Nebraska Children's Commission

First Meeting
June 7, 2012
1:00-3:15 pm
Hruska Law Center
635 S 14th Street, Lincoln, NE

Minutes

Call to Order

Kerry Winterer called the meeting to order at 1:00pm. The Open Meetings Act information is posted in the back of the meeting room as required by state law.

Roll Call

Commission Members present: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer.

Commission Members absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab.

Ex Officio Members present: Ellen Brokofsky, Senator Kathy Campbell, Senator Colby Coash, Senator Lavon Heidemann, Hon. Linda Porter, and Kelli Hauptman representing Vicky Weisz.

Also in attendance: Governor Dave Heineman; Vicki Maca, Sara Goscha, Terri Nutzman, Chris Hanus, Wes Nespor, Kathie Osterman, Russ Reno, and Bonnie Engel from the Department of Health and Human Services; Jeremiah Blake from the Governor's Policy Research Office; and Elton Larson from the Department of Administrative Services Budget Division.

Welcome – Governor Heineman

Governor Heineman welcomed members and thanked them for agreeing to serve on the Children's Commission. He stated they have a special responsibility and an opportunity to make a real difference for children and families in Nebraska and to assist the Department of Health and Human Services (DHHS) in the development of a strategic plan and structure of the Division of Children and Family Services. He encouraged the Commission to be very open and fully transparent in all discussions and ideas, no secret offline conversations with only a few members.

Approval of Agenda

A motion was made by Thomas Pristow to approve the agenda as presented, seconded by John Northrop. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen,

Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Adopt Procedural Rules

Roberts Rules of Order

A motion was made by Gene Klein to adopt Roberts Rules of Order, seconded by Thomas Pristow. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Rule for publication of public notices

A motion was made by Thomas Pristow to give published notice of meetings to members of the Commission by regular United States mail or e-mail and to the public by posting to the Nebraska Government Website public meeting calendar, seconded by Candy Kennedy-Goergen. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Presentation on open meetings/public records requirements

Wes Nespor, Deputy Administrator, DHHS Legal Services, provided a presentation on the general guidelines for open meetings and public records requirements. By default quorum for the Commission is 13 members and for simple motions to carry, a majority of voting members present in the quorum is required.

Comments – Senator Campbell

Senator Campbell thanked Governor Heineman and Kerry Winterer for their remarks, echoed the Governor's thanks to members for their willingness to serve on the Children's Commission, and the importance of setting a strategic direction. Copies of the *Health and Human Services Committee LR 37 Report – December 15, 2011* was provided to members. Senator Campbell encouraged members to be honest in the problems when discussing, share among all their concerns and questions, to be honest about the solutions, and to work collaboratively to find honest answers in building the future.

Self-introduction of Commission Members

Commission members introduced themselves giving a brief overview of their background.

Overview of Commission duties

Kerry Winterer provided an overview of the Commission's duties. The Nebraska Children's Commission was created as a high-level leadership body to create a statewide strategic plan for reform of the child welfare system programs and services, review the operations of DHHS regarding child welfare programs and services and recommend options for attaining legislative intent of LB821. LB821 also mandates the Commission to select a chairperson and vice-chairperson, hire staff, hire a consultant to provide assistance in developing the statewide strategic plan, and provide direction to DHHS in issuing an RFP for Medicaid analyst. The Commission will also create committees to examine state policy regarding the prescription of psychotropic drugs and the structure and responsibilities of the Office of Juvenile Services. The Title IV-E Demonstration Project Committee and the Foster Care Reimbursement Rate Committee will become a part of the Commission. The Commission shall provide a written report to the Health and Human Services Committee of the Legislature on the status of its activities on or before August 1, 2012, September 15, 2012, and November 1, 2012. The Commission shall complete the statewide strategic plan and provide a written report to the Health and Human Services Committee of the Legislature and the Governor on or before December 15, 2012.

The Commission will terminate on June 30, 2014, unless continued by the Legislature.

Members of the Commission will be reimbursed for their actual and necessary expenses as members in accordance with State employee reimbursement guidelines. To be reimbursed completion of the Direct Deposit Enrollment Form, Form W-4 (2012) and the Expense Reimbursement for Non-State Employees form are to be completed.

Election of Chairperson and Vice Chairperson

David Newell nominated Karen Authier to be Chairperson. No other nominations were received and nominations were closed. A motion was made by David Newell to appoint Karen Authier as Chairperson, seconded by Gene Klein. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Candy Kennedy-Goergen nominated Beth Baxter for Vice Chairperson. No other nominations were received and nominations were closed. A motion was made by Candy Kennedy-Goergen to appoint Beth Baxter as Vice Chairperson, seconded by John Northrop. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Background/overview of CFS Division and reform efforts

Thomas Pristow presented an overview of the Division of Children and Family Services and reform efforts.

New Business

Authorize Chairperson, Vice Chairperson, and CEO to hire staff (LB821, Sec 2(4))

A motion was made by Gene Klein to authorize Chairperson, Vice Chairperson, and CEO to move forward to get staff in place, seconded by John Northrop. A motion was made by Thomas Pristow to amend the previous motion to allow for one or two Commission members to provide input into the hiring decision and for the Chairperson, Vice Chairperson, and CEO to do the actual hiring, seconded by Lisa Lechowicz. Candy Kennedy-Goergen and Lisa Lechowicz volunteered. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

The Commission then voted on the main motion as follows: Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Authorize DHHS to issue RFP for strategic planning consultant (LB821, Sec 1(4))

A motion was made by Candy Kennedy-Goergen to authorize DHHS to issue RFP for strategic planning consultant, seconded by Kerry Winterer. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Volunteering to serve on committee to provide input are Lisa Lechowicz, David Newell, Gene Klein, Dale Shotkoski, Karen Authier, and Beth Baxter. Thomas Pristow set the timeline to have comments by Friday, June 15.

Authorize DHHS to issue RFP for Medicaid analyst (LB821, Sec 5)

A motion was made by Gene Klein to authorize DHHS to issue RFP for Medicaid analyst with members who want to participate in the development, seconded by Jennifer Nelson. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Volunteering to serve on committee are Jennifer Nelson and Beth Baxter. Karen Authier asked Beth Baxter to take the lead in gathering input. Thomas Pristow set the timeline to have comments by Friday, June 15.

Create committee to examine use of psychotropic drugs (LB821, Sec 3(2)(a))
Create committee to examine the structure and responsibilities of the Office of Juvenile Services (LB821, Sec 3(2)(b))

A motion was made by Gene Klein to create both committees and populate within next few weeks, each committee to have no more than ten members (can be non-members of Commission), and Chair and Co-Chair of committees be Commission members for a total of 12 members on each committee, seconded by Candy Kennedy-Goergen. Voting yes: Karen Authier, Beth Baxter, Nancy Forney, Candy Kennedy-Goergen, Gene Klein, Martin Klein, Norman Langemach, Lisa Lechowicz, Thomas Pristow, Jennifer Nelson, David Newell, John Northrop, Dale Shotkoski, Becky Sorensen, and Kerry Winterer. No opposition. Absent: Janteice Holston, Mary Jo Pankoke, and Susan Staab. Motion carried.

Committee regarding psychotropic drugs: Jennifer Nelson volunteered to Chair, and Candy Kennedy-Goergen volunteered to Co-Chair; Beth Baxter, Norman Langemach, and Vicky Weisz volunteered to serve on Committee.

Committee regarding Office of Juvenile Services: Martin Klein volunteered to Chair and Ellen Brokofsky volunteered to serve on Committee.

General Discussion no action item

Future Meeting Dates

Next meeting is July 16, 9:00-12:00pm, location to be determined.

Adjourn

A motion was made by Gene Klein to adjourn the meeting, seconded by Jennifer Nelson. The meeting adjourned at 3:24pm.

Nebraska Children's Commission

Review of Responsibilities

Work Plan

1. Formation of Commission Committees on psychotropic medication and juvenile services and development of committee work plans with attention to the language in LB 821 that outlines committee responsibilities.

2. Integrate the IV-E Demonstration Project Committee and the Foster Care Rate Reimbursement Committee into the structure of the Commission.

3. Hire staff and provide orientation to specific responsibilities of the position.

4. Create a statewide strategic plan for reform of the child welfare system programs and services with attention to the following steps:
   - Engage a strategic planning consultant and work with the consultant to establish a plan, including timelines, for the strategic planning process;
   - Review the operations of the department regarding child welfare programs and services;
   - Develop recommendations for child welfare restructuring and reform as specified in LB 821.

5. Coordinate with DHHS regarding an independent entity engaged as a contractor to conduct cross-system analysis of prevention and intervention programs and services provided by the department for the safety, health, and well-being of children with attention to current and potential funding sources for those programs.

6. Develop working relationships and establish a plan for cross communication with the following entities to work toward the shared goal of establishing collaborative public/private networks in each service area to strengthen the continuum of resources and services for children and juveniles impacted by the child welfare system or outside that system:
   - Service area administrators
   - Lead agency pilot
   - 1184 Teams
   - Child Advocacy Centers
   - Office of Probation Administration

- Crossover Youth Program
- Juvenile Service Delivery Programs
- Local Foster Care Review Boards
- Eyes of the Child Teams
- Office of the State Court Administrator
- Mediation Centers
- Behavioral Health Regions
- Child welfare advocates
- Community stakeholders

7. Submit written reports to the HHS Committee per the schedule provided in LB 821.

Committee to Examine Prescription of Psychotropic Drugs

Proposed Membership

Chairperson: Jennifer Nelson

Co- Chairperson: Candy Kennedy - Goergen

Commission members

- Beth Baxter
- Norman Langemach
- Vicky Weisz

Other individuals who have agreed to serve on the committee:

- Amanda Blankenship, CASA, Lincoln
- Carla Lasley, Collaborative Industries; formerly Division of Developmental Disabilities NDHHS
- Kayla Pope, M.D., psychiatrist, Boys Town National Research Hospital
- Blaine Shaffer, M.D., Chief Clinical Officer Division of Behavioral Health, NDHHS
- Gary Rihanek, PharmD, Wagey Drugs, Lincoln
- Kristi Weber, PRN (psychiatric and family medicine), VP of Program, Epworth Village; private clinical practice
- Gregg Wright, M.D., M.Ed Center on Children, Families and the Law; pediatrician; public health

Juvenile Services Committee

Proposed Membership

Chairperson: Martin Klein

Co-Chairperson: Ellen Brokofsky

Commission Members

- Senator Kathy Campbell
- Senator Colby Coash

Individuals who have agreed to serve on the Committee

- Kim Culp – Douglas County Juvenile Assessment Center Director
- Rachel Daughterty - Hall County Public Defender's Office
- Sarah Forrest - Voices for Children
- Judge Larry Gendler - 2nd Judicial District/Sarpy County Juvenile Court
- Kim Hawekottee – CEO, KVC
- Anne Hobbs – UNO Juvenile Justice Institute
- Ron Johns - Gering Detention Center Director
- Nick Juliano - Boys Town
- Corey Steel - Assistant Deputy Administrator for Juvenile Services/Office of Probation Administration
- Monica Miles Steffens - Juvenile Detention Alternatives State Director

Individuals who would serve in a resource/advisory capacity to the Committee

Terri Nutzman - Director of the Office of Juvenile Services - Resource to the Committee
Dr. Liz Neeley - Supreme Court Minority Justice Committee - Resource to the Committee

Department of Health & Human Services
DHHS
NEBRASKA

The History of Protection and Safety in Nebraska

1962

The Department of Public Welfare became an executive department.

The state Department of Public Welfare was responsible for monitoring the county public welfare offices, which were responsible for the administration of programs and service delivery and the costs associated with those responsibilities including child welfare.

1983

Beginning July 1, 1983, responsibility for direct administration of public welfare and social service programs was transferred from separate county public welfare offices to the state agency to provide for consistent program administration and policy statewide. The name of the state agency also changed from Public Welfare to Social Services to reflect more accurately its purpose of providing assistance to Nebraskans who can no longer provide for themselves. The DSS director was appointed by the Governor.

Central Office: The DSS Human Services Division set policies and procedures for programs for children, families and adults in the areas of Services to Children and Families, the Nebraska Center for Children and Youth, Community Service Block Grant, and Services to the Aged and Disabled. The Division Administrator reported to the agency Director.

Field: The state was divided into eight geographic Districts with District Administrators reporting to a Deputy Director for Client Services Delivery. Employees in the Districts were responsible for the delivery of services, including child welfare programs.

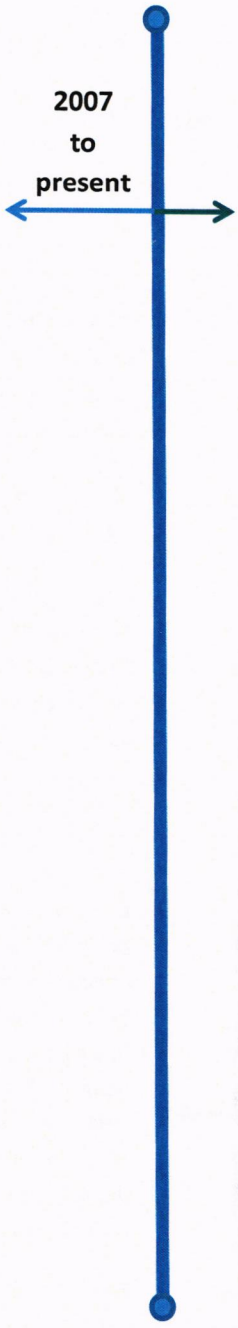
1997

The Nebraska Health and Human Services System (LB 1044) was created from a merger of five state agencies into one System with three separate agencies. It was managed by a Policy Cabinet consisting of the three agency Directors, a Policy Secretary and a Chief Medical Officer, all appointed by the Governor. The agencies that merged were the Departments of Health, Social Services, Aging, Public Institutions and the Office of Juvenile Services from the Department of Correctional Services. The three new agencies were Finance and Support, Regulation and Licensure, and Services.

