2016 and 2018 (with some internal fluctuation), and where ESA is performing well relative to the state.

Table 15: Rate of relative placement (for out of home cases)

Rate of Children Placed with Relatives During the SFY						
	Central	Eastern	Northern	Southeast	Western	State
SFY 16	39.7%	56.6%	56.3%	46.4%	50.5%	51.6%
SFY 17	43.8%	62.9%	62.1%	57.0%	65.3%	59.2%
SFY 18	40.9%	60.6%	52.3%	53.0%	63.5%	55.8%

Source: DHHS, November 2018.

This is a measure for which increased relative placement is desired. In reviewing the last three years of data, the ESA has been able to increase use of relative placement overall between 2016 and 2018 (with some internal fluctuation), and where ESA is performing better than the rest of the state.

Table 16: Placement moves

SFY16	Central	Eastern	Northern	Southeast	Western	State
Number of children	692	2785	1195	1134	625	6431
Average Number of Placements	2.17	2.59	2.28	2.95	1.77	2.47
SFY 17						
Number of children	785	2861	1141	1176	740	6703
Average Number of Placements	1.99	2.66	2.28	2.53	1.75	2.40
SFY 18						
Number of children	701	2724	852	1125	759	6161
Average Number of Placements	2.08	2.81	2.31	2.46	1.76	2.46

Source: DHHS, November 2018

This is a measure for which a lower number is desired, both for achieving permanency and child well-being. ESA's average has exceeded the state's each year. The state has remained relatively constant during the last three years, while ESA's average number of placement moves has been increasing.

Table 17: Rate of placement with siblings

	2016		2017		2018	
	Percent with All Siblings Together	Percent with at Least One Sibling	Percent with All Siblings Together	Percent with at Least One Sibling	Percent with All Siblings Together	Percent with at Least One Sibling
Eastern	60.3%	81.3%	57.4%	81.4%	57.8%	80.8%
Central	65.6%	83.8%	71.7%	89.1%	69.9%	84.1%
Northern	69.6%	85.7%	68.4%	83.3%	69.9%	84.1%
Western	81.4%	89.8%	78.3%	90.0%	78.6%	83.3%
Southeast	64.9%	84.1%	67.7%	84.3%	68.1%	82.3%
State	65.0%	83.5%	64.5%	84.0%	64.7%	82.3%

Source: DHHS, November 2018

This is an area in which a high percentage is desired. Overall, there is a relatively high rate of placement with at least one sibling, but the percent of all siblings placed together is much lower. Both the state and the eastern service area are trending down, while at least two Service Areas have made progress in this area over the last three years.

Table 18: Rate of placement within 25-30 mile radius from home

SFY 16

Placements' Distance from Child's Home - Percent of Placements

Distance	Central	Eastern	Northern	Southeast	Western	State
0-20 Miles	47.4%	94.6%	52.6%	60.4%	58.3%	74.3%
21-50 Miles	14.6%	2.3%	20.6%	15.9%	12.8%	9.4%
51-100 Miles	14.7%	1.2%	15.2%	12.5%	9.7%	7.4%
100+ Miles	23.3%	2.0%	11.6%	11.2%	19.2%	9.0%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SFY 17

Placements' Distance from Child's Home - Percent of Placements

Distance	Central	Eastern	Northern	Southeast	Western	State
0-20 Miles	51.6%	95.9%	55.8%	66.0%	59.1%	76.2%
21-50 Miles	13.8%	1.4%	18.2%	15.6%	12.2%	8.7%
51-100 Miles	11.0%	0.9%	14.9%	10.3%	9.4%	6.4%
100+ Miles	23.6%	1.8%	11.2%	8.1%	19.3%	8.7%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

SFY 18

Placements' Distance from Child's Home - Percent of Placements

Distance	Central	Eastern	Northern	Southeast	Western	State
0-20 Miles	48.7%	96.7%	52.4%	66.5%	59.6%	77.0%
21-50 Miles	13.9%	1.6%	18.0%	14.4%	11.0%	8.0%
51-100 Miles	9.9%	0.7%	17.0%	11.0%	8.8%	6.2%
100+ Miles	27.5%	1.0%	12.6%	8.1%	20.5%	8.8%
Grand Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: DHHS, November 2018

This is a measure where a higher percentage is desired. The ESA excels in this measure, but this is a measure where it is difficult to compare across Service Areas due to the urban nature of the ESA and the rural nature of most of the other Service Areas. This is not to undercut progress made by the vendor, but this is a measure where the ESA would be expected to do well relative to the other regions.

Table 19: Rate children remaining within same school districts after out of home placement

6/20/2016	Central	Eastern	Northern	Southeast	Western	State
Same	64.0%	77.9%	54.7%	69.2%	59.3%	70.6%
Different	36.0%	22.1%	45.3%	30.8%	40.7%	29.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6/26/2017						
Same	50.5%	75.4%	54.9%	71.6%	65.7%	68.8%
Different	49.5%	24.6%	45.1%	28.4%	34.3%	31.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
6/25/2018						
Same	53.4%	74.0%	53.4%	71.4%	65.2%	68.0%
Different	46.6%	26.0%	46.6%	28.6%	34.8%	32.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: DHHS, November 2018

Note: This is point-in-time data and excludes any children for which the home or current school district fields in N-FOCUS are blank.

This is a measure where a higher percentage is desired. The ESA excels in this measure, but like placement close to home, this is a measure the ESA would be expected to do well relative to the other regions because of the urban nature of the Service Area.

5.5.1. Rate of children where parental visitation is occurring

Parent/child visitation is a critical variable, linked to reunification outcomes. TSG requested but was unable to obtain data from DHHS on the percent of children who are having regular visits with their parents.

5.5.2. Medicaid/Health

TSG requested Medicaid utilization data by Service Area, including data on EPSDT compliance, but was not able to receive the data in time to include it in this assessment.

5.6. Outcomes Related to In-Home Cases

Going forward, DHHS will need to capture additional data regarding its in-home cases. TSG requested some data which is included here, but there were some measures the Department could not produce. This data, as well as measures related to monitoring for FFPSA compliance, will be needed.

Table 20: Rate of removal from in-home cases.

SFY 16	Central	Eastern	Northern	Southeast	Western	State
Removal After In-Home Case Started	10%	9%	15%	14%	17%	11%
In Home No Removal	90%	91%	85%	86%	83%	89%
Grand Total	100%	100%	100%	100%	100%	100%

SFY 17	Central	Eastern	Northern	Southeast	Western	State
Removal After In-Home Case Started	10%	8%	10%	11%	14%	10%
In Home No Removal	90%	92%	90%	89%	86%	90%
Grand Total	100%	100%	100%	100%	100%	100%

SFY 18	Central	Eastern	Northern	Southeast	Western	State
Removal After In-Home Case Started	5%	4%	5%	3%	6%	4%
In Home No Removal	95%	96%	95%	97%	94%	96%
Grand Total	100%	100%	100%	100%	100%	100%

Source: DHHS, November 2018

A lower measure is desired. This measure assesses whether safety can be maintained in in-home cases. For the last three years, the Eastern Service Area has performed better or equal to the State average.

5.6.1. Time to case closure for in-home cases

TSG requested this data by Service Area but was not able to receive the data in time to include it in this assessment.

5.6.2. Rate of families are completing services in the family plan

TSG requested but was unable to obtain data from DHHS on the percent of families who complete the services identified in their family plans as a means of assessing family engagement with services. TSG recommends that the agency begin to capture this measure going forward.

6. FINANCIAL REVIEW – COST PER CASE

Using a determination of total state expenditures by Service Area and Total Case Count, with some adjustments recommended by DHHS, TSG calculated the average cost per case. In conducting this analysis, TSG uncovered discrepancies between DHHS and PromiseShip’s case counts, which required reconciliation.

PromiseShip revenues and expenses are summarized in the table below³.

Table 21: PromiseShip Summary Revenue and Expenses

	SFY 2016	SFY 2017	SFY 2018
Revenue			
Program service revenues	59,723,649	65,491,200	70,494,362
Other revenue	351,749	604,107	246,871
Total revenue	60,075,398	66,095,307	70,741,233
Expenses			
Personnel	17,346,181	18,919,104	20,913,293
Contract services	41,181,868	44,242,494	45,528,822
Other expenses	3,185,323	3,155,979	4,307,006
Total expenses	61,713,372	66,317,577	70,749,121
Net contribution to fund balance	(1,637,974)	(222,270)	(7,888)

Reviewing the above, TSG notes:

- Revenues have grown at a compound annual growth rate (CAGR) of 8.6% since 2016
- SFY 2018 revenues are 99.7% from the State contract
- Personnel costs have grown from 28% to 30% of total expenses, while contracted services have fallen from 67% to 64%
- Over the past 3 years, PromiseShip has accumulated loss to its fund balance of \$1.9MM

6.1. State Program Reimbursement under the Vendor Contract

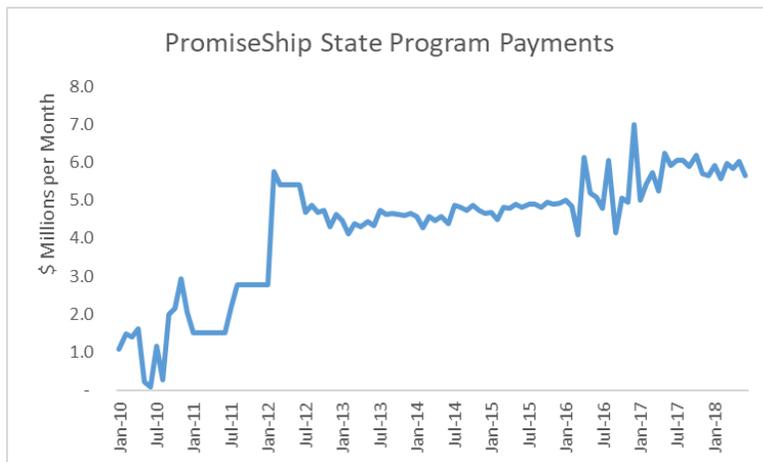
The chart below presents monthly program service revenues January 2010 through June 2018. During the period January 2010 through January 2013, PromiseShip (then NFC) was gearing up. In December of 2010, they took on case management responsibility in the ESA. By January

³ TSG analysis of interim (unaudited) financial reports provided by PromiseShip in the file: 5 - 3 Year Budget Comparison 10.29.18.xlsx

2013, PromiseShip reimbursements “settled down” into a long term, fairly steady payment pattern.

Overall, over the four and a half years between January 2013 and June 2018, PromiseShip monthly program reimbursements increased at a steady compound annual growth rate of 4.4%⁴.

Figure 22: PromiseShip State Program Payments, 2010 – 2019.



6.2. Other Sources of Revenue

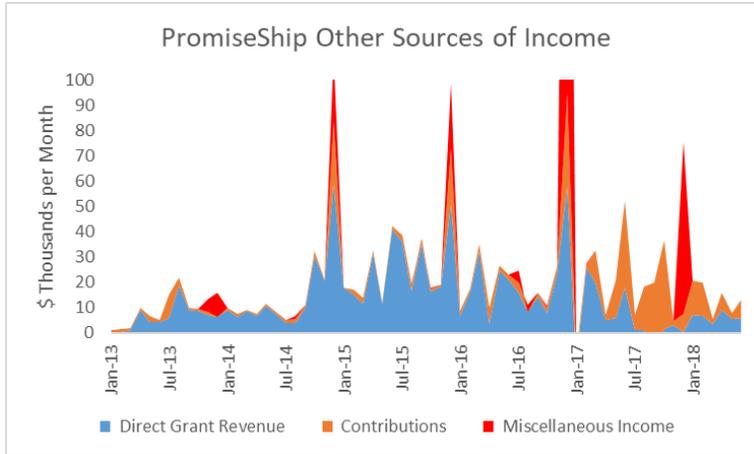
TSG understands that one objective of the public private partnership with PromiseShip is to leverage state funds with private contributions. In the period since January 2013, PromiseShip has typically raised between \$20,000 and \$40,000 per month in contributions and another grant revenue, as shown in the chart below⁵. In addition, PromiseShip has raised a total of \$599,000 since 2010 in miscellaneous income. These are the annual (red) spikes in the graph.⁶ In total, these other sources account for about 3% of PromiseShip’s annual revenue.

⁴ TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx

⁵ TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx

⁶ Note that the y-axis scale is adjusted in the chart so the top of the January 2017 bar does not appear. That amount is \$168,000. In addition, Miscellaneous Income ran slightly negative in several months, presumably accounting-related adjustments, none sufficiently material for TSG to investigate in the scope of this assessment

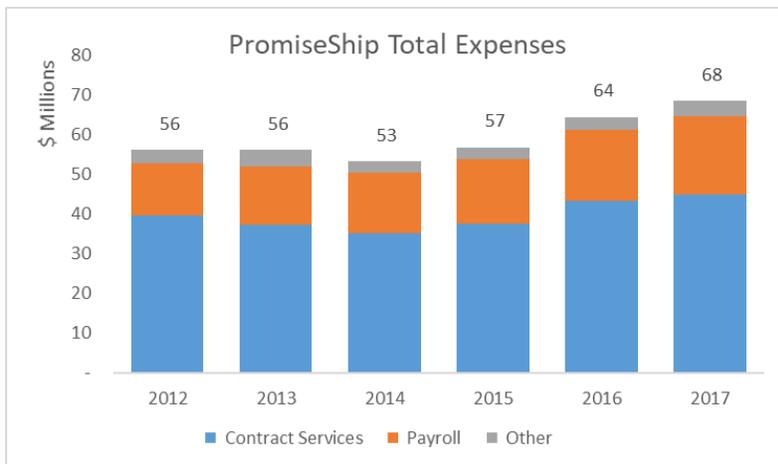
Figure 23: PromiseShip Other Sources of Income, 2013 – 2018.



6.3. PromiseShip Cost Structure

Since 2012 total expenses have grown at 3.4% per year, as shown in the graph below⁷. These amounts are totaled by State Fiscal Year through June 2018⁸.

Figure 24: PromiseShip Total Expenses, 2012 – 2017.

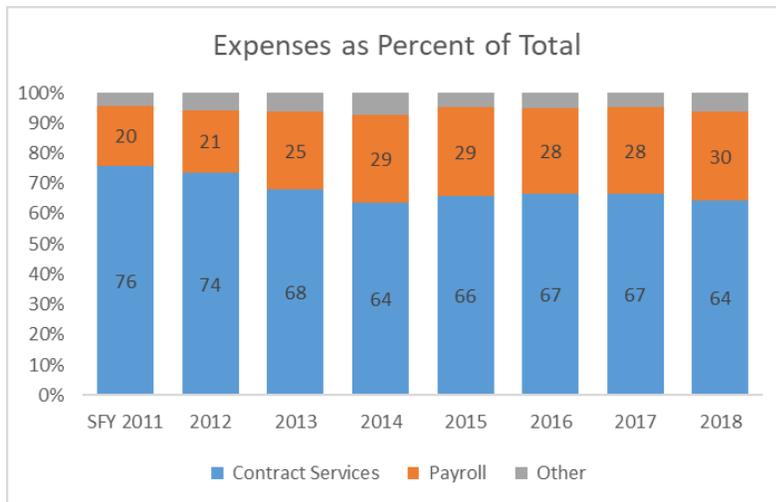


⁷ Expenses have grown at a CAGR of 7.7% since 2016, using the three-year numbers in the table at the top of this section

⁸ TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx

Payroll increased as a percent of total expenses through 2013 as PromiseShip took on case management responsibility. Since 2014, labor has remained consistently around 29% of total: labor and contracted services are used in the same proportion year to year⁹.

Figure 25: Expenses as Percent of Total, 2011 – 2018.



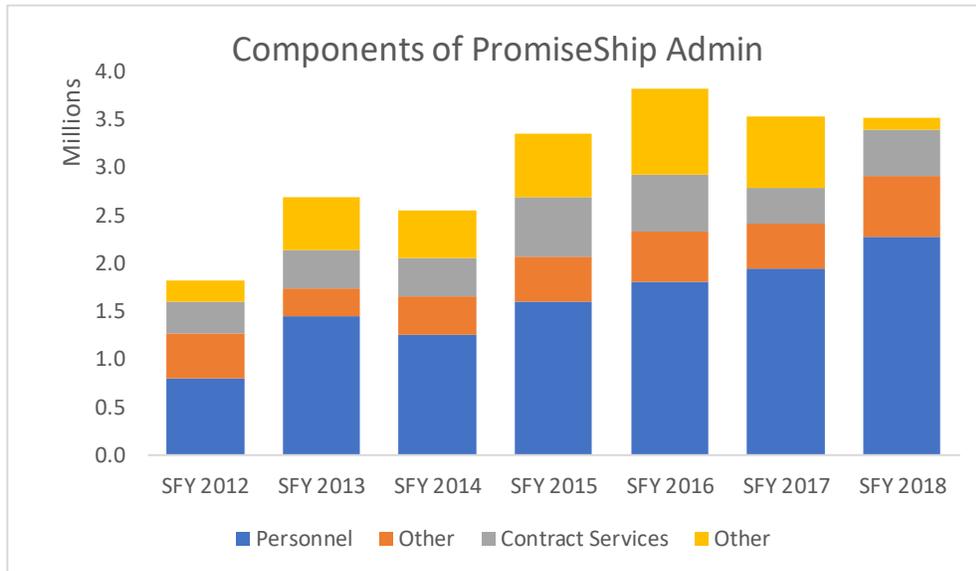
6.4. Administrative Costs

Administrative costs are expenditures other than those related specifically to case work. In total, Administration costs have not changed significantly over the past years, as shown in the chart below¹⁰.

⁹ TSG analysis of PromiseShip data in the file: 4 - 10 Year Financials 10.25.18.xlsx

¹⁰ TSG analysis of PromiseShip data in the file: 6 - Admin Breakdown.xlsx

Figure 26: Components of PromiseShip Administrative Costs, 2012 – 2018.



The table below describes the components of Administration for the past 7 years.

Table 22: Administrative Cost Detail, 2012 – 2018.

	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Personnel	795,713	1,444,694	1,252,107	1,598,628	1,800,648	1,939,746	2,269,509
Other	466,555	289,071	397,184	462,985	532,939	469,663	632,771
Contract Services	338,618	396,545	409,421	623,201	586,006	376,356	488,325
Other Facility	81,576	278,368	243,944	271,184	300,324	194,385	285,443
Professional Fees	18,057	52,117	16,066	58,359	171,695	128,704	172,783
Advertising/Mrktg	4,576	43,935	45,751	9,637	31,737	57,988	142,450
Building rent	118,327	181,726	185,009	326,316	388,920	367,313	-482,215
	<u>1,823,422</u>	<u>2,686,456</u>	<u>2,549,481</u>	<u>3,350,310</u>	<u>3,812,269</u>	<u>3,534,155</u>	<u>3,509,066</u>

Note that in terms often used by the State, “Administration” is something different, it is the fixed portion of the annual payment. That vantage does not factor into the TSG analysis of administration. In SFY 2018, the occupancy amount is negative because of a \$480,000

reclassification of space from administration to program costs. PromiseShip describes this as correction of previous accounting error.

6.5. PromiseShip Costs to Include in the Cost per Case Assessment

The easiest and most meaningful cost for analysis is the amount the State pays PromiseShip for its services. This bears directly on the question of how much it costs for the State to continue using PromiseShip to manage cases. However, this ignores some complications, each of which is relevant to some type of cost per case analysis.

- **PromiseShip Admin.** PromiseShip costs include overhead that are not directly related to managing cases. For example, they have administrative leadership, facilities, a computer system, and so forth. Thus, including these makes the comparison “unfair” in the sense that such a comparison is not really case-cost to case-cost. However, the question TSG was asked to address is whether the overall relationship is economically justified, not whether the direct costs of one case worker are equivalent. Thus, PromiseShip Admin needs to be included
- **PromiseShip Other Revenue.** PromiseShip has a small amount of revenue outside the State contract. This offsets some of PromiseShip’s costs and could be used to off-set the case cost. However, though these revenues are a “cost to society” for child welfare, they (once again) do not bear on the question of viability of the outsourcing relationship today. If the PromiseShip “went away” so also would the revenue, presumably. So, TSG has not included this in the case cost comparison.
- **PromiseShip Other Costs.** PromiseShip incurs costs other than those reimbursed by the historic payment method. Each month, there is a modest amount by which reimbursement exceeds or is less than actual costs. The TSG analysis ignores these. Once again, the purpose of this analysis is whether the economic relationship makes sense. Where the State did not pay for costs other than the contracted amount, these are not relevant to this particular cost per case analysis.

Thus, for purposes of the TSG case cost analysis, we have counted as cost the amount paid by the State through the PromiseShip contract. It does not matter whether the amount paid was as a fixed or variable payment—TSG looked only at the total.

6.6. Additional Costs for Comparability with Other Regions

For the analysis, TSG needs to compare all the costs for all the cases in a manner that is consistent across regions. Looking to the way cases are managed, the best method of comparing is full costs. This includes direct costs (and case units) of investigations, alternative response for all regions. It also includes all administrative costs, both State and PromiseShip.

TSG is thus comparing all the costs of supporting cases in a region. This is different from analyzing just the costs of PromiseShip and represents the most meaningful method of

comparing. It accounts for any inefficiencies related to handoff or duplication across the organizations. Thus, TSG is looking at the system-wide effect of outsourcing, not just at one component.

While PromiseShip manages ongoing cases in the ESA, they do not manage all cases: the State manages initial investigations as well as “alternative response”. In addition, the State incurs overhead costs that are allocated to the work of the Eastern Service Area.

Thus, to arrive at total costs that may be compared across regions, TSG adds:

- State N-FOCUS payments. These are providers charges paid on behalf of children in the region. For the Eastern Service Area, these are in addition to the charges paid through PromiseShip. In the case of the other regions, they comprise all the provider charges. Provider payments include payments made on behalf of investigations. This is to capture the full costs of a case. However, investigations cases are not included in the case count—to avoid double counting.
- State internal costs. These include allocations the state applies to each region¹¹:
 - State-Wide Cost Allocation
 - Termination Benefits
 - Chief Executive Officer
 - Internal Audit
 - HRD Human Resources
 - FS Accounting
 - FS Budget Unit
 - CLS Communications Services
 - SS Administration Support
 - SS Records Mgt, Wp, Scanning
 - SS Procurement
 - Building Division
 - SS Contracts & Subawards
 - SS Field Office Rent
 - IST Customer Services Administration
 - IST Customer Services Help Desk
 - IST Technical Services
 - IST Application Svcs Administrative Services
 - Information Security Office
 - Termination Benefits
 - Chief Executive Officer

¹¹ TSG analysis of information provided by DHHS in an email dated 11/19/2018

- Internal Audit

- PromiseShip Payment. In the table below, TSG uses the amount per the State payment system¹². The amount per the state system (below) differs from the amount in the PromiseShip internal accounting reports, which is \$70,976,021. This is different from the State number below by less than 1%.

6.7. Date of Costs Included

Payments to providers can be delayed from a few months to several years. In addition, the State does not record payments into N-FOCUS until after they are paid. N-FOCUS records could allow TSG to use either date of service or date paid. Neither is “right.” Date of service is better according to private sector GAAP. However, the State is on a cash basis.

Including cost by service date will seclude a tail of payments still not made as of October (4 months after year-end close). On the other hand, including cost as of payment date will include some costs paid for services in prior years. If caseload were constant, including case by paid date would be the best, because the payments for prior year services would “wash” in comparison to the payments delayed to future years. Caseloads dropped for PromiseShip in 2018. However, PromiseShip provider costs are included in the analysis as part of the total payment, not directly from N-FOCUS. Thus, it depends.

To sort this out, TSG considered cost pre-case both based on service and paid date. The two approaches produced nearly the same result. This is because the total statewide difference was only \$1,740,128 out of \$74,897,190 provider payments paid outside the PromiseShip contract.

This ambiguity about whether to use service or paid date further underscores the need to consider cost per case comparisons only within a range of +/-5%.

6.8. Costs Not Included

TSG excluded from costs:

- Provider services and transportation for YRTC cases, as these are Juvenile Justice cases.
- Adult Protection Services provider services. Although the labor costs include about 12 APS case workers. This is only because State accounting did not enable them to be separately identified. TSG estimates that roughly \$600K in labor costs are spread across all Service Areas, including Eastern Service Area.
- Any costs related to B2i cases. as these are not part of the child welfare program. Both provider payments and case workers are excluded, as well as case counts.

¹² TSG analysis of data provided by DHHS in the file NFC monthly payments data based on E1.xlsx

6.9. Total Costs Used in the Cost per Case Calculation

Therefore, total costs for the cost per case analysis are shown in the table below. The SFY2018 ESA costs are \$82,249,069¹³¹⁴¹⁵. State N-FOCUS Payments are according to date paid, since PromiseShip payments are as paid. State Internal Costs include allocations as described above. Direct Payment to ESA is the sum of checks paid to PromiseShip.

This amount differs from PromiseShip books for 2018 by \$600K (yet another reason to compare case costs within a range of +/-5%). Direct Payments to Northern Region are paid to three tribal offices for case management and administration. Note, that TSG adjusted our analysis based on DCFS input to adjust for: Native American cases, YRTC cases and one outlier case.

Table 23: Total Costs, by Service Area, 2017 – 2018.

	2017				2018			
	State N-FOCUS Payments	State Internal Costs	Direct Payments	Total	State N-FOCUS Payments	Internal Costs	Direct Payments	Total
Central	13,123,828	6,602,121		19,725,949	13,631,231	6,464,973		20,096,204
Eastern	1,950,965	10,441,844	63,311,114	75,703,923	1,789,339	9,271,199	71,188,531	82,249,069
Northern	17,644,623	7,723,001	3,176,053	28,543,677	19,365,453	7,517,637	2,430,190	29,313,280
Southeast	25,692,184	13,460,715		39,152,899	26,322,443	12,551,779		38,874,222
Western	12,065,366	7,540,293		19,605,659	13,184,762	7,149,798		20,334,560
Statewide	70,476,965	45,767,974	66,487,167	182,732,106	74,293,228	42,955,386	73,618,722	190,867,335
Non-Eastern	68,526,001	35,326,130	3,176,053	107,028,183	72,503,889	33,684,187	2,430,190	108,618,266

6.10. Cases

Calculating average cost per case is meaningful in the context of establishing trends against prior periods and comparing with the rest of the state. Thus, in order to make a meaningful comparison, TSG worked to make case counts consistent region to region and over time.

6.10.1. Using the Right Case Counts

There are several ways to count cases. Foremost, the key is to use a common method for PromiseShip and State cases. TSG counted cases as follows:

¹³ State Internal Costs are TSG analysis of DHHS data provided in the file: Foster Care Administration Data for Stephen Group.xlsx

¹⁴ N-FOCUS costs are provider payments and are a result of TSG analysis of data provided by DHHS in the file: Foster Care Administration Data for Stephen Group.xlsx

¹⁵ PromiseShip payment is the result of TSG analysis of data provided by DHHS in the file: NFC monthly payments Data based on E1.xlsx

- Court-involved cases. TSG counted individual youth involved in court cases. In some situations, an individual case might have more than one youth. TSG counted youth or “wards.”
- Non-court cases. These are more complicated, as they typically involve not only several youths, but also one or more adults in the household. Thus, it would become quite complicated to count individual youths. The standard applied by both PromiseShip and the State is to count non-court cases by family or “master case.” So, this is the convention TSG used.

Counting cases is thus a mix of individuals (court) and families (non-court). This is really adding apples and oranges. However, it is the only sensible approach, and TSG applied it consistently.

Cases reported for external purposes sometimes break out Native Americans separately. The TSG analysis includes cost and case counts of 337 Native American cases as of October 2108.

Cases can be reported in many ways. However, TSG used case count on the first day of each month. For example, one case might be open for seven months of the year, and another for 6 different months. Under the TSG method, these would be counted as 13 case-months. Yet, of course they are only 2 cases.

The TSG approach is much more accurate than considering annual case costs by dividing a whole year costs and cases. In the tiny example above, the annual approach would divide by only two cases - ignoring that neither case was open all year. Of course, the same argument could be made to use daily case counts (or even case counts by the hour). The TSG approach of counting cases by month produces sufficiently accurate and comparable case costs for the purpose of this assessment.

6.11. Reconciling Case Counts Between State and PromiseShip

PromiseShip and DHHS reported case counts from different sources. The reported case counts were not the same. TSG conducted a detailed analysis of October 2018 and found three types of differences¹⁶. Ultimately, TSG used State case counts for the analysis. This mis-match in case counts could not be reconciled by the State or PromiseShip. This is a major reason TSG compares cost per case within a range of +/-5%.

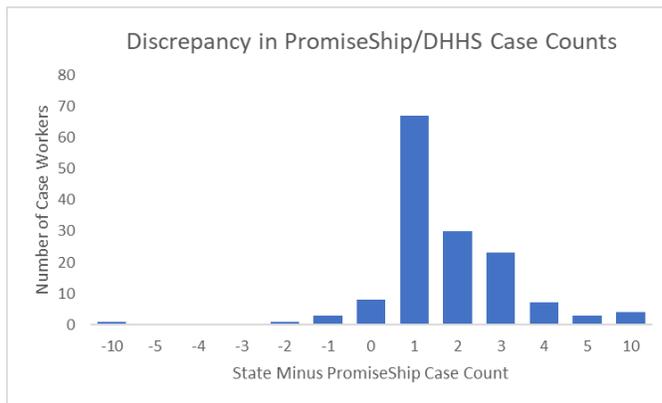
The differences seem to include:

- ESA cases worked by 37 State case workers. These can be Alternative Response or other cases the State retains.

¹⁶ TSG compared the DHHS file:

- 60 Case workers missing entirely from one list or the other. Note: TSG found and corrected for 8 individuals who were obviously the same, but names were entered differently in the two systems, like: Jeff and Jeffery V. There are some others that may have been married, but TSG was not able to confirm they were the same.
- Case counts different in October 2018 by a few cases for 147 case workers, as in graphed below.

Figure 27: Discrepancy in PromiseShip/DHHS Case Counts.



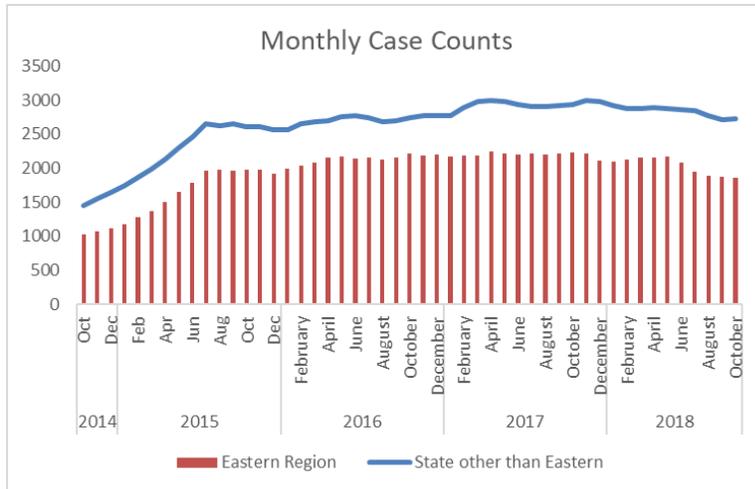
The last two differences could be timing or permanent. We don't know. More importantly DHHS doesn't know and does not appear to have in place a routine for finding differences and correcting the systemic causes.

6.12. Cases Over Time

In the Eastern Service Area, cases grew through June 2014, held steady until June 2018, and has declined since then. In the chart below, case counts per the State are shown by the line, and PromiseShip case counts are the bars. See that the difference has declined from 426 in January 2016 to 252 in October 2018. This seems to be because the total count has remained flat since 2016, while PromiseShip is taking on more of the cases. The case counts start later for PromiseShip only because that is the data TSG obtained.¹⁷

¹⁷ TSG analysis of PromiseShip case counts provided by PromiseShip in the file: Request 30 Caseload – revised.xlsx
State case counts provided in the file: Caseload for Stephens Group v2.xlsx

Figure 28: Monthly Case Counts October 2014 – October 2018.



6.12.1. Eastern Service Area Case Counts Used in the Cost per Case

TSG used case counts as reported by the State in its calculations of cost per case. There could be same error in the result, since the case counts are different between PromiseShip and DHHS. In October 2018, the difference is as follows:

Cases per PromiseShip	1,595
Cases worked by State employees	139
Unidentified differences	113
Cases reported by DHHS	<u>1,847</u>

Thus, unidentified differences represented 6% of the State case count. In addition, State workers managed 7.5% of ESA cases in October. The state count is consistently higher than the PromiseShip count (see chart above), however, that does not mean that the error is always in the same direction. So, TSG is confident in case cost calculation at the level of +/- 5%.

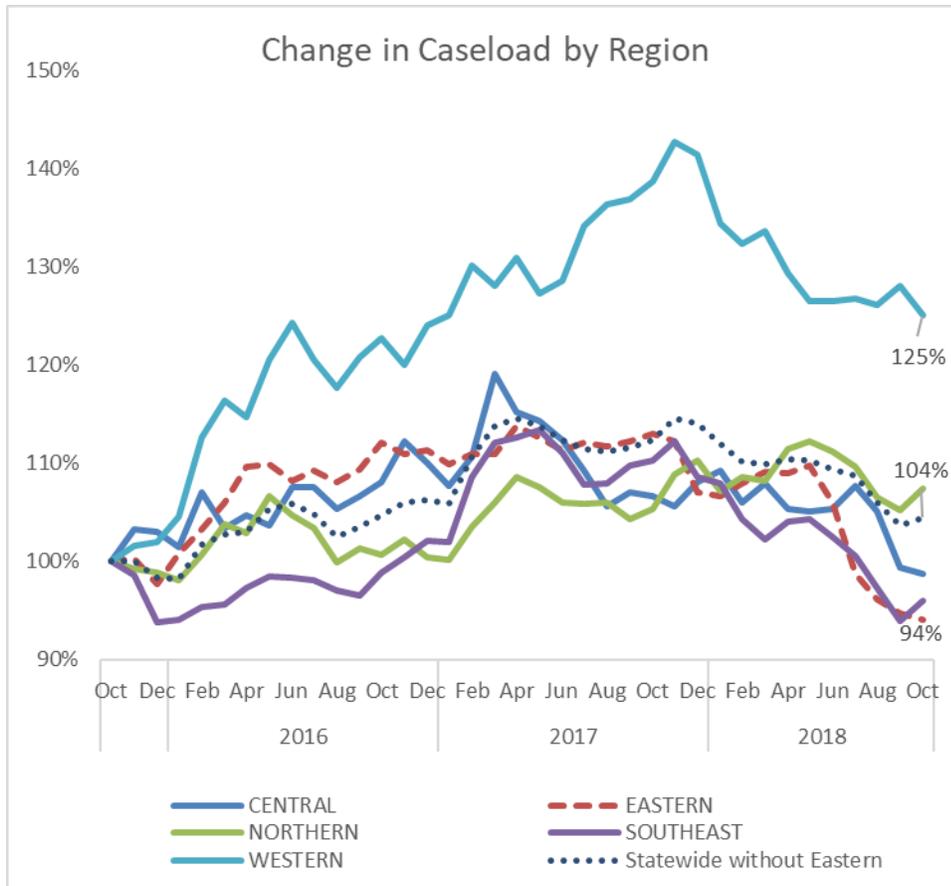
6.13. Case Counts in Other Service Areas

Case counts have increased 4% statewide total over the four years¹⁸. That growth was experienced differently in each region. The chart and table below show that ESA cases have decreased 6% over 4 years while Western Service Area has experienced the largest rate of case

¹⁸ This is point to point growth, not annual growth

growth, 25%¹⁹. The most important take-away from the graph below is that overall, case levels are the same as they were in October 2015. Even the Western Service Area’s growth expressed in terms of CAGR²⁰, is only 8% per year. TSG also notes the important decrease in cases since October 2017, especially in the ESA (i.e. PromiseShip).

Figure 29: Change in Caseload by Region, 2016 – 2018.



¹⁹ TSG analysis of State data in the file Caseload for Stephens Group v3.xlsx

²⁰ Compound Annual Growth Rate is the annual growth rate that would accounts for the increase from October 2015 to October 2018 (3 years)

Table 24: Cases by Region as of October 1 each year, 2015 – 2018.