Central Office: The Department of Services included programs for aging and disability services, protection and safely, behavioral health, disease prevention and health promotion, economic and family support, family health, rural health, minority health and women's health. This structure was fine-tuned and by 1999, the Office of Protection and Safety included Children and Family Services and the Office of Juvenile Services. A deputy director for the Office of Protection and Safety reported to the Services director.

Field: In 1997, the state was divided into six geographic Service Areas with Service Area Administrators reporting to a Chief Deputy Director. This changed by 2002 to three Service Areas and by 2004 to five Service Areas. Employees in the Service Areas were responsible for the delivery of services, including child welfare and juvenile services programs.

LB 296 created one Department of Health and Human Services under direction of a CEO. It includes six Divisions including Behavioral Health, Children and Family Services, Developmental Disabilities, Public Health, Medicaid and Long-Term Care and Veterans' Homes. The CEO and six Division Directors are appointed by the Governor.



Central Office: The Division of Children and Family Services includes protection and safety services and economic assistance services including child support. The Protection and Safety Section sets policy and procedures for child welfare and adult protective services. A Protection and Safety Policy Chief reports to the CFS director. The Administrator of the Office of Juvenile Services reports to the CFS Director.

Field: The state is divided into five Service Areas with Service Area Administrators assigned specifically to Protection and Safety (child welfare and juvenile services) work who report to a Deputy Director for Child Welfare Operations who reports to the CFS Director. The employees responsible for child welfare and juvenile services in the Service Areas are responsible for meeting the outcomes of safety, permanency and well-being.

Information gathered from the Nebraska Blue Book and historical documents.

Child Welfare

Child Abuse and Neglect Report

DHHS Intake/Hot Line

DHHS Initial Safety Assessment Field Investigation

Is child Safe?

Yes — No Lead Agency Involvement Case Closed

No

Temporary Custody Order Issued

DHHS Refers to Lead Agency

DHHS (Initial Assessment) Sole Responsibility

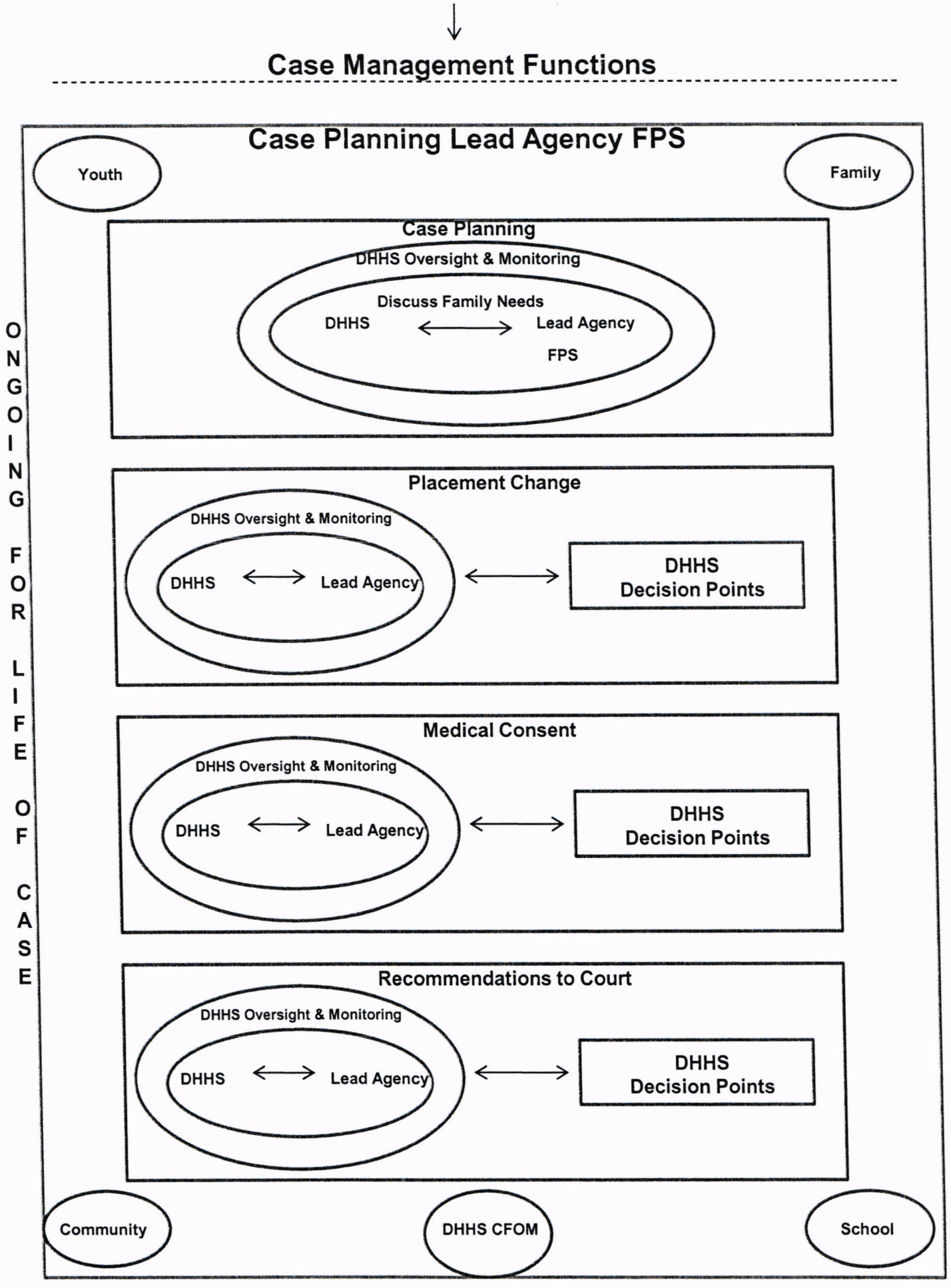
DHHS Oversight & Monitoring

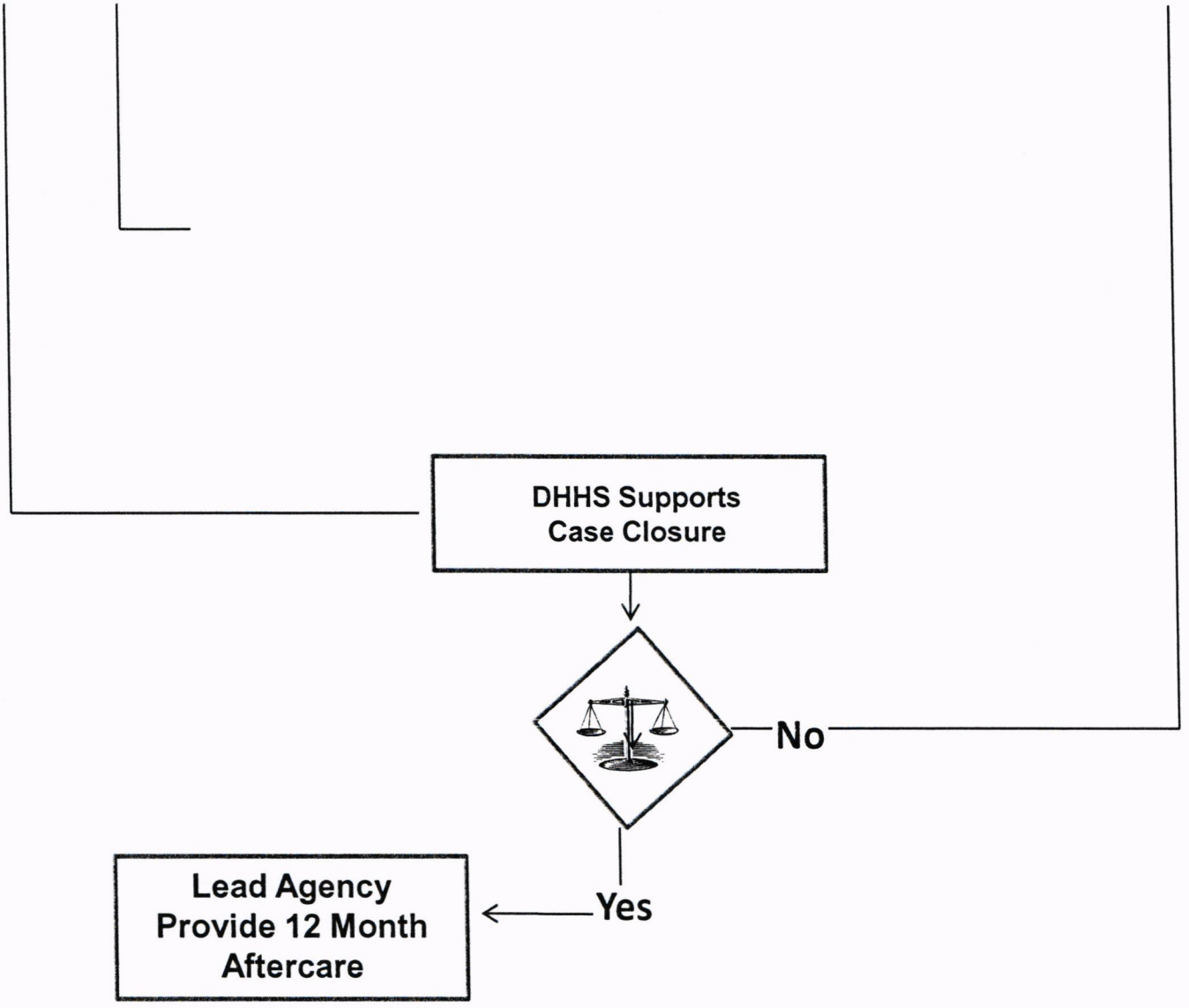
Discuss Family Needs

DHHS ⟷ Lead Agency

Initial Assessment

FTM


Case Management Functions
Case Planning Lead Agency FPS
Youth
Family
Case Planning
DHHS Oversight & Monitoring
Discuss Family Needs
DHHS
Lead Agency
FPS
Placement Change
DHHS Oversight & Monitoring
DHHS
Lead Agency
DHHS
Decision Points
Medical Consent
DHHS Oversight & Monitoring
DHHS
Lead Agency
DHHS
Decision Points
Recommendations to Court
DHHS Oversight & Monitoring
DHHS
Lead Agency
DHHS
Decision Points
ONGOING FOR LIFE OF CASE
Community
DHHS CFOM
School


DHHS Supports
Case Closure
No
Yes
Lead Agency
Provide 12 Month
Aftercare

Nebraska Families COLLABORATIVE℠

CFSR Measures from Nebraska DHHS COMPASS Reports:
http://dhhs.ne.gov/children_family_services/Pages/COMPASS.aspx
Historical Best Score data extracted from COMPASS Measure titled
"Trends in the past 5-years by quarter"

						May 2012		
CFSR Measure: Timeliness and Permanency of Reunification	Federal Benchmark	State Historical Best Score		ESA Historical Best Score		ESA Score	Douglas County Score	Sarpy County Score
Composite	122.6	Mar '10	114.11	Sep '07	120.75	114.1	114.0	115.1
Exits to Reunification in< 12 months of most recent entry	75.2%	Mar '10	67.6%	Mar '10	68.4%	59.6%	60.3%	53.6%
Exits to Reunification in <12 months of 1st Entry	48.4%	Mar '09	48.8%	Mar '09	51.4%	45.6%	44.9%	54.7%
Reentries into care in < less 12 months of discharge (lower scores preferable)	9.9%	Mar '12	11.7%	Mar '08	9.2%	10.5%	10.8%	9.2%
Median score in months (lower scores preferable)	5.4 months	Mar '10	7.9 months	Mar '10	7.6	9.4	9.3	9.5

						May 2012		
CFSR Measure: Placement Stability	Federal Benchmark	State Historical Best Score		ESA Historical Best Score		ESA Score	Douglas County Score	Sarpy County Score
Composite	101.5	Mar '12	97.26	Mar '12	97.11	97.69	98.38	93.46
Children in care for < 12 months with 2 or fewer placements	86%	Mar '12	88.2%	Mar '12	85.7%	85.6%	85.4%	85.7%
Children in care for 12-24 months with 2 or fewer placements	65.4%	Mar '11	58.9%	Mar '11	64.2%	62.9%	63.2%	67%
Children in care for 24+ months with 2 or fewer placements	41.8%	Mar '12	34.7%	Mar '12	35.6%	35.9%	37.8%	20.8%

						May 2012		
CFSR Measure: Timeliness and Adoptions	Federal Benchmark	State Historical Best Score		ESA Historical Best Score		ESA Score	Douglas County Score	Sarpy County Score
Composite	106.4	Sept '09	129.14	Sept '09	130.77	98.65	91.43	136.76
Exits to Adoption in < 24 months	36.6%	Mar '11	36.7%	Sept' 09	35.5%	25.6%	22.6%	40%
Children in Care 17+ months and adopted w/in 12 months	22.7%	Sept '09	28.7%	Sept' 09	27.8%	21.2%	20.7%	30.8%
Children in Care 17+ months & legally free for adoption w/in 6 months	10.9%	Sep '09	15%	Mar '10	17.6%	12.4%	12.4%	13.73%
Children Legally free for adoption and adopted in < 12 months	53.7%	Mar '10	68.7%	Sept '09	69.5%	44.3%	38.3%	69%
Median months in care (lower score is preferable)	27.3 months	Sept '10	27.7 months	Mar '10	28.6 months	31.34 months	32.26 months	29.8 months

						May 2012		
CFSR Measure: Permanency	Federal Benchmark	State Historical Best Score		ESA Historical Best Score		ESA Score	Douglas County Score	Sarpy County Score
Composite	121.7	Sept '09	160.1	Sep '09	154.6	149.41	149.76	154.44
Children in care 24+ months and discharged to a permanent home	29.1%	Sept '09	43.6%	Mar '09	41%	35.1%	34.7%	40%
Children legally free for adoption and discharged to a permanent home	98%	Sept '09	98.6%	Sep '07	98.8%	96%	96%	95.8%
Children in care 3+ years and discharged to Independent living or turned 18 (lower score is preferable)	37.5%	Mar '12	16.2%	Mar '12	17.4%	19.7%	18.9%	20%

						May 2012		
CFSR Measure: Safety	Federal Benchmark	State Historical Best Score		ESA Historical Best Score		ESA Score	Douglas County Score	Sarpy County Score
Absence of Recurrent Maltreatment	94.6%	March '09	93.3%	Sept '11	94.5%	93.3%	93.3%	100%
Absence of Maltreatment in Foster Care	99.68%	March '08	99.8%	Mar '08	99.82%	99.62%	99.57%	100%

The Privatization of Child Welfare

Shared decision making between private and public entities is critical for success

> The message for members of the Alliance for Children and Families is this: be prepared, and be at the table. Know what to expect, understand how to influence the process, and draw lessons from other states' missteps.

Fueled by the belief that privatization is a more effective way to deliver services, the movement to privatize child welfare services continues to gain steam. At least 14 states already have some level of privatization (see map on page 9), and the movement is seemingly on the horizon for several others. (See the online edition of this article at alliance1.org/magazine for background information about privatization in child welfare and how it changes the roles and responsibilities of public and private entities.)

Successes in Illinois, Florida, and other states provide evidence that privatization can lead to better outcomes for children and families, greater accountability, and increased efficiencies.

Yet, less successful implementations have marred public opinion. For example, in Nebraska, three of the original five private providers have declared bankruptcy or

Continued on page 8

withdrawn from their contract. Also, a lawsuit brought by the largest state employee union led to a court injunction that prohibits Washington from contracting with lead agencies.

"Privatization can be a scary proposition for providers," says Mike Patrick, COO and president of operations at Alliance for Children and Families member TFI Family Services, Topeka, Kan. "But when done correctly, it can be a huge success. I'm a big proponent."

> "Although there were a lot of critics at first, audits and independent reviews show the same thing: Kansas and its children are now in much better shape."
>
> —*Mike Patrick, COO and president of operations, TFI Family Services*

As with any endeavor, "doing it correctly" requires realistic expectations. For example, although privatization often is touted as a cost-saving measure, most evidence doesn't support this, at least not in the short term. Instead, efficiency and quality must be the true aspirations, says Alliance COO Polina Makievsky.

"States have to be motivated by the desire to pay for better quality and more efficient services that create meaningful change for children and families, not by a short-term fiscal benefit," she says. "In fact, some states have had to increase their spending after privatizing, a testament to what we already knew: the system, in general, is grossly underfunded."

Rough Transition in Kansas Evolves

When Kansas settled a 1993 lawsuit that alleged inadequate care, excessive caseloads, and poor outcomes in its child welfare system, it privatized in a hurry—the first state to do so.

The state moved to a privatized, performance-based contracting system. The state was split into five regions, with one provider selected for each. TFI Family Services was awarded the foster care and adoption contract for two of these regions. (See the online version of this article at alliance1.org/magazine for background information about performance-based contracting and how it relates to privatization.)

"The state had to invest more money in its child welfare system, but the quality of services went up exponentially, while ensuring children were safe and no longer lingering in the foster care system," Patrick says. "Although there were a lot of critics at first, audits and independent reviews show the same thing: Kansas and its children are now in much better shape."

So is TFI Family Services. The agency's budget has grown from about $7 million in 2000 to about $75 million today. The reintegration, foster care, and adoption contract represent about 60 percent of the agency's total budget.

The first few years were rough, Patrick admits. Agencies received no state funding for start-up costs, which were significant. Contracting agencies had to develop sophisticated internal management tools, such as comprehensive information technology systems, to quickly capture and measure outcomes. This was one of TFI's largest investments, but has proven to be one of the largest factors in the organization's success under the privatized system.

Moreover, the move to around-the-clock, community-based services and performance-based contracting was both a system and a culture change for the agency. It experienced high staff turnover during the first year. TFI invested in intensive training to ensure staff understood the direct line between their work, how the agency is judged, and long-term improvement for children. Today, internal surveying has revealed that staff have a greater sense of empowerment and increased job satisfaction.

True Partnership in Illinois

In Illinois, privatization happened more organically, says Erwin McEwen, director of Illinois Department of Children and Families (DCF).

Since the early 1900s, private providers have carried out the state's child welfare work. It was at their urging that the state created DCF during the 1950s. The standalone, cabinet-level department reports directly to the governor. A state-mandated Child Welfare Advisory Committee unites public officials and leaders of private agencies in a true partnership of joint decision making and accountability.

Several chief executives of Alliance member organizations are members of the advisory committee: Margaret Berglind,

president and CEO of Child Care Association of Illinois, Springfield; Bill Gillis, president and CEO of One Hope United, Chicago; Mary Hollie, CEO of Lawrence Hall Youth Services, Chicago; and Clete Winkelmann, president and CEO of Children's Home Association of Illinois, Peoria.

Despite the large role for private providers, until 1995, public sector caseworkers had overall authority for the approximately 80 percent of DCF adoption and foster care cases managed in the private sector. A lawsuit and consent decree compelled DCF to turn full case management authority over to private providers.

The state also shifted from a per diem foster care rate to a case rate, which was based on a caseload of 25 cases to every one caseworker. Today the state bases its case rate on a 15 to one caseload.

Performance-based contracting in adoption and foster care has been so successful that it was expanded to include other child welfare services in Illinois.

"I don't think people understand that it's far more expensive to operate a poorly run child welfare system," McEwen says. "Performance-based contracting incentivizes real outcomes, not just activities. We achieved cost-savings by reducing the number of children in foster care."

Inclusive Process Improves Outcomes in Missouri

In 2005, Missouri also privatized foster care management and implemented performance-based contracting. Alliance member Cornerstones of Care, Kansas City, Mo., was ready.

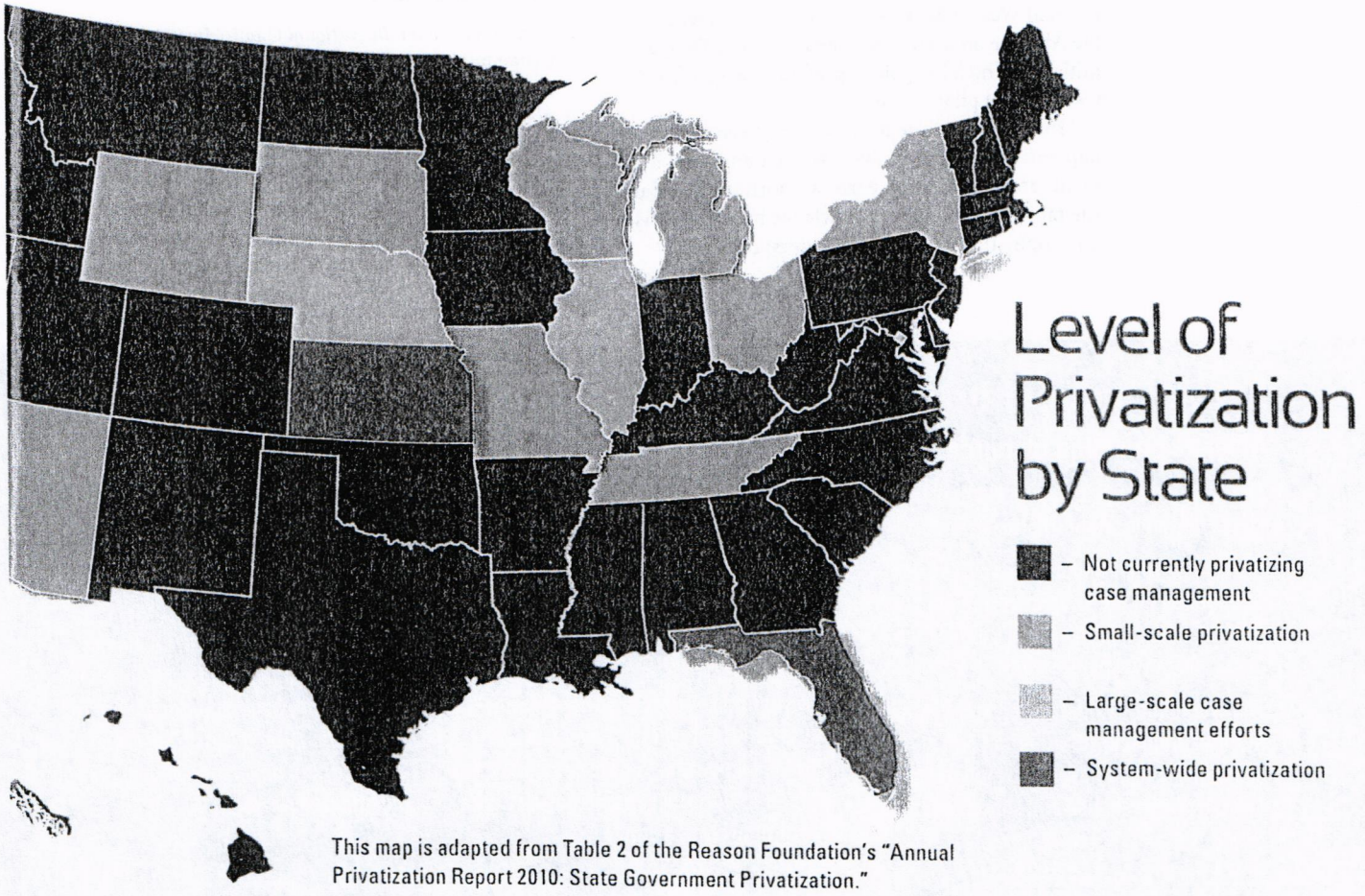
The organization had been created during the late 1990s as an alliance of five independent child and family service agencies. One of the primary goals of the creation of Cornerstones of Care was to position the organization for privatization.

Denise Cross, president and CEO of Cornerstones, was on the other side of the table when Missouri first explored privatizing foster care case management; she held responsibility for child welfare for the state.

"The process was very inclusive from the beginning, with private providers and state officials working collaboratively in the best interests of children," Cross says. "Providers helped plan what the system would look like and made sure we were identifying the right measures."

Under privatization, lead agencies receive a flat monthly case rate based on an average caseload. They can subcontract with other providers as needed, and performance goals are tied to financial incentives.

Continued on page 10



This map is adapted from Table 2 of the Reason Foundation's "Annual Privatization Report 2010: State Government Privatization."

Cornerstones is a lead agency in four western Missouri counties, and Cross says that the case rate gives the organization flexibility in meeting its performance goals.

"It's a good partnership for Cornerstones, and we have seen real improvements in quality and outcomes for Missouri kids," she adds. "We were very thoughtful going into this and have been able to manage the fluctuations in costs."

Private Providers Should Take a Seat at the Table

The biggest lesson for private providers, no matter where their state is with privatization discussions, is to be at the table.

Often private providers identify trends, emerging needs, and gaps in service, all of which may inform the public sector, Cross says. She urges Alliance members to begin conversations early with appointed and elected officials at the state, county, and local levels. Providers can play a critical role in shaping service delivery and performance outcomes. Ultimately, this helps to influence state law and public policy.

"Services may not look the way they've looked in the past," Cross adds. "It's important for providers to be very forward looking in advocating for children and families. It's too late by the time the RFP comes out."

The Alliance helps ensure its members have a voice in the privatization discussion at the national level through its seat on the advisory board of the National Quality Improvement Center on the Privatization of Child Welfare Services. Makievsky represents the Alliance on the advisory board for this five-year initiative, which has gained profound insight from research and pilot studies.

"This isn't the time to sit back and see what happens," Makievsky says. "The Alliance and its members must take an early, authoritative seat at the table. We bring our knowledge base, expertise, and sophisticated data. We understand the challenges, and we are the keepers of the solutions states urgently need." ■

Learn more about the National Quality Improvement Center on the Privatization of Child Welfare Services at uky.edu/SocialWork/qicpcw. For more information about the members in this article, visit their websites: cca-il.site-ym.com for Child Care Association of Illinois, chail.org for Children's Home Association of Illinois, cornerstonesofcare.org for Cornerstones, lawrencehall.org for Lawrence Hall Youth Services, onehopeunited.org for One Hope United, and tfifamilyservices.org for TFI.

Elements of Success

The states that have been the most successful in implementing privatization and performance-based contracting have incorporated these crucial elements of success:

- Private providers are involved early and continue to be engaged.
- A data-driven system quantifies the approaches that have the highest success.
- The state gives private providers full case management authority.
- Performance-based contracts include financial incentives and penalties.
- The state maintains adequate monitoring of private providers and performance outcomes.
- The system provides flexibility in achieving performance, which fosters innovation.
- The system is adequately funded, and providers are reimbursed enough to cover service delivery, infrastructure, and capacity building.
- Money saved is reinvested in the system.

Delve Deeper into Child Welfare Privatization

Alliance providing resources at 2011 National Conference and through the Severson Center

The Alliance provides several opportunities to learn more about privatization.

First, members are encouraged to attend a workshop on the subject during the 2011 Alliance and UNCA National Conference, Oct. 17-19 in Washington, D.C.