	Central	Eastern	Northern	Southeast	Western	Statewide	Statewide without Eastern
2015	467	1,971	825	926	395	4,584	2,613
2016	505	2,209	831	915	485	4,945	2,736
2017	498	2,227	869	1,021	548	5,163	2,936
2018	461	1,854	886	889	494	4,584	2,730

TSG used monthly case counts to calculate cost per case month. So, it added the number of cases in each month to arrive at a total shown in the table below. The 2018 total is 57,523 case months. This is NOT the number of youth or families in the system. It is the number of case-months worked during the year. Dividing annual cost by case-months produces a cost per case per month.

Table 25: Annual case-months used in the case cost calculation

	Central	Eastern	Northern	Southeast	Western	Statewide	Statewide without Eastern
SFY 2017	6,208	26,225	10,227	11,601	5,909	60,170	33,945
SFY 2018	5,983	25,953	10,719	11,869	6,374	60,898	34,945

6.14. Cost per Case

TSG calculated cost per case using the costs and annual case months u cases described above. Given the discrepancy in case counts, TSG shows a range of case costs +/- 5% of the cost for the state other than ESA. Even given the discrepancies in case count, TSG concludes that the ESA is slightly below the cost per case in the majority of regions. Note that ESA case cost increased in 2018 because case counts dropped, and total costs increased in 2018.

Figure 30: Cost per case per month – comparing regions, SFY 2017 & 2018

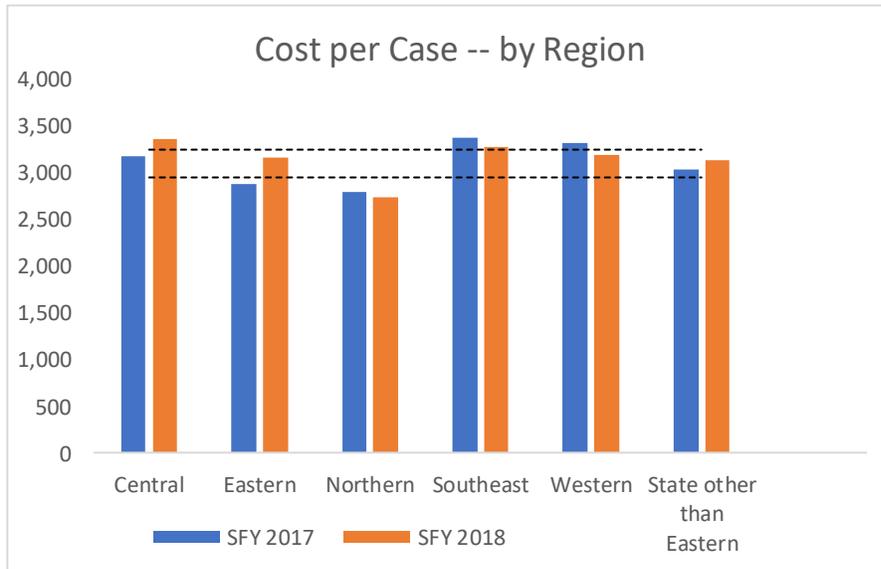


Table 26: Costs per Case per Month, rounded to the nearest \$100.

	SFY 2017			SFY 2018		
	Costs	Cases	Cost/Case	Costs	Cases	Cost/Case
Central	19,725,949	6,208	3,200	20,096,204	5,983	3,400
Eastern	75,703,923	26,225	2,900	82,249,069	25,953	3,200
Northern	28,543,677	10,227	2,800	29,313,280	10,719	2,700
Southeast	39,152,899	11,601	3,400	38,874,222	11,869	3,300
Western	19,605,659	5,909	3,300	20,334,560	6,374	3,200
All State	182,732,106	60,170	3,000	190,867,335	60,898	3,100
State other than Eastern	107,028,183	33,945	3,200	108,618,266	34,945	3,100

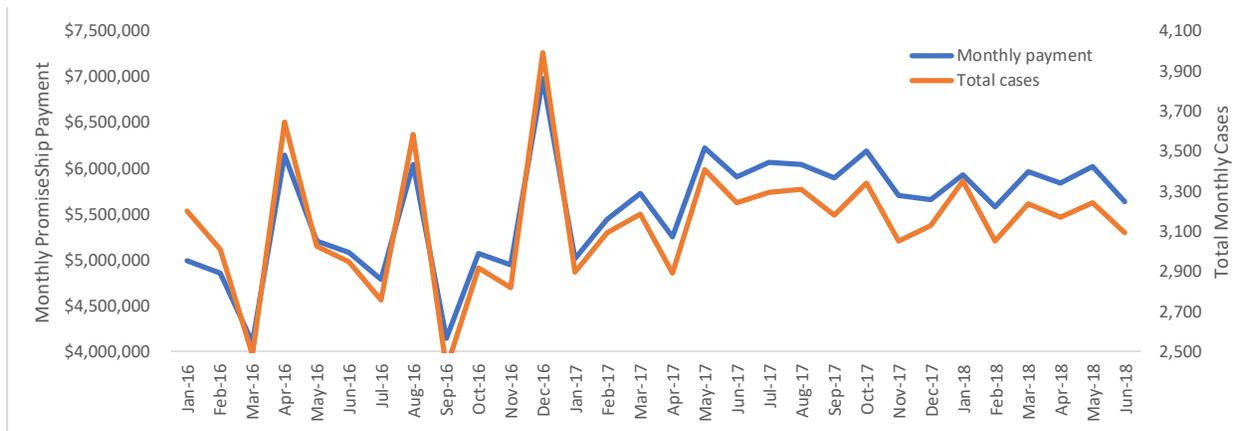
Some have suggested that the Southeastern Service Area is most similar to the ESA, in that it also contains urban areas. TSG notes that case costs in Southeastern Service Area are nominally higher than ESA. However, the difference is \$100 in 2018, less than the 5% confidence interval. So, given the discrepancy in case volumes the difference is insignificant.

6.14.1. Cost per Case – PromiseShip Only, to View in Greater Historic Detail

The chart below shows PromiseShip State payments and the cases worked and reported by PromiseShip. It is presented because it is “clean” in that it involves fewer assumptions or adjustments. This is useful for historical perspective, but not for comparing with other regions.

Notice the abbreviated y and z-axes in the chart. See that the costs have tracked with cases, reflecting that costs have historically been adjusted to actual through a “true-up” process.

Figure 31: Monthly PromiseShip Payments and Cases, 2016 – 2018.

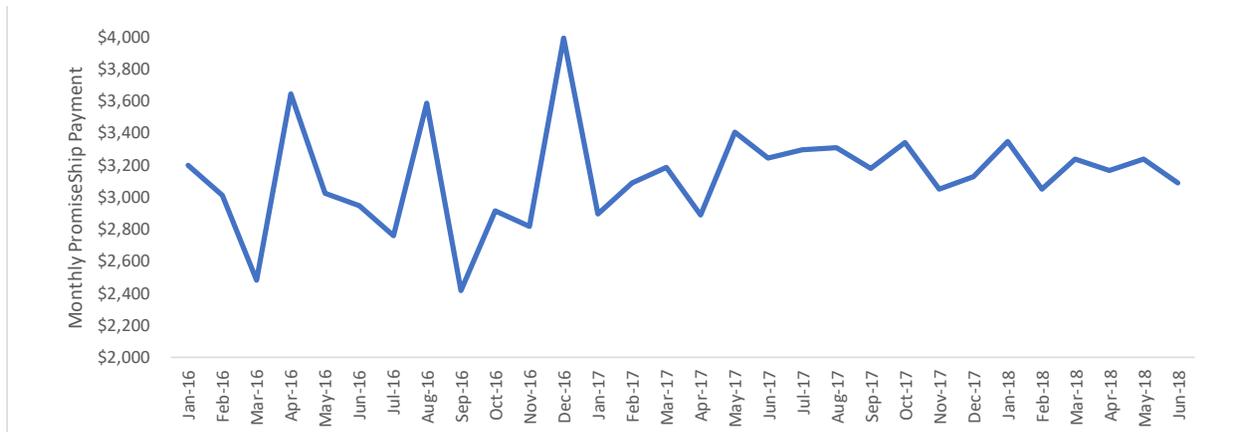


The chart below shows PromiseShip payment per case, which has ranged quite a bit over the past years. PromiseShip payment per case has moved as high as \$4,000 and as low as \$2,400.

Notwithstanding some swings, the per case amount is nearly the same in June 2018 as it was in January 2016. The three-year average is \$3,100 per case per month²¹. Wide swings in cost per case do not merely reflect changes in caseload or the underlying PromiseShip costs. Rather, they reflect a payment method that true-up costs periodically.

²¹ This is calculated: sum of costs for the range of months / sum of cases per month

Figure 32: Monthly PromiseShip State Payment per Case, 2016 – 2018.



TSG’s historical analysis of PromiseShip payments compared to PromiseShip-only cases reveals:

- Case cost has remained flat for the period since 2016
- Historical “Administration” payments cause wide swings in the graph, but do not represent changes in case cost
- Viewed in this narrow manner, 2018 case cost turns out to be the same as the fully-loaded method above, \$3,100 per case.

6.15. Findings from Case Cost Assessment

Overall, TSG found that the promise of lower costs through outsourcing is not being realized. ESA costs per case are the same as the rest of the state. This has happened in part because the PromiseShip relationship is neither constructed nor managed in a manner that would likely lead to lower costs (combined with higher outcomes).

1. DHHS lacks a definitive set of reports on which to base cost management. TSG’s assessment was challenged by not having unambiguous data:
 - a. PromiseShip case counts and cost numbers did not agree with those from the State
 - b. The State had difficulty creating a set of case and cost numbers
 - c. TSG was not able to compare the data provided to a definitive set of financial and operations reports that had been reviewed and discussed monthly by DHHS leadership. (No benchmark against which to gauge the rest of the numbers)

TSG was not able to obtain “the monthly report” by which DHHS management regularly manages costs. Without a report that has been through monthly management scrutiny, DHHS has limited ability to truly manage its costs.

2. DHHS lacks a regular process of managing case costs, as does PromiseShip. Without an accurate ability to build in controls to manage to cost per case, it would be nearly impossible to collaborate on areas of cost savings without accurate data on cost per case.
3. DHHS and PromiseShip manage costs independently. Although both are aware of significant differences in costs and case counts, neither is working to reconcile them. While DHHS and PromiseShip are different agencies, they are still working together to achieve the same goal: better case outcomes at lower cost. Yet, TSG found little on-going work to assure that efforts to manage the finances of cases in the ESA are coordinated. TSG also found instances in which the two sides know they are not working together and have not taken steps to correct it. For example:
 - a. Inconsistent case counts
 - b. FAMCare and N-FOCUS do not agree
 - c. Even the State’s record of FAMCare and the report from PromiseShip do not agree
4. DHHS and PromiseShip use different systems, because they cannot agree on how to account for cases. PromiseShip’s FAMCare system is a case management system, where N-FOCUS is primarily a case accounting system. PromiseShip purchased a new system because DHHS would not willing to accommodate innovation in provider services codes. This upgrade cost PromiseShip millions that added to the cost of overhead, instead of being used for services or returned to the taxpayers.
5. DHHS and PromiseShip know there are difference in the numbers they use for management, but have not addressed the differences
6. Case cost management is confounded by lack of clear definitions. TSG found that DHHS and PromiseShip do not share a common definition of:
 - a) When costs are incurred (cash versus accrual)
 - b) Terms used for tracking cases (wards, youth, master case, in/out of home...)
7. DHHS and PromiseShip do not collaborate on case cost management. TSG found no mechanism by which PromiseShip and DHHS are actively working together to find opportunities to reduce cost. TSG believes that taking advantage of private sector orientation to cost improvement is a fundamental reason for outsourcing in the first place. However, the two organizations are working in silos instead of collaborating together to improve costs.
8. TSG was impressed with the abilities demonstrated by individual analysts. This assessment would not have been possible without the support of both State and PromiseShip analysts. However, DHHS does not have accounting staff responsible for monitoring, assessing and recommending improvements to case costs and neither has a

team assigned to the job of cost management. DHHS should have a function working to report costs and then to find ways of improving them. They should partner in this endeavor with PromiseShip.

6.16. Summary Findings from Financial Review

1. Cost-plus. The current payment structure (Effective September 2018) is cost plus. It provides little incentive for PromiseShip to improve cost performance.
2. Manual data re-entry. PromiseShip re-enters provider payments manually into N-FOCUS. To save time, PromiseShip sometimes manually sums provider payments outside the system. This requires a staff of four. This wastes resources, introduces opportunities for error and could be easily replaced with Robotic Process Automation²².
3. Different service codes. PromiseShip and DHHS use different service codes for provider payments. DHHS was unaware if there is a crosswalk between the two lists. Accordingly, DHHS has no ability to compare provider payment practices across the FAMCare and N-FOCUS systems. It depends on the “recoding” PromiseShip clerks perform as they re-enter payments into N-FOCUS. This is wasteful, introduces the opportunity for error and prevents dependable analysis.
4. Financial controls. TSG is not convinced that the silo-based controls between PromiseShip and DHHS are strong. TSG is not an audit firm and defers to professionals in that area. However, TSG has seen enough to suggest that a study of inter-organizational controls is needed. The controls TSG observed lack coordination, analytical controls, reconciliations and management reporting—all crucial aspects of control systems.
5. Cost analysis. DHHS does not typically report or manage its total costs through cost analysis. DHHS is apparently not tracking trends or ratios of its operating costs or costs per case. TSG was not able to obtain a budget report that listed all case management costs. Without regular reports that are reviewed by management, it is hard to say that DHHS is managing its costs. Regular management analysis is a crucial form of management—offering far greater potential for control than tracking individual documentation or procedural violations. DHHS should develop a set of financial reports to manage child welfare costs. These should be reviewed by management on a monthly basis to assess and correct cost trends. These reports should include: total direct and fully-loaded case cost, case volume, and cost per case. This should be done by region

²² For an explanation of RPA capabilities as well as providers and software, see for example the discussion published by Gartner, available at: https://www.appian.com/resources/gartner-robotic-process-automation-rpa-competitive-landscape-consulting-and-system-integration-service-providers-google/?google_ad_keyword=robotic%20process%20automation%20software&matchtype=e&google_ad_campaign=881255669&utm_source=google&utm_medium=cpc&utm_campaign=amcl-2018&gclid=Cj0KCQiAoo7gBRDuARIsANeJKUbniG1Bh2dlrjIGcf4cA3jM5I2a1XMwmU4pRlek1IT1DaUSX5Vv y3MaAji7EALw_wcB

and by type of case. Reporting should be done for each major aspect of cost: labor, provider charges and administration. Cost management. Nebraska used outsourcing to try to manage costs. What it really needs to do is manage costs. However, that requires on-going reports and analysis. DHHS will have an effective cost management system when leadership discusses every month a report of variances in cost per case...and when variance reports are used to adjust staffing and contracting decisions. While social service bears little resemblance to manufacturing, in this one respect the tools will be helpful: DHHS would benefit from a cost accounting system. It also requires a team of analysts with the charge to both build regular reports and also to “explore” in the data—finding new relationships and trends.

6. Unaccountable caseloads. DHHS was not able to easily provide case volumes for analysis. The data source DHHS used archives cases after 12 months. Thus, DHHS has no record that users can use for analysis and management. Trend analysis is a crucial form of control. DHHS should develop a data repository suitable for on-going analysis of management questions. This should include direct case costs and labor as well as indirect costs, details about case demography, case performance, outcomes and so forth. The repository should be suitable for user reporting. In addition, DHHS should assign appropriately-skilled staff the responsibility to report trends, ratios and custom queries every month Financial management. DHHS is not supported by tools that allow it to evaluate the effect of case practice over time. This is the essence of evidence-based practice, the new foundation of child welfare services. This goes beyond cost accounting (above). This suggests that DHHS should be constantly looking for patterns and trends in the data. When the numbers present something notable, DHHS analysts and management should use that as a clue to finding new ways to manage cases for better results.
7. Unreconciled differences. DHHS reported that it suspects that there are differences between N-FOCUS and FAMCare but has not reviewed this as part of a process to eliminate differences. DHHS provided files of provider payments, and they did not agree—however the differences were not as they expected. Furthermore, TSG found that the unreconciled differences were millions per year. DHHS should conduct analysis on differences between FamCare and N-FOCUS, working to correct difference to nearly zero within one year. DHHS should make sure that provider costs per N-FOCUS tie to FAMCare and PromiseShip financials.
8. Consistent numbers. DHHS has several conflicting sources of data and doesn’t reconcile what the data it has. This is a significant amount of spending in the ESA that DHHS needs to control effectively. Also, the misalignment of N-FOCUS and FAMCare means it is also hard for PromiseShip to control. The opportunity extends beyond better managing between N-FOCUS and FAMCare. DHHS should be analyzing provider costs across \$120MM of provider services in all regions...what costs more or is more effective? TSG did not find a group of analysts within DHHS using the data to consider these questions. Analytical management should be a core competence.
9. Custom reports from N-FOCUS. PromiseShip cannot obtain custom reports from N-FOCUS. This is an important control and cost management issue as well.

10. Concentration of services. Many PromiseShip services are contracted with only a few providers. Fully 27% are sourced from a single provider. TSG found that 96% of services have 20 or fewer providers. TSG found that 71% of PromiseShip service charged were paid to 12 providers, while 96% of providers billed less than \$2 million over the past 3 years. DHHS and PromiseShip should work to expand the competitive nature of services. The original justification TSG heard for privatization of case management was to obtain better advantage from competition. Yet, PromiseShip’s services are very concentrated, not seeming to take advantage of competition in a manner much different from what the State does. Competition. The logic of outsourcing was allegedly to achieve the benefits of competition. However, TSG found a concentrated industry, not one characterized by the benefits of competition. See **Appendix C**.
11. Service rates. TSG heard a rumor that PromiseShip provided different billing rates by provider. This appears not to be the case, except for Foster Families. DHHS and PromiseShip should establish a regular two-way flow of information about management and accounting issues. The two groups should meet regularly. The two groups should work together to implement a collaborative quality improvement program. Open communication. See **Appendix C**.
12. Trust. TSG found far too much “management by rumor”. Culture of Distrust. TSG observed a level of distrust between State and PromiseShip not conducive to an effective partnership. This form of we/they relationship breaks down controls. Fixing this culture of distrust is core to achieving the benefit of working as partners.
13. Smaller caseloads. PromiseShip caseloads are lower than in the rest of the State. This raises the question, do smaller caseloads lead to better case performance, or at least lower turnover. TSG found no evidence that PromiseShip achieved better results through lower caseloads. This is not to say that lower caseloads are not better, only that TSG found no evidence. Caseload (i.e. staffing level) seems as though it should be a core management decision. Both PromiseShip and the State could do a better job of managing caseloads (staffing) to achieve optimum performance. See **Appendix C**.
14. Turnover. The DHHS method of reporting case worker turnover underreports the true impact. Looking at the frequency with which individuals stop working caseloads, turnover is 7%, not the 3% the state reports each month. Turnover of 3% would still be a big issue. The equates to 36% per year—a serious cost and performance challenge. However, TSG observes that statewide the rate is 59% annually (63% for ESA). TSG found that 95% of DHHS (100% of PromiseShip) case workers leave before they have been at it for 36 months. This is a very significant problem. PromiseShip has not done a better job at reducing turnover than DHHS. See **Appendix C**.

7. STAKEHOLDER ASSESSMENT

TSG considered stakeholder input as a qualitative source of information about the outsource in the ESA. This included review of PromiseShip’s annual survey and meeting with many stakeholders, as identified in the Approach Section, to assess their experience with the outsource in the ESA and relationship with the current vendor.

7.1. 2018 PromiseShip Annual Survey

In January 2018, PromiseShip piloted a new survey methodology, transitioning from a 10-week survey administration process to an annualized ongoing methodology. The new methodology ensures participants are offered the opportunity to participate in the survey year-round rather than during a short and specified timeframe. There was a decrease in total number of completed surveys compared to 2017 due to the change in survey administration. It is anticipated that the 2019 Survey will result in a significantly higher response rate as the survey will be administered over the course of a year, as opposed to the 7-month pilot.

PromiseShip developed the original Annual Survey in 2014, which was used for the 2018 Annual Survey to allow for comparison of items over time. There are four participant groups surveyed:

- Community Stakeholders—includes judges, guardian’s ad litem (GALs), attorneys, providers, and community members.
- Foster Parents—includes licensed foster parents and relative/kinship families.
- Parents of Youth—includes parents who are currently or previously receiving services from PromiseShip.
- Youth—includes youth who are currently receiving services from PromiseShip and who are at least 9 years of age and older.

Survey questions focused on perceptions of PromiseShip, including professionalism, collaboration with others, and quality of services provided. The survey questionnaire remained the same. All rating items used a 5-point Likert scale with 5 being ‘Excellent’ and 1 being ‘Fail.’

- In 2018, PromiseShip received survey responses from 193 Youth ages 12 and older. Although there were slight fluctuations in the individual item ratings there was no difference in the overall rating compared to previous years. Similar to past years’ results, the top rating for the Youth survey continued to come from the item: “My FPS treats me with respect.” This item rating was 4.7, which is a 0.1 increase from last year.
- Parents represented the largest group of respondents in the 2018 pilot. The overall average rating for the Parent survey in 2018 was 4.0. The item “My FPS schedules meetings that are convenient for my schedule” rated highest on the Parent survey with a 4.3 rating. In addition, the Parent and Youth surveys included the greatest number of positive comments about PromiseShip and/or the specific Family Permanency Specialist

(FPS) with whom they were working. Although the overall rating for parents was 0.2 lower than in 2017, there was a considerable amount of positive comments.

- Foster Parent respondents included both licensed and unlicensed foster parents. Of the 211 Foster Parents who completed the survey, 69 identified themselves as licensed foster parents, 134 as kinship/relative providers, and 8 did not self-identify. The overall average rating by Foster Parents in 2018 was 4.0, which is consistent with previous years. Overall ratings averaged 4.0, which is 0.1 point less than 2017 survey results. Ratings of 4.0 or above were given for items related to: FPS visits; Family team meetings; Monthly visits; and Professionalism of the FPS.
- In the 2018 Pilot, PromiseShip received 157 Community Stakeholder completed surveys. The overall average rating by Community Stakeholders was 3.2. Community Stakeholder ratings slightly decreased compared to the 3.5 rating in 2017, with an overall average rating of 3.3. Stakeholders included community members and professionals in education and the legal system (i.e., judges, attorneys, and GALs).

7.2. TSG Stakeholder Feedback

TSG interviewed the following stakeholders:

- Inspector General
- Judges (Sarpy and Douglas County)
- State Executive Leadership for CASA, as well as CASA leadership in Sarpy and Douglas counties
- Guardians ad litem
- Douglas Juvenile District Attorney Office
- Foster Care Review Board
- Nebraska Family Support Network
- Project Harmony
- Conducted a provider call with providers operating in both State and ESA
- Individual Service Providers: Nebraska Children’s Home Society, Capstone BH Services, Cedars

TSG asked each stakeholder if they had witnessed any quality issue or how they would compare DCFS caseworkers and PromiseShip caseworkers. Although not every comment was positive, on balance, TSG was unable to substantiate any quality or safety issue related to the outsource or the vendor’s performance. TSG has provided some sample comments below by major theme. TSG does not suggest making policy by anecdote but provides these comments only to offer some context into the types of discussions TSG had with stakeholders.

They spoke of the lack of vision for the outsource:

“There has never been a commitment from policy leaders to make this work. There was never a vision and the legislature was not even involved.”

Some spoke of the difficulty of the transformation. Some felt there was eventual benefit to the Service Area:

- “Privatization was poorly implemented when it was rolled out and there was a significant impact in the rural areas of the state.”
- “The transition was a real problem.”
- “It has been difficult, but it has brought system transformation.”
- “[The] Service network has become much stronger.”
- “Having a separate entity leads to a check and balance for the system.”

They spoke of the positive aspects of working with the vendor:

- “We have found PromiseShip to be data driven and more flexible than the bureaucracy of DCFS.”
- “There is more flexibility in determining the right service with PromiseShip as they think out of the box in working with families.”
- “PromiseShip always looks beyond the menu of services and there is not a one size fits all approach.”
- “PromiseShip is very willing to bring providers to the table.”
- “They are not as rigid as the state when it comes to services needed”

Some raised critical issues related to working with the vendor:

- “PromiseShip is putting too many inappropriate cases into voluntary services out of purview of the court.”
- “We spend more money in case management than we do on treatment”
- “The ESA vendor has been in self-protection mode ever since the start of the contract. They are constantly running out of money. The outcomes are worse than before. Their staff are poorly trained, and they do not have a workforce that thinks critically.”
- “Staff are not proactive when it comes to working on court cases in terms of case plans and are need better training in affidavit writing.”

8. OBSERVATIONS ABOUT PARTNERSHIP BETWEEN DCFS AND ESA VENDOR

States outsource child welfare case management for many reasons, but chiefly they do so to:

- Promote community ownership and accountability, and achieve quality outcomes;
- Allow for tailoring of services and a focus on meeting the needs of children and families in a local community or region; and,
- Provide for flexibility to create innovative solutions to meet local needs and to rapidly adapt to changing conditions.

In order to achieve these objectives, the state agency needs to collaborate with its vendor. The state contract needs to provide incentives toward high performance and allow for flexibility. Some of the factors TSG has observed in successful system as critical to effectiveness of the model include:

- Trust
- Communication
- Stability
- Shared purpose
- Inter-dependence

TSG finds that the relationship between DCFS and the ESA vendor is lacking in these essential building blocks. While the relationship has significantly improved, especially under the current leadership at DCFS, TSG finds that the relationship can be characterized by:

- Independent problem solving
- Missed learning opportunities
- Absence of communication which breeds misperceptions
- Unproductive competition
- Poor data sharing, especially financial data

This section of the report summarizes TSG’s review of the history and current state of the partnership. In general, it has improved recently. However, it still could best be characterized by a low level of communication, trust and collaboration, and by a form of ineffective competition.

This lack of collaboration manifests in many of the problems we have seen: FAMCare on top of N-FOCUS, numbers that are not reconciled, decisions on case transfer, and gaps in the case transfer process. This lack of collaboration, combined with a lack of clear shared vision and purpose for the outsource and a cloud of uncertainty that has loomed over the contract for many years, has also created a challenging environment for the vendor to operate. These are issues that must continue to be addressed with the current vendor, as well as with any future vendor in the

ESA. Failure to address these issues will limit the value the state of Nebraska will obtain from such an outsource.

8.1. Collaboration not Competition

Throughout our field work, TSG identified several concrete challenges that could be resolved through collaboration. The perpetuation of these challenges suggests the lack of a productive working relationship between DCFS and PromiseShip. Some examples include:

- Difference in case counts and the absence of effort on the part of DCFS or the vendor to reconcile these differences;
- Adherence to the agreed-upon case transfer protocol;
- Collaboration of continuous quality improvement resources and achievement of systems improvement; and,
- The challenge of building an evidence-based service array for FFPSA compliance.

Today, DCFS and the vendor approach problems like this independently.

In the absence of true collaboration, TSG is concerned that even with a performance-based contract that provides for greater accountability and an enhanced contract oversight approach at DCFS, the Department may not receive maximum value from this outsourced project due to a lack of collaboration.

- A truly collaborative case transfer process could improve permanency outcomes, if the Initial Assessment (IA) worker felt connected to the permanency work done by the vendor. It could improve the quality of the casework if an effective hand-off occurs.
- A collaborative approach to CQI could allow DCFS and the vendor to learn from each other's findings and improve statewide quality. The vendor has a robust continuous quality improvement program and is performing many types of case reviews, root cause analyses, and using a collaborative cross-department committee structure to tackle organizational problems. Today, DCFS does not have visibility to this program, nor does the vendor have visibility to the state's work because collaborative CQI meetings have been paused.
- A collaborative approach to service development with the vendor and providers could benefit children and families in all regions. The vendor has also developed new services collaboratively with its providers to meet the needs of children and families in the service area. The DCFS and the vendor could be working together to build new services so that other regions may benefit as well.

Besides the opportunity for DCFS and PromiseShip to work more effectively together, there is also an opportunity to improve collaboration among DCFS, State Medicaid, the MCOs, DCFS field offices and PromiseShip. This should include data sharing.

8.1.1. Collaboration

Unfortunately, collaboration seems to be one of those words people use without thinking about what it truly means. “Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible²³.” The objective of collaboration is to create a richer, more comprehensive appreciation of the problem among stakeholders than any one of them could construct alone.

Collaboration goes beyond tightly-worded contracts. It is more than meetings. It cannot be drawn into an organization chart. Nor can it be effectively written into performance requirements. TSG evaluated the current level of collaboration by investigating the preconditions that were set up for collaboration, the process created between DCFS and PromiseShip, and the outcomes that can be attributed specifically to collaboration.²⁴

1.1.1.1 *Preconditions for collaboration*

- Stakes are high and the parties are interdependent.²⁵ Surely the stakes are high for youth and families in the system. However, are the stakes high for the two main players: DCFS and PromiseShip? TSG found nothing to suggest that either organization would suffer from poor system performance, nor benefit greatly from exceptional performance. DCFS would face federal penalties if compliance metrics are not met. However, such penalties have not been levied, nor are they linked in a way that drives performance at the caseworker level. Likewise, PromiseShip could be fined if the state were fined and if PromiseShip were negligent. However, this seems not to present a serious threat.
- A glaring need for (or significant benefit from) working together²⁶. TSG observed nothing in the contract, management of PromiseShip, or PromiseShip management of itself suggested that the organizations faced meaningful consequences if they fail to work together.
- Shared understanding of the underlying causes of the problem. TSG did not find any evidence that PromiseShip and DCFS are working together to a common understanding of the underlying causes of involved families. They both use SDM, but in different

²³ One of the most respected authors on collaboration is Barbara Gray. Here, TSG quotes from her book, *Collaborating: finding common ground for multiparty problems*. 1989. Jossey-Bass

²⁴ TSG borrowed this list from table 2 in: *Toward a Comprehensive Theory of Collaboration*, the *Journal of Applied Behavioral Science* 27(2):139-162 · June 1991

²⁵ Logsdon, J. M. (1989) *Silicon Valley Traffic Congestion and Measure: A case of private-sector participation in collaborative problem solving*, Paper presented at the Academy of Management Meeting, Washington D.C. cited in xxx

²⁶ F Westley, H Mintzberg, *Visionary leadership and strategic management*, *Strategic Management Journal* 10 (S1), 17-32

manners. The two parties are working independently to improve their understanding of the underlying causes of reduced family safety. We did not find evidence that the two parties believe it is important to work together to address those causes. Instead, we found a culture that is focused on individual cases, not how the learnings from individual cases can be brought together across both agencies to improve care

- Incentives for (and lack of barriers to) breaking down the organizational walls. TSG found few incentives for breaking down the barriers to working together. Such incentives would provide at least the perception of greater personal or institutional rewards from working together. We found a few attempts to hold meetings (such as for reconciling provider payment records). However, these broke down quickly, with no repercussions to either organization or the involved individuals.
- How the parties are organized enabling them to collaborate. TSG observed nothing in either organization that suggested points for inter-organizational work. We observed this even where the benefits of working together are obvious, such as collecting accounting costs.
- Shared purpose. Surely, both organizations work to increase the safety of individual cases for which they have authority. However, TSG did not find that the relationship has been set up in a manner that DCFS is working to the purpose of increasing PromiseShip performance and vice versa. Instead, the relationship is set up as a form of competition, with the State trying to prove that they can do the job better, and PromiseShip fighting to prove relevance of the outsourced model. This is not a framework for collaboration or sustained success.

1.1.1.2 Process through which collaboration occurs

- Some form of institutional mediator. TSG did not observe any one person, or collection of people responsible for building integrated work. We expected to find a contract manager and did find one.
- Negotiated order. TSG found no evidence that DCFS and PromiseShip worked together to define the relationship between the organizations.
- Joint decision making. TSG did not find examples of joint decision-making. For example, case decisions are made first by DCFS, then handed off to PromiseShip, who then manages cases without State involvement in decision making.
- Agreed upon rules. TSG found that DCFS pushes rules onto PromiseShip, rule-making is not done through a process of agreement.
- Interactive processes. TSG found no examples of interactive processes. Instead, TSG observed linear process, during which the work is “thrown over the wall” and back.
- Temporary structure. The most relevant aspect of temporary structure in child protective services might be the case itself. This is a temporary team set up to achieve a “common” goal of improving family safety. A temporary structure to achieve collaboration would create some form of case management process through which State and PromiseShip

worked together—bringing their unique values to the case. However, PromiseShip cases are managed independently from the State. The case is “thrown over the wall” at which time PromiseShip is responsible. The two entities do not work together for the benefit of the children and families in need.

1.1.1.3 Outcomes of collaboration

- Enduring bridges and shared understanding. TSG found few bridges across which case “traffic” flowed both ways. TSG found little effort to develop shared understanding. Instead, we found both organizations using inconsistent terms and processes. For example, PromiseShip calls their case workers PFSs. PromiseShip uses different services codes.
- Distributed risks and costs of goal attainment. TSG found one example of distributed risk and cost of goal attainment. If the State is penalized for poor federal compliance, then PromiseShip might be penalized for the level to which it contributed to the fine. However, the mechanics are not spelled out, so it is hard to imagine how some risk might be realized
- Evidence that working together is responsible for success. Of the stories TSG heard concerning success, working together was never attributed as a cause. For example, federal compliance has improved in all regions. However, the local folklore is that the State and PromiseShip independently raised their individual performances—not that improvement resulted from working together.

8.1.2. Building the foundations of collaboration in the future

Building collaboration requires²⁷:

- The stakeholders are interdependent. Family safety is not something that any one party can create. DCFS and PromiseShip will collaborate only when their success is mutually interdependent. Things have to change. Going forward, DCFS cannot see itself as “winning” when PromiseShip loses. PromiseShip cannot be allowed to manage cases as if their case workers were the sole factor leading to safer families
- Solutions emerge by dealing constructively with differences. TSG found no regular process for identifying and resolving differences. Instead, we found that differences are sometimes ignored instead of trying to immediately resolve them.
- Joint ownership of decision. TSG found some examples where the parties had tried to work together, but that was stopped. The most significant decision made in the system is how to manage a case. TSG found in Texas a regular process of including investigators

²⁷ The following two lists are adapted from Barbara Gray, Here, TSG quotes from her book, Collaborating: finding common ground for multiparty problems. 1989. Jossey-Bass

and case managers in a case staffing at the point of handoff. The underlying belief in Texas is that the best-case management comes from working together. Nebraska needs to achieve at least this level of working together to achieve high case results.

- Stakeholders assume collective responsibility for the future direction of family safety. Both at the macro and case levels, family safety will best be achieved when DCFS and PromiseShip share responsibility for building better child protective services
- Collaboration is allowed to emerge (not written into a static contract). Contracts are not the best tools to build collaboration. DCFS should build a new form of vendor management today and with any future vendor in the new form of interaction that is designed to adapt to the changing opportunity to work together to improve family safety.

TSG observes that building this sort of collaboration will require:

- Both DCFS and PromiseShip must be held jointly accountable for improving family safety in the whole state, and especially in the ESA.
- DCFS and PromiseShip must work together to overcome the current culture of “we/they” silos. The relationship must be redefined as a joint effort.
- Systems must be adapted for collaboration. For example, PromiseShip must have access to custom reports from N-FOCUS. DCFS should learn from the benefits of FAMCare as a case management system—and work together with PromiseShip to find a unified systems strategy.
- The case management process must be integrated. This is not merely the systems. It is more than a common record of case assignments and events.
- The Legislature should give DCFS a clear mandate to work in common purpose with PromiseShip, and any future vendor.
- Accountability must clearly require both DCFS and PromiseShip, or any future vendor, to achieve better family safety in the whole state, and especially in the ESA. For example, PromiseShip should be accountable for transferring the innovative solutions that have proven successful.

8.1.3. Contract Monitoring is not Collaboration

The closest thing TSG found to collaboration was contract monitoring.

Instead of collaboration, we found it to be focused on a minimal legal compliance style of monitoring, due in large part to the fact that the contract deliverables are not clearly outlined and therefore become nearly impossible to monitor. Monitoring focus primarily on compliance with statutorily required documentation, such as staff background/criminal record checks.