The workshop, "Privatization and System Reform: Choosing Whether to Lead or to Follow," will review three models for system reform. It also will share variables that impact decisions concerning case management and risk mitigation. Presenters will focus on questions that individual organizations must address in order to decide whether to lead or follow in their state's reform efforts.

The second resource is the Alliance Severson Center. The Severson Center's DocuShare database provides access to various reports and articles about to privatization.

Additionally, members may contact the Severson Center directly with specific research requests related to privatization.

Learn more about the 2011 National Conference at alliance1.org/nc11. Visit alliance1.org/severson/docushare for information about DocuShare, and go to alliance1.org/severson/request to request customized research.

Child Welfare Privatization Initiatives—
Assessing Their Implications for the Child Welfare Field and for Federal Child Welfare Programs

Topical Paper #1

Assessing Site Readiness:

Considerations about Transitioning to a Privatized Child Welfare System

September 2007

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

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This project builds on the resources available at the Quality Improvement Center on the Privatization of Child Welfare Services (QIC PCW), funded by the Children's Bureau. We want to acknowledge all of the state and county child welfare administrators and private providers that shared their experiences with us and the QIC PCW. Additional information on child welfare privatization issues is available through the QIC PCW website: http://www.uky.edu/SocialWork/qicpcw/.

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Assessing Site Readiness: Considerations about Transitioning to a Privatized System

Introduction

In 2006, the Office of the Assistant Secretary for Planning and Evaluation funded the ***Child Welfare Privatization Initiatives Project*** to provide information to state and local child welfare administrators who are considering or implementing privatization reforms. The project will produce six technical assistance papers on a range of topics providing insights about factors that should be considered when approaching or improving upon, privatization efforts.

The purpose of this first paper is to help child welfare administrators think through key issues about transitioning to a privatized system of service delivery. The paper is organized around 12 overarching questions that administrators need to ask themselves when assessing the "readiness" of their site. Some questions encourage sites to explore specifically why they are privatizing services and whether or not privatization is the best approach to meeting agency goals. The remaining five papers in this series will examine other specific areas. These are:

- Models of Privatization Reform
- Evolving Roles of Public and Private Agencies
- Developing Effective Contracts
- Contract Monitoring and Accountability
- Evaluating Privatization Initiatives

This paper series builds on research, described below, conducted under the Quality Improvement Center on the Privatization of Child Welfare Services (QIC PCW), funded in 2005 by the Children's Bureau, US Department of Health and Human Services. It also draws from the research on privatization in other, closely related social services. Information used for this paper series comes from several sources, including:

- Telephone discussions with state child welfare administrators from 44 states and the District of Columbia;
- Regional forums with public and private agency staff and community stakeholders from twelve states that have privatized at least one component of the child welfare system;
- Literature reviews; and
- Follow-up interviews and correspondence with public and private agency providers and key stakeholders from several states.

From this work we have learned that many states and communities have strong privatization initiatives that continue to move forward. However, some communities have tested privatization and have pulled back from these efforts, largely due to poor performance on expected outcomes. Several existing initiatives have been significantly retooled based on lessons learned and unanticipated consequences of the privatized system.

Privatizing services is complicated and is often politicized. The purpose of this first paper is to inform public and private agency partners as well as legislators as they make decisions about privatizing service. It is designed to encourage agency administrators and legislators to ask critical questions and make important choices *prior* to the decision to transition services to the private sector.

This paper will begin by discussing the concepts of privatization and some of its core components. It will then present a series of questions and considerations that must be worked through in preparation for systems reform.

"Privatization" in Child Welfare Services

Although widely used, the term "privatization" has no single definition in child welfare or in other human services. Some use the term broadly and mean by it all contracted service arrangements, others use it more narrowly.

Research indicates that while all states contract out for some form of direct child welfare services, most restrict the decision making authority ceded to providers. In most cases, the state has retained authority for approving contractors' decisions related to reducing a child's level of care and permanency decisions (GAO, 2000; U.S. DHHS., 2001; Westat & Chapin Hall, 2002; McCullough, 2003). Two research efforts conducted in the last five years (Westat & Chapin Hall, 2002; Collins-Camargo, Ensign & Flaherty, in press) have identified only a limited number of state and local initiatives where for certain client groups, primary case management authority has been shifted to private provider(s).[1]

For the purpose of this paper series, "privatization" is defined as the contracting out of the case management function and/or decision-making authority (subject to periodic public agency and court review and approval periodically or for key events). It is not the geographic, financial or caseload size of the initiative that defines privatization, but the degree to which these essential functions are transferred.

Underlying this definition is the concept that this type of privatization enhances the need for partnership between the public and private sectors. Recognizing that this will always be a contractual relationship, privatization, due to its expanded reliance on the private sector, creates an opportunity and a fundamental challenge to each partner in the delivery of services and achievement of outcomes. In essence, the more responsibility the public agency gives to private providers, the more dependent they are on their performance. Partnership, accountability and trust become key features of the new system. This is sometimes overlooked in the controversy that surrounds the term.

Another key concept is that privatization is not a service model but rather a systemic reform that involves several design elements (contracting method, cost claiming and reimbursement, service delivery system, contract monitoring, etc.) all of which must be designed and aligned in order to operate efficiently and effectively. Further, many of these elements require ongoing refinements.

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[1] In addition to retaining the case management function, public agencies have retained the child investigation and protection functions that officials believed to be critical to meeting their legal responsibility for the safety and well-being of children.

The roles and responsibilities of workers in both government and provider agencies are among the issues that will need to be continuously refined. This is because even under a "fully" privatized system, the public agency will continue to play several important roles including contract procurement, monitoring, program funding and policy agenda setting. Ultimately, it is the public agency that is responsible for the care and safety of the children in state custody. For all of these reasons, what is being explored today by states and communities across the country is the relative *balance* that public and private agencies play in the delivery of child welfare services, and their respective roles when realignment does occur.

Finally, lessons learned from our research about privatization initiatives in child welfare are anecdotal. In fact, there is very little research that rigorously compares publicly and privately delivered services systems on client-level child welfare outcomes. There has also been very little rigorous research to confirm that one privatization model, contracting method or management model outperforms another (McCullough, 2005; Lee, Allen and Metz, 2006). In short, the information contained in this technical assistance series should serve as a starting point for a site's own research and assessment of its individual readiness to privatize a service, or a service system.

Key Considerations

1) *Why privatize services?*

It is sometimes overlooked that child welfare services began in the private sector (Embry, Buddenhagen & Bolles, 2000). It was not until the 20th century that a federal social security system, including a child welfare component emerged (Kahn and Kamerman, 1999). While the overall proportion of services delivered by mutual aid and religious charities has ebbed and flowed over time, several events during the 1990s generated a renewed interest in broad scale contracting efforts (increasingly labeled "privatization"). States experienced escalating costs for out-of-home care driven by increases in both the numbers served and the unit costs of care. In 1997, the federal government passed the Adoption and Safe Families Act (ASFA), and then, implemented Federal Child and Family Service Reviews (CFSRs). Together, these require states to achieve improved performance on child and family outcomes including child safety, timely permanence and well-being.

Why Privatize: To improve performance and reduce costs, several states and communities have experimented with privatization on a pilot basis and two states, Kansas and Florida chose to implement statewide reforms. Increasingly, a number of strategies including privatization, the application of managed care principles and most recently, the use of performance based contracts, are viewed as means of fusing programmatic and fiscal reforms (Wulczyn & Orlebeke, 1998; Embry, Buddenhagen & Bolles, 2000; McCullough, 2003).

The literature discusses several reasons that states have privatized social services including: the potential for higher quality, cheaper services by means of increased competition; greater flexibility within private organizations; a greater sense of mission and responsiveness to client needs among nonprofits (Sanger, 2001); and greater client choice. There are also a range of practical and political considerations that prompt privatization, including the ability to bring in new capacity quickly while at the same time limiting government growth; facilitating a marked change in the program

"culture" or philosophy; and bringing in new types of providers, such as small community based organizations or faith based organizations (Winston et al, 2002).

This said, the field is beginning to report back that privatization alone will not solve some basic problems that plague the child welfare system and it may not reduce costs. States that have privatized services struggle with the same issues that public agencies do including obtaining adequate community services for families and recruiting and retaining qualified staff (Center for Public Policy Priorities, 2005). 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 (Gleeson, Smith and Dubois, 1993). Early results indicate that simply transferring case management and decision making to the private sector may not improve case outcomes without adequate social, health and mental health resources and foster and adoptive homes in communities, and qualified agency staff that are offered ample supports.

Assessing Systemic Challenges: In light of these systemic challenges, some of the first questions that site officials must consider when assessing site readiness are:

- Does the community have sufficient resources and services for children and families to address their needs and achieve the outcomes of safety, permanency and well-being? If not, how can a privatized system address this? What resources will a private provider need to create additional community supports and/or create that capacity inhouse?
- Have additional funding streams been explored for new contracts (e.g. Medicaid and TANF) to provide additional services?
- Does the community have sufficient numbers of foster and adoptive homes? If not, what resources will providers need to conduct additional outreach and support services to meet these needs?
- If staff recruitment and retention are challenges, what resources and management skills will private agencies need to hire, train, and support staff to help minimize ongoing turnover?

Privatization and Costs: Another important question to ask when initially considering privatization: is the assumption being made that a privatized system will cost less? Research on privatization efforts have found that in most cases, overall spending increases with privatization efforts (Freundlich & Gerstenzang, 2003; Kahn & Kamerman, 1999; GAO, 2000). As an example, the budget for child welfare service in Milwaukee, Wisconsin grew significantly with privatization.[2] Freundlich & Gerstenzang (2003) point out that it is probably unreasonable to expect new privatization initiatives to achieve better outcomes for children and families and do so at a lower cost than the current system.

While there have been only limited examples of states and communities that have saved – or even controlled -- costs (McCullough & Schmitt, 2003), Illinois significantly reduced costs by converting their standard foster care contracts from cost reimbursement to performance based along with other concurrent reforms. Illinois

[2] Personal communication with Susan Dreyfus, COO, Alliance for Children and Families, Milwaukee, WI.

attributes the reduction in the state's foster care caseload from 52,000 in 1997 to approximately 18,000 today to the use of performance-based contracts (McEwen, 2006). One of the key lessons that the state learned was the value of reinvesting some of these funds back into the system to support reduced worker caseloads, recruiting foster homes, and providing more clinical services.

In summary, sites must ask themselves: *why they want to privatize a service or a service system* -- what they want this new system to achieve and why they expect private agencies to outperform the existing public system. They need to ask whether transferring case management will address these issues or whether other supports will be necessary.

The answers to these questions will impact contract design and monitoring and may also impact the roles and responsibilities of workers in the ongoing oversight of cases.[3] Clearly articulating the "why" is also the only way for states to know how they will define success once projects are implemented and should guide continuous quality improvement efforts (McCullough, 2005).

2) *What is the level of stakeholder support for privatization? How do you gain buy-in?*

Privatization can engender opposition from a range of stakeholders because it upsets the status quo service arrangements. There are multiple ways to mitigate this opposition and it is likely that several approaches may be needed to gain support. Due to the anxiety that privatization can cause, a first step for public agencies is to create a communications plan for both internal and external stakeholders to minimize the amount of misinformation (McCullough, 2005).

The literature on child welfare privatization emphasizes the value of listening to stakeholders that will participate in, or be impacted by, the new service delivery system (Kahn & Kamerman, 1999; McCullough & Schmitt, 2003; Figgs & Ashlock, 2001). States and communities that have privatized services report that it is important to include a broad group of community stakeholders somewhat early in the conceptualization and planning process, to not only get their input but to bring them along in planning and avoid costly oversights once new contracts are initiated.

Two studies of the Kansas experience with privatization (James Bell Associates, 2001; Figgs & Ashlock, 2001) underscore this issue. Many key stakeholders were not meaningfully involved in planning and design efforts early on. Because of this, faulty implementation decisions were made. Moreover, several external stakeholders including the courts were unclear about the distinct roles and responsibilities of the public and private agencies. Figgs and Ashlock (2001) found that without this initial buy-in and involvement, the courts, schools, and other local agencies did not trust that the private providers would deliver adequate services. Well into implementation, the private agencies had to conduct aggressive public relations campaigns to acquire the trust of other public entities and community based providers on which they relied.

There are also examples of sites that report successfully including stakeholders in planning endeavors. During regional forums held by the Quality Improvement Center on the Privatization of Child Welfare Services, representatives from El Paso County, Colorado described what they considered to be an inclusive planning process. The

[3] Personal communication with Ron Zychowski, CEO, Community Partnership for Children, FL.

County had a history with privatizing other services and had a clear vision that they wanted to partner with private agencies to deliver child welfare services (rather than simply "transfer case management") and wanted to better blend funding streams (Medicaid and IV-E) to expand services for families involved with the child welfare system. Forum participants from both public and private agencies explained that both elected officials and agency staff were interested in making this new system work and work well. This involved collaboration during initial planning as well as an emphasis on ongoing communication between systems once the new contracts were issued.