The historical nature of the relationship with PromiseShip has the contractor accountable. There is nothing articulated in the contract that would encourage accountability around “practice” issue improvements. There is often confusion from State staff about how to respond when practice issues must be addressed to ensure the appropriate changes occur.

Further, while PromiseShip appears to have a fairly robust continuous quality improvement process, many times that information is not thoroughly shared to reduce suspicion that State concerns are being addressed and ameliorated. Developing clearly articulated rules for discussion regarding practice issues would provide a platform for communication and learning for both the State and PromiseShip, all while strengthening a rather anemic monitoring process. The adage “what gets measured gets done,” clearly applies in the contract monitoring arena.

With clearly communicated contracted expectations that specifically address “how” work is to be completed along with a process for addressing issues that arrive will be imminently beneficial to both parties and provide a considerable benefit in reducing myths and miscommunications.

8.1.4. Florida Case Study

The Florida Community-Based Care model provides an instructive experience Nebraska could learn more about how to build public-private collaboration by investigating the Florida experience.²⁸

Over the past two decades, Florida has created a more collaborative approach to sharing responsibility for child welfare. Community-Based Care is a comprehensive redesign of Florida's Child Welfare System. It combines the outsourcing of foster care and related services to competent service agencies with an increased local community ownership of service delivery and design. This innovative statewide reform increases accountability, resource development, and system performance. This innovative new system includes key features that address common problems and challenges in child welfare systems, such as:²⁹

- Partnering with, local lead agencies through competitive procurement to engage community stakeholders in designing their system of care, and to develop and maintain a service delivery network within their service area.
- Formation and support of Community Alliances of local stakeholders, community leaders, client representatives, and other agencies funding human services. An Alliance may cover one or more counties, as determined locally. Duties of Community Alliances include, but are not limited to, joint planning for resource utilization, needs assessments and establishment of community priorities, determination of local outcome goals supplemental to state outcome requirements, and community education and advocacy.
- A formal process was developed for assessing and preparing local Department units and Lead Agencies to safely transition services from the state to the local provider network. The Department's readiness assessment process uses an external team of peer

²⁸ The following is adapted from Florida DFC at: <http://www.myflfamilies.com/service-programs/community-based-care>

²⁹ <http://www.myflfamilies.com/service-programs/community-based-care>

experts to assess the development of the local infrastructure and transition plans, as well as provide technical assistance to both parties prior to initiating transfer of any services.

Florida State University has assessed the Community Based Care results year after year.³⁰ They find, “Two areas of strength in the collaboration between Child Protective Investigations and Community-Based Care lead agencies, which can potentially be expanded, are the use of resource specialists and diversion staffings.” Florida continues to improve, as Child Protective Investigations works to allow Investigators (state employees) direct access to private partner resources including basic interventions such as flex funds, family support workers, daycare and other Community-Based Care lead agency resources. In addition, Florida is building up communication between the Investigator and the private case manager should after the case is handed off from the investigator.

8.2. Lack of Clearly Articulated Vision

Nearly ten years ago, Nebraska took a bold step into a new type of public private partnership, sourcing large sections of its child protective services to three private organizations. As with any new venture, that required a clear understanding of how the new sourcing strategy would improve on the old one.

TSG has investigated the mission of this re-sourcing by considering how the state expected the business model to change by sourcing through a private organization. Business model may seem like an odd term to apply in a social services arena. However, all private organizations work to a business model. Thus, partnering with a private organization demands that the state understand the motivations and expectations of its new partner.

Neither the enacting legislation, contract nor DCFS leadership communicated a vision with various stakeholders. TSG heard from providers, other agencies and interest groups that they were not clear at the outset and are still unclear about the objectives. Many of these are private organizations (non-profit), so they support the notion of privatization. However, they were never included in developing or at least told what the PromiseShip privatization was to achieve.

In the absence of a clearly articulated vision, TSG concludes that the relationship was set up for the purpose of enabling compliance, with some unstated assumption that this compliance is linked somehow to how individual families would express the “job to be done.” TSG found no evidence that the State anticipated that PromiseShip would aggressively seek out better ways to meet the needs of children and families as they would express them. Their job is to follow the rules. For example:

³⁰ Report to the Legislature Evaluation of the Department of Children and Families Community-Based Care Initiative, University of South Florida, Submitted to the Florida Department of Children and Families

- DCFS prescribed the training for case worker. PromiseShip was not encouraged (or technically allowed) to find better ways to train its case workers. This is especially onerous since PromiseShip case managers use FAMCare in addition to N-FOCUS
- DCFS prescribed that PromiseShip use only its N-FOCUS system, which is not technical based on a case process management technology. In addition, DCFS required that PromiseShip only paid approved codes. The state is not interested that PromiseShip's 5-day bed hold has proven to be less expensive and less disruptive to youth
- DCFS requires that PromiseShip use the same case management manuals—ignoring the opportunity for innovation.

All in all, the relationship is not one of peers collaborating to achieve better family safety.

8.3. Instability

The pall of uncertainty surrounding the privatization contract and assessments of the success or failure of the model have contributed to create a challenging environment.

With no clear vision, PromiseShip has made costly decisions, such as investing in a separate case management tool, FAMCare. Unlike the State, where investment is not accounted for in the operating budget, the private sector must amortize costly investments like this. It cannot make important investments if it does not know the duration of the contract.

Two years ago, it entered into a contract, and now is faced with the threat that the private operation could be returned to the state. Business cannot make effective investment decisions in such uncertainty. Since it might take years to build a new service or family program, and there is uncertainty about whether the vendor will remain in place to deliver the new service in a year, this disincentivizes investment in innovation.

In a similar fashion, grant partners and donors may be unwilling to offer support under such uncertainty. For example, PromiseShip believes it has lined up an investor who will provide substantial investment toward a building. However, that is awaiting clarity about the continuity of the relationship. TSG was told that this is but one example of the barriers uncertainty has placed in front of outside investment.

PromiseShip leadership described the effect of this uncertainty as “traumatic for workforce” and said it is hard to retain staff. We are told that many PromiseShip workers are looking for new employment, in anticipation of losing the contract. A large provider has said that “limbo has created an environment of us vs. them...they can't relax...people are worried about their jobs”.

TSG found no evidence proving this (turnover rates seem about the same as the State's own). Yet, that only makes sense—workers need to manage their own households and they may leave for more stable employment. Even though turnover does not show it yet, the effect is surely there. Fear (such as losing your job) creates a challenging environment in which to do your best work.

TSG is not suggesting any particular duration for a contract. Rather, we are observing that the uncertainty around duration has limited PromiseShip's ability to invest in better services and this fact needs to be taken into consideration with any future RFP and contract.

8.4. Summary

It is laudable that PromiseShip has done well in such an adverse situation. It is not clear that the contract set up a good relationship. DCFS and PromiseShip have not collaborated in the true sense of public/private sector collaboration. It's hard to describe the relationship as one that clearly puts in place innovative new measures to improve child safety. It suffers from no clear mission, no collaboration, mixed incentives, lack of analysis, and uncertainty. However, these are not endemic to privatization, nor the result of bad vendor performance. The root cause of the problem is that the parties failed to create an effective working relationship. This can be solved.

9. CONTRACTS AND CONTRACT MONITORING REVIEW

9.1. Contract Between the State and Vendor

TSG has reviewed the terms of every contract entered into by DHHS and NCF (now PromiseShip), since June of 2009, up to the most recent amendment of November 30, 2018. This review also included all contract amendments and attachments, as well as documents referred to in the contract that are binding upon the state and the contractor by agreement in the contract. These contracts and amendments are summarized in the Table below.

TSG also reviewed state contracts for similar outsource models in other states and made a comparison for best practice.

9.2. History

In June of 2009, the state entered into two contracts with Six Agencies: Boys and Girls, CEDARS, The Alliance for Children and Families/Region 3, KVC, NFC, and Visinet, for child welfare service coordination, to begin in November of 2009, with full implementation across the state to begin January 1, 2010. One contract was for infrastructure support and the other was for full service coordination (referred to in Table 27 as Original Contract). The contracts were for a five-year period, ending on June 30, 2104.

Table 27: DHHS and NCF Contract Summary.

	Contract	Time Period	Purpose
1	Contract for Infrastructure	June 15, 2009 to December 31, 2009	Develop infrastructure, staffing and services. \$908,600 for each contractor
2	Original Contract – Service Delivery	November 1, 2009 to June 30, 2014	\$19,185,452.07 to provide system of care services to families and children in ESA
3	Amendment One to Infrastructure	October 20, 2009 to March 31, 2010	Extended time for Infrastructure
4	Amendment Two to Original Contract	March 4, 2010 to June 30, 2014	Added services to scope of services
5	Amendment Three to Original Contract	July 2, 2010 to June 30, 2014	Added funding to infrastructure not to exceed \$1,147,045.66 and to service delivery \$20,664,740.93
6	Amendment Four to Original Contract	July 29, 2010 to June 30, 2014	Additional funding added performance measures section M to Article II scope of services
7	Amendment Five to Original Contract	October 14, 2010 to June 30, 2014	Additional funding not to exceed \$23,664,740.93 and scope of services amended to include

	Contract	Time Period	Purpose
			additional responsibilities for state and contractor
8	Amendment Six to Original Contract	December 16, 2010 to June 30, 2014	Added Case Management Services
9	Amendment Seven to Original Contract	January 1, 2011 to June 30, 2014	Additional funding not to exceed \$71,958,384.72 and Scope of Service changes
10	Amended and Restated Contract	August 16, 2011 to June 30, 2014	Additional funding not to exceed \$125,325,119.64 and added new Section on Performance Measures tied outcomes to Operational Manual
11	Amendment One to Restated Contract – Service delivery and case management	February 28, 2012 to June 30, 2014	Additional funding not to exceed \$136,733,797.00 and Scope of Service change – assume KVC cases
12	Amendment Two to Restated Contract	June 29, 2012 to June 30, 2014	Additional funding not to exceed \$162,856,438.00
13	Amendment Three to Restated Contract	June 27, 2013 to June 30, 2014	Additional funding not to exceed \$181,134,004.12 and added language to Section on Performance Measures and Specific Outcomes identified in contract
14	Second Contract - Service Delivery and Case Management	July 1, 2014 to June 30, 2015	New contract covering similar scope of service and added section on Performance Measures tied to outcomes. Contract amount not to exceed \$59,951,000.00
15	Amendment One to Second Contract	July 23, 2014 to June 30, 2015	Excluding responsibility over certain services
16	Amendment Two to Second Contract	June 6, 2015 to June 30, 2016	Extending the time period/additional funding not to exceed \$119,902,000
17	Amendment Three to Second Contract	November, 15, 2015 to June 30, 2016	Updating compliance with newly agreed to Operations Manual of 9/22/15
18	Third Contract - Service Delivery and Case Management	July 1, 2017 to June 30, 2019	New contract covering same scope of services Contract amount not to exceed \$71,500,000.00
19	Amendment One to Third Contract	January 3, 2018 to June 30, 2019	Added provision on consent to treatment
20	Amendment Two to Third Contract	February 12, 2018 to June 30, 2019	Changes to scope of services

	Contract	Time Period	Purpose
21	Amendment Three to Third Contract	August 30, 2018 to June 30, 2019	Additional funding
22	Amendment Four to Third Contract	November 30, 2018 to December 31, 2019	Extending time period and adding \$35,750,00.00 for July 1, 2019 to December 30, 2019

After a series of amendments and issues mostly related to funding, there remained only two outsourced contractors when DHHS subsequently amended the Original Contract to include caser responsibility for case management services on December 16, 2010, DHHS (Amendment Six to Original Contract). The two remaining contractors, NFC and KVC, had case management responsibility for most of the ESA coverage area.

After a few more amendments adding additional funding and some minor scope of service changes, the state issued a new contract (referred to as the Restated Contract in Table 27) on August 16, 2011. This contract completed the state's decision to transition all child welfare cases within the Eastern Service Area (ESA) to NFC. By February 2012, and through the second amendment to the Restated Contract, NFC assumed all of KVC's cases, whose contract with the state ended in April of 2012, and there was one sole contractor operating under the terms of the original contract, and the successive amendments.

The actual Second Contract with the contractor, not to include any amendments to the original contract, was entered into on July 1, 2014 by the state and NFC for the continued case management for all of the ESA, but this time this contract was for a one-year period, ending on June 30, 2015. That contract had very similar terms and conditions from the original contract and maintained the requirement that the Contractor follow the most recent state Operations Manual. There were three successive amendments to this contract, one excluding certain services and the other two extending the contract our one additional year from July 1, 2015 to June 30, 2016 and then from July 1, 2016 to June 30, 2017.

The State then renewed its full contract with NFC for the Third time on July 1, 2017 until June 30, 2019. This is the contract that NFC is currently operating under and, once again, the state followed suit in requiring NFC to agree to similar provisions that were contained in both prior contracts.

Most of the revisions centered around additional funding and some minor scope changes other than assuming responsibility for case management in 2010. This Third Contract was amended three times, with the most recent coming on November 30, 2018, extending the time frame to the end of 2019. PromiseShip currently is required to meet all the terms and conditions of this Third Contract, including the Operations Manual dated January 2, 2018, which has been updated from the one referenced in the Third Contract, which was dated April 15, 2016.

9.3. Contract Provisions

The contract entered into by Nebraska DHHS and NFC is logically broken up into the following five sections. Section I covers the Period of Performance and Termination; Section II covers the Amount of the Subaward; Section III the Statement of Work; Section IV General Terms and Assurances; and, Section V. Business Associate Provisions.

The purpose is stated as providing case management and an individualized system of care for families and their children and youth who are wards of the Nebraska DHHS involved in the child welfare or Juvenile Court system or who are non-court involved children and families involved in the child welfare system. The following three functions are required: Service delivery, service coordination, and case management for children and families in the ESA. The contract is a no reject, no eject subaward, so the subrecipient, by contract, agrees to accept and serve all children, youth and families referred by DHHS.

The key financial requirements are set forth in Section II, which include a capped allotment of a certain dollar amount, which it is estimated to cost the state for the delivery of the service for a one-year period. There is a fixed and variable payment structure identified and payments are made based on actual days in care. In addition, the contractor is required to track and report quarterly and annually its federal and state expenditures, including administrative costs in a format developed and designated by DHHS. This includes reconciling monthly statements to invoices for services for purposes of the state claiming federal reimbursement under Title IV-E. If at the end of the year the amount the state allocates is more than the actual cost of service, the contract requires that the difference be repaid by the contractor to the state.

Moreover, if there are any financial penalties assessed to the state for the contractor's failure to comply with a court order, or with any Federal standard, the contract requires that the Subrecipient pay the penalty or reimburse the state for the complete amount of the penalty.

Section III contains the Statement of Work, and this section is very prescriptive and outlines the specific scope of services that the state is contracting for in the ESA. The subsections that contain specific requirements of the Subrecipient include, but are not limited to:

- Abiding by all state and Federal law and policy, including complying with the most recent Department Operations Manual
- Providing service coordination and case management functions for both court-involved, and non-court involved children, youth and families
- Paying foster families for foster care consistent with rates approved by DHHS
- Recruiting foster parents and reporting on foster care capacity
- Allowing DHHS access to any and all information and data collected
- Accepting that DHHS maintains guardianship authority
- Maintaining a complaint process;

- Having an incident reporting process where DHHS is immediately notified of certain critical incidents
- Providing transportation to children
- Ensuring proper licensing and approval requirements
- Having a notification process for consent to treatment
- Responsibility over subcontractors
- Requirements for reporting abuse and neglect by staff
- The development of protocols for the referral process
- Substantive service coordination and case management functions
- Providing a complete continuum of non-treatment, non-Medicaid funded services, supports and placement resources
- Appropriate child placement practices
- Ensuring home studies and safe environment prior to placement
- Assuring Multi-ethnic placement training
- Compliance with Indian Child Welfare Act
- Requiring court attendance and court requirements
- Compliance with administrative standards, such as background checks, hiring standards
- Requiring documentation and reporting
- Requirements surrounding information system access and reporting
- Performance of quality assurance and the development of a quality assurance program
- Required Insurance coverage
- Required professional development training
- Required performance outcomes and accountability
- Compliance with state law regarding cooperation with Foster Care Review Office
- Requirements around Cost Allocation Plan for purpose of Title IV-E claiming
- Governance structure requirements
- N-Focus documentation requirements
- Agreement to be jointly responsible with DHHS to Federal reporting measures

Section IV General Terms and Conditions and Section VI Business Associate Agreement are standard terms for all state contract vendors to agree to.

9.3.1. Operation Manual

In each of the three contracts entered into by the State and NFC, that contract includes a specific provision under Section III, A 3 of the Statement of Work requiring the subrecipient to “comply with the most recent DHHS Operations Manual.” The most recent contract provision requires the contractor to: “Comply with the Operations Manual dated April 15, 2016 (hereinafter the Manual) as amended hereinafter by mutual consent of the parties. The Manual will describe in detail the parties’ required operational duties during the entire subaward period.” That Manual has been updated by agreement today to January 23, 2018.

A review of the Operations Manual of January 23, 2018, and each prior Operations Manual going back to the beginning of the State/ESA region contractor relationship, contains a number of substantive provisions related to operations, data and financial reporting, collaboration, and accountability. The Manual is considered part of the contract. The Manual also states its purpose to provide direction to the subrecipient in greater detail on the expectations for standardization in the operation and delivery of case management and related services.

The Operations Manual has a number of sections that, as stated, describe in detail the operational expectations and duties of the contractor as well as the state. It starts by delineating in detail the roles and responsibilities of the state and Subrecipient and even provides a roles and responsibilities matrix that defines the responsibilities associated with the day to day operations of delivering case management to children and families in the ESA. The current Manual covers the following areas:

- Referrals from the state to the Subrecipient
- Structured Decision Making practice
- Intake process
- Initial Assessments
- Safety Planning
- Out of Home Assessments and Placement
- Coordinated Response Initiative
- Background checks
- Process for approval of placements in relative and kinship care
- On-going case management responsibilities of subrecipient
- Adoption and guardianship practice
- Practice for handling dually adjudicated youth
- Interstate Compact On Placement of Children
- Incident reporting

The Manual also expands upon a number of areas in the contract and covers in great detail key areas of operation in the ESA, including, but not limited to:

- Caseload Ratio Requirements
- Documentation and File Retention, including N-Focus documentation
- Record keeping, including home study, criminal history record check, training records, etc.
- Standards for transporting youth
- Required reports, including monthly, quarterly and annual financial reporting, caseworker training reports, and an Annual Report including reporting on collaboration, coordination with tribes, disaster plan, monthly case worker visits, adoptions, continuous quality improvement, independent living, how the contractor uses evidence-based models, programs,

- Continuous Quality Improvement program and including support in meeting the statewide Federal Child and Family Service Reviews (CFSRs)
- Insurance requirements
- Professional development staff training
- Professional accountability, with outcomes of safety, permanency and well-being
- Responsibility for cases transferred to and from the ESA
- The development of an individualized Transitional Living Plan with the involvement and leadership of youth, which describes how youth of various ages and stages of independent living will be assisted in the following areas
- Following the state foster care and guardianship rates and process as outlined in DHHS regulation and policy

9.4. Performance Standards and Outcomes

One of the key areas of focus in a child welfare contract that outsources any aspect of service delivery, service coordination and case management are performance standards and outcomes. From the Original Contract in 2009, to the current contract entered into in 2017, DHHS has assured that the contract terms, including the language agreed to in the Operations Manuals, contained identified language related to performance standards and outcomes. Each contract has required the subrecipient to be responsible for meeting specific outcome measures related to safety, permanency and well-being.

The outcome measures that the subrecipient must meet in the current contract are contained in Section 12 of the Operations Manual, entitled Professional Accountability. These outcome measures are standard Federal child welfare safety measures and are consistently used throughout the national child welfare industry to meet the objectives of enhanced safety, well-being and permanency. They are made applicable to the subrecipient in the contract by way of the Operations Manual.

Section three, subsection 27 of the contract Statement of Work also makes reference to the fact that the Subrecipient is responsible for meeting the outcome measures established by DHHS and federal authorities. This provision also requires the subrecipient develop strategies which contain the action steps necessary to achieve the outcome measures, and “when quarterly indicators are not met, notification must be given to the subrecipient by DHHS and then the subrecipient would be required to develop a Performance Improvement Plan within 14 days. The provision stops short, however, of addressing what takes place if the subrecipient fails to develop a performance improvement plan or continues to fail to achieve the outcomes.

9.4.1. Accountability

As mentioned, the contract performance measures are appropriate child welfare performance measures, since the mainly follow the Federal guidelines. However, under the terms of the

existing contract they have acted more “to guide and measure performance” rather than incentivize desired outcomes.

There are no documented incentives or rewards for meeting the performance measures and there are no real measurable consequences outlined for failure to meet any of the outcomes. When the Subrecipient is unable to meet the desired performance, they are only held to developing and submitting a “Performance Improvement Plan” and there is no well-defined process for assuring the Performance Improvement Plan is acceptable to agency standards, is guided by quality, and will have a substantial likelihood of improving performance. Thus, the contract remedy is vague and unenforceable.

In the past when PromiseShip failed to meet the desired outcomes, DHHS would send a letter to PromiseShip from the ESA and PromiseShip would meet the terms of the contract and submit to the state its Performance Improvement Plan, but there would be no further action or consequences and TSG could find no evidence of any penalties being assessed for failure to meet any of the same outcomes in future reporting periods. Nor could TSG find any evidence of on-going monitoring to ensure that the PromiseShip was in fact making the Improvement Plan practice changes in the next quarter.

In the current contract, the only ability for the state to actually assess any penalties or remedies for non-performance is limited to the following two defined areas:

1. The subrecipient fails to comply with a court order and the court imposes a financial penalty or sanction on DHHS; or
2. The subrecipient fails to comply with any Federal standards or requirements and such financial penalty or sanction is imposed by the Federal Government upon the state as a result of such failure to comply.

Thus, the state’s current ability to penalize PromiseShip is very limited and is not directly connected to any failure to meet safety, permanency and well-being outcomes.

By contrast, the states of Florida and Texas operate similar child welfare case management outsource models and have developed contracts with clearly defined consequences for failing to achieve desired outcomes.

In Florida, for example, the contract requires that each community-based care agency acknowledge and agree that its performance under the contract will meet the Federal outcome measures or the state will “provide for graduated penalties for failure to comply with contract terms.” The contract goes on to specifically allow for “financial penalties, enhanced monitoring and reporting, corrective action plans, and early termination of contracts or other appropriate action to ensure contract compliance” when any of the Federal and State outcomes are not met. Finally, the Florida outsource contract specifically requires that any financial penalties incurred as a result of not meeting any of the performance measures “require the subrecipient Agency to reallocate funds from administrative costs to direct care for children.”

In Texas, where the State outsources service coordination and case management for all pre-foster care “at risk” children and youth, who have been part of an abuse or neglect investigation, in the El Paso region, the state contract with the outsourced contractor identifies the performance measures that the contractor is required to meet, which are based on three key areas: reducing recidivism, successfully closing cases within defined criteria, and reducing the time by which cases are kept open. Texas goes beyond Nebraska in tying these specific outcomes to incentives and remedies, however. The Texas contract specifically incentivizes the contractor to achieve the desired outcomes by providing rewards and remedies tied directly to the outcomes. Where the contractor fails to meet any of the desired outcomes, the contract provides that a portion of the daily rate, which is retained by the state in the form of a holdback, “will be retained” by the state “as a remedy,” and where the contractor meets the desired outcome, the “retainage will ... accrue” to the contractor. This is a clear example of a performance-based contract with accountability.

9.5. Specific Findings Related to the Actual Contract

1. **Lack of clear purpose for outsource:** In reviewing the original Nebraska contract, as well as successive contracts and amendments, the purpose defined in the contract sets the base level as to what the State intends to do, rather than why the state is doing so. This purpose is rudimentary and fails to provide guidance to potential vendors and contractors to deliver the best outcomes in a community setting, using community resources. There is no provision that truly embraces such a desired community-based purpose.
2. **Contract Terms and Conditions Satisfy Baseline Operational and Financial Standards:** The contract terms and conditions adequately cover the key financial and operational standards and the Operations Manual clearly delineates the roles and responsibilities of the parties. The contract also evinces a spirit of collaboration and cooperation in its literal terms, and the state has set appropriate parameters to guide expectations around satisfactory performance.
3. **The Contract Lacks Meaningful Incentives and Consequences:** As mentioned above, the penalties for failure to meet any of the contract conditions are specifically tied to situations where there has been a monetary fine assessed by a court against the state, or where the Federal government has assessed a fine or penalty against the state for the subrecipient’s failure to meet any Federal standards or outcomes. These penalties are not connected to the key safety, permanency and well-being outcomes the state lists in the Operation Manual, and there are no incentives to promote and reward quality outcomes. That is something the state should improve going forward. In the future, there should be an incentive for vendors to do a great job, not merely a good job, especially when it concerns the health and welfare of children.
4. **Contract Stability Lacking:** There have been successive contracts and amendments with different durations, and there has been a lack of continued stability in the contracting. The initial term was for a five year period, the second contract was for a one year period, and the third one for a two year period. There were successive amendments throughout

extending deadlines and providing for additional funding. Normally, a state contract of this size and magnitude involves a number of employees, subcontracted service providers, and stakeholders, and terms are for extended periods of time with the state having the option to exercise renewals after the original term concludes. This gives both the state and vendor, as well as stakeholders, the sense of stability needed to ensure a well-experienced, dedicated and tenured workforce, as well as the opportunity to make significant capital investments that will improve the quality of services. To the extent the state continues to have short term contracts for the outsource model, it will continuously be forced to plan for a transition back to an insource model, which consumes valuable resources from the organization.

5. **The Contract Lacks Flexibility for Innovation:** In reviewing the state contract, the Statement of Work, including the Operations Manual, very specifically identifies all the operational expectations and requirements in a manner that does not bode well for any innovation or thinking “out of the box.” Understandably, the state wants to assure that any contracted vendor in an outsourced model is abiding by the most appropriate “practice model” especially where the safety and well-being of children in the state’s care are involved. However, a number of provisions in the contract that relate to the practice model can be improved upon by a vendor or contractor given the flexibility to deviate, so long as the changes are in line with enhancing child safety and well-being. An important component of a privatized model is for the private vendor to bring to the state enhancements and innovations from the private sector. Thus, where the contract’s Statement of Work has requirements that are beyond following Federal or state law or rules, the state could benefit by identifying the standard and then providing for private sector innovation in allowing the vendor to submit a plan to be approved by the state. Here the state would retain the ultimate authority for approval, and the vendor would not be constrained to follow the exact letter of every practice guideline and could utilize enhancements from the private sector.
6. **Need for Transparency:** Nebraska is lacking some of the public transparency measures used in other states. For example, the Florida Community-Based Care contract requires that the outsourced agencies post on their websites, at a minimum, the following information:
 - The performance on each Federal outcome measure for the previous 12 months;
 - The average caseload of case managers, including only filled positions;
 - The turnover rate for case managers and case management supervisors for the previous 12 months; and,
 - The percentage of required home visits completed.
7. **Need for Transition Plan:** One of the most important requirements in an outsourced contract is to assure that there is an efficient transition back to the state, if, for some

reason, the contractor no longer offers the service, or another vendor where to be chosen during a subsequent re procurement to assume the contract. We did not find any such provision in the original ESA contract. The Florida contract, for example, contains the following language related to the requirement up front of a transition plan for any selected vendor:

“The Lead Agency shall submit a transition plan six (6) months prior to any contract ending date unless notified by the Department that it intends to renew or extend the contract. If a new provider is awarded the contract, the Lead Agency will meet with the Department and new contracted Lead Agency to develop a mutually agreed upon transition plan.”

Nebraska needs to include a similar transition plan requirement in its contract.

8. Need for Further Collaborations: There are a number of state agencies that the outsourced vendor will need to interact with, including the state child investigators on every hand off of a case to case management services. There are also interactions with state and local agencies involved with health, education and law enforcement. Having a clear understanding of roles and responsibilities, as well as ensuring the most effective collaborations will only enhance the case management and foster care experience for a child. The contract should, therefore, place the burden on the outsourced vendor to work collaboratively with all of these agencies and also develop more formalized collaborations so as to reduce any blurred lines and also promote seamless and efficient case management. An example of this is seen at Appendix D where the Florida community-based care agencies are required by contract to enter into a number of different collaborative agreements with state, county, and local community stakeholder agencies.

9.6. Contract Monitoring and Oversight

In a child welfare system reliant on the performance of private providers, contract monitoring and continuous quality improvement are separate, yet inextricably linked components of a comprehensive approach to managing outcomes. This is particularly true in a performance-based or shared risk environment where quality-related outcomes may result in financial rewards or penalties. As DCFS seeks to develop and incorporate performance-based payment criteria into contracts with their subcontracted provider(s), collaboration and coordination between contracting monitoring and continuous quality improvement (CQI) efforts become increasingly important.

Contract monitoring typically reviews and evaluates organizational compliance with statutorily mandated legal and procedural requirements such as employee criminal record / background checks, fingerprinting, training activities, staff turnover and records maintenance. In an integrated system, monitoring must also evaluate fiscal and programmatic components, including compliance with federally mandated sub-recipient requirements, expenditures and cost

allowability, as well as contractually established family and child safety, permanency and well-being outcome expectations.

Quality assurance/CQI activities ensure compliance with federal child-welfare requirements, such as those established within ASFA and monitored through the CFSR but should also focus on validating ongoing compliance with case-specific state policy requirements, adherence to nationally recognized best practices, and the analysis of performance data. This function is responsible for the identification of performance shortfalls, completion of root-cause analysis, development of improvement initiatives, and ongoing monitoring for changes in performance. Together, these efforts and the regular review of performance outcome data drive systems improvement.

TSG met with State Office and ESA staff to identify all of the resources involved in the oversight of the PromiseShip contract. TSG assessed the level of staff resources, qualifications of staff, and the scope of monitoring responsibilities performed and found that that contract oversight staff are experienced, tenured, and express an understanding of the importance of contractual requirements and the linkage between these expectations and a provider's ability to generate quality outcomes. However, while the Contract and Operations Manual provided for clear direction and collaboration around oversight, DCFS has not enforced or continued to carry out these activities. As DCFS shifts toward a truly performance-based contract, a much more structured, coordinated, and better resourced approach to contract monitoring, quality assurance, and utilization management is needed.

TSG found few contract monitoring/oversight activities were contractually delineated. This is consistent with discussions with DCFS leadership staff; leaders confirmed that at the time the state originally outsourced operations in the ESA and later when the case management function transferred to the vendor, the state's approach to managing this contract was intended to be "laissez-faire" and state staff were directed to take a limited approach to contract oversight.³¹ This approach fostered a historical relationship between DCFS and PromiseShip that largely allowed the vendor to be independently accountable for their performance.

Over time and especially in recent years as the state identified different needs for oversight, the approach to monitoring the contract evolved. In some cases, the state scaled back resources for monitoring, and in other cases added staff. As an example of the former, the state originally used Child and Family Outcome Monitors (CFOMs) to attend court and conduct document review (of placement changes and court reports). These positions were part of the day-to-day quality assurance activities conducted by DCFS in overseeing the vendor's performance of case management. By January 2018, those positions were reallocated and DCFS amended the contract with PromiseShip so that the state would no longer review and sign off on these tasks. This was viewed positively as a way to reduce cost and redundancy, and evidence of growing trust

³¹ Doug Beran phone call 12/12/18.

between DCFS and PromiseShip. Conversely, the state has also added staff. Following the Nebraska Auditor of Public Account's 2018 audit, DCFS created a dedicated position to conduct financial oversight of the vendor.

Although the approach and resources used to manage the contract with PromiseShip have been fluid over time, TSG identified the following current resources at DCFS who are involved with management of the PromiseShip contract:³²

- State Office contract monitoring: This function is responsible for conducting contract monitoring of all DCFS contractors. The director of this function reports to the Deputy Director Research, Planning and Evaluation. The resources dedicated to this function include 1 director, 1 supervisor, and 14 contract monitors. Of the 14 contract monitors, 1 is dedicated to the PromiseShip contract (though not exclusively, this resources also performs monitoring of other contractors in the Eastern Service Area who do business in other parts of the state). This team performs compliance-oriented monitoring with contractual requirements.
- Eastern Service Area contract management: The Regional Administrator (RA) for the Eastern Service Area is the day-to-day contract manager and provides programmatic oversight of the vendor. The RA is responsible to address concerns and issues as they arise related to the vendor operations, but not the contract. The RA does not have staff solely dedicated to contract management responsibilities; the RA and leadership team perform these duties in addition to their other responsibilities.
- Financial oversight: DCFS recently created a new Financial Administrator position at State Office, who reports to the DCFS Deputy Director. The position has been allocated but DCFS has not yet received approval to fill it.³³ Prior to this dedicated resource, financial data was examined episodically by CFOs or other staff, but no formal financial monitoring activities were built into the contract.

Major findings identified related to contract monitoring:

- It is hard to overcome initial “laissez-faire” approach.
- Contract oversight has been inconsistent.
- Some of the “best practices” in the contract have been watered down or not enforced (i.e., CQI state and local meetings).
- Existing monitoring resources fragmented and can be at odds.
- The monitoring level not tied to contract scope and amount.
- There have been no Utilization Management and weak financial controls until 2018.

³² Interview with Ross Manhart, 12/12/18.

³³ Email Lori Harder, 12/12/18.

- Transformation of the contract oversight function is needed to manage a truly performance-based contract. Contract monitoring staff will have to be trained and provided with tools to be able to shift to a more performance-based contract monitoring approach.
- Today's monitoring is compliance-based not performance-based: This approach is driven by the fact that the existing contract is not a performance-based contract – staff cannot assess remedies or incentives based on performance so there is a separation between review of the vendor's performance and review of the vendor's contractual compliance. Contract monitoring staff are performing compliance-oriented reviews of the vendor's performance; reviews are not linked to the vendor's performance. There is also a lack of connection between review of performance data and review of financial data and contract requirements.
- Existing staffing resources for monitoring are not aligned to the size and scope of the contract. There is only one part-time monitor on the contract monitoring team assigned to this contract and the financial administrator position has not yet been filled.
- Existing staff resources has been fluid and piecemeal, and the result is fragmentation: Over time, DCFS' approach to managing this contract has changed due to internal and external direction.
- Contract monitoring activities are not data driven: The State Office contract management team does not review performance data and does not review Performance Improvement Plans (PIPs). PIPs are reviewed by the DCFS Director and the Eastern Service Area Administrator, but that review is disconnected from the Contract Monitoring function.
- Staff have indicated that the existing contract is difficult to monitor because contractual language is "broad and vague" and deliverables are not clearly articulated.

10. CONTINUOUS QUALITY IMPROVEMENT

10.1. State CQI Program

TSG identified the following current resources at DCFS who are involved with quality assurance/continuous quality improvement related to the PromiseShip contract:³⁴

- **State Office Continuous Quality Improvement:** This function is responsible for conducting CQI related to all of the Service Areas, including the Eastern Service Area. The Deputy Director of Research, Planning and Evaluation oversees this function, which includes:
 - A case review team (21 allocated positions) who perform CFSR reviews, other targeted reviews, and data analysis and a systems team. For the next two years, this team will be focused primarily on CFSR-related work.
 - A systems team responsible for data analytics and N-FOCUS system changes (approximately 4 allocated positions).
- **Eastern Service Area Quality Assurance:** The Regional Administrator for the Eastern Service Area conducts programmatic quality assurance activities, including meeting with the vendor on a quarterly basis. There are not dedicated positions for this function; the RA and leadership team are responsible for these activities.

10.2. PromiseShip CQI Program

By contract, the vendor is required to establish a continuous quality improvement program and perform quality assurance activities: “The Subrecipient will develop, implement and monitor improvement plans based on outcomes of quality assurance and subaward/contract monitoring results conducted by DHHS and Subrecipient's internal Quality Assurance system.”

Further, required CQI activities (see attachment) are described in the Eastern Service Area’s Operations Manual as covering areas of:

1. Federal Compliance including state and federal CFSR reviews,
2. Participation in state CQI activities and workgroups,
3. Provision of information for statewide and local quality assurance reviews,
4. Out-of-home care providers (foster, adoptive, residential, relative),
5. Personnel files,
6. Participation in site visits.

³⁴ Interview with Ross Manhart, 12/12/18.

A review of PromiseShip’s approach to CQI indicates their efforts exceed contractual and operating expectations articulated by DCFS. Further, as an accredited organization, CQI activities are robust, aligned and compliant with recognized standards of best practice.

The structure and approach of their efforts are best described in their Annual Report to DCFS. In summary, the report describes PromiseShip’s CQI structure as including five separate workgroups; Operations Management, Quality Management, Risk Management, Staff Management, and Utilization and Network Management. Each workgroup has a specific charter (objective) and annual plan that support PromiseShip’s Strategic Plan and agency wide CQI Plan. Workgroups are guided by a chairperson, co-chair, CQI/DM Supervisor, and workgroup members from diverse agency departments and roles.

Workgroups evaluate a variety of inputs (e.g. data reports, survey results, formal and informal feedback) and use these data to inform and develop improvement strategies including formal improvement plans, process updates, and changes to policy and procedure. After initial implementation of an improvement strategy, the workgroups utilize the Plan, Do, Check, Act system to evaluate the implementation, monitor results and make adjustments as needed. PromiseShip workgroups are supported by the CQI/Data Management (DM) Department and the Review and Prioritization Board (RPB). Finally, workgroups are accountable to PromiseShip Executive Team.

PromiseShip’s QA staff report they are responsible for conducting a variety of reviews across the agency. These include: operational reviews, case narrative reviews, quality reviews (which include practice specific targeted reviews by worker or topic area), qualitative reviews, and external reviews, including CFSR outcomes. The CQI team is responsible for managing PromiseShip’s CQI process and conducting operationalized quality improvement activities. Members of the CQI team attend each QA Workgroup meeting, providing technical assistance and acting as a Subject Matter Expert (SME) to support CQI related activities and improvement strategies. The CQI team also includes oversight of PromiseShip’s Records Department. The Records Department is responsible for ensuring the integrity of family case records and managing CQI activities related to the case record.

Similar to DCFS, PromiseShip staff indicate several frustrations with related to their collaboration with the state. In particular, they echo DCFS’ quality assurance staff’s comments about the limited coordination of quality improvement efforts between the state and provider. For instance, they report the most recent Statewide CQI meeting they participated in was held more than one year ago.

Finally, limitations of the state’s data system, N-FOCUS have resulted in the need to procure, implement and utilize external data systems including FamCare and Mindshare to access the information they require to execute effective continuous improvement efforts. In particular, identified issues with N-FOCUS include:

- Data is not current and may be over a month old,

- Data is only accessible via pre-designed reports,
- The provider does not have the ability to create ad-hoc reports,
- The process to have reports created takes an excessive amount of time, and
- The system does not capture usable data for in-home families.

While PromiseShip has robust continuous quality improvement process and has developed internal and external initiatives to address performance shortfalls, it is clear those efforts are not thoroughly shared with the State. As a result, the impression exists that performance concerns are not consistently addressed and ameliorated.

10.3. TSG's findings

The Contract and Operations Manual, which together establish the requirements for the ESA vendor, provide a strong foundation for accountability. However, when examining CQI activities in practice, there are stark differences between what was envisioned and what is occurring. TSG concludes that the state has not maximized its value from the outsourcing of case management but that it is not due to the contract, but rather in oversight provided by DCFS.

Further, state leadership staff (both in State Office CQ and the ESA) are experienced, tenured and well-qualified to complete the work with which they are charged. They relayed ideas to TSG for systems improvement – even improvements that could be implemented within the limits of the existing contract. However, several factors have limited the effectiveness of the CQI program:

- There has been a lack of shared vision and direction provided to internal DCFS CQI resources over the life of the PromiseShip contract on the DCFS approach to managing the contract. Conflicting direction from prior Department executives and the intervention other leaders and stakeholders has resulted in a lack of coordination and clarity in roles and responsibilities between State Office CQI and Eastern Service Area leadership. The result has been some uncertainty and potential duplication. Both entities have been examining performance data on the vendor's performance. Both have had meetings with the vendor (latter is more of a leadership meeting).
- Over time, DCFS has stopped enforcing certain practices which are clearly established in the contract or Operations Manual. For example, the Operations Manual speaks to the use of Performance Improvement Plans (PIPs) when the vendor does not meet performance standards. However, the state has not applied an individual PIP to PromiseShip in several years; PromiseShip is included in the state's PIPs to the federal government but not individually asked to submit a PIP.
- There has been a lack of sustained coordination between DCFS and PromiseShip's CQI functions. The Operations Manual compels the vendor to collaborate with the state and participate in statewide and local CQI meetings. However, these meetings have been suspended due to internal DCFS direction. DCFS's State Office CQI team had been building an inclusive CQI process including meetings with PromiseShip and other

providers and were successful in that effort, but due to resource issues and leadership direction, ceased these activities. As a result, in interviews with TSG, DCFS's CQI staff and PromiseShip CQI staff indicated they have little interaction and do not feel connected to, or collaborative with, quality improvement activities completed by the other.

- In today's contract, there are separate contract managers, contract monitors, financial monitors, and CQI resources. These functions report to different leaders in the organization which may contribute to fragmentation. There may be more efficient ways to use existing resources and improve coordination.
- The level of staff resources is not aligned with the need for CQI. DCFS QA staff expressed the desire to be able to monitor PromiseShip more closely but feel limited due to staff numbers and workloads. The current resources dedicated to the CQI function for this contract are not sufficient. The CQI team has approximately 21 allocated positions statewide, but this team is primarily working on CFSR issues and is not directly related to the monitoring of this contract.

10.4. Utilization Management

Utilization Review or Management is not part of the current approach to DCFS' management of the contract with PromiseShip, although PromiseShip has built its own Utilization Management team who is involved in the authorization of services.

The original contract and its extensions do not discuss establishment of this function at DCFS and DCFS leadership staff have self-identified this gap. The lack of UM function is consistent with the lack of other financial controls in today's contract. A UM function would:

- Compare vendor capacity and the vendor service array with the needs of children and families served;
- Compare vendor capacity to national standards;
- Assess the appropriateness of the amount and scope of services provided to families.

Going forward, as Nebraska implements a performance-based contract with greater financial controls and examines more closely the types of cases it sends to the vendor, the necessity of UM is heightened. This will be discussed further in the Path Forward section of this report.

As noted in the above Contract Section, there is little articulated in the contract that would encourage accountability around "practice" issue improvements and state staff express confusion and feel they have a limited ability to respond when practice issues must be addressed and to ensure the appropriate changes occur. As a result, contract staff express that they do not effectively monitor the public-private partnership to a degree which truly holds the provider accountable.

PromiseShip's contract monitoring staff perform legal compliance reviews of providers they contract with. These reviews are similar in nature and content to the state's contract monitoring

efforts and, in many respects are duplicative. Both state and PromiseShip staff are cognizant of this duplication and, to the degree possible, share significant findings when appropriate.

However, while meeting with staff from agencies that subcontract with both DCFS and PromiseShip, the fact that they are subject to monitoring by both entities was discussed and identified as being somewhat of a burden, as the intent of the reviews are identical. It is worth noting that at least one provider indicated that PromiseShip contract monitoring staff are viewed as being extraordinarily collaborative and accommodating when scheduling and completing contractual reviews.

11. VENDOR PROCESS FINDINGS

TSG compared several aspects of the ESA vendor’s process to assess whether the outsource allowed for innovation in the service array, readiness for the Family First Prevention Services Act (FFPSA), and how the vendor performs case management. TSG found:

- The outsourced region has built a robust service array, including several services available nowhere else in the state.
- In preparation for FFPSA, the outsourced region spends a fraction of its budget on preventive services but does place a heavy emphasis on placing children in foster care or kinship care with relatives.
- While the outsourced region’s contract limits the ability to implement flexibility in delivering case management, the vendor has worked to improve performance through technology, training and other avenues.
- The case transfer process is lacks clarity and creates challenges for DCFS and PromiseShip.
- DCFS’ desire to increase reliance on Alternative Response and Non-Court Voluntary Services should continue since no evidence of harm to safety of children but will require greater collaboration and additional need to reduce case transfer ambiguity.

11.1. Service Array

TSG assessed whether the service array and capacity in the ESA, and whether the vendor demonstrated an ability to build an innovative service array. TSG found that the Eastern Service Area has a more robust supply of providers than the rest of the state and that PromiseShip did built some innovative services in response to the needs of the children and family it serves, through collaboration with providers in the Service Area.

Some of the services could be considered evidence-based by today’s FFPSA standards and DCFS may consider evaluating whether any of the new services can be replicated in other regions of the state, since PromiseShip has shown to have a larger array of services than DCFS.

11.1.1. Overview on Nebraska Service Array

Nebraska has been on the cutting edge to provide early intervention services to families through its Maternal, Infant Early Childhood Home Visiting Programs. Nebraska has long been involved in Alternative Response programming in various counties and has focused on poverty screening. These prevention programs are important as Nebraska DCFS works to implement the new federal FFPSA.

With regard to secondary and tertiary prevention efforts, Nebraska has worked hard to reduce its reliance on group care placements and has laid the groundwork statewide to comply with this new federal law. The State of Nebraska has recently embarked on a Statewide child abuse prevention initiative designed to give the local community partnerships a long-term planning

process to address abuse prevention issues in their respective communities. Bring Up Nebraska focuses on preventing crisis through long term planning. The community collaboratives include the following agencies: Dakota County Connections, Douglas County Connections, Families First Partnership (Lincoln County), Fremont Family Coalition, Hall County Community Collaborative, Lancaster County, Life Up Sarpy, Norfolk Family Coalition, Panhandle Partnership, York County Health Coalition and Zero 2 Eight Collaborative. This is cross State agency, public/private not for profit collaborative. It is important to note that the PromiseShip catchment area is included in this overall Statewide effort, but it shows community-based innovation to address issues related to improving safety, permanency and well-being.

However, there are opportunities to continue to improve service delivery and address gaps in the service array. In its 2018 Annual Report, the Foster Care Review Board Annual Report recommends the following to address gaps with the existing service array:

“Establish an effective, evidence supported, goal driven, outcome-based service array throughout the State to meet the needs of children and families involved in the child welfare system to include the following:

- Preventative services for neglect and substance use in collaboration with DHHS Behavioral Health;
- Out of home services such a family support and parenting time services that have the least traumatic impact on children;
- Stabilization of placements and recruitment of foster parents based upon the needs of the child/youth in collaboration with foster care providers;
- Creation of treatment foster care services which actively engage families and would meet the needs of older youth;
- In-home supports for foster parents especially relative/kin placements;
- Mental and behavioral services for children/youth in collaborations with DHHS Behavioral Health;
- Developmental disability services for children/youth in collaboration with DHHS Developmental Disabilities; and,
- Enhanced services and case management for older youth.”

11.1.2. PromiseShip Requirements Regarding Service Array

The Nebraska DHHS 2017-18 Contract with PromiseShip states that:

The subrecipient is responsible to develop and sustain an array of services and supports designed to meet the unique needs of children and families. All services and supports must be accessible to all children and families served by the subrecipient in the Eastern Service Area. The service array will include services and supports that assess the strengths and needs of children and families; addresses the need of families in addition to individual children in order to create a safe home environment, enable children to remain

safely with their parents when reasonable and assist children in foster and adoptive placements achieve permanency. The service array must be inclusive of practices that are evidence based, trauma informed and culturally and linguistically appropriate.

11.1.3. TSG Findings about PromiseShip's Array

PromiseShip has demonstrated innovation in its service array, including creation of new programs and use of evidence-based programs.

PromiseShip has developed several services based on needs identified in the Eastern Service Area.³⁵ These services are not all evidence-based programs, but they have been developed in response to specific needs identified and built in collaboration with other stakeholders in the area.

Some examples of new services developed include:

- **Intensive In-Home I and II:** This service is used for family stabilization/preservation and includes intensive interventions to help children/families develop skills to achieve safety and stability. Level I is designed for in-home families and Level II is designed for either in-home families or families that are reunifying. The levels differ based on the intensity of services. Level II includes the option of team delivered services, with an involved clinician. Level II is intended to be a more short-term service (90 days), while Level I has the expectation that goals can be accomplished between 120-160 days.³⁶
- **Integrated Family Care Program:** In response to the need to address families with housing issues/homelessness, PromiseShip developed this 90 day program, which places the whole family into a mentor home. There is a second level to the program that allows the family to transition into a rental home.
- **Pathways to Permanency program:** Out of recognition that families are often going to multiple providers for services which can result in logistical challenges such as transportation and result in fragmented care (i.e., through multiple service plans), PromiseShip, providers, and the Child Saving Institute built an all-inclusive agency model so that families can go to one provider to receive multiple services. There are approximately 6 agencies that offer this service today.
- **Professional foster care:** In response to a lack of Medicaid-funded services for children with a level of needs, PromiseShip built this program which pays foster parents a higher rate so one of the parents can provide one-on-one care for the child (in lieu of other employment).

³⁵ Notes from 10/22/18 meeting with PromiseShip.

³⁶ Services Quick Reference Guide for CRI.

PromiseShip has also incorporated evidence-based services including but not limited to:

- Nurturing Parenting
- Shared Family Care
- Teaching Family Model
- Common Sense Parenting
- Bridges out of Poverty
- Trauma Systems Theory
- Safe and Connected
- Motivational Interviewing
- Homebuilders IFP model; and,
- Cognitive Behavioral Therapy.

The extent to which these services are used (measured in expenditures and clients served) will be discussed further as part of assessing the state’s readiness for FFPSA.

DCFS has expressed concern that some of these services such as professional foster care are not cost effective for the state and the rates paid in the ESA have created challenges for replication. TSG reviewed national data from the Report on a 2012 National Survey of Family Foster Care Provider Classifications and Rates, and the breakdown of rates paid in Nebraska, and finds that the rate is not out of line with what other states pay for their highest needs youth. In addition, this service is only used for approximately 8 children (that is a point in time count in November 2018), so it is not a significant cost driver. It can be one of many tools in the service array, and with appropriate Utilization Management, can be limited for youth with complex needs.

11.2. Alignment with Requirements of Family First Prevention Services Act (FFPSA)

The Bipartisan Budget Act of 2018 (H.R. 1892), signed in February 2018, includes sweeping changes to child welfare funding through the inclusion of the Family First Prevention Services Act (FFPSA). This legislation significantly alters how Title IV-E funds can be spent by states. Prior to the Act’s passage, Title IV-E funds could only be used to cover the cost of foster care maintenance for eligible children in out-of-home care; administrative expenses to manage the program; and training for staff, foster parents, and certain private agency staff; adoption assistance; and kinship guardianship assistance.

Under the new law, jurisdictions with an approved Title IV-E plan will be able to use Title IV-E funds to cover the cost of prevention services that would support the ability of youth at imminent risk of entering foster care to remain living in the home of their primary caretaker; parents or relatives. States will be reimbursed for 50% of the cost of prevention services for up to 12 months. Trauma-informed prevention plan must be created, and services are required to be evidence-based, meaning the efficacy and long-term impact of the services implemented have been assessed using a rigorous evaluation protocol.

The Act also seeks to reduce the use of congregate or group care placement while placing a stronger emphasis on the placement of children in the homes of qualified relatives or family foster homes. Unless a child qualifies for placement in a treatment-based setting known as a Qualified Residential Treatment Program, is a victim of (or is at risk of) being sexually trafficked, is pre- or post-natal and in need of parenting support or is in a supervised setting for youth 18 or older, the federal government will not reimburse states for children placed in group care settings for more than two weeks. Residential settings identified as QRTPs must include a trauma-informed treatment model, be accredited by a nationally recognized accrediting body, and employ registered or licensed nursing staff and other licensed clinical staff in the care and treatment of children in their care.

The child must be formally assessed by a party independent of the state agency or residential facility within 30 days of placement to determine if his or her needs can be met by family members, in a family foster home or another approved setting. The lack of available relative of foster family placement is not sufficient to qualify a child for placement in a QRTP. Though federal guidance surrounding the scope and content of this assessment has not been released, the intent of the Act is clear in that it will serve to limit the ability of states to use congregate care placements for all but those youth who have the most significant needs.

As passed, the legislation largely becomes effective in October 2019 (Federal Fiscal Year 2020). However, states, tribes and territories were afforded to delay implementation of FFPSA for a period of up to two years to permit sufficient time to implement policy or systemic changes necessary. The election to delay implementation of FFPSA was to be submitted by November 9, 2018. With the exception of requirements related to the criminal record and registry checks for staff working in child care institutions, DHHS elected to pursue implementation of authorized, eligible prevention services.

11.2.1. FFPSA Eligible Prevention Services³⁷

State Title IV-E agencies may claim reimbursement for mental health and substance abuse prevention and treatment services provided by qualified clinicians, and in-home³⁸ parent skill-based programs that include parenting skills training, parent education, and individual and family counseling that have been rated and approved by the Title IV-E Prevention Services Clearinghouse and are identified in the state's five-year Title IV-E prevention program plan (section 471(e)(1) of the Act). Additionally, interventions designed to offer support and assistance "navigating" the child welfare system will also be eligible for federal reimbursement.

³⁷ Extracted from ACYF-CB-PI-18-09, published 11/30/18

³⁸ The term In-home services has been federally interpreted as the setting where the child is continuing to reside rather than the location where the service is offered or provided.

Title IV-E prevention services must be rated as promising, supported, or well-supported in accordance with HHS criteria and be approved by HHS (section 471(e)(4)(C) of the Act) and included as part of the Title IV-E Prevention Services Clearinghouse (section 476(d)(2) of the Act). Revised criteria published by the Administration for Children and Families on November 30, 2018 further clarify their approach to evaluating and assessing evidence-based services as meeting these criteria.

FFPSA requires: “At least 50 percent of the amounts expended by the state for a fiscal year (FY) for the Title IV-E prevention program must be for services that meet the well-supported practice criteria (section 474(a)(6)(A)(ii) of the Act). The state may provide Title IV-E prevention services as specified in the child’s prevention plan for up to 12 months beginning on the date the state identifies the child as either a “candidate for foster care” or a pregnant or parenting foster youth in need of those services (sections 471(e)(2)(A) and (B) of the Act) (see section B.1 below). The state may claim Title IV-E reimbursement for prevention services until the last day of the 12th month if services were provided for the entire 12-month period, or if services are provided for less than the entire 12-month period, the end of the month in which the child’s Title IV-E prevention services ended.

A state may provide Title IV-E prevention services to or on behalf of the same child for additional 12-month periods, including for contiguous 12-month periods. In order to claim Title IV-E for each additional 12-month period, the state must determine and document in the child’s prevention plan that the otherwise eligible candidate for foster care or pregnant/parenting youth meets the requirements in section 471(e)(4)(A) of the Act on a case-by-case basis.”

The Clearinghouse will rate a service or program as a ‘promising,’ ‘supported,’ or ‘well-supported’ practice if it meets the below criteria that collectively assess the strength of evidence for a practice and build from the *Study Rating Criteria* [section 471(e)(4)(C) of the Act].

Promising Practice: A service or program will be rated as a ‘promising practice’ if the service or program has at least one study that achieves a rating of ‘moderate’ or ‘high’ on Study Design and Execution and demonstrates a favorable effect on at least one ‘target outcome.’

Supported Practice: A service or program will be rated as a ‘supported practice’ if the service or program has at least one study carried out in a usual care or practice setting that achieves a rating of ‘moderate’ or ‘high’ on Study Design and Execution and demonstrates a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome.

Well-Supported Practice: A service or program will be rated as a ‘well-supported practice’ if the service or program has at least two studies with non-overlapping analytic samples carried out in a usual care or practice setting that achieve a rating of ‘moderate’ or ‘high’ on Study Design and Execution. At least one of the studies must demonstrate a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome.

Does Not Currently Meet Criteria: A service or program will be rated as ‘does not currently meet criteria’ if the service or program has been reviewed and does not currently meet the evidence criteria for ‘promising,’ ‘supported,’ or ‘well-supported’ practices.

11.2.2. Evidence Based Services Under Review

Presently, the Title IV-E Prevention Services Clearinghouse is in the process of reviewing and rating services for HHS approval. The first services and programs selected for systematic review met at least two of the following conditions:

1. recommendation from state or local government administrators in response to the FRN;
2. rated by the California Evidence-Based Clearinghouse;
3. evaluated by Title IV-E Child Welfare Waiver Demonstrations;
4. recipient of a Family Connection Discretionary Grant; and/or
5. recommendation solicited from federal partners in the Administration for Children and Families, Health Resources and Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Office of the Assistant Secretary for Planning and Evaluation, and the Substance Abuse and Mental Health Services Administration.

Evidence based services presently being reviewed by the Clearinghouse include:

Mental Health:

- a. Parent-Child Interaction Therapy
- b. Trauma Focused-Cognitive Behavioral Therapy
- c. Multisystemic Therapy
- d. Functional Family Therapy

Substance Abuse:

- a. Motivational Interviewing
- b. Multisystemic Therapy
- c. Families Facing the Future
- d. Methadone Maintenance Therapy

In-Home Parent Skill-Based:

- a. Nurse-Family Partnership
- b. Healthy Families America
- c. Parents as Teachers

Kinship Navigator Programs

- a. Children’s Home Society of New Jersey Kinship Navigator Model

b. Children’s Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)

Findings from the review of the initial programs being reviewed are scheduled for release in Spring 2019. After completing the review of the initial services selected, the Clearinghouse will select additional services and programs for review on a rolling basis using the revised initial criteria.

11.2.3. State Plan Requirements

The state is required to describe how it will assess children and their parents or kin caregivers to determine eligibility for Title IV-E prevention services and describe the HHS approved services the state will provide, including:

- whether the practices used to provide the services are rated as promising, supported, or well-supported in accordance with the HHS practice criteria as part of the Title IV-E Prevention Services Clearinghouse;
- how the state plans to implement the services, including how implementation of the services will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices;
- how the state selected the services;
- the target population for the services;
- an assurance that each HHS approved Title IV-E prevention service provided in the state plan meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (Attachment III); and
- how providing the services is expected to improve specific outcomes for children and families.

In addition, States must include a well-designed and rigorous evaluation strategy for each service they elect to implement, which may include a cross-site evaluation approved by ACF. The Children’s Bureau may waive the evaluation requirement for a well-supported practice if the evidence of the effectiveness of the practice is compelling and the state meets the continuous quality improvement requirements identified in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice.

Finally, additional guidance and procedures for states, territories and tribes seeking to implement evidence-based services approved by the clearing house will be published in the upcoming Title IV-E Prevention Services Clearinghouse Procedures Handbook.

11.2.4. Maintenance of Effort (MOE)

The November 2018 Program Instruction provides clarification to states surrounding the calculation of MOE. FFPSA requires states to use Title IV-E prevention services to supplement,

and not supplant, FY 2014³⁹ “state foster care prevention expenditures”, as defined by the Act. After implementing FFPSA, the state agency is then required to maintain at least the same level of “state foster care prevention expenditures” each FY as the amount the agency spent in FY 2014.

Federal statute defines “state foster care prevention expenditures” as:

- State expenditures and federal matching funds provided to the state for Title IV-B, Temporary Assistance for Needy Families (TANF), and the Social Services Block Grant (SSBG); and
- State expenditures for foster care prevention services and activities under any other state program (except Title IV-E).

ACF has clarified that state foster care prevention services and activities must have been approved by the Title IV-E Prevention Services Clearinghouse as being allowable for Title IV-E prevention reimbursement and meeting the standards outlined in the statute at section 471(e)(4) of the Act as follows:

- Services or activities are one of the allowable types of services:
 - Mental health and substance abuse prevention and treatment services; or
 - In-home parent skill-based programs that include parenting skills training, parent education, and individual and family counseling;
- Populations served are children who are candidates for foster care, pregnant or parenting youths in foster care, or their parents and kin caregivers;
- Services are rated as well-supported, supported, or promising as outlined in the law and in accordance with HHS practice criteria as part of the Title IV-E Prevention Services Clearinghouse; and,
- Services or activities are trauma-informed.

Finally, “state foster care prevention expenditures” must include only those prevention services or activities that have been approved by the Title IV-E Prevention Services Clearinghouse at the time the state submits its initial five-year prevention plan.

11.2.5. Payor of Last Resort

Federal requirements have identified Title IV-E to be the payor of last resort for interventions which may be covered by public or private third-party payors, including private insurance or Medicaid. However, use Title IV-E prevention program funding may be used, pending

³⁹ States with less than 200,000 children may opt to use an alternate funding year to calculate their MOE baseline.

reimbursement from the public or private source that has ultimate responsibility for the payment, to prevent delaying the timely provision of appropriate early intervention service.

11.2.6. Alignment of PromiseShip's Service Array with FFPSA

As the subcontracted provider responsible for the largest child welfare service area population in Nebraska, the ability of PromiseShip to establish and provide an array of well-supported evidence-based services is critical to the State's ability to draw down federal funding for prevention activities provided to children at imminent risk of entering foster care.

DCFS has taken a pro-active approach to the new legislation and, as previously mentioned, intends to implement Title IV-E reimbursable prevention services in October 2019. A series of workgroups and committees have been established, each responsible for a separate requirement of the act or within the state Title IV-E plan. These groups have begun to meet and are actively publishing their progress on a department-maintained website⁴⁰; In addition, the department is preparing an RFP for evidence-based prevention services which is scheduled for release in the imminent future.

Through correspondence and interviews with DCFS staff, TSG has determined that the only contracted evidence-based child welfare service is a Family Centered Treatment (FCT) pilot project initiated in November 2018. However, this service is not presently being evaluated by the federal FFPSA Clearinghouse and is listed on the California Evidence-Based Clearinghouse as a Promising Practice. While the intervention is relevant for the child welfare population, it is unlikely to reach the level of a Well-Supported Practice in the near future. As a result, this intervention will only be federally reimbursable if statewide Well-Supported practices are implemented, offered with fidelity and account for 50% of evidence-based service related expenditures. Presently, there are other child welfare services available across the state which may contain a component of an evidence-based model but are not provided with full fidelity to the model.

Similarly, PromiseShip reports having contracts with multiple providers who offer evidence-based interventions as part of the program model or prevention services they are contracted to provide. It is important to note that only three of the following interventions, Trauma Focused Cognitive Behavioral Therapy, Parent Child Interactive Therapy and Motivational Interviewing, are currently being reviewed by the FFPSA Clearinghouse. Of the remaining therapies offered, those rated Promising, Supported or Well Supported by the California Clearinghouse are likely to be similarly rated by the FFPSA Clearinghouse. Beyond the timelines for service approval already articulated by ACF, it is not clear when additional services may be selected for review. Services provided by PromiseShip's subcontractors include:

⁴⁰ http://dhhs.ne.gov/children_family_services/FamiliesFirst/Pages/Agendas-and-Minutes-.aspx

Table 28: Services Provided by PromiseShip's Subcontractors.

Intervention	CEBC - Scientific Rating	Currently Under Review by FFPSA Clearinghouse
Cognitive Behavioral Therapy	1 - Well Supported by Research Evidence	
Cognitive Processing Therapy	1 - Well Supported by Research Evidence	
EMDR	1 - Well Supported by Research Evidence	
Incredible Years	1 - Well Supported by Research Evidence	
Motivational Interviewing	1 - Well Supported by Research Evidence	Yes
Parent Management Training	1 - Well Supported by Research Evidence	
Parent Child Interactive Therapy	1 - Well Supported by Research Evidence	Yes
Trauma Focused Cognitive Behavioral Therapy	1 - Well Supported by Research Evidence	Yes
Child-Parent Psychotherapy	2 - Supported by Research Evidence	
Common Sense Parenting	2 - Supported by Research Evidence	
Homebuilders	2 - Supported by Research Evidence	
Seeking Safety (adult)	2 - Supported by Research Evidence	
Circle of Security	3 - Promising Research Evidence	
Life Space Crisis Intervention	3 - Promising Research Evidence	
Nurturing Parenting	3 - Promising Research Evidence	
Systemic Training for Effective Parenting (STEP)	3 - Promising Research Evidence	
Teaching Family Model	3 - Promising Research Evidence	
Celebrating Families	NR - Not able to be Rated	
Strengthening Families	NR - Not able to be Rated	
Trauma Systems Therapy	NR - Not able to be Rated	

Intervention	CEBC - Scientific Rating	Currently Under Review by FFPSA Clearinghouse
C3 De-Escalation	Not listed on CEBC	
Dialectical Behavioral Therapy	Not listed on CEBC	
Living in Balance	Not listed on CEBC	
Moral Recognition Therapy	Not listed on CEBC	
Shared Family Care	Not listed on CEBC	

While service providers under contract with PromiseShip may offer the above-referenced evidence-based services, there is no evidence that they are offered with a high degree of fidelity to the model or that data is collected to support the efficacy of individual interventions. The requirement to do so is new and will be imperative when it comes to implementing and being reimbursed for services rated less than well-supported by the FFPSA Clearinghouse.

In addition, during fiscal year 2018, PromiseShip reports expenditures of \$2.5 Million for intensive in-home services (level I, and II), approximately 3.63% of a \$70 million budget. While expenditures of this level for prevention services is commensurate with budgets reported by other private child welfare lead agencies in states such as Florida, funding at this level is extraordinarily low in consideration of the intent of FFPSA.

The following table offers a breakdown of provider payments for Intensive In-Home (preservation) services, as those expenditures are most likely to be eligible for reimbursement under FFPSA. These providers are often paid on a case-rate basis and expenditures were not tracked by intervention type, as a result it is difficult, if not impossible, to accurately assess the degree to which expenditures were made for well-supported interventions. It is worth noting, the requirement to expend prevention-related funding on the basis of a particular type or level of intervention has never been a federal requirement and has only been a consideration since passage of the Act in early 2018. Services listed on the California Evidence Based Clearing house which are offered by these providers and likely to be qualified as Promising, Supported or Well Supported by the FFPSA Clearinghouse are also identified in the chart.

Table 29: Services listed on the California Evidence Based Clearing house

In-Home Preservation Service Level & Provider	CEBC Listed EB Practice(s) Provided for Intensive In-Home	FY2018 Expenditure
Intensive In-Home Level 1		
APEX	Nurturing Parenting	\$12,451
Boys Town	Teaching Family Model, Common Sense Parenting	\$512,252
CSI	Circle of Security, Nurturing Parenting	\$ 92,758
Heartland Family Service	Nurturing Parenting, Circle of Security, Cognitive Processing Therapy, Incredible Years, TF-CBT	\$208,766
KVC	Motivational Interviewing	\$76,798
OMNI	Kazdin Parent Management Training, Homebuilders	\$80,817
Owens and Associates	Motivational Interviewing and Nurturing Parenting	\$14,411
Paradigm Inc.	Nurturing Parenting, Motivational Interviewing, Cognitive Behavioral Therapy, Systemic Training for Effective Parenting	\$125,882
Release Ministries	Strengthening Families, LifeSpace Crisis Intervention	\$ 224,630
Total Expenditures Level 1		\$ 1,348,765
Intensive In-Home Level 2		
APEX	Nurturing Parenting	\$3,903
Boys Town	Teaching Family Model, Common Sense Parenting	\$291,447
CSI	Circle of Security, Nurturing Parenting	\$28,628
Heartland Family Service	Nurturing Parenting, Circle of Security, Cognitive Processing Therapy, Incredible Years, TF-CBT	\$307,839
KVC	Motivational Interviewing	\$59,487
OMNI	Kazdin Parent Management Training, Homebuilders	\$ 175,956
Paradigm Inc.	Nurturing Parenting, Motivational Interviewing, Cognitive Behavioral Therapy, Systemic Training for Effective Parenting	\$77,364
Release Ministries	Strengthening Families, LifeSpace Crisis Intervention	\$250,501
Total Expenditures Level 2		\$ 1,195,126

Therefore, TSG recommends that DCFS continue to work with PromiseShip to ensure that it is spending the appropriate focused attention, time and money on the types of prevention services that are classified or will be classified as “well-supported” by the Federal government and that the spending on prevention-related programs meets applicable Federal standards. The fact that

access to providers who have been trained or have the ability to be trained and offer these programs is greater in the ESA than other areas of the State, should cause concern to DCFS that PromiseShip is spending such a low amount today on high fidelity prevention. This could substantially impact the State's ability to draw down Federal funds in the next few months when the FFPSA funding kicks in. DCFS should continue to work with PromiseShip on this issue today, but also ensure that the next contract requires that the vendor meet certain benchmarks related to FFPSA or be held liable to meaningful consequences for failure to meet the required level and program funding and fidelity.

11.2.7. Licensed Relative Foster Care

FFPSA places a heavy emphasis on placement of youth into licensed relative foster homes. In order to maximize title IV-E reimbursement, it will be imperative that all areas of the state, but in particular the Eastern Service Area, seek to maximize federal reimbursement for youth in out-of-home relative care.

As depicted in Table, fiscal Year 2018 expenditures for relative foster care totaled \$7,690,957. Of this \$571,333.50 (7.43%) was for children in licensed relative placements.

Further delineating expenditure data by IV-E eligible and non-eligible expenditures identifies 44.81% of expenditures as being made for title IV-E eligible children. PromiseShip presently identifies approximately 17% of relative/kinship providers are licensed. This is typical in that relative caregivers often perceive licensing requirements to be intrusive or onerous considering they are providing care to children they are related to. During FY2018, \$3.18 million dollars were expended for title IV-E eligible children placed in the homes of unlicensed relatives. As a result, these expenditures were not federally reimbursable, as shown in Table.