El Paso County, Colorado spent approximately eight months planning the new service delivery system before anything was implemented. County staff met with the provider community as well as foster parents, partnering Child Placement Agencies, Juvenile Court, Guardians Ad Litem, Court Appointed Special Advocates, Respondent Attorneys, local Community Mental Health Center, County Commissioners, and the State Department of Human Services to develop the new service delivery structure. It was reported that as planning went on, county officials kept adding stakeholders to the planning meetings to ensure broad community and stakeholder support for this new approach in serving foster children in El Paso County (Flaherty, 2006).[4]

The broader literature suggests that during the planning phase, program planners might hold focus groups and/or conduct surveys with representatives from key stakeholder groups in and outside of the child welfare system. To varying degrees, those encouraged to participate in initial discussions include:

- The service provider community that would be affected and would be involved in bidding and ultimately delivering target services;[5]
- Representatives of all levels of the public agency (caseworkers, supervisors, managers and top administration);
- Juvenile and family court judges;
- Parents and youth who receive services
- Foster and adoptive parents (or associations);
- Monitors of court negotiated agreements;
- Unions of employee organizations and/or their professional organizations;
- Members of the state legislature and legislative committees;
- County commissioners;
- Auditors; and
- The broader service community e.g. mental health and substance abuse providers.

Explore what they consider to be challenges and constraints in the current system to ensure that you address these obstacles to the best of your ability in the newly privatized system. Explore people's recommendations for a new system and their concerns about shifting case management to the private sector. Discussions with the provider community should include identifying appropriate and attainable client and systems outcomes, along with benchmarks and quality assurance systems to monitor

[4] Information collected during the regional forum was later expanded by personal communication with Rick Bengtsson, Child Welfare Manager, El Paso County, Department of Human Services.

[5] This process must be done in light of state procurement rules so that the integrity of competitive bidding is not compromised.

success. Only in this way can leaders in both the private and public systems design contracts and systems that are responsive to the realities on the ground.

Whether or not private providers and other key players participated in the initial conceptualization of contract requirements, once contracts are drafted, consider hosting informational meetings with potential bidders to get their comments and ideas about the proposed scope of work. Receiving this form of input on contracts before they go out for official bidding can help reduce confusion and minimize implementation barriers.

Public Agencies and Unions: The experiences of states and communities that have privatized tells us that the greatest opposition will likely come from public agency workers and their unions. Agency officials must expect that merely conducting a readiness assessment will produce anxiety and resentment among agency staff and negatively impact morale.

This can be moderated by reaching out to agency workers and their unions early in the process in order to understand and address their concerns. Several states have engaged in "workforce transitions" that bring public employees that might be displaced, into the privatization planning process, and offer them training and other benefits. A 1997 GAO report on the experience of six state and community governments that had privatized services found that all select sites had provided safety nets for displaced workers. Workers were offered early retirement, severance pay, buy-outs and, in some cases, the opportunity to compete with private providers for the contract work. In some cases, workers were offered career planning and training to move into the private sector (GAO 1997b). Some sites required contractors to give public agency staff preferential consideration in hiring practices.

Dependency Courts: Much has been written about the particular importance of engaging the courts in the planning for privatization efforts (McCullough 2005, Snell, 2000). The courts play a critical role in the child welfare system and can support or hinder implementation activities (Meezan and McBeath 2003). The role of the courts is unique. Ultimately, all decisions influencing the achievement of key outcomes (case plan approval, key decisions on placement and permanency, case opening and closing) must be approved by the courts. Therefore, their impact on the success of privatization initiatives is amplified.[6] Politically, judges can play prominent roles in community affairs. Therefore, it is advisable to consult with them early and often when undertaking systemic reform of the service delivery system.

Court personnel should be involved in planning activities also because there are a range of practical questions that must be addressed about the new system. These include whether public or private agency staff are best equipped to represent cases in court and to what extent this role is shared between systems (McCullough, 2005). Private agencies must be clear about the informational needs of the courts and how court work will impact their staffing and training plans. (There are also a range of liability issues for private agencies that assume case management and court work, discussed later in this paper.)

Community Service Providers: Another important constituency is the broader group of community service providers on whom the private agency will depend, in order to meet client service needs. These providers need to be invited to the table and

[6] This is particularly key when communities use performance-based contracts. Everyone must be on the same page about specific priorities and quality services when agency payments are impacted by performance on matters that receive judicial review.

brought along in program planning or they may be less likely to collaborate in the new system.

Research in Kansas provides another cautionary tale. Due partly to limited initial community involvement in planning, in Kansas, private foster care providers had tremendous difficulty coordinating and paying for community services especially community mental health, in the early years of privatization (James Bell Associates, 2000). The providers were unable to leverage payment for specialized assessments and services ordered by the courts – but seen as unnecessary by the community providers and therefore screened out for reimbursement.

Even in cases when collaboration begins early, public agencies must be prepared to provide ongoing support to initiatives to help coordinate and link providers if contracts demand that private agencies access these services. One example is Florida. Like Kansas, some jurisdictions in Florida have struggled with ensuring children involved with the privatized system are able to access quality mental health services. In February, 2007 Florida implemented a child welfare prepaid mental health plan to try to ensure better access to, and improved quality of mental health services. Over 20,000 Medicaid eligible children in the child welfare system are currently enrolled in the Child Welfare Prepaid Mental Health Plan (CWPMHP).

Although this is a statewide plan, each lead agency (which oversees child welfare services in a given region) along with the families, caregivers and treatment providers has control of the review for appropriateness of services. The state health care organization authorizes certain services but the local community determines what level of care to request. Each lead agency has assigned staff to manage the CWPMHP at the local level. These staff are known as the Points of Contact (POCs). The Florida Coalition for Children, a statewide organization of lead agencies and child welfare providers, also has staff positions to provide the technical support to the Points of Contact and monitoring of performance. There are weekly calls and quarterly statewide meetings to keep this new project on track. CWPMHP is beginning to collect data which will be shared through various communication mechanisms (Florida Coalition, June 2007).[7]

3) *Has the public agency set aside enough time for planning and designing the initiative?*

Decisions to privatize services are often mandated by governors and state legislatures. Privatization is sometimes implemented in a context of class action lawsuits or responses to negative publicity from child deaths or other examples of severe abuse. In short, privatization is frequently politicized and controversial. This was the case in Kansas, Florida, and Wisconsin and most recently in Texas.[8] These pressures can lead to reduced time and insufficient attention to project planning.

Research on existing privatization efforts indicate that many states and communities were under a great deal of pressure to plan and release request for proposals (RFPs) within a compressed timeframe and did not have sufficient time to prepare (Kahn & Kamerman, 1999; Mahoney, 2000; U.S. DHHS, n.d.). Failing to

[7] From Charlotte McCullough unpublished report (2007).

[8] At the time that this paper was drafted, efforts to privatize a region's foster care program in Texas have been delayed, if not halted.

adequately plan services and contracting mechanisms, and adequately support private agency infrastructure needs, puts private providers at financial risk, and reduces the likelihood that public agencies will get the quality of work that they had expected.

As will be discussed in this and/or following papers, there is much to think through before launching privatization initiatives. Some key elements include:

- Program goals, desired outcomes and performance indicators;
- The service needs and service utilization patterns of the target population, based on accurate baseline data;
- Contract risk arrangements, case rates or other contracting mechanisms based on reliable actuarial data;
- Strategies to monitor contracts and hold agencies accountable;
- Roles and responsibilities of public and private agency case managers and administrators (and how the public system will prepare its staff for new roles of contract management versus traditional case work);
- Private agency qualifications (e.g. credentialing) and readiness (e.g. do agency staff have sufficient clinical expertise in working with families and communities);
- Agency grievance and appeal processes;
- How the new service providers will interface with other community services and insure service access for families;
- Rollout schedule of reforms. Should they be:
    - Piloted geographically or rolled out in full?
    - Phased in programmatically or all at once? For instance, when implementing performance based contracts, should providers be held harmless for a transitional period to assess the extent to which performance measures are realistic and/or to determine the training and support needs of new agencies before penalizing them financially (O'Brien, 2005);
- How cases will be transferred to the private agency (how families will be notified, how case records will be copied and transferred, etc.).

These topics are complex and decisions should be based on careful attention and research. In 2006, the Quality Improvement Center on the Privatization of Child Welfare Services held three regional forums with twelve states and/or communities that had privatized at least one component of their child welfare system.[9] Based on their experience, participants (including public and private agency administrators as well as community stakeholders) were asked how much time should be set aside for sites to assess and plan for a privatized system. The general consensus was that sites should allot 12-18 months to prepare to transition services (Flaherty, Collins-Camargo & Lee, unpublished).

Finally, systems reforms takes time to fully implement and it may take longer than planned to see improved outcomes for children and families. There is the possibility that new projects will not show improved outcomes within the first year, or longer. Due to the resources required to transition services (both human and financial), prior to implementation, it may be helpful to have discussions about how the new public/private partners will respond if there are no differences in outcomes, and possibly higher costs, in the first year or two of operations.

[9] These states and jurisdictions were: El Paso, Colorado; Washington, DC; Florida, Kansas, Illinois, Michigan; St. Louis, MO; New Mexico; New York City, NY; Franklin County, OH; Philadelphia, PA; and Milwaukee, WI.

4) *Are there sufficient administrative and cost data to develop contracts and estimate case rates and other service costs?*

As sites consider privatizing services, they must do so with sufficient and accurate information about costs, caseload trends, service utilization and performance on child welfare outcomes in the current system. Accurate data is critical to establishing sufficient case rates for private providers, appropriate performance benchmarks and performance indicators.

When Kansas privatized, the state faced challenges resulting from unreliable administrative data on caseload trends, characteristics and costs. As a result, officials were unable to establish a baseline for the pricing of foster care. In transferring the existing state caseload to the private sector, Kansas mislabeled much of the state's existing foster care population as "new referrals" rather than identifying them as older, more deeply entrenched cases which would likely require more intensive services and a longer duration of service delivery (James Bell Associates, 2001; Snell, 2000; Westat & Chapin Hall, 2002).

The National Child Welfare Resource Center for Organizational Improvement (NRCOI) writes that data used to develop contracts must be seen as reliable and valid by both agencies and providers. "It is critical to talk about this issue at the very beginning of negotiations with providers, to understand that it will be difficult, and to expect to invest significant resources (of both time and money) into developing good data to guide negotiations on assessing current performance and planning for improvements" (O'Brien, p. 1 2005).

State officials in Illinois describe their success in this area and its impact on gaining buy-in from the provider community when it was negotiating new foster care contracts in the mid 1990s. When Illinois changed its contracts from fee-for-child payment to performance based, private providers were concerned about the data by which performance would be measured as this information would drive the new payment system. Providers wanted to be confident that the data would be accurate and reliable. In response, the state contracted with the Chapin Hall Center for Children at the University of Chicago to administer the management information system used to guide decisions about performance and payments to private agencies. Erwin (Mac) McEwen, Director of Illinois Department of Children and Families wrote at the time, this was critical because "Unless private providers believed in these policies and the practices for implementing them, it would be impossible for policies to succeed" (McEwen, 2006).

The lack of quality information related to costs, service utilization and caseload trends is one of the greatest obstacles to planning efforts. Researcher Charlotte McCullough, who has conducted several national surveys on financing reforms in child welfare and has helped several states think through site readiness issues, reports that many states use "guesstimates" about actual costs and service patterns because the actual data are not available. The hardest information to gather is client use of external services outside of the child welfare system, most commonly, mental health and substance abuse treatment. This information is important to redesigning both program and fiscal models and planning for the coordination of services.

Once programs are implemented, reliable data tracking systems are critical to contract monitoring and quality assurance (QA) systems. MIS systems should be designed to track both contract performance and client outcomes. In many instances,

substantial investments in software, hardware and training are needed to ensure that information technology is available and used for system implementation and improvement (Westat & Chapin Hall, 2002).

5) *Is there viable competition in the marketplace to deliver target services?*

It is argued that one of the defining features of a privatized system is competition in the marketplace. It is assumed that competition will encourage providers to work efficiently and effectively. Competition is expected to result in higher quality, less expensive services because the purchaser can shop around for the best products at the cheapest costs (Winston et al., 2002, Nightingale and Pindus, 1997).

However, competition does not exist in all communities for all services. Because barriers to entry are substantial, competition may not exist prior to privatization or even following implementation. In fact, informal discussions with state child welfare administrators held during the QIC PCW needs assessment found that the lack of capable providers to deliver services was one of the most common barriers to initial or expanded privatization efforts among those states that identified barriers (University of Kentucky & Planning and Learning Technologies, 2006). States and communities considering privatization are advised to examine the provider landscape and assess whether there are viable providers to provide the targeted service.

For instance, instead of issuing an RFP, Florida issued an "Invitation to Negotiate" for lead agencies, to assess provider capacity and determine if agencies had the necessary infrastructure to provide quality services (Freundlich and Gerstenzang, 2003). Florida's assessment of agency capacity focused on:

- agency purpose and relationship to community,
- quality assurance system,
- organizational stability,
- human resources management,
- information systems, and
- proposed service delivery model for lead agency services and activities.

It is interesting to note that the state did *not* initially score providers on their capacity to deliver child welfare services, but rather looked more generally at infrastructure and management issues (Freundlich and Gerstenzang, 2003). In fact, a great deal of attention was paid to the provider's financial security including matters of:

- Existence of security bonds, liability insurance and performance bonds,
- Savings to cover at least 60 days of agency operations,
- A viable, long term business plan,
- An accounting system that uses cost centers that would allow providers to assess costs by case and predict costs into the future, and
- A risk management program.

6) *If necessary, how can public agencies expand provider capacity and thereby increase competition?*

Child welfare can learn much from other fields about expanding competition in the marketplace. Cohen and Eimicke (2001)[10] suggest that government agencies might offer providers "capacity building grants" to encourage them to enter the system. Alternatively, government can help to pay for contractor expansion such as purchasing facilities or hiring new staff. The authors caution that although both approaches will increase competition, they may also reduce potential cost savings from privatization, at least in the short term.