Table 30: Fiscal Year 2018 Expenditures for Relative Foster Care

	Qtr1	Qtr2	Qtr3	Qtr4	FY 2018 Total
CRI FC – Relative/Kinship Licensed (0-5)	\$40.00			\$140.00	\$180.00
CRI FC – Relative/Kinship Licensed (12-18)				\$175.00	\$175.00
CRI FC – Relative/Kinship Licensed (6-11)				\$161.00	\$161.00
CRI Relative/Kinship FC (0-5)	\$12,520.00	\$7,600.00	\$8,420.00	\$7,740.00	\$36,280.00
CRI Relative/Kinship FC (12-18)	\$7,950.00	\$6,400.00	\$2,450.00	\$4,525.00	\$21,325.00
CRI Relative/Kinship FC (6-11)	\$8,349.00	\$5,681.00	\$7,015.00	\$7,475.00	\$28,520.00
FC – Relative/Kinship Licensed (0-5)	\$45,935.00	\$56,992.50	\$64,767.50	\$80,615.00	\$248,310.00
FC – Relative/Kinship Licensed (12-18)	\$10,842.50	\$21,315.00	\$34,350.00	\$37,590.00	\$104,097.50
FC – Relative/Kinship Licensed (6-11)	\$39,502.00	\$50,935.50	\$62,186.50	\$65,786.00	\$218,410.00
Relative/Kinship FC (0-5)	\$673,300.00	\$639,232.50	\$602,807.50	\$579,472.50	\$2,494,812.50
Relative/Kinship FC (12-18)	\$562,747.00	\$573,833.00	\$546,827.50	\$550,360.50	\$2,233,768.00
Relative/Kinship FC (6-11)	\$598,902.50	\$598,796.00	\$566,094.50	\$541,125.00	\$2,304,918.00
Grand Total	\$1,960,088.00	\$1,960,785.50	\$1,894,918.50	\$1,875,165.00	\$7,690,957.00

Table 31: Non-IV-E Eligible Expenses

	Qtr1	Qtr2	Qtr3	Qtr4	FY 2018 Total
IV-E Non-Eligible					
CRI FC – Relative/Kinship Licensed (0-5)	\$40.00			\$140.00	\$180.00
CRI FC – Relative/Kinship Licensed (12-18)				\$175.00	\$175.00
CRI FC – Relative/Kinship Licensed (6-11)				\$161.00	\$161.00
CRI Relative/Kinship FC (0-5)	\$11,700.00	\$4,920.00	\$8,400.00	\$5,140.00	\$30,160.00
CRI Relative/Kinship FC (12-18)	\$7,675.00	\$6,175.00	\$2,450.00	\$4,225.00	\$20,525.00
CRI Relative/Kinship FC (6-11)	\$7,659.00	\$3,818.00	\$7,015.00	\$4,301.00	\$22,793.00
FC – Relative/Kinship Licensed (0-5)	\$30,980.00	\$25,650.00	\$28,817.50	\$39,285.00	\$124,732.50
FC – Relative/Kinship Licensed (12-18)	\$4,575.00	\$11,270.00	\$21,500.00	\$21,192.50	\$58,537.50
FC – Relative/Kinship Licensed (6-11)	\$22,533.50	\$30,728.00	\$34,090.50	\$33,951.00	\$121,303.00
Relative/Kinship FC (0-5)	\$396,087.50	\$319,552.50	\$309,335.00	\$277,032.50	\$1,302,007.50
Relative/Kinship FC (12-18)	\$352,794.50	\$353,243.00	\$340,065.00	\$332,975.50	\$1,379,078.00
Relative/Kinship FC (6-11)	\$327,679.00	\$286,357.00	\$281,141.50	\$289,663.00	\$1,184,840.50
IV-E Non-Eligible Total	\$1,161,723.50	\$1,041,713.50	\$1,032,814.50	\$1,008,241.50	\$4,244,493.00
IV-E Eligible					
CRI Relative/Kinship FC (0-5)	\$820.00	\$2,680.00	\$20.00	\$2,600.00	\$6,120.00
CRI Relative/Kinship FC (12-18)	\$275.00	\$225.00		\$300.00	\$800.00
CRI Relative/Kinship FC (6-11)	\$690.00	\$1,863.00		\$3,174.00	\$5,727.00
FC – Relative/Kinship Licensed (0-5)	\$14,955.00	\$31,342.50	\$35,950.00	\$41,330.00	\$123,577.50
FC – Relative/Kinship Licensed (12-18)	\$6,267.50	\$10,045.00	\$12,850.00	\$16,397.50	\$45,560.00
FC – Relative/Kinship Licensed (6-11)	\$16,968.50	\$20,207.50	\$28,096.00	\$31,835.00	\$97,107.00
Relative/Kinship FC (0-5)	\$277,212.50	\$319,680.00	\$293,472.50	\$302,440.00	\$1,192,805.00
Relative/Kinship FC (12-18)	\$209,952.50	\$220,590.00	\$206,762.50	\$217,385.00	\$854,690.00
Relative/Kinship FC (6-11)	\$271,223.50	\$312,439.00	\$284,953.00	\$251,462.00	\$1,120,077.50
IV-E Eligible Total	\$798,364.50	\$919,072.00	\$862,104.00	\$866,923.50	\$3,446,464.00
Grand Total	\$1,960,088.00	\$1,960,785.50	\$1,894,918.50	\$1,875,165.00	\$7,690,957.00

12. REVIEW OF PROMISESHIP CASEWORKER PROCESSES

TSG engaged in a review of PromiseShip’s operations to identify similarities and meaningful differences in how it performs the case management function and the related outcomes it achieves. TSG met with PromiseShip leadership/administrative staff, supervisors, and Family Support Workers (caseworkers), including staff from Douglas and Sarpy counties.

TSG observed many similarities in how PromiseShip’s and DCFS’ caseworker and supervisory staff perform case management for ongoing cases; the vendor is subject to the same state and federal requirements and the contract and Operations Manual are prescriptive.

The Operations Manual explicitly states that PromiseShip must meet all statutory, DCFS regulations, policy, administrative memos, and local protocol for ongoing cases including court and non-court families. The Operations Manual does not create exemptions from such requirements. In addition, the vendor must mirror the processes used by the state in several key areas which informs how workers do the day-to-day job:

- Training: All Family Permanency Specialists and Family Permanency Specialist Supervisors at PromiseShip must participate in the same pre-service training related to Child and Family Services, which is offered by the University of Nebraska-Lincoln Center on Children, Families and the Law.
- Decision Making: PromiseShip staff must be trained in and use the same Structured Decision Making® (SDM) assessment tools (and same construction of safety and risk) throughout the life of the case, which informs key case actions (i.e., decision to remove, decision to reunify, placement).

TSG also observed areas in which PromiseShip’s FSRs operate differently from the state, in the areas in which it has been permitted to innovate. Some examples (not an exhaustive list) of these differences include:

- Additional proprietary training program;
- Organization of teams by court/judge to maximize efficiencies;
- Mobile workforce, aided by technology;
- Electronic filing of court reports (in Douglas County);
- Creation of a 24-hour “after hours” unit to respond to intakes and emergencies after hours (which could otherwise be a worker responsibility)

Some findings from staff interviews and observation:

1. It is unrealistic to expect significantly different performance outcomes if so, much of how the vendor has to do the job is the same as the State’s.

2. PromiseShip has implemented process improvements over time and shown the ability to identify innovative practice solutions. A vendor could go further if permitted to by Contract or Operating Manual.
3. Ambiguity remains in the case transfer process. Although the Operations Manual addresses this process, but TSG found gaps in comprehensiveness of this process and staff. Staff indicated there was a general process flow and provided TSG with high level flow charts. However, in interviews, they identified points in the process where ambiguity exists and where staff do not always adhere to the process.

There is a need to clarify the case transfer process to ensure the state and vendor have an understanding of the roles involved, responsibilities, tasks, and sequence of the process. Process mapping is a business planning and management method that describes and illustrates the flow of work by formal components of a system. Process mapping has many uses including planning, assuring effective and efficient work flow, identifying gaps or ambiguous processes, operations monitoring, and can be an evaluation tool when tied to process and outcomes related data.⁴¹

Based on TSG’s experience with the Texas child welfare system, TSG has found value of process mapping for leadership, managers, and caseworkers in terms of process compliance and the ability to identify process improvements. In order to accurately map the “as is” case transfer process, so that recommendations can be made for the “to be” process, TSG conducted focus groups with PromiseShip and DHHC caseworkers and supervisors in both Douglas and Sarpy Counties. Our objectives for this task were to document the case transfer process (from the point of intake through the transfer of case management to PromiseShip), assess overall process compliance with the Operations Manual⁴² for the Intake, In-Home, and Out-of-Home casework processes in the Eastern Service Area, and identify any operational concerns and recommendations for improvements.

The following process maps are swim lane diagrams, which capture tasks in the swim lane of the responsible party. The maps begin in the upper left corner and are read from left to right and top to bottom. The rectangles are process steps and the diamonds represent decision nodes where multiple outcomes are possible.

12.1. Hotline Intake Process

The Hotline Intake Process Map illustrates the process steps and responsible DCFS roles from the point of receipt of a telephone call through the assignment to an Initial Assessment (IA) worker for an investigation. Using the SDM Intake Screening decision-making process, hotline workers accept or reject the intake. Intakes that are not accepted may be closed or referred to the

⁴¹ “Using Concept Mapping as a Planning Tool: Child Welfare Citizens Review Panels”; J. J. Miller and Blake Jones; Evaluation and Program Planning; Vol. 53, Dec., 2015, pp. 99-106

⁴² Eastern Service Area Operations Manual; 1/23/2018

Alternative Response model, FAST, or a community resource. Accepted intakes are assigned a priority and assigned to an IA worker.

12.2. In-Home Case Transfer Process Map

The In-Home process map illustrates the process from the point of assignment of a case to an IA worker through the point at which case management transfers to the PromiseShip caseworker. The pentagon shape with the text “In-Home Link” connects the prior map to this page in the upper left corner.

Unlike the previous process for the intake function which is performed exclusively by state workers, this process map includes the roles of state and vendor staff. This map is not inclusive of every task performed by an IA worker during an investigation and some attempts were made to consolidate tasks related to gathering evidence and completing the Safety and Risk Assessments.

The map captures the decision logic on which cases transfer to PromiseShip. In-Home cases may be Safe or Conditionally Safe with a Plan. If the IA worker finds the family is Unsafe, the path followed flows onto the Out-of-Home process map. In addition to a determination of Safety/Risk, the decision to transfer a case to PromiseShip is ultimately determined based on whether the IA worker discerns that the family needs case management or can be referred directly to community providers.

The transfer process culminates in a staffing, after which case management is transferred to the PromiseShip worker, though the IA worker has some final tasks in N-FOCUS to complete. The process also includes an optional joint family visit if the workers agree it may be helpful for the family.

12.3. Out-of-Home Case Transfer Process Map

The Out-of-Home process map begins at the point in which the IA worker determines the child/youth is unsafe, and is inclusive of the tasks performed by DCFS, the county attorney, and PromiseShip staff through the transfer of case management. As depicted, DCFS staff engage PromiseShip at different points in the organization throughout this transfer process, including initially if services are needed, and later when case management transfers. During the engagement of PromiseShip Utilization Management staff to start services, the IA worker remains the primary worker on the case.

The formal case transfer occurs after the Protective Custody Hearing, though as with In-Home cases, the IA worker has remaining tasks to complete.

Figure 33: Eastern Service Area Intake Process

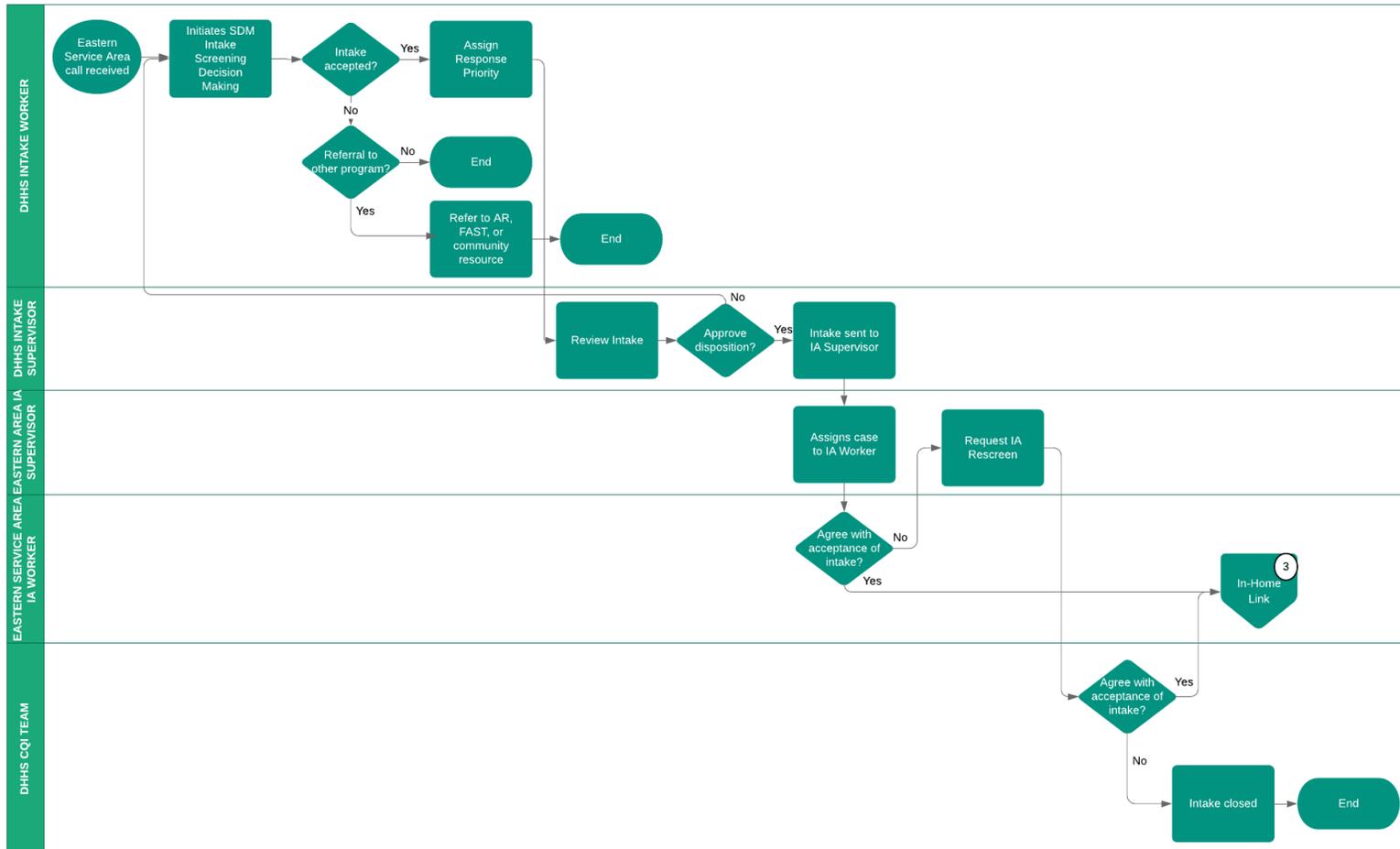


Figure 34: Eastern Service Area In-Home Case Transfer Process Map

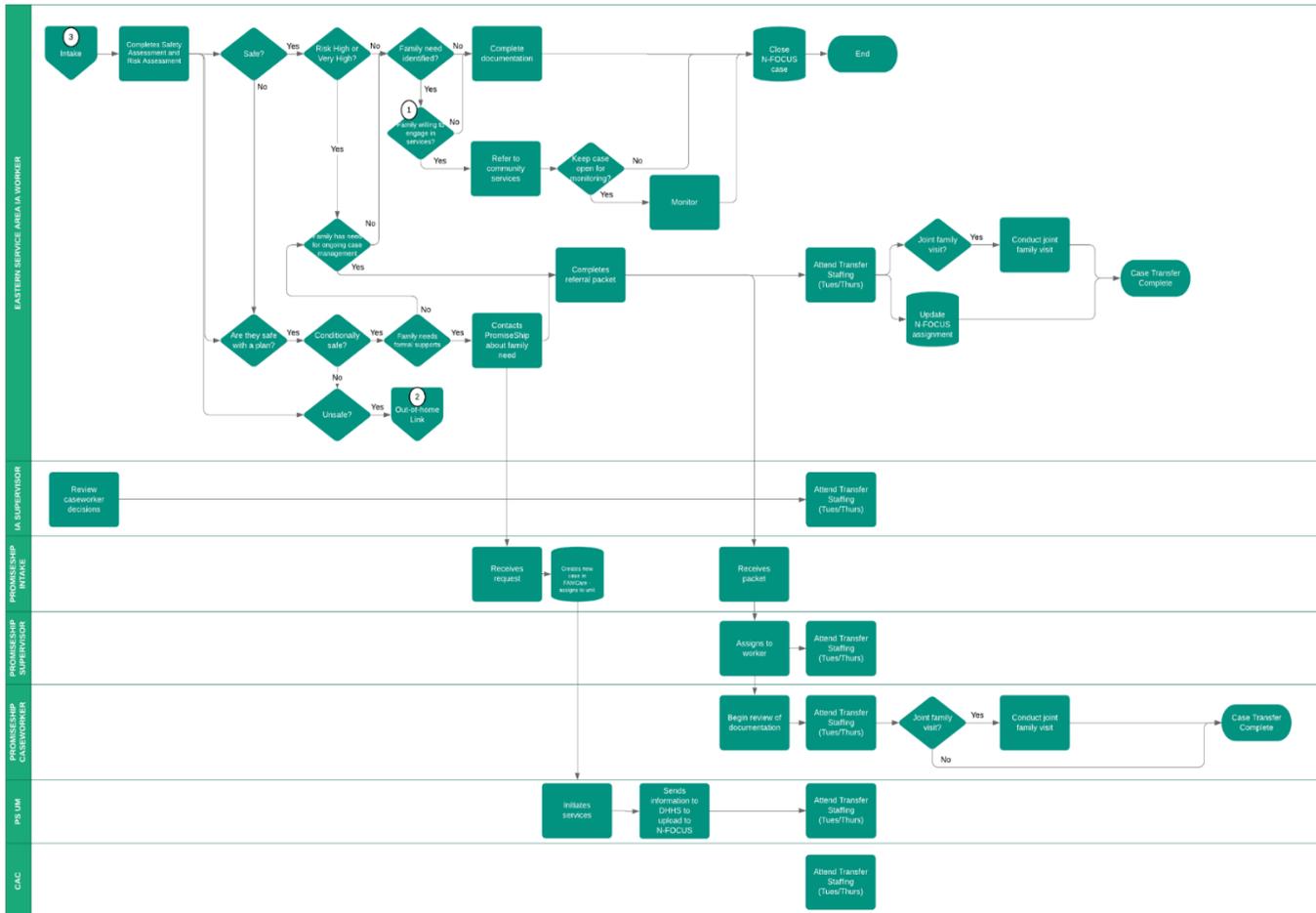
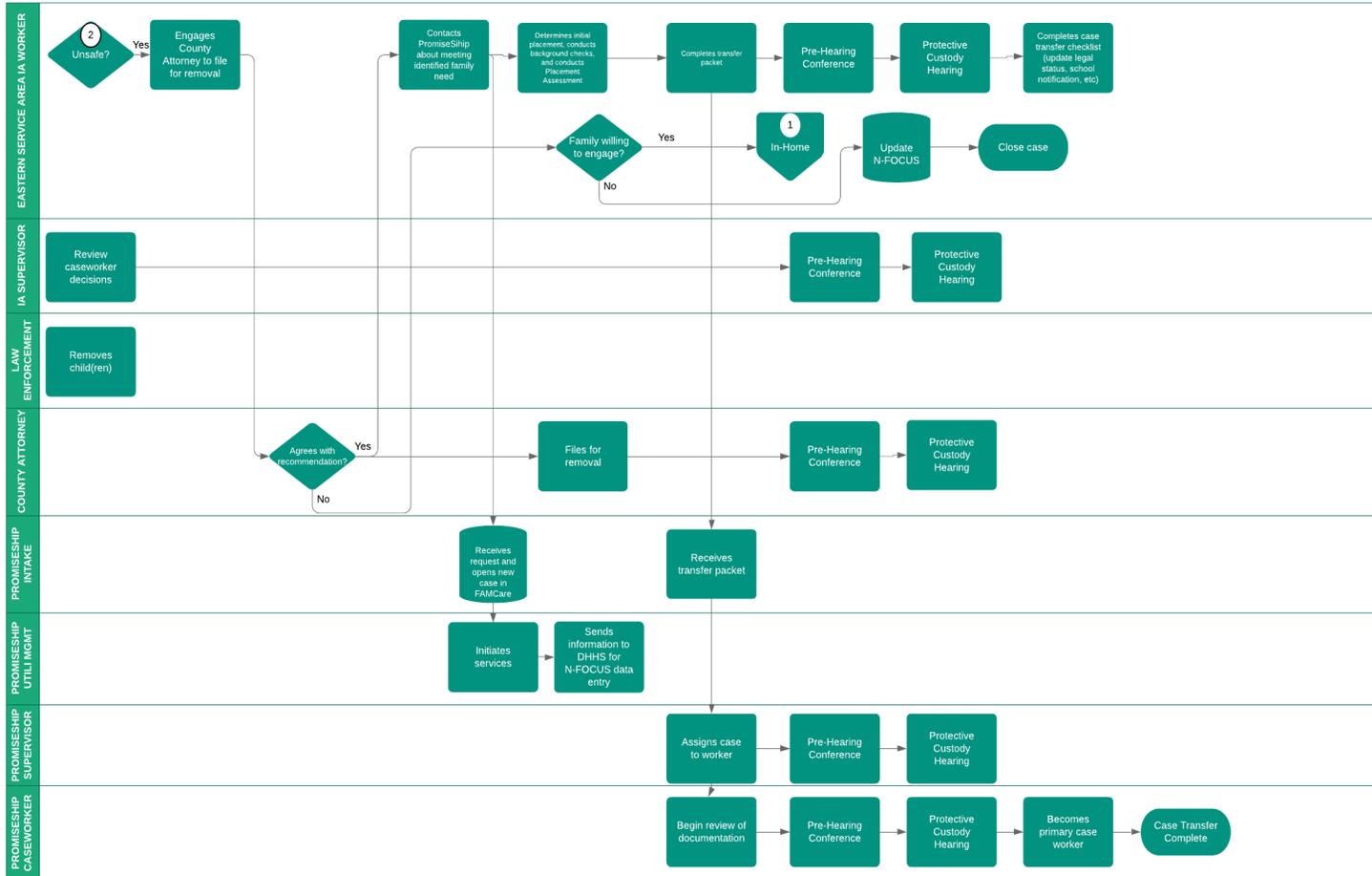


Figure 35: Eastern Service Area Out-of-Home Case Transfer Process



12.4. Process Mapping Findings

TSG appreciates the experience and insights of DCFS Eastern Service Area administration, management, supervisors, and caseworkers, as well as PromiseShip leadership, management, supervisors, and caseworkers and found them to be engaged and enthusiastic about working collaboratively to identify and improve the case transfer process, not only for their own benefit but to improve safety, permanency, and well-being for the children and families they serve.

Generally, the casework practice and process followed in the Eastern Service Area comport with the Operations Manual and attending state law, rules, and policy, but there is room for significant improvement. During TSG focus groups, participants from DCFS and PromiseShip agreed on the need to clarify several of the same process points they labelled as “messy” and “areas of gray.”

TSG’s findings include:

1. One “area of gray” involves the process of IA case workers calling PromiseShip Utilization Management for services during the SDM Safety/Risk Assessment process before the IA case is closed. When UM agrees with the services requested by IA and proceeds to assure the services are provided there is no problem. In cases where UM does not agree with the services requested by the IA case worker, the services provision process can proceed without timely UM feedback to the IA case worker on changes to the services requested allowing for IA case worker input. IA still has full case management responsibility during these circumstances.
2. Another “messy” process point involves In-Home cases after the process of transferring full case management responsibility from the Eastern Service Area Office to PromiseShip has been completed. When a new allegation of child maltreatment is determined after case transfer PromiseShip may call the Hot Line based on state law mandatory reporting requirements and may prepare an affidavit that should be reviewed by DCFS. We heard concern from Hot Line leadership that there is some ambiguity regarding the correct application of Protection and Safety Procedure #33-2012: “Subsequent Intakes on Current Initial Assessments” (10/16/12) and the lack of available IT licensed technology for face to face communication with the Hot Line during these circumstances in the Eastern Service Area when it is available across the rest of the state. We heard several process concerns about ambiguity regarding which organization does the case work for a resulting Court Case for a new maltreatment allegation under these circumstances as well as issues with timely documentation into NFOCUS by IA or PromiseShip for the new allegation and related important information. Immediate issues are worked out at the supervisory level. However, systemic ambiguity appears unresolved. Eastern Area Office and PromiseShip case work supervisors also agreed there is often ambiguity about responsibility for such tasks as transportation and moving the child/youth’s belongings during these types of cases.
3. There are several process points where staff do not always follow the process including making joint family visits and conducting warm transfers. We could not identify a

standard policy reference in the Eastern Service Area Operations Manual regarding joint visits and warm transfer of In-Home cases.

12.5. Opportunity to Expand AR, Community Referrals, and Voluntary Non-Court Cases

With this understanding of the process flow for a case, TSG asked DCFS for data to breakdown what types of cases are transferred to PromiseShip, as defined by various safety/risk combinations assessed using the SDM tools. Table 32 illustrates the cases that were transferred to PromiseShip in 2018 (as either court or non-court cases) and cases that were not (either referred to Alternative Response or closed), by risk level.

Generally, there are patterns, which suggest consistency in how DCFS assesses and transfers cases. For example, most cases with a finding of “conditionally safe with a plan” and “unsafe” are transferred to PromiseShip regardless of risk, and most cases with a finding of “safe” are not transferred to PromiseShip. Of these cases, the typical cases that are transferred have “Very High” or “High” risk.

As the chart indicates, there are a non-trivial number of cases have the same risk level that are not handled the same. There are instances in which PromiseShip receives lower risk cases or does not receive higher risk cases, as might be expected. The occurrence of some of these variations is expected within an SDM framework. However, TSG finds as shown in the process maps above, that there are ambiguous decision nodes in the case transfer process where discretion influences the case transfer decision.

Table 32: Disposition of Eastern Service Area Intakes, by Safety and Risk Level, 2018

Safety & Risk Level	PromiseShip Involvement			No PromiseShip Involvement			Total
	Cases Transferred to PromiseShip (Court)	Cases Transferred to PromiseShip (non-court/Voluntary)	% PromiseShip Involvement	AR	Closed	% No PromiseShip Involvement	
Safe-Very High Risk	20	62	41.4%	15	101	58.6%	198
Safe-High Risk	51	273	31.0%	53	669	69.0%	1,046
Safe-Moderate Risk	24	12	3.9%	66	812	96.1%	914
Safe-Low Risk	1	2	1.8%	34	132	98.2%	169
Safe-No Risk Determination	2	3	27.8%	3	10	72.2%	18
(Conditionally) Safe w/Plan-Very High Risk	9	58	90.5%	0	7	9.5%	74
(Conditionally) Safe w/Plan-High Risk	21	139	88.4%	1	20	11.6%	181
(Conditionally) Safe w/Plan Moderate Risk	4	63	75.3%	0	22	24.7%	89
(Conditionally) Safe w/plan Low Risk	0	8	80.0%	1	1	20.0%	10
Safe w/No Risk Determination	1	1	28.6%	1	4	71.4%	7
Unsafe-Very High Risk	118	5	93.9%	0	8	6.1%	131
Unsafe-High Risk	91	17	93.9%	0	7	6.1%	115
Unsafe-Moderate Risk	29	3	91.4%	0	3	8.6%	35
Unsafe-Low Risk	6	0	85.7%	0	1	14.3%	7
Unsafe-No Risk Determination	25	0	96.2%	0	1	3.8%	26
No Safety Decision-Very High Risk	0	0	#DIV/0!	0	0	#DIV/0!	0
No Safety Decision-High Risk	0	2	100.0%	0	0	0.0%	2
No Safety Decision-Moderate Risk	0	0	#DIV/0!	0	0	#DIV/0!	0
No Safety Decision-Low Risk	0	0	#DIV/0!	0	0	#DIV/0!	0
No Safety Decision-No Risk Determination	10	2	15.2%	3	64	84.8%	79

Source: DHHS, December 2018

Table 33: Share of Cases Sent to PromiseShip, by Select Safety and Risk Levels, 2016 – 2018

	2016		2017		2018	
Safety & Risk Level	Sent to PromiseShip	Not Sent to PromiseShip	Sent to PromiseShip	Not Sent to PromiseShip	Sent to PromiseShip	Not Sent to PromiseShip
Safe-Very High Risk	40.0%	60.0%	36.2%	63.8%	41.4%	58.6%
Safe-High Risk	26.5%	73.5%	30.5%	69.5%	31.0%	69.0%

Source: DHHS, December 2018

TSG also examined initial assessments with a subsequent Substantiated Maltreatment by safety/risk level and disposition. The far column “Initial Assessments” presents the rate of maltreatment recurrence (12-month) by safety/risk level and then each of the columns presents the rate for each of the interventions (i.e., the cases sent to PromiseShip and cases not sent to PromiseShip). Overall:

- The recidivism rates among cases sent to PromiseShip are highest for the Safe with “Very High” and “High” risk and Conditionally Safe with “Very High” risk. Cases with similar risk levels that are referred to AR or closed have lower rates of maltreatment recurrence (potentially due to the fact that the reason they scored this way was more due to history than a current issue).
- The rate of maltreatment recurrence for families served by DCFS through the Alternative Response model was 0%.
- The rate of maltreatment recurrence for cases closed by the Department was low, with the exception of Conditionally Safe with a Plan “No Risk Determination” and Unsafe “Very High” risk.

TSG finds that DCFS’ strategy to use AR and referrals to community programs is not driving recidivism (though this data is lagged two years and should be monitored closely). In addition, TSG finds that DCFS’ strategy has cost savings potential.

If DCFS can refer appropriate cases to community services (where case management is not needed and evidence-based services are not needed), this saves a monthly average of approx. \$3,100 if the case was otherwise going to be sent to the vendor for full case management. Based on the average life of a case, this could cut the monthly average cost in half based on experience in other states (\$1400 per case - Texas FBSS). (*Note: TSG is working on getting this final estimate from Nebraska for final report.*)

In addition, there is a need for a third option: referral to the vendor so the family may access evidence-based services, with case supervision verses case management. Experience from other states such as South Carolina suggests this is also a cost-effective option to consider for some families. For example, in South Carolina, the state uses case supervision with evidence-based services such as the Specialized Alternatives for Families and Youth (SAFY) program, which provides statewide community-based child welfare prevention services at a cost of \$1,460 per family.

Taken together, the cost savings potential of employing these three options provides more reason to clarify the case transfer process so DCFS can be assured that cases that should go to the vendor do, and that cases are assigned the appropriate level of case oversight to ensure family needs are met with the most cost-effective approach.

Table 34: Initial assessments with a subsequent Substantiated Maltreatment, Eastern Service Area Intakes, 2018

Safety & Risk Level	Cases Transferred to PromiseShip (Court)	Cases Transferred to PromiseShip (non-court/Voluntary)	AR	Closed	Initial Assessments
Safe-Very High Risk	10.0%	8.1%	0.0%	4.0%	5.6%
Safe-High Risk	15.7%	3.7%	0.0%	1.5%	2.7%
Safe-Moderate Risk	4.2%	0.0%	0.0%	1.2%	1.2%
Safe-Low Risk	0.0%	0.0%	0.0%	0.8%	0.6%
Safe-No Risk Determination	0.0%	0.0%	0.0%	0.0%	0.0%
(Conditionally) Safe w/Plan-Very High Risk	33.3%	3.4%	0.0%	0.0%	6.8%
(Conditionally) Safe w/Plan-High Risk	0.0%	7.2%	0.0%	0.0%	5.5%
(Conditionally) Safe w/Plan Moderate Risk	0.0%	1.6%	0.0%	0.0%	1.1%
(Conditionally) Safe w/plan Low Risk	0.0%	0.0%	0.0%	0.0%	0.0%
(Conditionally) Safe w/plan No Risk Determination	0.0%	0.0%	0.0%	25.0%	14.3%
Unsafe-Very High Risk	2.5%	0.0%	0.0%	12.5%	3.1%
Unsafe-High Risk	1.1%	0.0%	0.0%	0.0%	0.9%
Unsafe-Moderate Risk	0.0%	0.0%	0.0%	0.0%	0.0%
Unsafe-Low Risk	0.0%	0.0%	0.0%	0.0%	0.0%
Unsafe-No Risk Determination	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-Very High Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-High Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-Moderate Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-Low Risk	0.0%	0.0%	0.0%	0.0%	0.0%
No Safety Decision-No Risk Determination	0.0%	0.0%	0.0%	3.1%	2.5%
Grand Total	4.4%	4.3%	0.0%	1.6%	2.4%

13. PATH FORWARD

Based on what the existing vendor has been able to achieve and despite the obstacles that have emerged in the current outsource model, TSG recommends that, should Nebraska continue to use an outsource model in the ESA, DCFS should make some important changes in the manner in which it manages the vendor relationship, which could allow the state to realize the benefits of outsourcing more fully.

Should DCFS continue with the current ESA outsource model, TSG has developed an actionable road map to help DCFS move forward in partnership with the vendor selected to ensure the state maximizes the value of the outsource model. This path includes the following components:

- Clear vision
- Stakeholder engagement
- Performance-based contract with transparency
- Transformed contract oversight model
- True collaboration between DCFS and vendor
- New process for handoff and case supervision
- Utilize innovation to lower costs and improve outcomes
- Prepare for and meet FFPSA
- Improve coordination with Medicaid

TSG’s overarching recommendation is for DCFS to prioritize real collaboration with the ESA vendor so that the two entities can partner in addressing any issues as they occur in real time.

One example is for the two entities to work together to develop a new case transfer process that is efficient and maximizes the chance for a successful case outcome (i.e., how can IA staff help permanency objectives? How can the vendor simplify the process for DCFS? How can the vendor have knowledge of the process so staff can anticipate the types of cases that will transfer)? How can DCFS ensure adherence to the process?)

Overall, TSG observes that building this sort of collaboration will require:

Both DCFS and the vendor to be held jointly accountable for improving family safety in the whole state, and especially in the ESA, with the goal of long-term success and improvement.

DCFS and the vendor must work together to overcome the current culture of “we/they” silos. The relationship must be redefined as a joint effort of shared success, not a “vertical competition.”

Systems must be adapted for collaboration and knowledge sharing. For example, the vendor must have access to data extracts/custom reports from N-FOCUS. DCFS should learn from the benefits of systems like FAMCare as a case management system—and work together with any future vendor to find a unified systems strategy

The case management process must be integrated. This is not merely the electronic systems, but staff from DCFS and the vendor. It is more than a common record of case assignments and events.

Accountability must clearly require both DCFS and the vendor to achieve better family safety in the whole state, and especially in the ESA. For example, the vendor should be accountable for transferring the innovative solutions that have proven successful to create best practice models statewide.

13.1. Vision

1. Establish a clear vision for the ESA outsource.

As DHHS/DCFS considers a new sourcing relationship, it should have a plan for the benefit of the model. Essentially, benefit happens when the outsourced relationship achieves something the state could not have on its own. The state needs to work with the new partner to define where benefit might come from. The plan must include a clear vision for outsourcing that includes a method for:

- Managing and/or reducing costs;
- Measuring, managing and improving outcomes; and,
- Working together like private-sector partners do to improve performance.

This vision should shape not only the RFP and contract, but also the approach to contract oversight. A vision should describe what the vendor plans to do differently to achieve better results collaboratively. It would describe where the State will encourage innovation and the few areas where innovation is not permitted. It would spell out the outsourcer's responsibility for sharing the goals and how each could support their partner.

Unless DHHS/DCFS fixes the lack of vision, any future outsourcing will likely repeat the mistakes highlighted in this and prior reports. DCFS needs to establish the foundation and process for on-going knowledge of and control over its partner's success. This means that DCFS and the vendor become partners, moving toward shared success, and never competitors.

2. Engage stakeholders around the vision.

A future procurement will present an opportunity for DCFS to start fresh in the inclusion of stakeholders in its vision not only for the purpose of the outsource (i.e., why the state is continuing to outsource, what it hopes to gain), but also its approach to contract oversight.

If Nebraska desires to create a community-based care model where the community takes ownership and accountability for child welfare outcomes, as Florida and other states have done, DCFS should begin by engaging ESA stakeholders to establish consensus and shared ownership of its vision for the outsource. This will be especially important if the state successfully

implements a performance-based contract. Performance-based contracting is relatively new for child welfare providers and many stakeholders and service providers may not be familiar with the concept. DCFS should take a proactive role in managing this significant shift towards collaborative success.

To make this recommendation concrete, TSG suggests the following:

- Stakeholder meeting prior to the RFP release if time allows;
- Community forum and ongoing engagement post-RFP release;
- Establishment of regular, ongoing stakeholder meetings facilitated by DCFS for stakeholder input on how the outsource is functioning;
- Requirement that the vendor increase its stakeholder engagement efforts also by submitting a robust Stakeholder Engagement Plan and implementing the strategies contained therein.

13.2. Performance-Based Contract

3. Create an improved, performance-based contract.

TSG reviewed other state performance-based child welfare contracts and past iterations of the DHHS/NFC (PromiseShip) contract and identified a number of best practice elements that would improve Nebraska's service delivery. TSG recommends enhancement of the RFP/contract with the following elements:

- Clearly articulate DHHS/DCFS' vision in the RFP and contract.
- Include performance objectives, metrics and outcomes, and provide for a mechanism to assign financial incentives/penalties to performance.
- Require the vendor to develop an array of services to meet federal FFPSA requirements, which will ensure Nebraska maximizes federal funding opportunities.
- Include financial controls that were including creation of a Utilization Management function at DCFS and financial reporting requirements.
- Require transparency in contract outcomes. Provide quarterly reports on DCFS website for stakeholders to access.
- Develop a clear data sharing collaboration that allows a learning culture that reinforces the vision and builds focus on shared success.
- Include requirements for a transition process, based on requirements contained in the Florida case management outsource (provided in Contracts Review section) or Medicaid managed care organization contracts.
- Strengthen contract elements related to provider evaluation, including areas such as:
 - The agency's Cost Allocation Plan,
 - Financial transactions (validation of whether they are reasonable, allowable and eligible for federal reimbursement)
 - Timeliness and Effectiveness of Case Intake and Transfer Activities

- Case Management
- Consent for Services and Release of Information
- Purchased Client Services Array
- Quality Assurance Plan and Activities
- Service Network Monitoring
- Workforce Development Plan
- Validation of Self-Reported Performance

In addition, in the contract going forward, DCFS needs to ensure that there is a transition plan requirement so that, if, for some reason the vendor no longer offers the service the vendor is required to submit a transition plan prior to any contract ending date.