This issue is complex in child welfare because federal Title IV-E funding only reimburses after services are delivered and only for certain, limited activities. That said, some child welfare agencies have supported capacity building, primarily through the use of start-up funds. Learning from Kansas and its own early implementation efforts, Florida began to offer its lead agencies transition funding to support start up costs including efforts to write agency systems of care and contracting procedures for local service networks. Other sites, such as Milwaukee, Wisconsin, have provided grants to private providers to open new facilities.[11]

The payment structure itself can have an effect on competition. Pure performance-based contracts can exclude organizations with fewer resources – often smaller community based organizations or faith based organizations -- since they often cannot bear the financial burden of providing services until payment points are achieved (McConnell et al., 2003). Public agencies might reach out to a wider pool of private bidders especially those that do not consider themselves eligible due to agency size or lack of history of child welfare service delivery, by creating several smaller contracts that may be more appropriate for smaller community based or faith based groups.

Philadelphia has always relied on private agencies to deliver prevention and foster care services. Partly due to its multi-ethnic demographics, the city has worked hard to support smaller, community based organizations that reflect the communities being served.[12] The city offers its providers free, ongoing training on case management services as well as parent education and other services. To encourage participation of smaller providers, the city has also authorized that larger providers may serve as fiduciary agents (or fiscal sponsors) to smaller groups. A sponsor is a nonprofit corporation that receives and disperses funds for organizations and provides administrative and financial supports to programs that lack this capacity (Green et al., 2006). In Philadelphia, the Greater Philadelphia Urban Affairs Coalition provides a variety of business services, including payroll, accounting, and auditing services to its member programs. They also offer providers access to group vendor discounts for goods and services, including office supplies and insurance coverage and access to legal services. The Coalition charges providers five to eight percent of project budgets for this service.[13]

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[10] As described in Winston et al., (2002), pp. 23-24.
[11] Personal communication with Bill Fiss, Department of Health and Family Services, Wisconsin.
[12] Personal communication with Dianne Rufin, Philadelphia, Department of Human Services.
[13] Personal communication with Trino Boix, Operations Manager, Greater Philadelphia Urban Affairs Coalition.

Another means of increasing competition is to allow the public agency (or units of the agency) to compete against private providers for the contract(s). While we are not familiar with any such instances in the privatization of child welfare services, this has happened in other human services, such as Temporary Assistance to Needy Families (TANF) (Nightingale and Pindus, 1997).

7) *Do private providers have sufficient skills and administrative capacity to manage large scale contracts, and monitor service delivery and client outcomes?*

As described in the literature, some of the most common challenges and knowledge gaps reported by private providers who manage new, risk-based direct service contracts include:

A lack of knowledge of contract risk issues. There are presently a broad spectrum of contract models ranging from "no-risk" purchase of service contracts where private providers are reimbursed at agreed upon rates for services, to higher risk managed care and/or performance based contracts. The latter types of contracts introduce risk to the private provider because payment under these contracts is not strictly linked to service delivery, but rather to the achievement of specific contract goals, which may be achieved only after incurring service expenditures for some time.

It is well documented that rate setting is one of the biggest challenges in privatization efforts (Kretman, 2003; U.S. DHHS 2003). Several factors determine the financial risk to providers who are not reimbursed under traditional purchase of service contracts. The contractor may be required to absorb costs in situations when they are serving more cases, providing more services, providing more expensive services or providing services for a longer period than originally planned. One national study found that states use a range of information to develop case rates. They use historical data about past expenditures and target populations and often the geographic region being served. Due to challenges in identifying service costs, several states and jurisdictions were found to estimate case rates and then further negotiate these rates with private providers as additional data and experience using the rates became available (Westat & Chapin Hall, 2002).

Even after establishing negotiated rates, many states have implemented means to further mitigate provider risk. These include using:

- Risk corridors whereby providers are sheltered from expenses that exceed a certain level but must also reimburse the state if they spend less than a certain level, or
- Risk pools whereby contractors can pull down funds needed, based on agreed upon formulas.

Capacity to track and report client outcomes and other data. While many private agencies have strong internal management information systems (MIS) and case tracking systems, others do not. When assessing readiness, public agencies must decide whether the private agency will be able to use the public agency's SACWIS (or comparable agency system) or whether the private agency's own system should interface with the state's SACWIS. Alternatively, will data need to be entered into both systems? Ideally, private agency systems should be able to track:

- The case plan
- Client location and status
- Service utilization and
- Service costs.

The system should be user-friendly and be able to generate useful reports easily and quickly (McCullough, 2005).

Ability to recruit, train and retain qualified staff and managers. For over a decade, the child welfare system – both public and private agencies - has struggled to hire and retain qualified staff. When assessing readiness, public agencies should not assume that the private providers will be able to recruit, train and retain new staff more easily than the public agency. This issue will be explored more fully in later papers.

Florida addressed many of these uncertainties by implementing a "readiness assessment" process for all new providers. For the six year period between 1999 and 2005, the department systematically transitioned the management and day-to-day operations of the child welfare system to lead agencies in 22 regions of the state. From the outset, contracts included a start-up period to enable lead agencies to build the infrastructure and finalize a series of deliverables that were submitted to the department -- including specific plans for: their system of care, human resources, network development, quality assurance systems, fiscal and risk management, and transition.

Even with a phased-in approach, researcher Charlotte McCullough reports that the state realized after several lead agencies made the transition that a formal, standardized assessment of readiness was needed to ensure that both the lead agency and its local public partners were fully prepared to implement the approved plans. The Department developed a readiness assessment tool and a formal process for assessing and preparing local department units and lead agencies to become ready to safely transition services. The Department's Readiness Assessment process utilized an external team of peer experts to assess the development of the local infrastructure and transition plans, and provided technical assistance to both public and private agencies prior to initiating transfer of any services. The assessment tool and process were refined on several occasions to reflect challenges encountered and lessons learned at each stage of the statewide roll-out (McCullough, 2003).

8) *Do private agency front line staff have sufficient skills and knowledge about child welfare policies and evidence based reforms to deliver services?*

When designing privatization initiatives, states must decide what level of credentials should be required of private agencies. Must agencies be accredited? Will contracts specify worker credentials or will this be left to the private agency? These decisions will be driven partly by the anticipated division of activities and functions between agency workers and other community based agencies that can provide clinical and other special services.

With the privatization of the case management function, public agencies will need to decide whether private agencies must meet all of the existing child welfare training and certification requirements of public agency workers. Other decisions involve who

will provide the training and how it will be funded. Title IV-E funding can be used to reimburse 75 percent of state's training expenditures related to foster care and adoption services *for public agency workers*. Training delivered to *private* agency workers is reimbursed at 50 percent (GAO, 2004).

It cannot be assumed that public agency workers will transition to the private agencies bringing with them their skills and experience with child welfare issues (James Bell Associates, 2000). In Kansas, the public agency remained fully staffed with few workers transferring to the private agency and in other states, only limited numbers of agency workers transferred to the private providers.

Due to the extensive hiring that will need to take place as private agencies take on significant new child welfare functions, training might be offered on flexible and ongoing schedules so that new workers can be trained shortly after they are hired. Kansas, for example, worked with its Training Institute (the University of Kansas) to shorten traditional training modules from 1-2 days to 3-4 hours, to permit new workers to remain in the field as much as possible. Much of the initial training focused on enabling new workers to examine their own belief systems about parenting, ethnicity and social class, and familiarize them with basic child welfare policies and state statutes (Ortega and Levy, 2002). The University of Kansas training team works closely with the state's private providers to develop ongoing training programs. Considered to be part of their technical assistance program, private agency management help design advanced training topics which sometimes involves bringing in local or even national experts, to train on specific topics (Ortega and Levy, 2002).

The third paper in this technical assistance series, **Evolving Roles of Public and Private Agencies**, will more thoroughly discuss transitioning from publicly to privately delivered service systems and states' experience with front line training needs.

9) *Is the public agency prepared to design a new service delivery system, and assume new roles focused on contract design, procurement, and monitoring?*

As has been discussed, designing a new service delivery system involves several considerations and should be driven by system goals, target population and even scope of system reforms. Designing the contracting models goes beyond the financial approach used to support services. It involves several complex decisions about whether or not to use a lead agency, the type and structure of contracts and the extent to which the public agency continues to oversee individual cases.

Public agencies must consider whether they want to function primarily as an administrative oversight agency and transfer all operations to the private sector, or whether they want to contract out for specific functions and retain decision making and/or service coordinating activities.

Designing new service delivery systems, as well as assuming new responsibilities for contract design, procurement and monitoring, are complex issues that go well beyond the scope of this paper. Each will be discussed more fully in later papers, including the lessons learned to date. But, following are some limited considerations on each topic.

Contract Design: Once sites have settled on a program model and contracting method, they must be able to prepare contracts that are clear and complete. Contracts often lack the needed specificity because the agency does not have sufficient experience preparing contracts and/or, information is not available. McCullough (2005) reminds us that "[a]fter a decade of experimentation, there is still no compelling evidence of the efficacy of one financial approach over another." From a survey of private agency administrators in five states that had privatized some component of their service system, she found that administrators of every program discussed challenges in their initiative's chosen contracting mechanism (McCullough 2005 p19).

A number of key topics that should be fully clarified in service contracts:

Specific target population,

- Service provision (scope and duration),
- Special populations that are explicitly included or excluded from the target population,
- Responsibility for determining federal/state (if local initiative) funding eligibility and reporting,
- Billing and payment arrangements, including when and under what conditions financial incentives and penalties will apply,
- Standards for program and client data collection and reporting,
- A quality assurance plan that describes how the contractor's performance will be assessed, and
- Agency grievance and appeal processes.

Procurement Process. The process for letting, evaluating, and awarding contracts must be transparent and fair, in reality and in perception. How bids are evaluated, scored, and awarded can have important ramifications for the level of controversy surrounding privatization – processes that lack transparency or appear open to favoritism or corruption can lead to legal and political problems. In addition, the level of specificity and prescription within the RFP can affect the quality of the service approach. The public agency letting the contract needs to balance the goal that providers meet certain quality thresholds with the desire to encourage bidders to be innovative in service design and delivery (McConnell et al., 2003). As a result, certain process and outcomes must be defined and prescribed, while leaving sufficient discretion in how these are met.

Monitoring. Effective monitoring is critical to successful privatization, but has been an ongoing challenge in privatization initiatives. A 1997 GAO study found that monitoring contractors' performance was "the weakest link" in the process (GAO, 1997a). More recent studies have found similar challenges. A 2002 GAO study of TANF contracting found significant problems tracking TANF fiscal and program activities in 15 states over two years, and noted potential problems in over a quarter of states (GAO, 2002). In a separate 2003 HHS study of TANF case management privatization, in two of the six projects studied, state auditors exposed inadequacies in state monitoring (McConnell et al., 2003).

There are cases where public agency casework staff have been shifted to contract oversight positions without sufficient training and ongoing guidance. Adequate

MIS infrastructure is often lacking. In short, when planning and preparing for privatization efforts, contract monitoring can require large scale investment in computers, software and training on both the side of the public and private sectors (Embry, Buddenhagen & Bolles, 2000).

In most cases, monitoring assesses compliance with statutes, regulations and the specific terms of the contract agreement. Today, with the new emphasis on performance contracting, there is an expanded interest in also monitoring major outcomes – the effect of the services on clients. Contracts are being monitored, and in many cases rewarded, on the basis of child and family outcomes in addition to their compliance with process or practice standards.

A Westat and Chapin Hall (2002) study found that the two most common forms of contract monitoring for child welfare fiscal reform initiatives were the use of collaborative case reviews and analysis of management information systems. Among the 22 states studied, case reviews involved ongoing collaborative decision making meetings or periodic case reviews where public agency staff look over a sample of cases to examine service provision and costs. Public and private agency staff discussed service quality, patterns of expenditures and permanency plans. States are also increasingly relying on management information systems to monitor services. For instance, New York has implemented a new interactive MIS (called EQUIP) that allows the public agency to tie reimbursement to child outcomes (O'Brien, 2002).

Eggers (1997) recommends that plans for contract monitoring (and by extension, quality assurance systems), must be thought through prior to the release of an RFP for services. The plan should be included in the contract and describe:

- Reporting requirements,
- How information will be shared (through reports, shared MIS, meetings),
- Agreement to share (and means of access for) client records,
- What happens when there is non-conformance with contract requirements (e.g. use of corrective action plans),
- How providers will be held accountable, and
- Complaint and appeal processes.

The National Child Welfare Resource Center for Organizational Improvement has examined state quality assurance systems and prepared ***A Framework for Quality Assurance in Child Welfare.*** The Framework serves as a helpful guide for state officials and includes both case studies and steps to design effective QA systems (O'Brien, 2002).

10) *Are roles and responsibilities clear between the public and private sectors?*

Coordination between the public and private agencies is a critical task – even in full scale privatization -- because the public agency is still ultimately responsible for the quality and nature of the services clients receive, the achievement of client outcomes, the appropriate use of taxpayer funds, and compliance with the law. In addition, in

nearly every community in the country, child investigations and protective services are still being carried out by the public agency.[14]

Establishing clear roles and responsibilities between agencies has emerged as one of the most complex challenges of privatization. Elements that must be considered include:

- Developing and coordinating case plans for new entrants (because the public agency will conduct the investigation and may coordinate early services);
- Determining funding eligibility for programs (with the need to train contractors to understand multiple program rules);
- Bringing into line the goals of public and private agencies (contract employees may focus more on performance targets while public employees may focus more on process and timeliness);
- Coordinating services and information to keep clients from "falling between the cracks" (different or incompatible management information systems can make this more difficult); and
- Encouraging good working relationships among staff when cultures, pay, and compensation policies can differ significantly.