13.3. Contract Oversight

While DCFS initially took a limited approach to contract oversight which was difficult to overcome, TSG recommends implementation of strong oversight approach from the beginning of this contract. This approach will integrate Contract Monitoring, Continuous Quality Improvement, and Finance resources to provide a comprehensive means to oversee and drive performance in the ESA and statewide. This effort will focus not on compliance but shift towards a model of shared solutions that resolve problems and improve performance not just in ESA, but across the state.

4. Create an integrated Quality Assurance Team (QAT).

To address fragmentation of existing contract oversight resources, DCFS should establish a team consisting of staff from Contract Monitoring, CQI, Finance, as well as Eastern Service Area administrators. This team should meet internally at least monthly to review vendor performance. At least quarterly, the team should meet with the vendor to discuss findings and opportunities for improving performance.

5. Designate appropriate resources and clarify the responsibilities of all of the resources on the QAT.

DCFS leadership should designate the following roles and clarify their responsibilities in the oversight of the ESA outsource contract:

- Contract Manager – DCFS should designate a single entity as responsible for all contract oversight, including requiring the vendor to complete Performance Improvement Plans (PIPs) and the assessment of financial incentives and remedies. This individual should lead the QAT and attend all internal and external meetings with the vendor.
- Contract Monitor – The Contract Monitoring Team should designate one full-time contract monitor to the ESA outsource contract. This individual should be responsible for conducting on-site visits with the vendor, monitoring vendor compliance with new

contract requirements, using a new contract monitoring tool and working with the vendor to build a collaborative relationship towards the shared vision.

- Continuous Quality Improvement Team – This team should designate the appropriate level of staff resources to conduct oversight of the quality of the vendor’s performance through data analytics and live case reads.
- Finance Administrator – DCFS should fill a dedicated Finance Administrator position. This position should be responsible for developing, clarifying and reviewing vendor financial reports and reconciling vendor financial data with DCFS financial data. In addition, this position should advise the QAT on the amount of financial incentives and remedies to provide, based on the vendor’s performance.
- Regional ESA administrator/leadership team – On a day-to-day basis, the Regional ESA administrator/leadership team is responsible for resolving issues as they occur between DCFS staff and the vendor. The Regional ESA administrator provides the QAT with input on the vendor’s operations.

DCFS leadership should ensure that each of the functional areas included in the QAT remain sufficiently resourced to maintain strong fidelity to the mission and that they remain independent in the execution of their responsibilities.

6. Empower the QAT with the authority needed to carry out roles and responsibilities.

TSG found that previously, DHHS’ contracts and Operations Manuals included best practice components, but that dilution of contract requirements and a lack of enforcement prevented the state from realizing the benefits of the contract and left the focus on compliance and not improving performance. The QAT needs to have clear direction and consistent support from DCFS leadership so that it can carry out its roles and responsibilities and implement the contract provisions as intended in achieving the vision for the outsource model.

7. Develop Contract Monitoring staff to engage in performance-based contract monitoring.

Use training and professional development opportunities to develop staff working in the contract monitoring capacity to enable them to participate fully on the QAT and engage in on-site monitoring using a new contract monitoring tool. Consistently work to ensure that QAT staff are connected to the vision and the goals of the model.

8. Develop a new contract monitoring tool.

Develop a new contract monitoring tool aligned with new contract requirements and vision to help the Contract Monitoring staff conduct duties, including on-site visits.

9. Transform CQI from maintaining federal compliance to managing family safety.

When privatization began a decade ago, Nebraska struggled, as did many other states, to achieve compliance with federal outcome targets. The notion of these metrics was that if predefined targets were achieved, then the money spent on child protective services would be achieving an outcome.

To some extent, this flies in the face of the quality revolution in the private sector. Ed Deming and others proved to private companies in the 1980s that arbitrary production goals always reduced performance. (Deming started his career in a federal agency.)

The quality revolution brought to the private sector a new wave of data analysis: statistical process control, averages, variances, control limits, etc. During that same time, private sector cost accounting added a dimension and became Activity-Based Management, determining how process drives costs. To date, DCFS has not changed its business process towards a statistics or cost accounting model that can be useful to improve case management. TSG found little analysis of historical case cost and performance data that could be used to improve outcomes or reduce costs. DCFS is still largely managing by simple target metrics imposed externally.

TSG finds that Nebraska's CQI function has driven significant performance improvement over time and staff are capable and engaged in ongoing systems improvement today. However, the state has not been able to adopt many of the best practices in data analytics used in the private sector and may need additional resources to obtain these marketplace capabilities. A true public-private partnership with a vendor who is using advanced analytics may also offer DCFS an opportunity to benefit in a way it may not be able to on its own.

To conduct the level of analysis it should be doing today, DCFS will need to:

- Build a cross-functional team of analysts;
- Invest in capabilities for advanced data analytics;
- Work collaboratively with the vendor and other private groups;
- Collaborate with other state agencies who share the responsibility for supporting healthy families: Medicaid, mental health, public health, etc.; and,
- Iterate through many generations of learning. This should become a core competence of child welfare services.

10. Use CQI staff to conduct live case reads of the vendor's in-home and out-of-home cases.

Staff already perform case reads for CFSR purposes; this recommendation would be to dedicate some resources to sampling live vendor cases each quarter and provide real-time feedback to the vendor to enable action to be taken immediately to address any issues identified. These reads would give DCFS insight into the quality of case management performed by the vendor.

11. Develop the tools to enable data-driven oversight of the vendor.

The CQI Team should design a vendor scorecard containing key performance indicators (as included in the contract), financial data, and any operational metrics to facilitate the QAT's review.

12. Continue with plans to reinstitute quarterly state and ESA CQI meetings to facilitate collaboration with the vendor's CQI team and other providers.

The DHHS CQI Team should facilitate meetings with the vendor's CQI team, as well as providers, on a quarterly basis at the state-wide level, as well as in the ESA. This will provide for sharing of findings and coordination of resources. TSG understands that the State Office CQI leadership has recommended reinstituting these meetings for 2019.

13. Collaborate with the vendor to establish joint CQI activities.

The DHHS CQI Team should work with the vendor CQI Team to maximize resources available for systems improvement activities. Especially given the state's focus on CFSR reviews, DHHS could delegate monitoring of in-home cases to the vendor and could apply findings to other Service Areas.

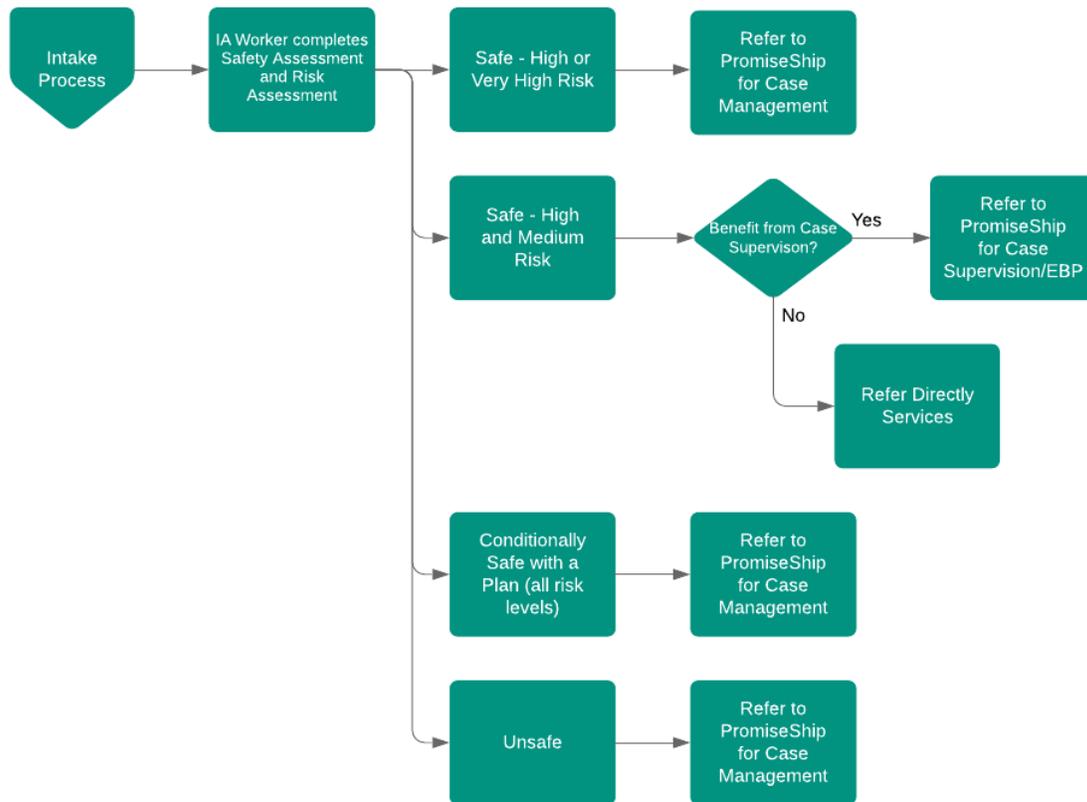
14. Improve collaboration with the vendor on financial management.

- Collaboration: DHHS should lead the way in finding ways to work together on the key issues of financial management: turnover, provider payment, case cost and performance analysis. Collaboration requires an approach to contracting that is quite different from what DHHS has done with the existing vendor in the past. It requires joint work teams, combined quality management, combined efforts to improve analysis. All these must be built on a foundation of trust and respect.
- Shared systems: TSG is well aware that federal rules require that N-FOCUS continue to serve as the official record of provider payments and case activity. However, this need not mean that the vendor is relegated to re-entering information manually and getting no access to custom N-FOCUS reports. The new contract should re-engineer the way systems are used. Ensuring that numbers tie together, eliminating duplicate effort, supporting advanced cost analysis (e.g. Activity Based Costing) and tying costs and performance across the whole system.

15. Develop a multi-tiered case management model, which will maximize cost effectiveness.

DCFS continues to refer more families to AR/non-voluntary community services and is examining closely which cases actually require case management. DCFS can take this concept further through the creation of a three-tiered case oversight model, as shown in Figure 36.

Figure 36: “To Be” Case Transfer Process



In this model, the levels of case management include:

- Highest level: Case management, referral to vendor
- Mid-Level: Case supervision and evidence-based service, referral to vendor (lower rate than case management)
- No case oversight: Direct referral to service provider

Other states, such as South Carolina, have used this approach to achieve significant cost savings – the average monthly payment for case supervision was \$1,460. In Nebraska’s case, if the average monthly payment to a vendor is \$3,100 today and the average in-home case is approximately three months, DCFS can expect to pay \$9,300 per case that receives case management. If a case supervision rate is established on par with South Carolina’s of \$1,460, the per case savings is estimated to be \$4,920. If a family is referred directly to a community provider, the savings would be even greater.

It is important to note that this comparison is based on the rate Nebraska has in place today. If Nebraska establishes two rates for case oversight (case management and case supervision), it is likely that the case management rate will increase above \$3,100. The current rate is a blended rate for all acuity levels, and if the less complex cases are not included, the cost for the cases requiring case management will increase.

16. Monitor recidivism of families by level of case oversight provided to ensure safety.

DCFS should continue to monitor whether maltreatment recurrence occurs, and by level of case oversight provided, to ensure that families receive the most appropriate level of case oversight.

17. Provide more structure to the case transfer protocol to ensure consistent referrals of appropriate cases to the vendor occurs.

DCFS should revisit the case transfer protocol (specifically the decision node of whether a family requires case management) to ensure consistent criteria are used in this determination. DCFS may consider creation of an internal Utilization Management function for the purpose of ensuring cases are initially classified into the appropriate level of case management and regularly reviewing instances in which families need to move to different level of case oversight (such as from case supervision to case management).

13.4. FFPSA Compliance

There remain to be significant “unknowns” and assumptions surrounding the path to implement the FFPSA at the federal and state levels. For instance, while the Act indicates there will be funding available to implement evidence-based services at the state level, it is unclear whether this funding can be extended to fund the implementation services not yet listed on the federal Clearinghouse but identified in an approved state plan.

While one can presume the Clearinghouse will most-likely approve the twelve interventions currently under review by Spring 2019, it is uncertain when additional services, particularly those potentially meeting the promising or supported levels, will be identified for review or how long it will take for those services to be approved by the Clearinghouse.

18. DHHS should require the vendor to begin to develop a comprehensive array of well-supported, evidence-based services and ensure any future contract has meaningful consequences for the ESA vendor not meeting FFPSA standards

As the entity responsible for the largest population of children and families engaged in child welfare services, it is imperative that the vendor begin to support the development of a comprehensive array of available well-supported, evidence-based services aligned with the provisions of FFPSA. This is not an explicit current contract requirement, however the outsource partner must begin working to build capacity to ensure conformity to the federal law. Services

selected should be aligned with prevalent needs of families with children at imminent risk of removal and be implemented with a focus on fidelity to the model.

The current vendor should make reasonable efforts to expand its in-home prevention efforts to ensure that the entire state will be able to meet the federal prevention programming standards, and the State should ensure in any future contract that the ESA vendor is held responsible for any loss of federal funds due to insufficient array, preparedness or other factors.

19. Develop a statewide plan to implement interventions capable of addressing gaps in the service array or level, in collaboration with the vendor.

Collaboration with the outsource vendor will be critical, as the state’s Title IV-E Prevention Plan will need to be aligned with, and reflective of, services provided in the ESA. To this end, a statewide plan to implement interventions capable of addressing identified gaps in the available service array, either in service type (focused on mental health, substance abuse, or parenting) or level (promising, supported, well-supported) should be developed.

In the event the plan includes services which are not currently under review by the Clearinghouse, DCFS and the vendor should work with the model developer to create a program summary which provides evidence identifying how the intervention meets the intent and requirements of FFPSA. Such effort may facilitate review and approval of the service by the Clearinghouse.

20. Develop a roadmap for implementing selected services.

Selected interventions require funding and time to implement. Model developers, especially those already identified by the Clearinghouse, have limited capacity to train providers and it is important DCFS and the vendor get ahead of other states in their requests to these developers.

Finally, the ESA has the most robust provider capacity in the state. As a result, undue burden may be placed on the Area to support the state’s requirement to expend 50% of funds on well-supported interventions. This should be considered in the development of the statewide plan and reflected in the vendor’s efforts to meet FFPSA expenditure requirements.

21. Develop a statewide plan for evaluation of selected services or request a federal waiver of the requirement to evaluate well-supported services.

Not only will the evaluation of selected services require funding but may necessitate partnerships with universities or other qualified organizations capable of completing research-based outcome assessment which rise to the level required by FFPSA. DCFS should develop this evaluation in partnership with the vendor.

22. Align provider agreements with FFPSA requirements and collect payment data by intervention.

The outsource vendor and DCFS must align subcontracted provider agreements with the intent of FFPSA and collect payment data by intervention. The current vendor presently pays many in-home service providers a case rate and is unable to identify payment for specific evidence-based interventions if that provider offers multiple interventions. Going forward, reimbursement should only be available for interventions approved by the Clearinghouse, therefore contractual payment structures must be aligned with this requirement.

23. Maximize federal funding by licensing relative caregivers.

During FY2018, the existing vendor reports spending \$3.18 million for relative/kinship providers caring for title IV-E eligible children. PromiseShip reports having a strategy to work with these caregivers to support efforts to license them in accordance with requirements articulated in FFPSA.

Supporting efforts to license of relative/kinship caregivers may necessitate changes to state licensing statute or policy. PromiseShip should continue to work in partnership with the statewide FFPSA workgroups to recommend and advance changes capable of expediting licensing these relative caregivers. Doing so will support maximization of federal title IV-E claims.

13.5. Improve Coordination With Medicaid

The importance of readily available medical, behavioral health, and specialty services cannot be overemphasized for children/youth removed from their homes as a result of a child protective services investigation. Often these children have serious, untreated trauma-related and behavioral health needs, as well as physical health needs.

The pervasive prevalence of behavioral health needs among children/youth in state foster care programs, estimated as high as 80%⁴³, has spurred many states to actively improve the operational relationship between the child welfare lead agency and the state Medicaid lead agency resulting in integrated child welfare tailored delivery models through managed care.

Through TSG interviews with state DCFS workers, supervisors, and providers; meetings with several divisions of DHHS; conversations with Judges, CASA, and Guardian Ad Litem; and our review of the current Nebraska Medicaid managed care organization (MCO) contract in comparison with several other state Medicaid MCO contracts (e.g. Texas, Washington, and Florida), TSG has identified the following gaps:

- Lack of connection between DCFS and the state Medicaid agency.
- General opinion of caseworkers that MCOs are not responsive when Behavioral Health services are needed.

⁴³ National Conference of State Legislators: Mental Health and Foster Care; 5/9/2016

- There is a lack of access to specific types of Behavioral Health services, such as Multi-Systemic therapy or waiting lists if the service is available.
- Caseworkers fill the gap and try to find services, as opposed to the MCO serving in this role.
- Medical necessity is often used by the MCOs for residential services discharge purposes for the highest Behavioral Health risk children/youth without a community based plan of care provided through the MCO, leaving DCFS with the medical and psychiatric responsibility for finding adequate care to maintain safety and well-being, often resulting in expensive out of state placements.
- Although MCOs and the Division of Medicaid & Long Term Care host scheduled meetings concerning high needs DCFS children and youth on a case by case basis, these meetings are not as effective as they could be given that the MCOs are limited by the current benefits structure and MCO contractual responsibilities.

Nebraska DHHS has the need, opportunity, and the expertise to develop an integrated Child Welfare Medicaid benefit and delivery structure within its existing Medicaid managed care program. This will ensure timely access, targeted care coordination and case management for high risk/high needs children/youth, and improved access to behavioral health evidence-based treatment models.

In response to these gaps, TSG recommends that:

24. DHHS should create an on-going Child Welfare Leadership Team composed of DCFS, DM & LTC, DBH, and DDD.

The purpose of this team would be to develop a planning path forward for child welfare centric improvements to the next generation Nebraska managed care contracts, focused on improving access; MCO active care coordination for high needs/high risk children and youth; MCO responsibility for finding accessible services in real time; development of Behavioral Health Evidence Based Practice/Best Practice provider capacity based on value based payments and incentives for outcomes; improved use of shared data, and the development of an MCO electronic case record of DCFS enrolled children and youth similar to the Texas Health Passport.

This record would be available for providers, supporting integrated and continuous care, and for DCFS/vendor case workers, supporting due diligence monitoring and active support for each out of home child/youth's overall health, EPSDT periodicity compliance, and Behavioral Health and specialty needed services.

25. Consider adapting the two-week requirement to a 72-hour requirement for a face-to-face assessment of the child's immediate medical status.

Currently state law requires a medical examination within two weeks of a child's removal from their home.⁴⁴ Several states are moving in the direction of a more immediate assessment. The shorter timeframe would ensure that children are connected to services more immediately upon entering care.

26. Improve data sharing between DCFS and DM<C, about Medicaid utilization of children in foster care.

We have observed that currently there is little capacity to analyze data across both Divisions. During our on the ground work we participated in several meetings where we requested data from Medicaid claims specific to the child welfare enrolled children/youth population, specifically Medicaid utilization by DCFS children and EPSDT periodicity compliance. In another instance we requested data from PromiseShip billings to the MCOs. In both instances we have been unable to access this data during the time period of this project.

Improved data sharing and the implementation of a shared data platform that would include the ESA vendor, would substantially work to make better more timely decisions on interventions, which would benefit the state both in terms of lower costs and improved outcomes. This should be an internal priority within DHHS.

⁴⁴ Nebraska Rev. Statute 43-1311

14. APPENDIX A: COMPLETE REVIEW OF PRIOR AUDITS AND REPORTS

TSG reviews past audits and reports as a foundation for its own assessment. This are presented in reverse order. The purpose of TSG briefing of these report is to glean implications, not to merely repeat the findings. For details, readers are encouraged to read the documents themselves, which are cited in the text.

14.1. State Auditor of Internal Accounts, 2018

The State of Nebraska, Auditor of Public Accounts published on August 3, 2018, “Attestation Report of the Nebraska Department of Health and Human Services Program 354 – Child Welfare Aid, July 1, 2016, Through December 31, 2017.”⁴⁵

The audit reported that total ESA (PromiseShip) expenditures had risen since 2008:

Table 14-1: PromiseShip Payments According to Audit Report

	FY 2008	FY 2013	FY 2017
Eastern/NFC	\$41,819,920	\$51,349,900	\$63,311,114
Other Areas/DHHS	\$65,509,969	\$68,663,179	\$61,470,119
Eastern/NFC wards ⁴⁶	2,683	2,228	1,960
Other/DHHS wards	4,260	3,432	2,438

This table signals two very important questions: why are PromiseShip costs increasing while costs for other areas seem to be declining. The auditor did not divide reported costs by the number of wards to factor out the effect of changes in case volume. TSG simply used the auditor’s costs and case units in the table below. It shows ESA cost per ward more than doubling from \$15,587 to 32,301.59. That represents a compound annual growth rate⁴⁷ of 8.5%. This is much faster growth compared to the other regions, which have grown at 5.8% per year. In 2008, the cost per ward was about the same in ESA, \$15,000. Today, the \$32,000 PromiseShip cost per ward is 28% higher than the cost per ward for the rest of the State.

⁴⁵ Report available at” http://www.auditors.nebraska.gov/APA_Reports/2018/SA25354-08032018-July_1_2016_through_December_31_2017_Attestation_Report.pdf

⁴⁶ The term “ward” is used in various manners within child protective services. As used here, TSG surmises that the auditor means youth, as distinct from case

⁴⁷ Compound annual growth rate (CAGR) is the annual rate by which the initial value would grow over the number of periods to reach the ending value

Table 14-29: Annual Costs per Ward Calculated from Information in Audit Report

	Annual Cost/Ward			CAGR
	FY 2008	FY 2013	FY 2017	
Eastern Cost/wards	\$15,587.00	\$23,047.53	\$32,301.59	8.5%
Other DHHS Cost/wards	\$15,377.93	\$20,006.75	\$25,213.34	5.8%

The audit acknowledged that a 2014 legislative report had identified cost issues and called for a restructuring of the region, but that no restructuring had happened and that the contract had been extended without bid.

The audit reported several adverse findings, some of which seemed to TSG that they were related to PromiseShip and others to DHHS performance (indicated by parentheses):

1. (PromiseShip) Errors. Of 113 claims randomly selected and paid through NFOCUS, 45 lines tested had errors, a 40% error rate.
2. (PromiseShip) Unreasonable Expenditures:
 - The NFC contract was not competitively bid
 - Monitoring of contract requirements was inadequate
 - A contract amendment contained a provision requiring DHHS to reimburse NFC's losses above \$400,000
 - \$1,110,337 in questioned costs, including payments for fundraising, gifts, entertainment, and meals
 - NFC ordered 155 computers for \$216,735 on 6/29/2017; however, the contract with DHHS ended on 6/30/17
 - Many more items reported
3. (PromiseShip) Duplicate, unsupported and overclaims. The auditor tested 45 claims and noted questioned costs totaling \$306,380, including charge for one client that totaled \$274,562.59
4. (PromiseShip) Activity Not recorded accurately in NFOCUS. NFC explained that it did not record certain accounts in NFOCUS; these accounts totaled \$1,677,374 during fiscal year 2017
5. (DHHS) Federal funds not fully utilized for adoption assistance. At least \$962,485 which DHHS failed to charge Federal funds for respite care costs arising from adoption assistance agreements
6. (DHHS) Spending authority exceeded. As of June 30, 2017, DHHS had exceeded its appropriated spending authority by at least \$8,744,997
7. (DHHS) Inadequate support for rates: Rates for various child welfare services totaling millions of dollars were not adequately supported
8. (PromiseShip?) Payments more than two years after service: Auditors noted 129 claims, totaling \$97,263.93

9. (DHHS) Contractual aid payments not adequately monitored: DHHS did not obtain adequate documentation to support expenditures paid to contractors and subrecipients. Seven of 10 payments tested were not adequately monitored
10. (DHHS) No evidence of contractor financial stability: Contrary to an express statutory requirement, DHHS did not obtain evidence of financial stability or liquidity before contracting

14.2. Letter to Senator Merv Riepe

Nebraska Revised Statute §43-440 required that DCFS provide a report of NFC (PromiseShip) performance⁴⁸. This was done most recently in a letter to Senator Merv Riepe. That reported outcomes in three groups:

- Outcome 1: Safety, PromiseShip exceed the federal target
- Outcome 2: Permanency, PromiseShip exceeded the federal target for two of three indexes, and failed on the third (timeliness and permanency of reunification)
- Outcome 3: Well-Being, PromiseShip exceeded federal target (though performance has been dropping over the past months)

In addition, DCFS assessed and reported results of having participated in the Federal Round 3 Child Family Services Review (CFSR) the week of June 5 – 9, 2017. This assessed 18 detail-level process metrics as well as seven outcomes. Results are reported below. The report shows many process elements for which PromiseShip falls short.

⁴⁸ This report is available at:
https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Health_and_Human_Services__Department_of/305_20180905-092602.pdf

Table 14-310: Child Family Services Review as Reported

ITEMS	DOUGLAS			OUTCOMES	ALL	Foster Care Only	In Home Only
	Overall Scores	Foster Care Scores	In Home Scores				
Number of Cases	33	20	13	Safety Outcome 1 (Item) (DHHS Only)	71%	73%	70%
Item 1 Timeliness of Investigations (DHHS Only)	71%	73%	70%	Safety Outcome 2 (Items 1 & 2)	58%	70%	38%
Item 2 Services to prevent Removal or Re Entry	82%	100%	67%	Permanency 1 (Items 4 - 6)	40%	40%	NA
Item 3 Risk and Safety Assessment and Mgmt	58%	70%	38%	Permanency 2 (Items 7-11)	70%	70%	NA
Item 4 Stability of Foster Care Placement	75%	75%	NA	Well-Being 1 (Items 12-15)	45%	50%	38%
Item 5 Permanency Goal	65%	65%	NA	Well-Being 2 (Item 16)	82%	89%	33%
Item 6 Achieving Permanency	45%	45%	NA	Well-Being 3 (Item 17 & 18)	55%	60%	44%
Item 7 Sibling Placement	81%	81%	NA				
Item 8 Parent/Sibling Visitation	71%	71%	NA				
Item 9 Preserving Connections	80%	80%	NA				
Item 10 Relative Placement	90%	90%	NA				
Item 11 Child/Parent Relationship	64%	64%	NA				
Item 12 Needs & Services (Child, Parent, Foster P)	48%	50%	46%				
Item 12A Needs & Services - Child	79%	90%	62%				
Item 12B Needs & Services - Parents	52%	56%	46%				
Item 12C Needs 7 Services - Foster Parents	65%	65%	NA				
Item 13 Child and Family - Case Planning	63%	68%	54%				
Item 14 Caseworker visit with Child	82%	90%	69%				
Item 15 Caseworker visit with Parents	52%	50%	54%				
Item 16 Educational Needs of the Child	82%	89%	33%				
Item 17 Physical Health of the Child	79%	80%	75%				
Item 18 Mental/Behavioral Health of the Child	59%	71%	38%				

14.3. Letter to Patrick O'Donnell, Clerk of the Legislature

Nebraska Revised Statute 68-1207.01 requires that DCFS submit an annual report to the Governor and Legislature outlining child welfare and juvenile services caseloads, factors considered in their establishment, and the fiscal resources needed to maintain them⁴⁹. This letter dated September 15, 2018 is that report. The report observed that 95.2% of ESA case workers are in compliance with caseload standards, highest in the state.

⁴⁹ See report at:

https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Health_and_Human_Services__Department_of/538_20180905-092427.pdf

Table 14-4: Case Work Compliance as Reported

Total Staff			
Average of June 2018			
Service Area	Total Staff	Staff In Compliance	Percent In Compliance
Central	60	57	95.0%
Eastern	208	198	95.2%
Northern	66	57	86.4%
Southeast	98	81	82.7%
Western	51	42	82.4%
State	483	434	89.9%
Green indicates improvement from prior month			
Red indicates regression from prior month			

This report is based on the following required caseload per worker:

- Out of home youth standard ≤ 16
- In home families' standard ≤ 17
- Initial assessment Standard ≤ 1 (does not apply to PromiseShip)

The report also presented that PromiseShip has the higher case worker tenure compared to the Southeast region, which is also urban. PromiseShip tenure is higher than some other regions, which is widely understood to be a reflection of the alternate job opportunities in urban areas.

14.4. Letter to Patrick O'Donnell, Clerk of the Legislature

Nebraska statute 43-4406 requires an annual report to the Legislature. This letter of September 15, 2017 is that report. This report presents a number of useful headcount metrics, costs, training metrics and the like. None of the information in the report is parsed in a manner that enables understanding the effect of outsourcing.

14.5. Nebraska Child Welfare Blueprint Report March 2017

14.5.1. Findings

This is an opportune moment in the evolution of state's child welfare reforms to continue strengthening the child welfare agency's response to the needs of children and families while also strengthening community capacity to meet families' needs. In short, now is the time to stay the course and continue making progress for Nebraska's children and families.

Keeping children out of foster care and safe and stable at home

- Home visiting is a powerful intervention that holds promise for reducing child maltreatment across the state, but it is not reaching all the families who could benefit.

Targeting these interventions to communities with high rates of child maltreatment could go a long way toward supporting families before maltreatment occurs.

- Bring Up Nebraska initiative is identifying best practices for implementing partnerships focused on prevention and will focus future efforts in counties with high rates of child maltreatment. Partners in the initiative include the DHHS, the Nebraska Children and Families Foundation (NCFE), the Office of the First Lady, the Child Abuse Prevention Fund Board, Casey Family Programs, and the Sherwood Foundation. Continued commitment to this effort will help Nebraska position itself as a national leader on prevention.
- An initial evaluation of Alternative Response (AR) showed promising results on some key measures. These include: children in AR have remained just as safe as children in traditional response, families receiving AR are more likely to receive appropriate services, and they seem to receive those services more quickly than families in traditional response.
- Key questions that should be addressed as the state continues to expand AR include:
 - Are families able to access the services that meet their needs?
 - How many families involved with AR later become involved with the child welfare agency?
 - Does AR engage families in a voluntary process, or do families feel they don't have the option to decline services?
 - Do child and family outcomes improve as a result of the intervention?
 - How does the AR approach of working with lower risk families inform future prevention efforts, such as how to identify what families need to prevent deeper systems involvement?

Ensuring children and youth in foster care are safe and their needs are met

- All caregivers, whether kin or non-kin, must have the training and support to meet the needs of children who have experienced trauma.
- The number of children in foster care who are placed in kinship care — relatives or close family connections — has grown steadily since 2012, from 28% in 2012 to 49% in 2015. Despite this impressive progress, there are some remaining concerns about the state's kinship care strategy.
 - There are still too many kinship foster parents in the state who are not licensed. Unlicensed kinship placements do not receive training and support and are also not eligible for federal Title IV-E foster care funding.
 - Family Finding practices are not consistently used across the state. There should be more consistent application of these strategies so that searching for and engaging family for children and youth in foster care is standard practice across the state.
 - Engaging all potential family connections early and effectively can prevent delays in children exiting foster care as quickly and safely as possible.

- Less than 8 percent of children in foster care are now in a group care placement, defined as any placement that is not with a family. Stakeholders should monitor whether children in group care are receiving the services that match their needs and pay close attention to how they are supported for transitions back to their families and communities.

Creating a sense of urgency so that all children and youth leave foster care to permanent, loving families and adult connections

- Families who have had their children returned to them and those who have adopted or granted guardianship of children need access to the same community supports to help children and youth heal from trauma.
- Through the Eyes of the Child Initiative (TTEOC), has helped remove systemic barriers to timeliness of court hearings for children in foster care, but delays remain that must be addressed to help children leave foster care safely and quickly. Areas for improvement identified by stakeholder groups include:
 - Additional court staff to schedule hearings within required deadlines, particularly in regions with large child welfare populations.
 - More timely filing of Termination of Parental Rights (TPRs) to prevent delays in adoption.
 - On-going training and education for judges and attorneys on the impact of court timeline on outcomes for children and families, and adherence to progression standards for juvenile courts, recommended by the Supreme Court Commission for the Protection of Children in the Courts.
 - More consistent efforts to ensure legal representation for every youth and to engage young people in court.
- The Barriers to Permanency Project, initiated in 2013, resulted in a comprehensive review of children who had been in foster care for 3 years or more and identified the top barriers to helping children with timely exit from foster care. The review found that the three primary barriers were court delays, lack of caseworker continuity, and lack of relative searches early in the case. Resulting in:
 - 55% of the children whose cases were reviewed left foster care shortly after the review was completed.
 - DHHS made improvements to its computer systems to make relative searches easier and the findings of search efforts more accessible to caseworkers.
 - The time period for appellate court decisions decreased after an internal review of the appeals process prompted a change in procedures.
- Young Adult Bridge to Independence Act in 2013 extends services and support to youth aging out of foster care from age 19 to age 21 and allows them to choose whether or not to stay in foster care with case management support, Medicaid and a monthly stipend.
 - 89% of eligible youth participate in the program and almost two-thirds of program participants are either working or attending school.

- Only 16% of program participants qualify for federal Title IV-E funding. DHHS should
- strengthen their processes for assessing eligibility.
- More robust data collection protocols and a stronger evaluation design should be developed to accurately measure program success and better understand the experiences of youth in the program.
- It is critical that programs designed to build community networks for families be available to children after they return home or leave foster care for guardianship or adoption. The supports families need — when they need it — to prevent entry in or return back to the child welfare system.

Recommendations

Continued progress will be dependent on staying the course on the programs and policies that have already contributed to improved outcomes and doubling down on some of the more intractable challenges that continue to get in the way.

- Address gaps in behavioral health services for children and families. Gaps in substance abuse treatment and mental health services were two of the most commonly cited areas of concern.
 - Create a comprehensive plan to address substance use and child welfare involvement. Parental substance use is the second biggest reason children are removed from their families.
 - Focus on access to community based mental health services. Efforts to ensure statewide access to high quality mental health services in communities have fallen short. Access to trauma-informed and culturally responsive mental health services is a critical component of any child welfare system and must be available for both parents and their children.
 - More strategic use of Medicaid can be applied across the continuum - to prevent child welfare involvement, support children youth and families already in the foster care system, and to address the occasional crisis for children who have already left foster care but are still dealing with the impact of the earlier trauma they experienced.
 - The Nebraska Systems of Care Initiative (NeSOC), holds promise for continuing to monitor progress in accessing behavioral health services for children and families. The stakeholders involved in NeSOC are already in the process of mapping out available behavioral health services in the state and identifying gaps that need to be filled.
- Create partnerships with foster parents to meet children’s needs.
 - Support and training for all foster parents. Nebraska should assess the current capacity to provide foster parents with the knowledge and skill necessary to meet children’s needs and to be full partners in achieving better outcomes.

- Treatment foster care for children with serious social, emotional and behavioral issues is not a robust part of the continuum of child welfare services in Nebraska and currently, there is no payment structure to support it.
- Use of a combination of federal Title IV-E, Medicaid and mental health funding to support treatment foster care could help Nebraska reduce placement moves and achieve more timely return home, adoption or guardianship.
- Understand and address racial inequities.
 - Stakeholders recommended that the Nebraska Children’s Commission form a Race Equity and Inclusion committee to further examine racial disproportionality and provide targeted policy recommendations.
 - Future efforts should involve the tribes and the Indian Child Welfare Act Coalition.
- Address workload and turnover issues. The Office of Inspector General and the Foster Care Review Office have made several recommendations to improve workforce challenges:
 - Develop a formula to accurately measure current caseloads
 - Provide appropriate funding levels to support the right number of staff
 - Support an in-depth study of workforce issues
 - Providing adequate training, supports, and mentoring to retain staff
- Develop standardized data measures. In 2014, DCFS developed a monthly continuous quality improvement (CQI) process to standardize how performance outcomes are tracked. The process has begun to transform how the agency approaches service delivery and helps the agency prioritize resources and services. However, more standardization is needed.
 - Common data measures will go a long way toward ensuring that investments are targeted in the right places to improve outcomes for children and families.

Data would also track movement in and out of the child welfare system, referred to as longitudinal data, rather than relying on a specific point in time, which does not give a full understanding of children’s experiences while involved with the system.

14.6. OIG Annual Report, 2016-2017

In 2012, the Office of Inspector General of Nebraska Child Welfare (OIG) was created to provide increased accountability and oversight of the child welfare and juvenile justice System

and assist in improving system operations.⁵⁰ Much of this report covers topics unrelated to privatization.

Through investigations and reviews, the OIG reports having repeatedly uncovered evidence that high caseload and workload burdens, staff turnover, and vacancy issues for CFS staff have negatively impacted child welfare operations in Nebraska. The OIG has repeatedly noted in Annual Reports that DHHS has never complied with the minimum caseload standards required by Nebraska law since 2012.⁵¹ TSG notes that the message seems confused about caseloads, as the DHHS report to Patrick O'Donnell (reviewed below) suggests that 89.9% of caseworkers statewide and 85.2% of PromiseShip case workers were compliance with caseload standards (Note the date of this report, 6 years ago). OIG complains that DHHS (statewide) has not fully addressed recommendations related to staffing, especially supervisory staffing, at the Child Abuse and Neglect Hotline. OIG does recognize that its recommendations for enhancing efforts to reduce caseworker turnover have been fully implemented. None of the findings in the OIG annual report indicated problems especially linked to PromiseShip or privatization.

14.7. Hornby Zeller, 2014

In December 2014, Hornby Zeller Associates delivered a second report this one prepared for the Nebraska Legislative Council. This reported an evaluation of the privatization “pilot project”:

- Comparison of the performance of case management functions by Nebraska Families Collaborative (NFC) in the Eastern Service Area with that of the Department of Health and Human Services (DHHS) in the remainder of the State
- Analysis of whether case management should be a duty of the DHHS or performed by a private entity pursuant to a contract with the Department and whether the cost is reasonable, given the outcomes and cost of privatization
- Update to the information and data from the 2012 Assessment of Child Welfare Services in Nebraska report

This report began with speculation about the generic reasons for outsourcing Child Protective services. Years after-the-fact, the outsourcing was re-dubbed a “pilot” and Zeller projected objectives onto it. Their list is not bad, though the need to do that years down the road evidences the poor method by which outsourcing was launched in the first place. The report reminds us of what Lewis Carrol wrote, “If you do not know where you are going, then any road will get you there.” Except it seems in 2009 DHHS neither knew the destination, nor found a useful road.

⁵⁰ This report is available at:
https://nebraskalegislature.gov/FloorDocs/105/PDF/Agencies/Inspector_General_of_Nebraska_Child_Welfare/285_20170913-145750.pdf

⁵¹ Neb. Rev. Stat. § 68-1207.

Regarding outcomes, Zeller concluded there had been no benefit from outsourcing:

“At this point in the evolution of privatization in Nebraska, roughly five years since the start of the process and nearly three full years since the privatization of case management, it is clear that the outcomes achieved for families and children by NFC are no better than those produced by DHHS. Neither are they any worse.

“Noting that the results NFC has achieved are essentially the same as those DHHS produces does not, however, settle the question of whether privatization of the case management function should continue. If those results can be achieved at a lower cost, the State may still find privatization attractive, although that situation could no longer be characterized as a reform of child welfare.”

Regarding cost savings, Zeller concluded costs were lower for PromiseShip:

When we looked simply at the total costs of serving child welfare cases, we concluded that DHHS spends an average of \$98 per case per day, while NFC spends an average of \$75. These are total costs, without regard to the source of the funds, i.e., state or federal. [Zeller did not provide the basis for these numbers, nor was TSG able to replicate them.]

In addition, Zeller observed disallowances of federal Title IV-E funds, which cost Nebraska over \$20 million. These resulted from the structure of the privatization contracts where fixed payments were not linked to individual children and families.

Zeller laid out three options going forward. It dismissed the first as only avoiding disruption. It acknowledged that failure to achieve better outcomes favored the second. It argued that the third works to better address the underlying issues.

1. Stay the Course – leave the basic division of labor as it is now
2. Reverse Course – bring case management services back in house
3. Re-tool for Reform – fix the method of managing outsourced AND internal services

14.8. Digital Commons, University of Nebraska

In 2013, the Digital Commons center at University of Nebraska’s Department of Psychology reported a “Case study of the effects of privatization of child welfare on services for children and families: The Nebraska experience”.⁵² The report reviews “twelve considerations in a description of the large-scale effort to privatize child welfare services in the state of Nebraska that began in 2008.” The report concludes that, “the cost of child welfare services in Nebraska

⁵² This report is available at:
<https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1825&context=psychfacpub>

increased by 27% and the private agencies invested over \$21 million of their own funds as they attempted to uphold contracts.”

The report struggles to apply general observations to the PromiseShip case. It lays out a generic mission for privatization:

“It is argued⁵³ that marketplace competition increases efficiency by making service providers motivated to be as productive as possible without wasted expense. It is also argued that effectiveness is increased through creation of a situation in which providers most capable of producing desired outcomes of child welfare services are rewarded by continued and increased funding. Further, some view the private sector as more capable of developing new services and changing in response to consumer needs. Finally, consumer choice and competitive bidding for government contracts is proposed to make agencies more accountable for delivery of desired outcomes.”

If those were the reasons for the Nebraska outsourcing, the PromiseShip relationship is not established to drive improvement:

1. Efficiency. The contract as currently structured, provides cost advances, and protects Promise ship on the downside. It also provides no upside, were PromiseShip to improve cost performance
2. Providers are rewarded for outcomes. PromiseShip is offered no performance incentives, and faces no penalty for low case performance (other than the threat of sharing part of a federal fine)
3. Developing new services. TSG could not find any extent to which DHHS has encouraged (even allowed) PromiseShip to innovate in services practice. For example, PromiseShip created a 5-day-bed-hold to assure a placement is still available after a youth leaves the home. DHHS would not even record those charges in NFOCUS. In fact, PromiseShip has developed a number of innovations. However, TSG observed no window DHHS has into those innovations.
4. Consumer choice. The Nebraska outsourcing is not structured to enable families (youth) to select. The contract has not been rebid since inception—even the State has abrogated its prerogative of choice

The report highlighted a 2002 Child and Family Services Review (CFSR) that assessed seven safety, permanency, and wellbeing outcomes in regard to the provision of child welfare services.

⁵³ The Digital Commons report does say who established these as the objectives of the Nebraska case. Alas, why the State outsourced is core to understanding whether privatization has achieved its objectives. This is also addressed at the beginning of the TSG report

That audit reported that the state failed to achieve substantial conformity with any of the seven outcomes.⁵⁴

The Digital Commons report goes on to explain that in September 2008, Nebraska’s Division of Children and Family Services released their Recommendations for the Reform of Out-of-Home Care. That report made recommendations for reforming out of home care. Under the proposed framework, the DCFS would retain responsibility for “initial assessments of child or community safety and...for all key case decision making, such as decisions related to safety assessments, case plans and court reports, treatment needs, and recommendations for case closure, including adoptions”. Responsibility for day-to-day provision of child welfare services and services coordination was to be allocated to private, contracting agencies. This is what led to the current contract with PromiseShip⁵⁵.

By 2011, most of the private agencies contracted by DHHS were failing. A state audit found that the cost of child welfare services in Nebraska increased by 27% over the course of the reform effort and the private agencies invested over 21 million dollars of their own funds as they attempted to uphold contracts. Further, the privatization effort had not created the intended improvements in the range and quality of services for children and families.⁵⁶

The Digital Common report considered the effectiveness of privatization along ten dimensions. Along each dimension, the report concluded that DHHS was ill-prepared and failed to execute the privatization well.

The report reviews a federal report⁵⁷ and suggests that, “privatization alone is not capable of improving the quality of child welfare services or reducing their cost”. The report suggests how important it is that “capability of the private sector to adequately deliver services must be carefully assessed”. TSG did not find strong evidence to suggest that DHHS conducted such an assessment at the beginning. The report also argues that, “cost savings should not be a key reason for privatization, as they may not materialize”. TSG did not find strong evidence that DHHS has documented a strong case one way or the other for cost reductions.

⁵⁴ U.S. Department of Health and Human Services (U.S. DHHS), Administration for Children and Families, Administration on Children, Youth and Families, Hubel et al. in Children and Youth Services Review 35 (2013) 30 Children’s Bureau (2003). Final Report: Nebraska Child and Family Services Review.

<http://ncl1.nlc.state.ne.us/epubs/H8060/B002-2002.pdf>

⁵⁵ As well as other private organizations, in the beginning

⁵⁶ Nebraska Department of Health and Human Services (DHHS), Auditor of Public Accounts (2011). Attestation report of the Nebraska Department of Health and Human Services Child Welfare Reform Contract Expenditures: July 1, 2009 through March 31, 2011. Lincoln, NE: Nebraska Auditor of Public Accounts

⁵⁷ U.S. Department of Health and Human Services (U.S. DHHS). Office of the Assistant Secretary for Planning and Evaluation (2007). Child welfare privatization initiatives: Assessing their implications for the child welfare field and for federal child welfare programs. <http://aspe.hhs.gov/hsp/07/CWPI/site/report.pdf>

The Digital Commons study concluded that, “Nebraska’s experiment with privatization provides a clear warning to other states considering similar initiatives: the cost of providing services for the children that need child welfare services will increase if the government shifts responsibility for service provision to a private agency while remaining responsible for oversight of these services, at least in the near term.” It further concluded that services outcomes had not improved as a direct result of privatization.

14.9. Hornby Zeller, 2012

The Center for the Support of Families and Hornby Zeller Associates was retained under authority of Legislative Bill 1160 conducted an evaluation of privatization efforts. The bill required analysis of three separate but interrelated topics:

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

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

The report addressed three questions:

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

Findings

Zeller looked at CFSR metrics, finding at 2011 that PromiseShip failed every target—and that the State also failed many (red italics) indicates failed federal CSFR target):

Table 14-5: 2011 CFSR metrics as Reported in Zeller

	Federal Target	Promise Ship	State	SE Region
Safety	94.6%	88.7	92.0	91.2
Reunified within 12 Months	48.4%	35.4	41.3	34.8
Re-entering Care within 12 Months	9.9%*	27.3	11.8	12.0
In Care 17+ Months Who Get Adopted	22.7%	10.9	23.0	28.1
In Care 17+ Months Who Are Freed	10.9%	10.7	13.3	14.9
Get Adopted within 12 Months	53.7%	23.7	56.5	71.1
In Care 24+ Months, Discharged to a Permanent Home	29.1%	22.4	37.1	39.3
Discharged to a Permanent Home	98.0%	94.3	97.5	99.4
In Care Less than 12 Months, Two or Fewer Placements	86.0%	82.9	86.4	87.5
In Care 12-24 Months, Two or Fewer Placements	65.4%	61.8	62.5	65.2
In Care 24+ Months, Two or Fewer Placements	41.8%	37.0	34.7	34.7

* Lower is better

In addition, Zeller reviewed the results of what they called a “Mini CFSR”. That focused on more detailed process measures. For the 2010 PromiseShip received no “strength” ratings and failed all but six metrics. However, in the 2012 audit, PromiseShip failed only four metrics and received a “strength” rating in three areas. A dramatic improvement.

The 2012 report concluded:

1. It is not at all clear that privatization improved outcome achievement. Nor is it clear that it detracts from that achievement.
2. Whether the services are delivered privately or publicly, the approach will need to change if the outcomes are to improve.
3. While DHHS must pay attention to those measures for federal purposes, its decision to adopt the federal measures as internal tools of accountability without modifying them does not provide appropriate guidance to workers and supervisors
4. Inadequate measures were being used to guide internal operations. This is not an issue of public or private administration. It is a question of what is needed for the effective administration of the child welfare system by anyone

14.10. Platt Institute, 2012

The Platt Institute published a report suggesting, Next Steps for Child Welfare Reform in Nebraska.⁵⁸ That report found:

Nebraska should follow the path of other states with difficult privatization implementation issues and fix the underlying systematic issues. The one unintended and painful benefit of privatization in Nebraska is that it has spurred the legislature to take comprehensive actions to fix child welfare services in a way that years of poor performance by the state agency did not. Privatization brings all the ongoing structural issues to the forefront of the discussion. Kansas and Florida, the two states with statewide implementation of privatized case management, had privatization difficulties similar to Nebraska. However, they did not turn back case management function to the state child welfare agency. Instead they persevered to develop a higher-quality child welfare system.

...the evidence does not justify returning all child welfare case management back to state provision. In fact, state provision of services is also suffering from similar negative outcomes for children. Rather than institute yet another reorganization plan, the legislature should give DHHS an opportunity to present and implement their operational plan

...Given that ... these agencies along with DHHS have been working together to develop an operational plan to resolve many of the issues in the Health and Human Services Committee's December 15 [2011] report, they should be invited in to participate in a collaborative effort to rectify all the specific issues."

14.11. DHHS Report to the Legislature: Legislative Resolution 37 (2011): Review, Investigation and Assessment of Child Welfare Reform

In this report, DHHS says, "Privatization is a tool, not an end in itself, to child welfare reform."⁵⁹ The report goes on to admit, "The success of states and communities in addressing child welfare is primarily predicated on ensuring that all three branches of government are involved in the development of a strategic plan and an implementation plan *prior to initiating contracting with statewide lead agency.*" (TSG added italics)

This report acknowledges: "a contractor's ability to perform will be limited by many of the same barriers faced by the previous public system...Private agency workers experience the same frustrations that public agency workers experience such as high stress, lack of career advancement opportunities, and lack of educational preparation for child welfare work.

⁵⁸ This report is available at: https://www.platteinstitute.org/Library/docLib/20120208_Child_Welfare_report.pdf

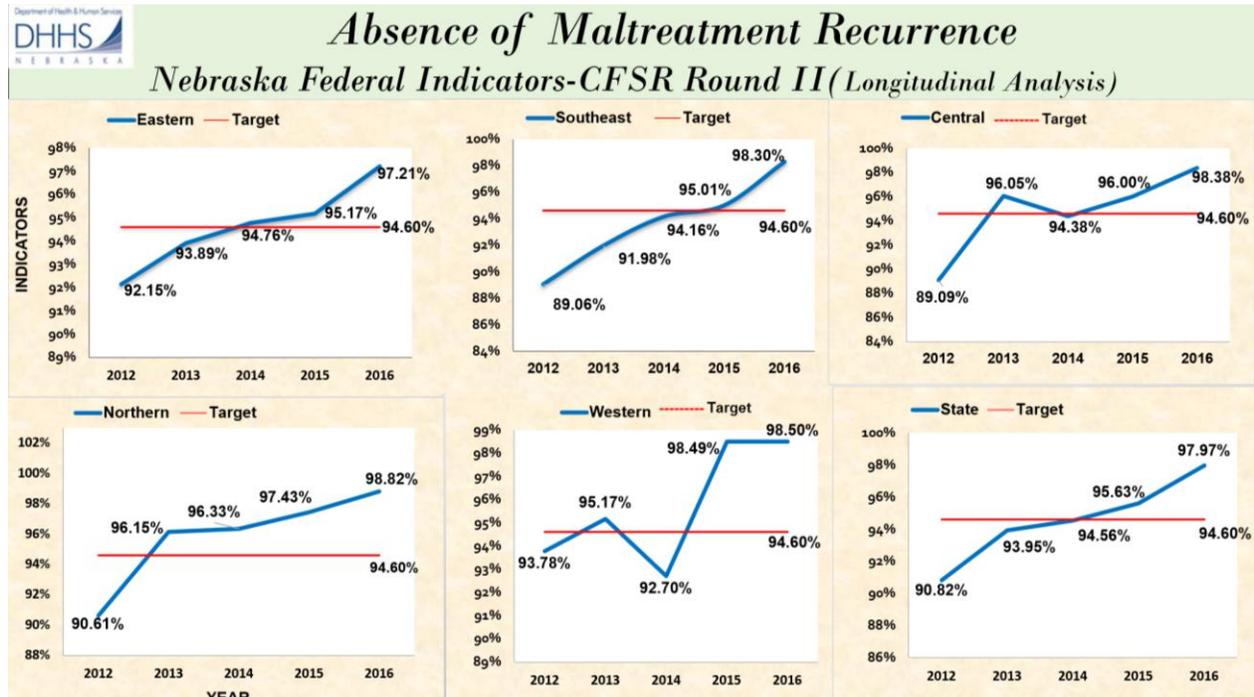
⁵⁹ This report can be viewed at: https://nebraskalegislature.gov/pdf/reports/committee/health/lr37_intro.pdf

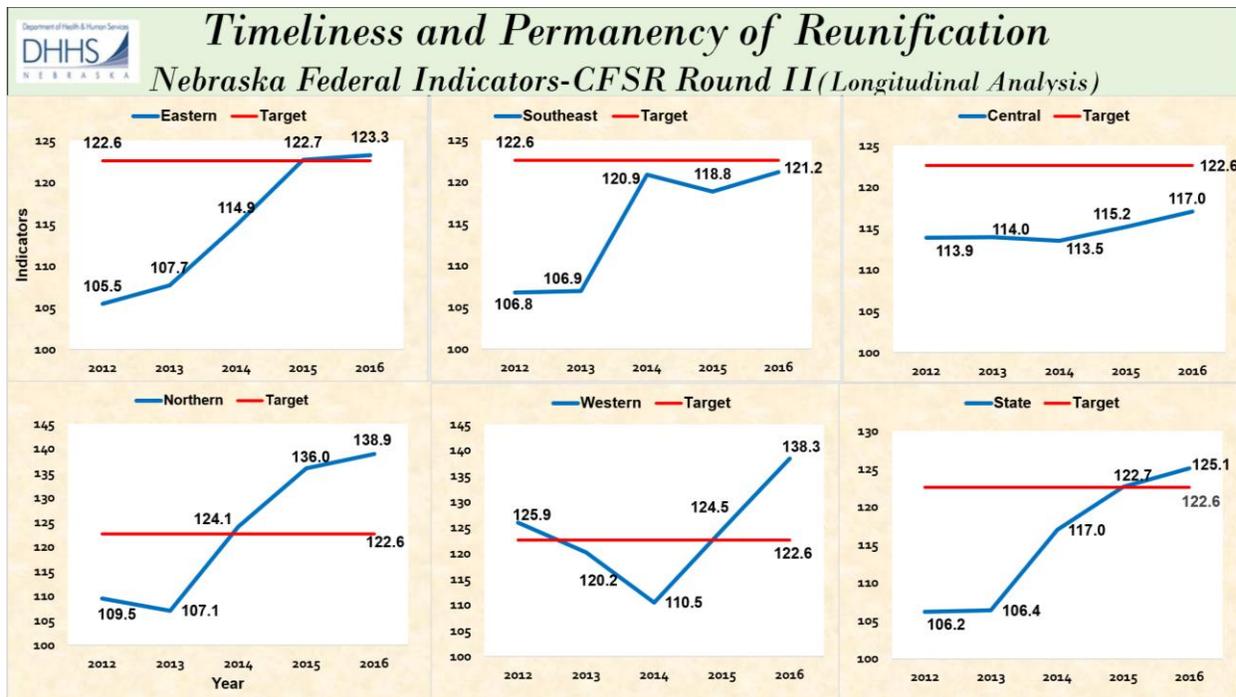
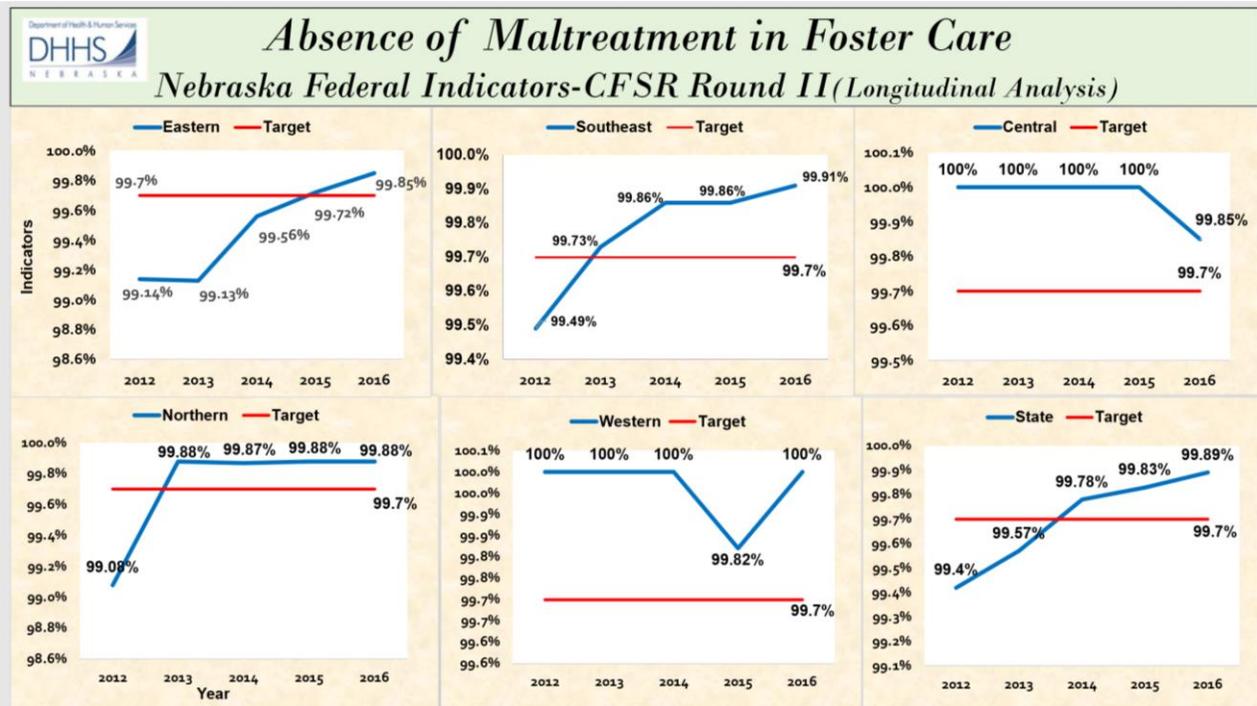
Early results indicate that simply transferring case management and decision making to the private sector may not improve case outcomes without adequate social, physical, and mental health resources; and foster and adoptive homes in communities; and qualified agency staff that are offered ample supports.”

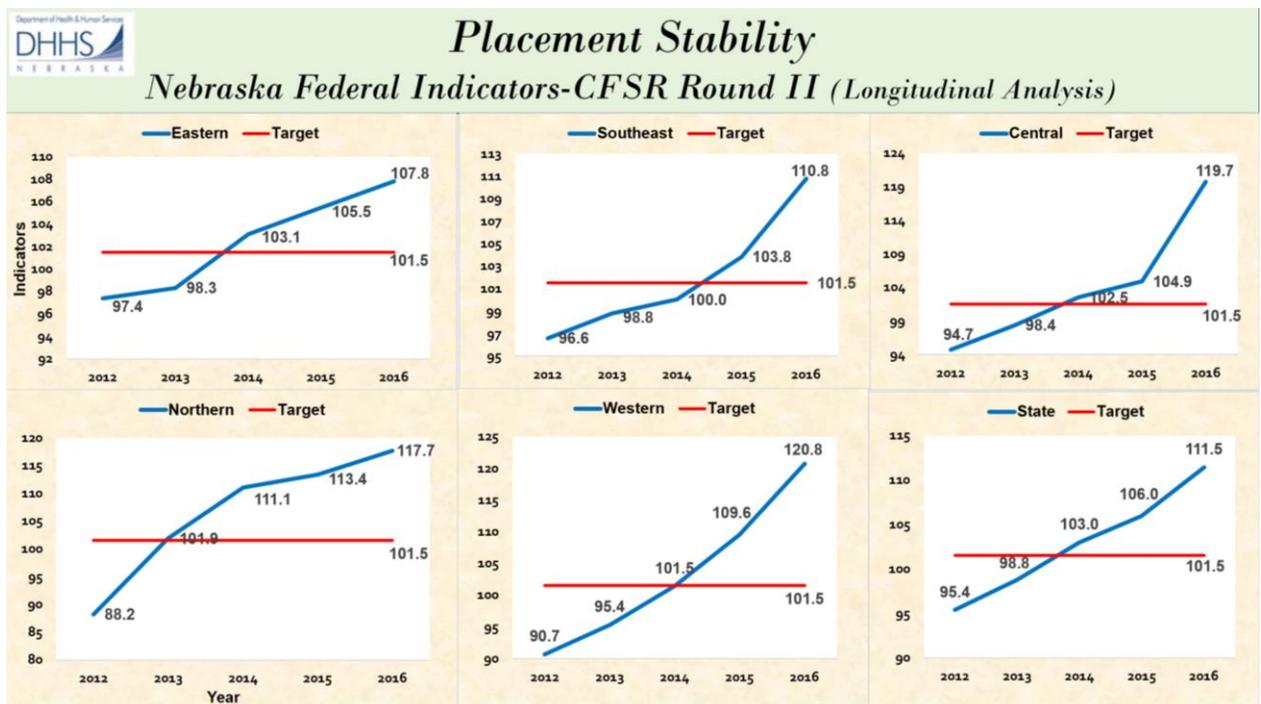
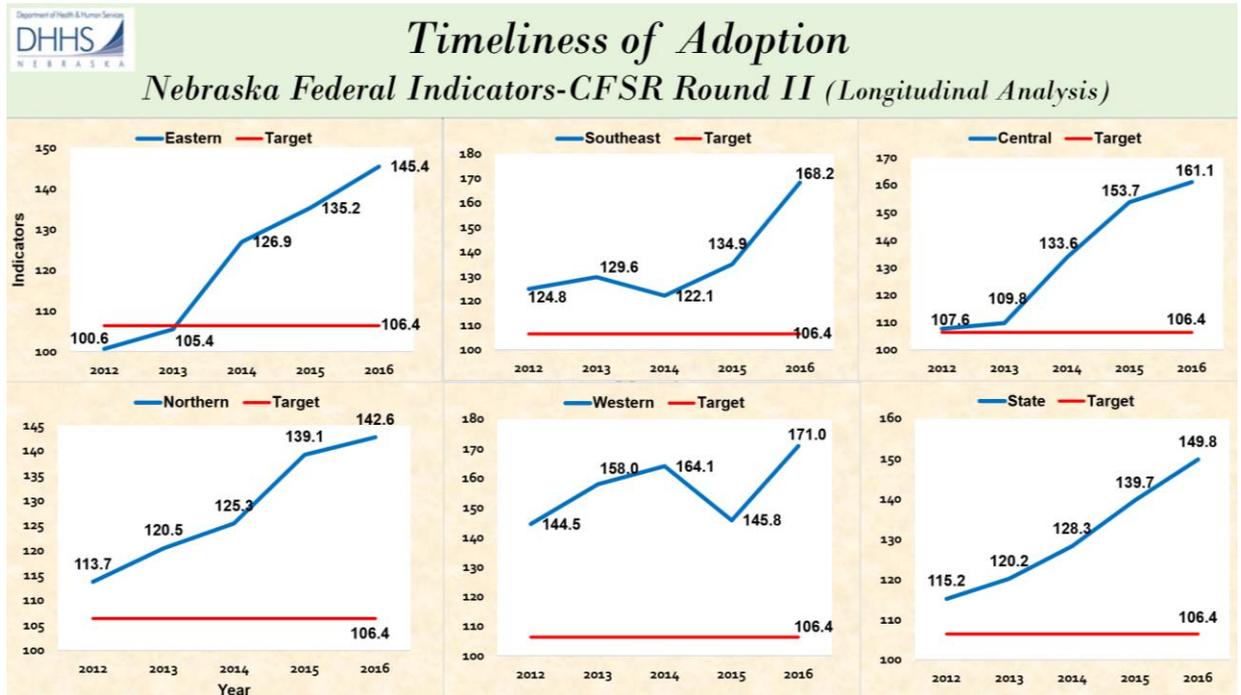
This DHHS report is essentially a forecast of the ensuing six years—while DHHS acknowledged the challenges, it did not address them.

15. APPENDIX B: PERFORMANCE ON CFSR ROUND II MEASURES

Note that the following graphs were prepared by DHHS and shared with TSG in December 2018.







16. APPENDIX C: ADDITIONAL FINANCIAL ANALYSIS BEYOND COST PER CASE

TSG also analyzed differences in caseload and turnover between ESA and the other Service Areas.

16.1. Provider Payment Structure

The contract as currently amended pays PromiseShip a monthly advance with a true-up to “actual and allowable” costs. The contract was most recently amended August 30, 2018⁶⁰. Key payment provisions now include,

“Fixed payment of \$1,750,000 each month for services provided July 1,2017 through August 31, 2018, ... In addition to the above fixed payments, DHHS will pay to Subrecipient an advance payment of \$5,500,000.00 each month for actual and allowable costs of services provided from September 1, 2018 through June 30, 2019

"No variable payment shall be due and owing for services provided on or after September 1, 2018

“If Subrecipient's total actual and allowable costs pursuant to this subaward are less than the total advance payments paid to Subrecipient under Article II, Section B (1), (2), and (3) for the period of reconciliation, DHHS may withhold the difference from the next advance payment, and if the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS shall reimburse Subrecipient for the difference”

“If Subrecipient's total actual and allowable costs pursuant to this subaward are less than the total advance payments paid to Subrecipient under Article II, Section B (1), (2), and (3) for the period of reconciliation, DHHS *may* withhold the difference from the next advance payment, and if the total actual and allowable costs pursuant to this subaward exceed the total compensation paid, DHHS *shall* reimburse Subrecipient for the difference up to and including the total subaward specified in Article II, Section A. At the end of the subaward term, DHHS will conduct a final reconciliation consistent with the terms of this Agreement, and if the total actual and allowable costs reported pursuant to this subaward are less than the total compensation paid, Subrecipient shall repay the excess funds to DHHS.” (italics added)

Thus, PromiseShip is no longer paid a variable rate for services, but a fixed amount of \$5.5 million per month (\$66 million annualized). This advance payment amount is considerably less than prior year payments totaling \$70.8 million for SFY 2018. However, these payments are considered an “advance” and the contract requires a true-up. The contract anticipates

⁶⁰ Case Management Subaward Between the Nebraska Department of Health and Human Services and Nebraska Families Collaborative Amendment Three, dated February 12, 2018

“reconciliations” of actual cost, not more often than monthly. As a result of the reconciliation, the State “may” recover any overpayment and “shall” reimburse for any shortfall.

The contract says that PromiseShip must repay any amount that payments exceed actual costs. However, it seems to leave open the question of what happens if actual expenses exceed the amount of the original contract in 2016. Also unclear is what happens if actual expenses are between \$66 million and \$71 million.

16.1.1. Fee for service, value-based and performance-based contract elements

TSG did not observe any aspects of the contract or payment structure that hold PromiseShip accountable (or reward PromiseShip) for outcomes performance. PromiseShip seems to be at risk if the State incurs a penalty for underperforming the federal metrics. PromiseShip is at risk if the whole state falls below the federal standards, and then to the extent federal penalties derive from PromiseShip performance. However, the mechanics of implementing that seem unclear, and are untested.

16.1.2. Controls

PromiseShip reports it has controls over provider payments at several points:

- A provider payment cannot be initiated unless the case is set up in N-FOCUS, then again in FAMCare
- Services cannot be ordered without a Services Referral, which is approved by the Supervisor as well as Utilization Management
- Rates for services are set in the system, not subject to change outside the rate approval process
- Rates for services are the same across all providers
- Utilization Management verifies the availability of Medicaid or third-party insurance in 100% of cases before the services are initiated
- Payments are initiated by the system only, not manually. Using system-level controls

TSG is not in a position to test compliance of these controls. State Internal Audit has already reviewed and reported on the question of compliance.

However, without testing the controls, TSG does feel controls are not especially strong:

- Manually entering into two systems is inherently a control issue
- Manual reconciliation of the two systems is weak control
- Summing some charges outside the system is a dangerous practice—one which unnecessarily adds changes for error
- Failure to automatically compare the entries in both systems invites inevitable differences
- Delays alerting FAMCare of case closure inevitably leads to billing errors

- Supervisor and Utilization Management reviews offer a weak form of control. The practice makes sure the PFS knows “someone is watching,” but this form of control is not a strong method of assuring that charges are appropriate
- Ultimately, building a trusting, collaborative work relationship between DHHS and PromiseShip would offer the best form of control. TSG did not find that sort of relationship. TSG was not made aware of any efforts toward collaboration on addressing the control issues both parties seem well aware of.

16.2. Description of Provider Base and Payments

16.2.1. Services are spread across 316 providers

PromiseShip has paid for services provided by 316 payers in the past three years⁶¹. KVC is the largest, and formerly shared case management in the region with PromiseShip as one of the outsourced services providers. Father Flanigan’s is also known as Boys Town.\

Table 16-1: Services Concentration

	SFY 2016	SFY2017	SFY2018
KVC Behavioral Healthcare Nebraska	4,206,625	3,830,084	4,090,474
Father Flanagan's Boys' Home	4,146,647	4,684,543	4,064,499
Omni Behavioral Health	2,877,408	3,275,215	3,291,796
Beneficial Behavioral Health S	2,659,165	3,282,573	2,913,813
Apex Foster Care, Inc	2,056,733	2,491,433	2,755,903
Heartland Family Service	968,411	1,233,037	1,835,108
Child Saving Institute	1,487,732	1,688,449	1,665,877
Lutheran Family Services	2,123,185	1,823,670	1,601,821
Nebraska Children's Home Society	1,403,767	1,607,398	1,481,236
Owens & Associates, Inc	1,402,552	1,681,204	1,339,610
Release Ministries, Inc.	667,582	670,641	1,285,372
Children's Square U.S.A.	803,699	1,144,590	1,231,665
Christian Heritage	857,804	1,034,879	1,044,891

⁶¹ TSG analysis of PromiseShip data in the file “7 - Contract network details - Oct 18.2018.xls”

16.2.2. Many Services are Contracted to Only a Few Providers

PromiseShip contracts with multiple providers for most charge codes. FAMCare includes 247 charge codes for different services type. Some of the most competitive charge types are listed in the table below. PromiseShip draws on 60 providers for Individual Therapy and 20 for Group Therapy⁶².

Table 16-2: PromiseShip Multiple Providers

Sample of Largest Service Types	Number of Providers
Individual Therapy	60
Initial Diagnostic Interview	43
Family Therapy	37
Interpreter/Translation Services	34
Parenting Time (Visitation)	32
Psychological Testing	32
Family Support Services	27
Child Care-Daily	24
Child Care-Hourly	23
Group Therapy	20

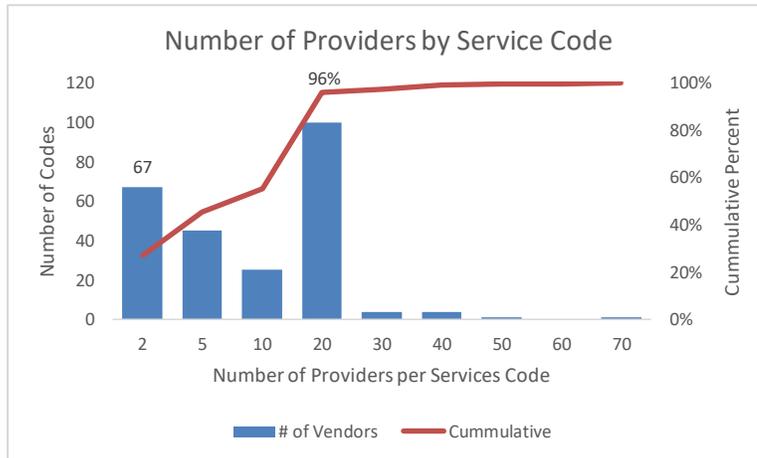
The largest providers by amount are listed in the table below, which lists all providers with 2018 payments greater than \$1 million.