When designing the new service models, decisions must be made about specific roles of both the public and private agency workers. Questions include:

- Who handles matters of eligibility for Federal title IV-E and Medicaid dollars and other requirements? If this function has been transferred to the private sector, how does the public agency verify these findings?
- Who has primary responsibility for developing the case plan, the public or private provider?
- Who presents information about the case and makes recommendations to the court about the case plan including goals, services, etc. – the public or private agency worker, or both?
- What are the decisions that can be made by the private provider?
    - Selecting services
    - Level of placement
    - Visitation
    - Case goal
    - Whether and when to return a child home
    - Recommendations for termination of parental rights (TPR)
- For which of these decisions does the private provider seek approval from the public agency worker? How does this work and in what timeframe?

In many communities and states, these relationships and roles have evolved over time as public agencies become more confident in the decisions about, and services delivered to, clients.

It is also important to keep in mind that contractors need to have adequate control over case management decisions when using risk-based contract arrangements such as managed care and performance-based contracting. In many cases across the

[14] Exceptions to this include jurisdictions in Florida and Arkansas where child protection investigations are carried out by law enforcement, generally local sheriff's offices.

country, private agencies are reimbursed for performance, but do not have final decision making authority over how they direct services and resources. This disconnect between financial risk that private providers assume and the actual control they have over casework, will continue to challenge privatization efforts (Westat &Chapin Hall, 2002).

11) *What are the legal risks with privatization?*

There are a range of legal issues that must be considered when privatizing services. The federal government is actually silent as to whether the case management function can be privatized. McHugh (2000) found there is nothing stated that directly sanctions, nor prohibits it.

> "Instead, federal law holds states ultimately responsible for the placement and care of children in foster care and for all other federal mandates under Title IV-E and other provisions of the Social Security Act. Moreover, under federal constitutional law, some public child welfare agencies have been held legally responsible under certain circumstances for ensuring that children are not harmed while in state custody based on involuntariness of state's action. Accordingly, if a public agency were to privatize all or any case management responsibilities, federal law would seemingly still hold the public agency accountable for its contract agent's actions." (McHugh, p. 13, 2000)

In addition to federal law, states must examine their own laws which may specify certain purely government functions in the delivery of child welfare services. North Dakota, for instance, amended its child protection statute in 2005 allowing it greater flexibility to contract out child welfare services (Section 50-25.1-06). Other states, including Arizona and Texas, are looking into more subtle legal issues. These states have determined that state law does not explicitly prohibit privatization of services, but are exploring whether state law and court rules might preclude the private agencies from presenting the "state's" recommendation in court, even if they serve as the agent of the state.[15]

Finally, states must consider the liability issues of the private agencies. Will private agency workers have legal representation in courts? If, for example, private providers are representing the case in court themselves, does state law grant immunity to the provider as an agent of the state? If not, what are the legal consequences of this for the private agencies? What are the financial consequences for the private provider for legal representation and insurance coverage? Some locations are trying to determine whether State attorneys will be able to represent the private agency case workers in court as they currently do for public agency, child protection staff (McCullough, 2005).

[15] Personal communication with Charlotte McCullough.

12) ***Will privatizing services alone bring about improved outcomes or will the agency need to implement other reforms in tandem with privatization to improve system performance?***

When considering whether privatization will benefit the current system, agency leaders must examine how privatization will support or complicate other reforms underway. Initiative planners must determine whether they will need to adjust other features of the service system when cases and case decision making authority are transferred.

Privatization efforts should be considered *part* of a state's or community's overall reform agenda. As discussed earlier, privatization alone will not likely solve all problems facing an often overburdened and under funded system. In Illinois, state staff recognized that there were a complex set of interrelated pressures hindering agency performance which needed to be addressed on several fronts (Shaver, 2006). Some of the core design changes involved a re-design of front-end operations (reducing caseloads of investigative workers, implementing a new risk assessment tool, reducing time to service referral), redesigning contract monitoring (doing away with the dual case management system where public and private agency caseworkers jointly reviewed all key case decisions), developing the performance-based contracting system and adding guardianship as a permanency option. In short, privatizing case management and redesigning the payment structure of the foster care contracts was just part of the state's overall reform agenda to improve permanency rates.

Conclusion

The first round of Child and Family Services Reviews confirmed what many have known – state and county child welfare systems continue to struggle to achieve timely permanence for children. The reviews also confirmed the chronic barriers states face in delivering services, including the fact that large caseloads and staff turnover limit caseworker visits with children and thereby fetter a state's ability to ensure federal goals of timely permanency and safety (US DHHS, 2004).

The reasons for undertaking privatization reform are varied but a common theme is improving outcomes for children and families. To achieve these results, privatization efforts must be based on careful up-front assessment of current issues facing the child welfare system, thinking through where improvement is most desired, and scrutinizing the capacity of private providers to deliver on expected results. Most experienced observers advise a thoughtful and inclusive planning process that includes a focus on contract design and infrastructure needs of the private provider community. Public agencies must also assess their own ability to take on new monitoring functions and oversee new, or expanded, contracts. Sites embarking on this assessment must be prepared to do this work in a politicized context.

One of many benefits reported by those states and communities that have privatized large segments of their child welfare system is that privatization can leverage support from the community and expand the political base for advocacy and program expansion. In addition, by broadening the service provider community, the system can offer more specialized and, in some cases, more culturally appropriate services.

In short, privatization can improve service delivery and child and family outcomes, but it remains a complex systemic reform that requires considerations of multiple political and program factors. As noted in this paper, it is important that sites undertake this process in an informed manner to a number of points; specifically:

- **Mandates alone won't achieve outcomes.** Writing a contract that demands a certain level of performance will not ensure that intended outcomes will be achieved. Just as public agencies have struggled to continuously improve service delivery, private agencies will have their own set of struggles. Short and long-term plans for staff training, contract monitoring, technical assistance, and corrective action must be thought through prior to implementation.
- **Successful initiatives are partnerships.** Private agencies may not be able to leverage needed community services and build capacity without the support of the public agency. In fact, private community-based agencies may be less well-equipped to broker needed health and mental health services from other community providers than the public agency. Initiatives must be planned with time and resources dedicated to knowledge transfer and opportunities for collaborative problem solving.
- **You can't get something for nothing.** Improving quality of services delivered and the outcomes achieved requires investing needed resources, at least in the short-run. Recent privatization reforms teach us that privatization can help achieve outcomes, spur innovation, and align performance with financial incentives. However, these reforms also show that in most cases, enhancing system performance comes at a higher cost than the current system.
- **Don't ignore staffing issues.** Again, a change of this magnitude will have multiple ramifications for staff in both public and private agencies. Public agency staff may not support the change, and private agencies will face many of the same difficulties recruiting, training, and retaining child welfare staff. Early discussion of needed supports is critical.

It must also be remembered that privatization, or systemic, fundamental reform cannot be planned in a vacuum. Sufficient time must be devoted to a thorough assessment of where you want to go and what in the current system supports or inhibits performance. New service delivery systems must be designed to take advantage of system strengths and to address identified barriers to performance. In addition, the best-intended reform can get quickly off-track (even before implementation) if the planning process is not inclusive. The child welfare system involves many key players in the delivery and oversight of services – early involvement and buy-in from these players is important to designing and implementing efforts.

Many scholars of child welfare privatization initiatives have suggested that the effectiveness of privatization efforts depends on the quality of planning and implementation activities carried out by the public and private sectors (Nightingale & Pindus 1997, Freundlich & Gerstenzang, 2003; McCullough, 2003). Public agency officials must select among a range of service delivery models, contract payment methods, quality assurance and contract monitoring methods. Each component must be designed, and then aligned with other design features to achieve agency goals (McCullough, 2005). The next paper in this series will present a range of structural models and fiscal arrangements used by states and communities today and will highlight lessons learned to help states weigh options. Future papers will provide detailed

information about how states have divided roles and responsibilities, developed contracts and carried out contract monitoring and accountability functions.

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CASA
Court Appointed Special Advocates
FOR CHILDREN
NEBRASKA CASA ASSOCIATION

Nebraska CASA Association
1618 L Street
Lincoln NE 68508-2509
402.477.2788 (local)
800.788.4772 (toll free)
www.nebraskacasa.org

CASA Fact Sheet

- CASA stands for **C**ourt **A**ppointed **S**pecial **A**dvocates.
- CASA volunteers are trained citizens who are appointed by a judge to speak in court for the safety and well-being of abused and neglected children.
- CASA programs in Nebraska operate in compliance with the Nebraska Court Appointed Special Advocate Act (Nebraska Revised Statutes § 43-3701 *et seq.*) and National CASA Standards for CASA Programs
- CASA has been in Nebraska for over 25 years.
- 22 CASA programs serve 36 Nebraska counties
- 1,237 Nebraska children had a CASA volunteer in 2011.
- 561 CASA volunteers advocated for abused and neglected children throughout Nebraska in 2011.
- On December 31, 2011, there were 1,400 children on a waiting list for CASA services (represents only children in the counties where there is a CASA program).
- Children with a CASA volunteer spend an average of *four fewer months* in out-of-home care than children without a CASA volunteer.
- **If the average length of stay in care were shortened by *just one month* for each of Nebraska's foster children, it would realize an annual savings to Nebraska taxpayers of $10.6 million**

***A child with a CASA/GAL volunteer is more likely to find a safe, permanent home:**

- More likely to be adopted
- Half as likely to re-enter foster care
- Substantially less likely to spend time in long-term foster care
- More likely to have a plan for permanency, especially children of color

Children with CASA volunteers get more help while in the system . . .

- More services are ordered for the children

. . . and are more likely to have a consistent, responsible adult presence

- Volunteers spend significantly more time with the child than a paid guardian ad litem

CASA volunteers improve representation of children.

- Reduce the time needed by lawyers
- More likely than paid lawyers to file written reports
- For each of nine duties, judges rated CASA/GAL volunteers more highly than attorneys
- Highly effective in having their recommendations adopted by the court

Children with CASA volunteers do better in school . . .

- More likely to pass all courses
- Less likely to have poor conduct in school
- Less likely to be expelled

*Source: National CASA Association.

To give a child a CASA volunteer is to give them a voice.
To give them a voice is to give them hope,
and to give them hope is to give them the world.
~Pamela Butler, former CASA child.

CASA Programs in Nebraska

CASA Connection (Platte & Colfax Counties)

CASA For Douglas County

CASA for Lancaster County

CASA for York County

CASA Project of Dodge County

CASA of Northeast Nebraska (Madison County)

CASA of Scotts Bluff County

CASA of South Central Nebraska (Adams, Clay, Nuckolls & Webster Counties)

Cass County CASA

*** Cheyenne County CASA**

Dawson/Gosper County CASA

Fillmore County CASA

Heartland CASA (Hall, Hamilton, Howard & Merrick Counties)

Kearney/Buffalo County CASA

Keith County CASA (Keith, Perkins & Garden Counties)

**** Lincoln County CASA**

Otoe County CASA

Phelps/Harlan County CASA

Prairie Plains CASA (Red Willow, Furnas & Hitchcock Counties)

Sarpy County CASA

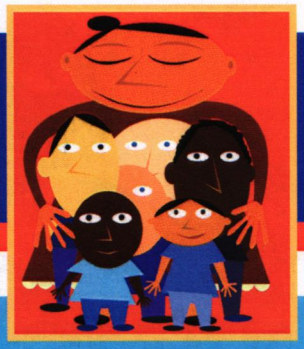
Saunders County CASA

Southeast Nebraska CASA (Seward & Jefferson Counties)

* New program in 2010.
** New program in 2011.

Nebraska CASA Association

10 Good Reasons to Support the Growth of CASA in Nebraska



1 Children without CASA Volunteers are twice as likely to spend more time in foster care.

Children with a CASA Volunteer are substantially less likely to spend time in long-term foster care (defined as more than three years in care). About 13% of children who had CASA Volunteers were in foster care for more than three years, compared to 27% of children who had no CASA Volunteer.

2 Children with CASA Volunteers are less likely to re-enter the foster care system.

Two comparative, national studies determined that children without a CASA Volunteer were 16% more likely to re-enter foster care (as the result of a subsequent incident of abuse or neglect that caused their removal again), compared with children who had CASA Volunteers, who experienced re-entry rates ranging from 1.4% to 9%. This is particularly significant because judges generally assign CASA Volunteers to children whose cases present the greatest challenges.

3 Children with CASA Volunteers are more likely to receive the services they need.

Most child welfare agencies must manage care and services for children within limited budgets, and children's caseworkers are not always in the best position to advocate for additional resources when they are needed. In 2006, the U.S. Department of Justice Office of the Inspector General conducted an audit of the National CASA Association and its programs. It determined that children and families with CASA Volunteers received more necessary services. Research conducted by the U.S. Department of Health and Family Services determined that "CASA Volunteers are excellent investigators and mediators, remain involved and fight for what they think is right for the child." The study concluded, "We give CASA models our highest recommendation."

4 Judges believe in the power of CASA.

In an independent survey published in 2005 of more than 550 judges, 97% agreed that children were better served with CASA advocates. The judges felt that the type and quality of information they received from CASA Volunteers was beneficial to their decision making and to the children and families they served.

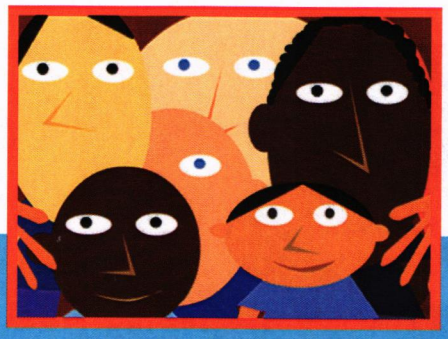
5 CASA Volunteers strengthen continuity for kids.