For many services codes, PromiseShip draws on fewer providers. Fully 27% of services codes are sourced from a single provider. The chart below shows that 67 codes have only one provider (i.e. fewer than 2), and that 96% of charge codes draw on fewer than 20 providers. Or, said another way, only 4% of services are competed to 20 or more providers. TSG is not in a position to have an opinion on whether this is “enough,” only observes a high incidence of services being contracted to a few providers.⁶³

⁶² TSG analysis of PromiseShip data covering contracts between 7/2017 through 10/2018. This data comes from a PromiseShip file: “Contract network details - Oct 18.2018.xls”

⁶³ TSG analysis of PromiseShip data in the file “7 - Contract network details - Oct 18.2018.xls”

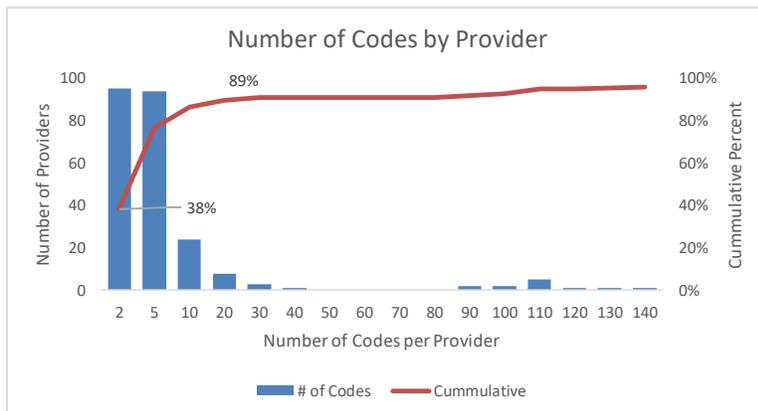
Figure 16-1: PromiseShip Number of Services by Provider



16.2.3. Many Providers Provide Narrowly-focused Services

PromiseShip providers tend to provide services under only a few billing codes. TSG found that 89% of providers bill fewer than 20 codes. 38% bill only one code (i.e. fewer than 2 in the chart).⁶⁴

Figure 16-2: PromiseShip Number of Codes by Provider



The table below shows the providers with the broadest services offerings.

⁶⁴ TSG analysis of PromiseShip data in the file “7 - Contract network details - Oct 18.2018.xls”

Table 16-3: PromiseShip Number of Service Codes by Provider

Sample of Largest Providers	# of Service Codes
Boys Town	131
OMNI	125
CSI	112
Lutheran Family Services	106
APEX	105
NOVA Treatment Community	103
NE Children`s Home	101
KVC	100

16.2.4. Dollar Value of Services Highly Concentrated

TSG found that 18% of the \$129 million of contract payments over the past 3 years has been to Kinship Foster Parents managed directly by PromiseShip. Boys Town (Father Flanagan's Boys' Home) received 10% of contract payments. TSG found that 95.5% of PromiseShip providers (other than Kinship Parents) billed less than \$2 million over the past 3 years.⁶⁵

⁶⁵ TSG analysis of PromiseShip data in the file "8 - PromiseShip payments by provider State FYs 2016 – 2018.xls"

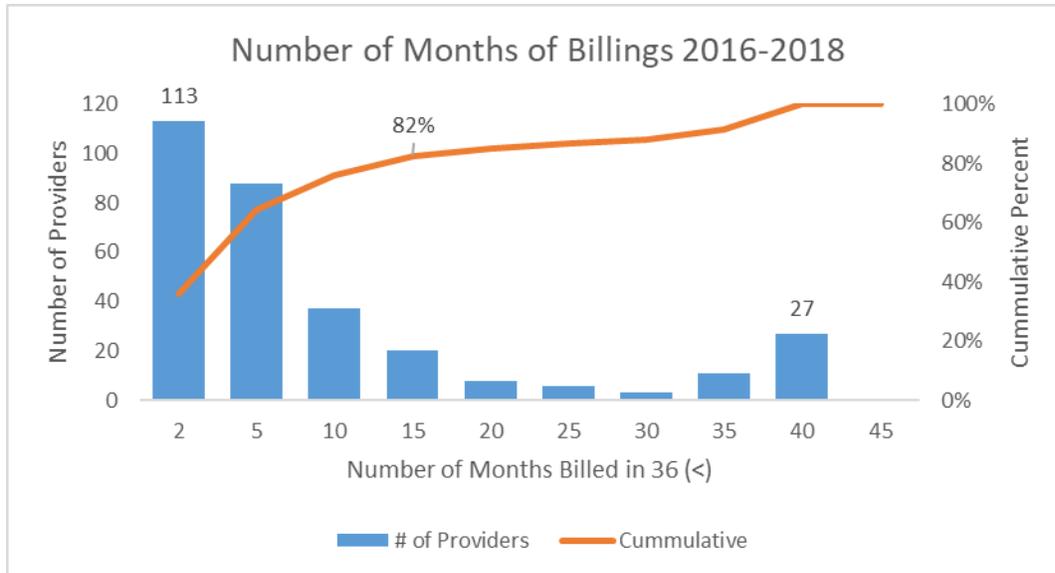
Table 16-4: PromiseShip Provider Concentration

Sample of Largest Providers	Amount over 3 Years	Percent of All Contracts
Kinship foster parents	\$22,796,200	18%
Father Flanagan's Boys' Home	12,895,689	10%
KVC Behavioral Healthcare Nebraska	12,127,183	9%
Omni Behavioral Health	9,444,419	7%
Beneficial Behavioral Health S	8,855,552	7%
Apex Foster Care, Inc	7,304,069	6%
Lutheran Family Services	5,548,677	4%
Child Saving Institute	4,842,058	4%
Nebraska Children's Home Society	4,492,401	3%
Owens & Associates, Inc	4,423,365	3%
Heartland Family Service	4,036,556	3%

One aspect of these small relationships with many providers is that providers do work for PromiseShip on an on-and-off basis. The chart below shows that only 27 of 313 providers billed all 36 months during the period. Most (82%) providers billed for services fewer than 15 months out of the past 36. The chart also shows that 113 (36%) billed for only one month of services during the three years. Accordingly, PromiseShip maintains a great many provider relationships for which it only rarely contracts services.⁶⁶

⁶⁶ TSG analysis of PromiseShip data in the file "8 - PromiseShip payments by provider State FYs 2016 – 2018.xls"

Figure 16-3 PromiseShip Number of Billing Months by Provider



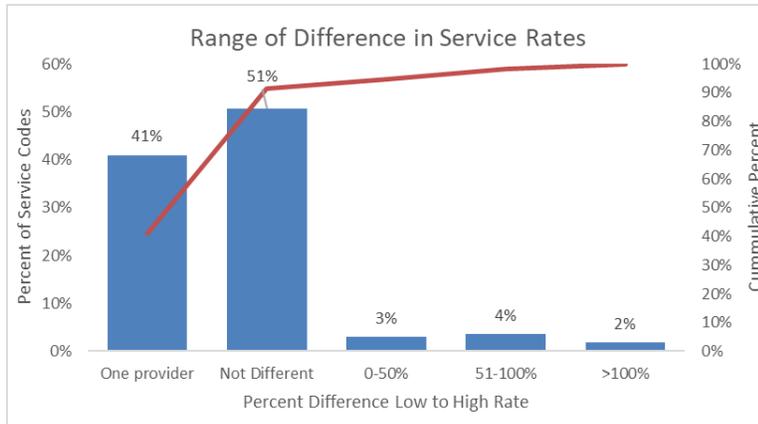
16.2.5. Payment rates vary little by provider

PromiseShip pays the same rates for most services types. PromiseShip provided detail charges by provider for all provider charges in September 2018, this represented 9,741 charges. TSG requested this sample, as a reasonable representation of actual charges (not depending merely on rate books).

For 41% of services types, PromiseShip uses only one provider. For the next 51% (total of 92%) there is no rate difference between the providers. The remaining 8% have percentage differences as shown. Most (83%) of the total payments where rate variance is large was for kinship payments. Thus, services rates were the same for virtually all payments to commercial providers in September.⁶⁷

⁶⁷⁶⁷ TSG analysis of PromiseShip data in the file “8 - PromiseShip payments by provider State FYs 2016 – 2018.xls”

Figure 16-4: PromiseShip Range of Service Rate Differences



16.2.6. The five-day bed-hold

One notable difference between the State and PromiseShip cost structures is the “5-day bed hold.” These contracts provide emergency agency supported family foster care beds for up to five days and allow PromiseShip to avoid the tragic experiences of other states, where children in transition are forced to sleep in cars, motels, offices or other unsuitable arrangements. PromiseShip contracts for these services with KVC and Omni Behavioral Health. The Auditor of Public Accounts’ report questioned these costs. PromiseShip supports this service as necessary and reasonable⁶⁸:

- Prevents the tragic experiences of other states
- Places children in a safe supported family setting
- Prevents night to night placements that harm children
- Provides a short period of time to coordinate the appropriate next long-term placement / treatment setting for these youths
- Provides time to coordinate services that allowed 5 children to return home, preventing an extended stay in foster care
- Allows providers to build specialized targeted family foster homes specifically designed to serve this unique group of youth, avoiding costlier residential placement

PromiseShip paid for 5-day bed hold services on behalf of 130 children. According to PromiseShip, the total cost of 5-day bed hold for these children was \$142,850⁶⁹. This included \$36,450 that was paid to the providers to ensure that a specialized placement was available

⁶⁸ TSG analysis of the arguments provided by PromiseShip in the document 23 - 5-day bed Fact Sheet v2.pdf

⁶⁹ TSG is merely reporting numbers provided by PromiseShip in the document 23 - 5 day bed Fact Sheet v2.pdf

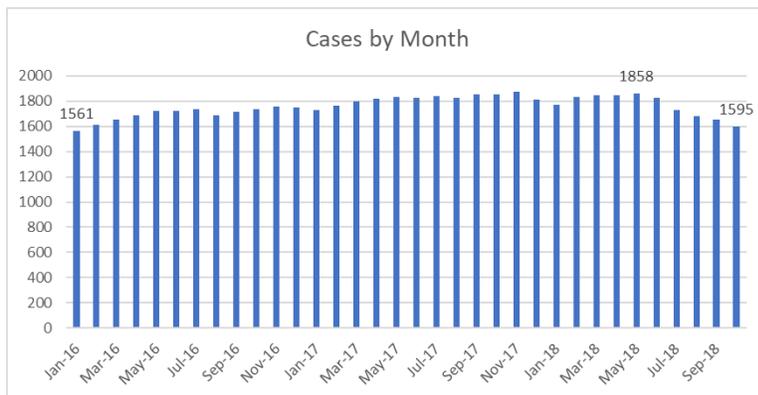
whenever it was needed and \$106,400 paid for the actual bed days utilized. TSG observes that the argument for benefit seems strong and the overall financial impact is relatively small.

16.3. Caseloads

16.3.1. Total number of ESA cases, past 3 years

The total number of cases managed was about the same in October 2018 as in January 2016. Cases grew modestly through 2017 and have recently been declining. See table below.⁷⁰ Note that this data is from PromiseShip and differs slightly from the data used for the cost per case analysis. This data was used in this section of the report because the assessment is about PromiseShip and its operations, not comparing to other Regions.

Figure 16-5: PromiseShip Cases by Month



The mix has shifted to court cases, which have increased from 78% to 88% of total cases since January 2016. Much of this has resulted from a shifting away from complex cases, which have dropped from 10% to 3%. In addition, the percentage of non-court cases has dropped from a high of 10% to the current 7%.

PFSs working court cases tend to have larger caseloads. PFS

16.3.2. Individual caseloads

PromiseShip PFSs are managed in teams linked to the court their cases are in, so the non-court cases are managed in a separate team as well. While the average SFY 2018 PromiseShip caseload is 11.1, individual monthly caseloads range from 1 to 25 in the ESA, and up to 48 in the rest of the state⁷¹. Caseloads are lower in the ESA, as shown in the table and chart below. The

⁷⁰ TSG analysis of PromiseShip data in the file “Request 30 Caseload – revised.xlsx”

⁷¹ TSG analysis of data from DHHS in the file, “Caseload for Stephen Group v3.xlsx”

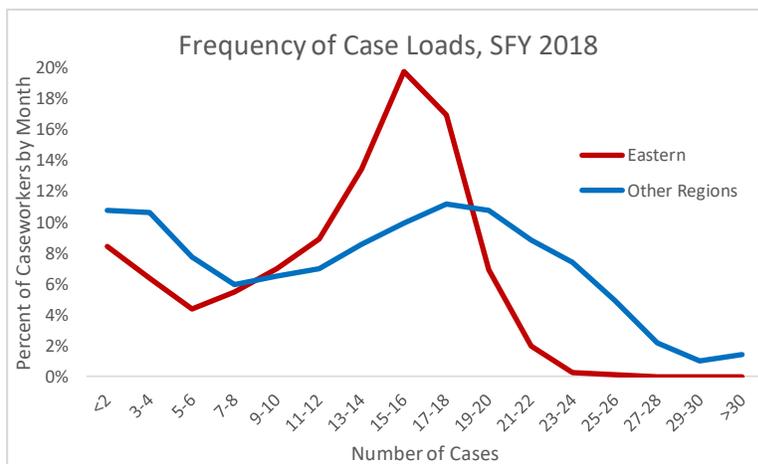
number of monthly PFS caseloads managed by PromiseShip was 2,298 in SFY2018; that is roughly 200 case workers for 12 months.

TSG notes how the ESA caseload distribution is more concentrated around the average, while in the rest of the state caseloads are spread out across a wider range as well as a higher average.

Table 16-5: Caseload Average Compared

	Eastern	Other Regions
Average	11.1	12.2
Median	13	12
Max	25	48
Number of monthly caseloads	2,298	2,819

Figure 16-6: Frequency of Caseloads by Caseworker

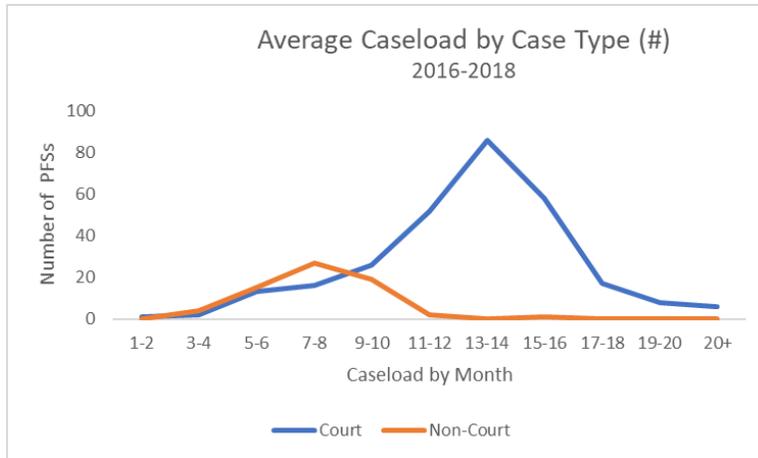


16.3.3. Caseloads, comparing court and non-court

PFSs who work court caseloads carry larger caseloads. The chart below graphs monthly caseload for court and non-court PFSs since 2016⁷². The first chart shows that relatively fewer PFSs work non-court cases. The most frequent (mode) caseload for a non-court PFS is 7, while for a PFS working court cases is 13. The averages are 12.4 and 6.9 respectively.

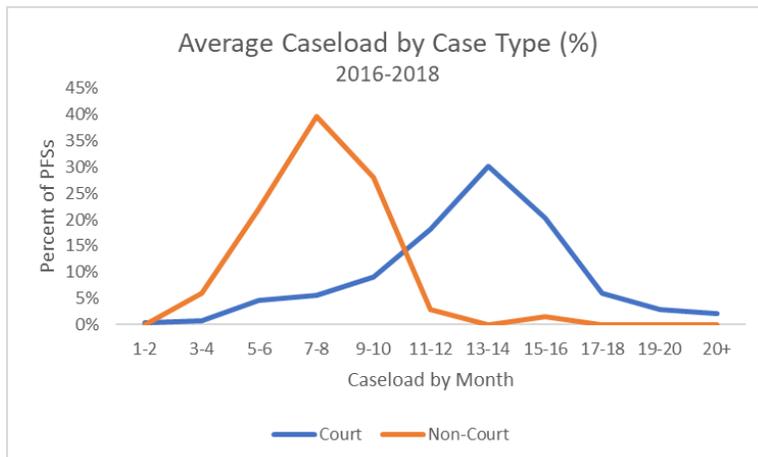
⁷² TSG analysis of PromiseShip data in the file “Request 30 Caseload – revised.xlsx”

Figure 16-7: Average Caseload by Case Type – Number



The second chart, below, graphs the same information as a percent of total cases. This demonstrates that PFSs working court cases have a wider range of caseloads⁷³.

Figure 16-8: Average Caseload by Case Type – Percent



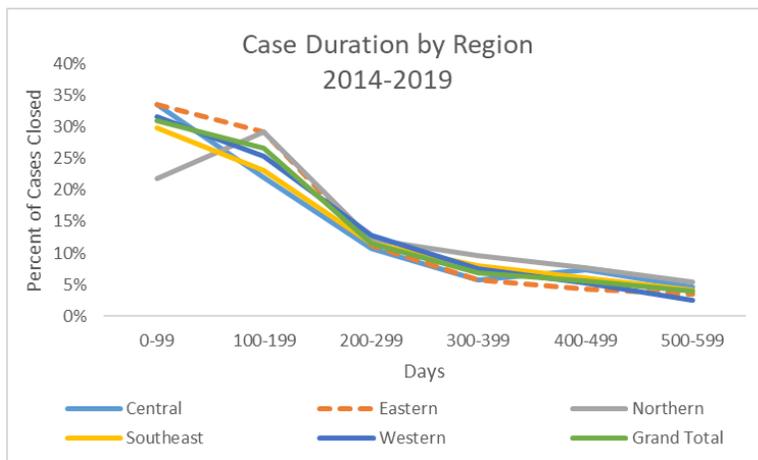
16.3.4. Case duration

Cases tend to stay open about the same length of time across all regions. The chart below presents the percent of each region’s cases (y-axis) that closed in various numbers of days (x-

⁷³ TSG analysis of data provided by PromiseShip in the file, Request 30 Caseload – revised.xlsx

axis)⁷⁴. The data covers cases closed in the calendar years between 2012 and September 2018. Each region tends to close between 30 and 35% of cases within 99 days. In ESA (PromiseShip), 12% of cases remained open longer than 599 days, in Southeast region, 17% (not shown). Thus, Eastern cases may be closed a bit faster than cases in other regions, but not by a significant amount.

Figure 16-9: Case Duration by Region



16.3.5. Case duration comparing court to non-court

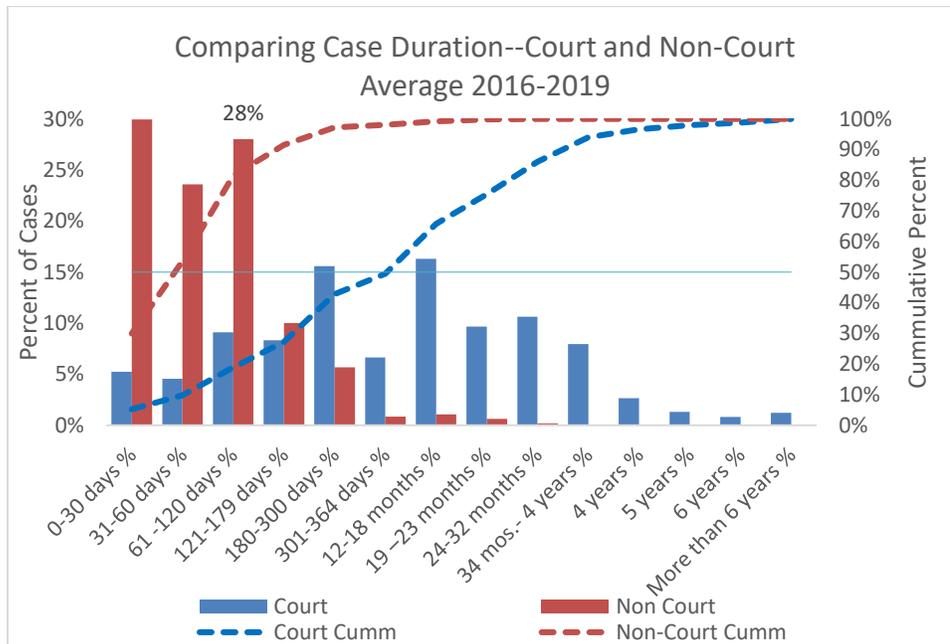
Court cases are typically placed out of home. The chart below shows the percent of cases that are open at points of time. It compares cases with “court involved youth”, to those that are without court supervision. For example, on average over the past 3 years, 28% of Non-Court cases have been open 31-60 days (two months). The median⁷⁵ range for Court cases is in the range 301-365 days, nearly 3 years⁷⁶.

⁷⁴ TSG analysis of data from DHHS in the file, Stephens Group Days Case Open.xls

⁷⁵ Half of cases are older, half newer. That is, where the cumulative percent line crosses 50%

⁷⁶ TSG analysis of PromiseShip data in the file, 26 - Data Request #26.xls

Figure 16-1024: Comparing Case Duration Court and Non-Court



The chart above suggests a strong benefit for PromiseShip when cases are taken on by the court: they last 3 years instead of 2 months. Under the payment method of per case per month, PromiseShip is paid on average 18 times as much for a Court vs. Non-court case. Note that this is average. The chart shows that some Court cases are sometimes be closed more quickly that some Non-court cases. However, on the median, court cases last much longer.

16.3.6. Caseload comparing Court and Non-court, In and Out of Home

Court cases are generally out of home, but not always. While only 1% of cases are non-court cases managed out of home, fully 16% of court cases are managed in-home. This is shown in the table below⁷⁷. The “Other” category includes cases that were moved in or out of court during the month, and complex cases.

⁷⁷ TSG analysis of data provided by PromiseShip in the file: Request 30 Caseload – revised.xlsx

Table 16-6: Caseload comparing Court and Non-court, In and Out of Home

	Court	Non-Court	Other	Total	Court	Non-Court	Other	Total	Court	Non-Court	Other	Total
Out of Home	1,189	14	54	1,257	84%	12%	82%	79%	95%	1%	4%	100%
In home Master Case	219	107	12	338	16%	88%	18%	21%	65%	32%	4%	100%
Total Cases	1,408	121	66	1,595	100%	100%	100%	100%	88%	8%	4%	100%
In Home Youth	347	261	23	631								
Youth/Master Case	1.6	2.4	1.9	1.9								

16.3.7. Caseloads compared to federal standard

Another important aspect of cases is shown in the table above. Throughout the TSG analysis, we use master case count for in-home cases and youth count for court-involved cases. See that for PromiseShip, court-involved cases average 1.6 youth, while non-court cases involve 2.4 youth.

16.3.8. Caseload by PFS over time, comparing court and non-court

Median caseloads have increased since SFY 2017⁷⁸. In 2017, the median caseload for a PromiseShip PFS working court case was 14. In contrast, the median caseload for a non-court case was 9. Caseloads in 2018 have dropped considerably. Median court caseload dropped from 14 to 12. Median Non-Court caseload dropped from 9 to 5.

Table 16-7: Caseload by PFS over time, comparing court and non-court

	Oct 2017			Oct 2018			Non-Court/Court Caseload	
	Court	Non-Court	Total	Court	Non-Court	Total	2017	2018
Average Cases	13.8	9.8	13.2	11.5	5	10.3	71%	43%
Median Cases	14	9	14	12	5	11	64%	42%

⁷⁸ The analysis in this section is based on data provided by PromiseShip in the file, 28 - Data Request #28.xls

Thus, all caseloads have declined for both court and non-court cases. In addition, the relationship between court and non-court caseloads has widened considerably. In 2017 a non-court case worker carried 64% of the median caseload for a court worker. Today, the gap has widened to 42%.

16.4. Caseloads Compared to Federal Standard

Caseload standards are offered by the Council on Accreditation.⁷⁹ The standard is, “Ongoing and preventive services workers should be working with no more than 15-18 families (cases) at a time, with no more than 10 children that are in an out-of-home placement. The table below is taken from a federal compliance report for October 2018 and shows that each region except Northern meets the caseload hurdle. It also confirms that the ESA (PromiseShip caseloads are smaller than other regions.

Table 16-8: Statewide Report of Federal Caseload Compliance

Statewide Report of Federal Caseload Compliance			
Average of October 2018			
Service Area	Total Staff	Staff in Compliance	Percent in Compliance
Central	60	56	93.3%
Eastern	203	196	96.6%
Northern	61	52	85.2%
Southeast	95	87	91.6%
Western	53	43	81.1%
State	473	436	92.2%
Green indicates improvement from prior month			
Red indicates regression from prior month			

16.5. Turnover

Turnover is the subject of a confusing array of methods. DHHS and PromiseShip reported it in a different manner. Federal compliance metrics do not seem to point to the real question. Turnover is important because when a case manager leave case work a new case worker must be

⁷⁹ For further information, see: <https://coanet.org/standard/cps/14/>

trained. It takes many months of training and experience to reach full performance. The cost is high when Nebraska loses a caseworker—both financially and to case continuity.

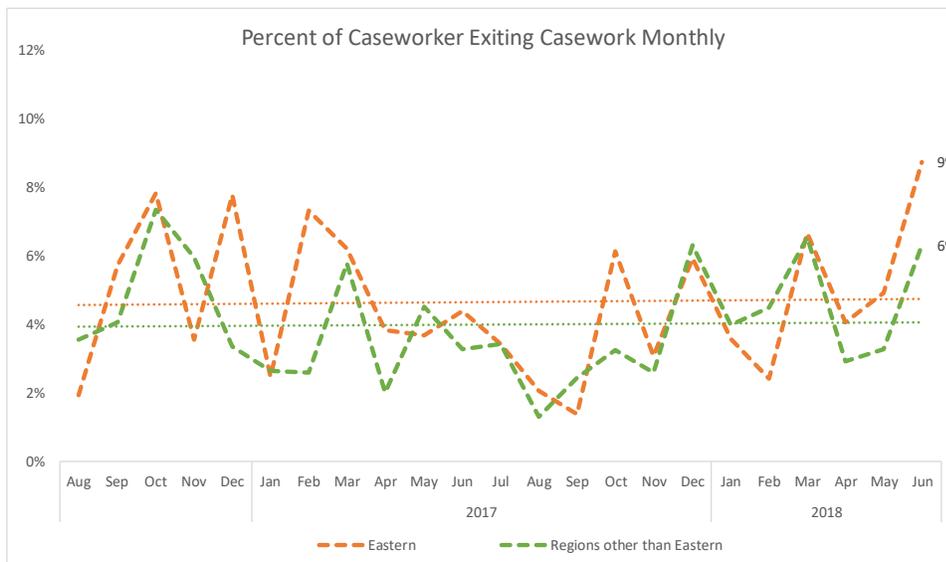
16.5.1. Assessing Turnover by Observing Case Workers' Actual Case Assignments

TSG assess caseworker turnover by looking not at employment, but at actual case assignments. For this analysis, it is less important whether a person left employment—rather whether she is still working cases. A state caseworker can transfer to other positions within the State, while a PromiseShip employee has more limited options for transfer. The TSG analysis factors all this out—looking simply at whether the worker is managing cases.

The method was to observe by individual whether the number of cases was non-zero. When an individual stopped working cases, that was deemed an “exit”.⁸⁰

Using this method, TSG found that in the ESA about 4% of caseworkers stop carrying cases each month, a rate that has held consistently through the past two fiscal years. This is similar to rest of the State.⁸¹ PromiseShip believes it is experiencing slightly more turnover recently because of uncertainty about the future of the DHHS contract.

Figure 16-11: Percent of Caseworkers Exiting Case Work

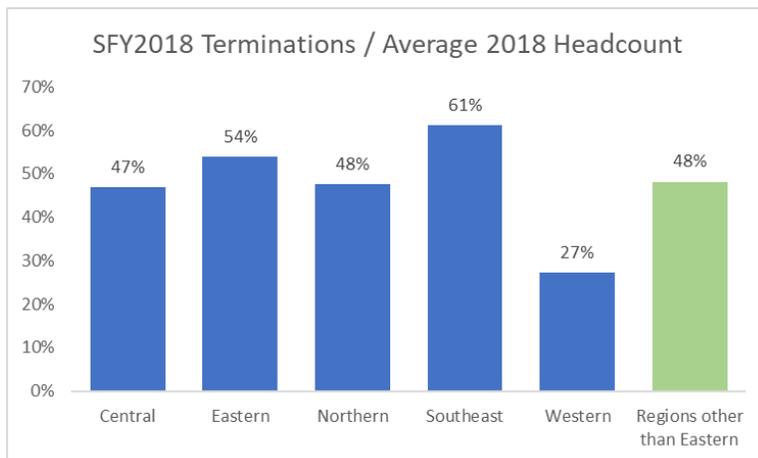


⁸⁰ TSG is using the term “exit” to distinguish from “termination” which suggests change in employment. The purpose is to observe when an individual must be replaced as a case manager

⁸¹ TSG analysis of DHHS data from the file “Caseload for Stephens Group v3.xlsx”

Annually, 51% of caseworkers leave case work each year across the state. The rate is slightly higher in ESA, as shown in the chart below.

Figure 16-12: Terminations / Count of Caseworkers

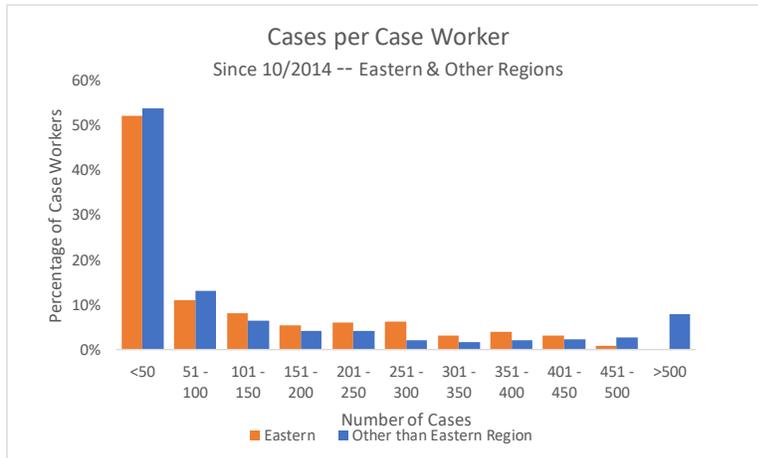


16.5.2. Case Workers Working Cases for Fewer than 36 Months

TSG recognizes that turnover is costly. After completing formal training, 95% of caseworkers work cases for fewer than 36 months. The chart below shows that 41% of ESA case workers manage cases for fewer than 6 months (37% for the rest of the state). It shows a tendency for a few case workers to remain longer—well beyond 36 months. In general, state case workers carry heavier caseloads (analysis above) and stay longer than PromiseShip PFSs. However, both groups lose case workers quickly, which is also a national trend. This compares with data from PromiseShip showing that the average length of employment for people who left employment in the past 90 days is 499 days—less than 18 months.⁸² However, TSG recognizes that PromiseShip has only been working cases for a few years.

⁸² TSG analysis of PromiseShip data in the file “18 - #18 Terms for FPS 90 Day.xlsx”

Figure 16-13: Cases per Case Worker



16.5.3. Low Experience Level of Case Workers

A related metric is how many cases a caseworker works. TSG looked at total cases, assuming that case work experiences a “learning curve”. A caseworker that has worked hundreds of cases is likely to perform better than one that has not—no matter how many months those cases cover. TSG found that 59% of caseworkers across all regions work fewer than 50 cases in their career. Indeed 80% work fewer than 200 cases. Thus, TSG observes that most case workers never get “far down the learning curve”—they fail to gain the experience level required to achieve high case performance.

Looking to traditional turnover information from PromiseShip, a similar picture emerges. PromiseShip reports having lost 252 PFSs since the beginning of calendar 2015: 227 voluntary and 25 involuntary⁸³. Note that the TSG method found 257 “exits”—essentially the same number as terminations⁸⁴. ESA caseworker “exits”. PromiseShip also reports having hired 343 new PFSs in the same period.⁸⁵

16.5.4. State Reported Turnover

DHHS provided TSG a file that reported turnover rates of 3-4% per month⁸⁶. However, that report seems to underreport the number of case workers leaving “active duty” and overreport the number of case workers. According to the DHHS count in the turnover report, the agency had

⁸³ TSG analysis of PromiseShip data in the file “17 - FPS Termination Data Update B.pdf”

⁸⁴ This number is created by summing the terminations graphed using the “exit” method described above over the period January 2015 through October 2018.

⁸⁵ TSG analysis of PromiseShip data in the file “19 - Number of New Employment Offers to Caseworkers.pdf”

⁸⁶ DHHS data in the file “Headcount and turnover for state 2018.xlsx”

430 case workers: 362 working cases and 68 working cases. This is only DCFS employees. However, the state N-FOCUS system listed 411 unique individuals working cases, including those employed by PromiseShip. Of those, 183 were in the ESA and 228 in the rest of the state. TSG was not able to obtain solid information about which of the ESA caseworkers are employed by PromiseShip. However, 51 of the 183 are not listed in the PromiseShip records. Thus, TSG's best estimate is that DCFS had 279 caseworkers in its employ with active caseloads in September 2018—not 362 as reported in the turnover report.

In addition, the DHHS turnover report listed 19 separations during August (average of 14 in each month of SFY2018). Confirming that number, DCFS's case files show that 19 case workers ceased have caseloads during September. TSG found an average of 16 caseworkers stopped working caseloads each month in calendar 2018—a few more than DHHS reported for the other months in the year.

Thus, it appears that DHHS' reported turnover numbers include far more workers in the denominator (and possibly a few too few in the numerator), thus under-reporting the real business effect of turnover. TSG recognizes that DHHS is compelled to report turnover using standard federal methodology. However, the purpose of the TSG assessment is to assess to business facts of the situation, not federal reporting compliance. Accordingly, TSG has observed the real impact on DCFS' need to replace and train new case workers—by using the “exit” method described above.

Turnover is thus a serious issue for child protection in Nebraska. The problem seems to effect DCFS and PromiseShip equally. In fact, other states nationally face high caseworker turnover. However, TSG finds that the State seems to be under-reporting the true dimension of the problem. In addition, TSG found no indication that DCFS is collaborating with PromiseShip to improve turnover.

17. APPENDIX D: FLORIDA REQUIRED COLLABORATIONS

In Florida for example, the contract requires the following such agreements and collaborations:

- “The Lead Agency shall work in partnership with local agencies on the implementation and ongoing management of local interagency or working agreements.
- The Lead Agency shall work with the Department’s regional, circuit, or county staff to establish and take the lead on maintaining working agreements with other providers and Department entities, local housing authorities, local work force initiatives, and other local organizations in order to fully implement the requirements of the local child welfare System of Care. Working agreements shall clarify roles and responsibilities, establish a shared vision, and promote integrated community support and services in order to improve outcomes for families involved in the child welfare system.
- The Lead Agency shall establish and maintain working agreements to include joint operating procedures with entities providing child protective investigations in counties served by the Lead Agency under this Contract.
- The Lead Agency shall assist the Department’s regional staff in developing interagency working agreement(s) with Federally Qualified Health Care Centers or Rural Health Care Centers that are located in its area of operation to address at least the following areas where applicable: dental services for children and families; medical and behavioral health care services for children and parents, including for parents without health care insurance coverage; nursing case management and health care coordination; and supportive services, such as transportation.
- The Lead Agency shall work in partnership with the Department and its local Managing Entity on the development and implementation of a working agreement addressing the integration of child welfare and behavioral health.
- The Lead Agency shall dedicate resources to the execution of, and work in conjunction with the Department on the implementation and ongoing management of local and state plans for the promotion of adoption, support of adoptive families, post adoption services and support, and prevention of abuse, abandonment, and neglect of children;
- The Lead Agency shall dedicate resources to the execution of, and take the lead on, the implementation and ongoing management of local action plans for the early development and education of children and youth in out-of-home care. The goal of the local action plan is to improve the educational, employment and life skill outcomes for children and will address the need to identify any barriers that stand in the way of their doing well in school and work. The plan should also include assisting young children in school readiness, including access to quality child care, Early Head Start or Head Start, early childhood special education, Early Steps, and other early development and learning opportunities;
- The Lead Agency shall participate in regional, local and community level task forces related to human trafficking.....;

- The Lead Agency shall work with the Department's regional criminal justice staff to establish and maintain working agreements with all local law enforcement agencies contained within the Lead Agency's service area. These working agreements shall clarify the roles, responsibilities, and information-sharing requirements as they relate to the reporting, investigation, and recovery of missing children. The Lead Agency will also ensure that it has provided and continually updates all law enforcement agencies