Most CASA Volunteers serve as their child's advocate from the time a judge appoints them until the court's involvement in the child's life is concluded. That might be over a period of weeks, months or even years. The steady presence of a CASA Volunteer helps ensure that information about a child's experiences, needs and wishes does not get lost when changes in systems or service personnel occur.

6 CASA Volunteers improve safety for children.

CASA Volunteers are mandatory reporters of child abuse and neglect. Their frequent contact with children puts them in a unique position to notify the authorities when safety concerns arise.

CASA®
Court Appointed Special Advocates
FOR CHILDREN
NEBRASKA CASA ASSOCIATION



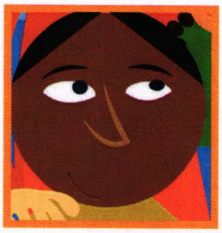
7 CASA Volunteers provide valuable information to professionals.

County child protective services caseworkers are chronically overburdened; their average caseloads may range from 10 to more than 25 families (averaging about 2.5 children per family). As required in federal standards and state guidelines, child protective service caseworkers are required to make a minimum of one face-to-face visit to a child once per month. On average, caseworkers are typically unable to exceed that standard as a result of insufficient resources for better staffing ratios, and excessive staff turnover in this difficult profession.

In comparison, CASA Volunteers visit their children an average of once per week. CASA Volunteers typically have substantial contact with a child's circle of support and others who play an important role in the child's well being. Because CASA Volunteers share their reports with the child's assigned caseworker as well as the judge, they often provide CPS caseworkers with information that they would not otherwise have. This helps make children safer.

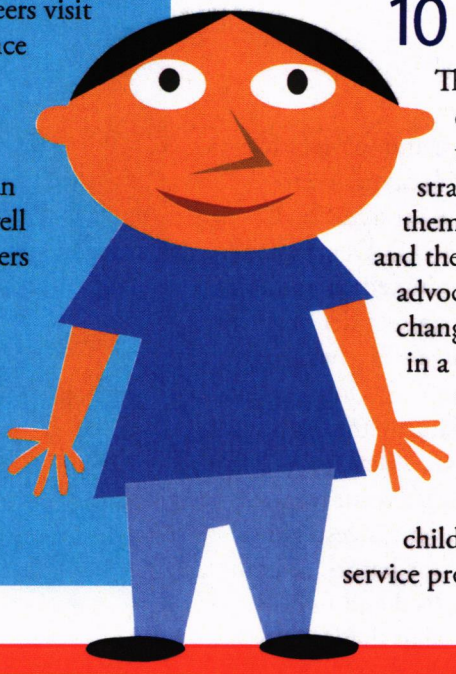
8 CASA Volunteers improve collaboration between the systems serving children.

Because CASA Volunteers have contact with key service providers and community resources touching many aspects of a child's life (education, recreation, health, mental health and more), they serve to strengthen collaboration and communication among the programs and systems that serve child victims of physical and sexual abuse and neglect. This holistic approach helps target resources, increases efficiency, and raises questions, problems and issues earlier (when they are generally less expensive to address).



9 CASA is a highly cost-effective program.

With a service delivery model that uses volunteers supervised by professionals, CASA programs in Nebraska provide continuous contact with children and reports to the court at an average cost of $1,020 per child, or about $2,450 per volunteer. This cost includes recruitment, screening, training and supervision of volunteers as well as visits to children and contacts with educators and service providers. Nebraska is one of only seven states that does not provide state funding for CASA; therefore, local programs must rely on county funding and charitable contributions for their operating expenses. CASA program operational costs are uncommonly modest.



10 CASA invests the community in its children.

Through this unique opportunity to help a child, CASA Volunteers learn to understand the need of kids and families, and the strategies that are most effective in supporting them. They observe the challenges of the courts and the child welfare system, and are important advocates for public policy change when such change is needed. CASA Volunteers also invest in a very practical and personal way. In addition to donating significant time to serving children – almost 15,000 hours in 2009 – they also donate the cost of their transportation to visit their assigned children, their families, foster families and service providers.

Nebraska CASA Association

1618 L Street, Lincoln NE 68508-2509
Phone 402.477.2788 (local) 800.788.4772 (toll free)
For more information, visit www.nebraskacasa.org

Thanks to the National CASA Association, Children's Justice Act, Nebraska Children & Families Foundation, Nebraska Department of Health and Human Services and the Community Services Fund for their continuing support.

Nebraska's Regional Behavioral Health Authorities

Behavioral Health is essential to overall health.

Prevention Works

Treatment is Effective

People do Recover

Regional Behavioral Health Authorities

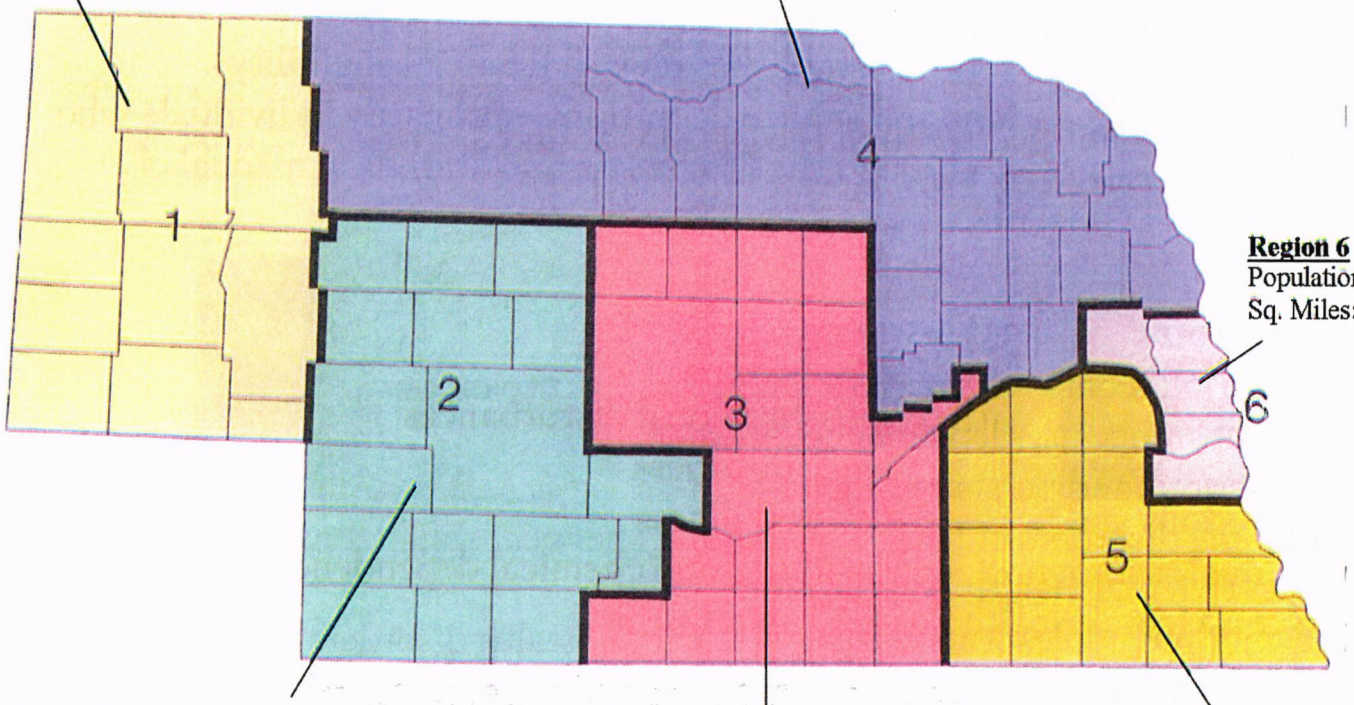
- Six Regional Behavioral Health Authorities (RBHAs) first created in 1974 through the Nebraska Comprehensive Community Mental Health Services Act with revised responsibilities and authority in 2004 under the Nebraska Behavioral Health Services Act which reaffirmed the roles and responsibilities of the RBHAs to reflect the evolution of the publicly funded behavioral health system in Nebraska.

- Governed by a Regional Governing Board consisting of elected officials (Commissioners or Supervisors) from counties served.

- To accomplish the intent of the Act the following Nebraska Behavioral Health System partners are responsible for the delivery of services:
  - Department of Health and Human Services, Division of Behavioral Health
  - 6 Regional Behavioral Health Authorities
  - The Lincoln Regional Center

- Regional System provides for:
  - Local participation and autonomy in the development and delivery of needed services
  - Counties and the State come together to share resources to meet local needs

Nebraska Behavioral Health Regions



Region 1
Population: 90,410
Sq. Miles: 14,116

Region 2
Population: 102,311
Sq. Miles: 15,171

Region 3
Population: 223,143
Sq. Miles: 14,972

Region 4
Population: 216,388
Sq. Miles: 21,000

Region 5
Population: 413,557
Sq. Miles: 9,308

Region 6
Population: 671,287
Sq. Miles: 2,036

- Each Regional Behavioral Health Authority contracts with a network of behavioral health providers (and also provides services based on statutory requirements).

- Eligibility
  - Financial (LB871 effective 7-18-12 establishes revised financial eligibility)
  - Clinical (defined in regulations and service definitions – primarily individuals who have a diagnosis as identified through the Diagnostic and Statistical manual of Mental Disorders--DSM-IV)

- Service Populations
  - Children and adolescents with serious emotional disturbances
  - Adults with substance use/dependence disorders
  - Adults with serious and persistent mental illness
  - Adults with dual disorders of mental illness and chemical dependency
  - Adults under a Mental Health Board Commitment
  - Adults and children/adolescents with major mental health disorders
  - And adults and children/adolescents with substance abuse problems

REGIONAL BEHAVIORAL HEALTH AUTHORITIES' ROLES AND RESPONSIBILITIES

Provider Network Development and Management

- Determine standards for network providers.
- Monitor provider enrollment.
  Develop annual regional plan of expenditures.
- Contract or provide technical assistance to community teams and family support networks.
- In addition to the Network services, Regions provide services to address specific populations and fill gaps in the service array.

Program Development and Management

- Assess the current service delivery and identify gaps.
- Plan to ensure a balanced, integrated service system.
- Develop strategies to effectively meet needs, fill gaps, overcome barriers and determine effective use of resources.
- Coordinate services for youth, prevention and the emergency system.

Evaluation and Quality Management

- Ensure the effective utilization of resources.
- Ensure quality services and improvements as necessary.
- Track outcomes and performance standards in our network providers.
- Support and fund utilization of evidence-based practices.

Fiscal Management and Accountability

- Develop and manage contracts with network providers
- Maintain accountability for the public funds it administers.
- Conduct annual fiscal and programmatic reviews of contract providers.
- Serve as a fiscal agent for related grants as needed.

Advocacy

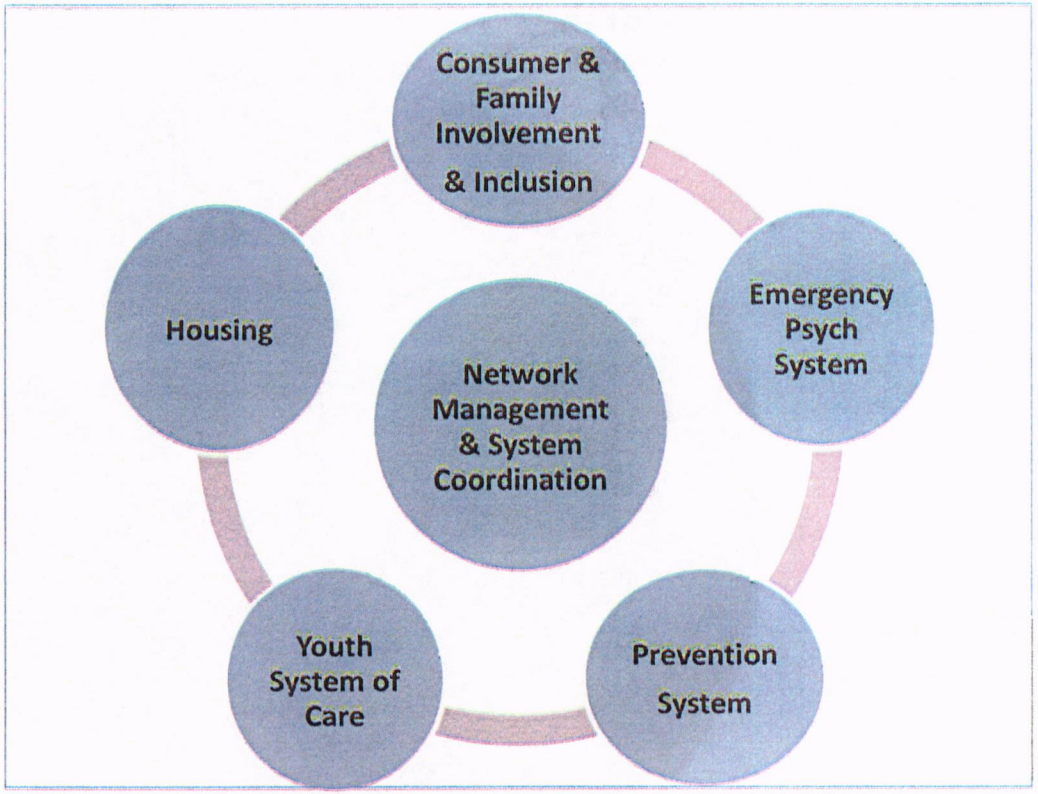
- Advocate for children, adults and families who experience behavioral health problems.
- Advocate for system improvements.

System Coordination

Building on Individual, Community & System Strengths

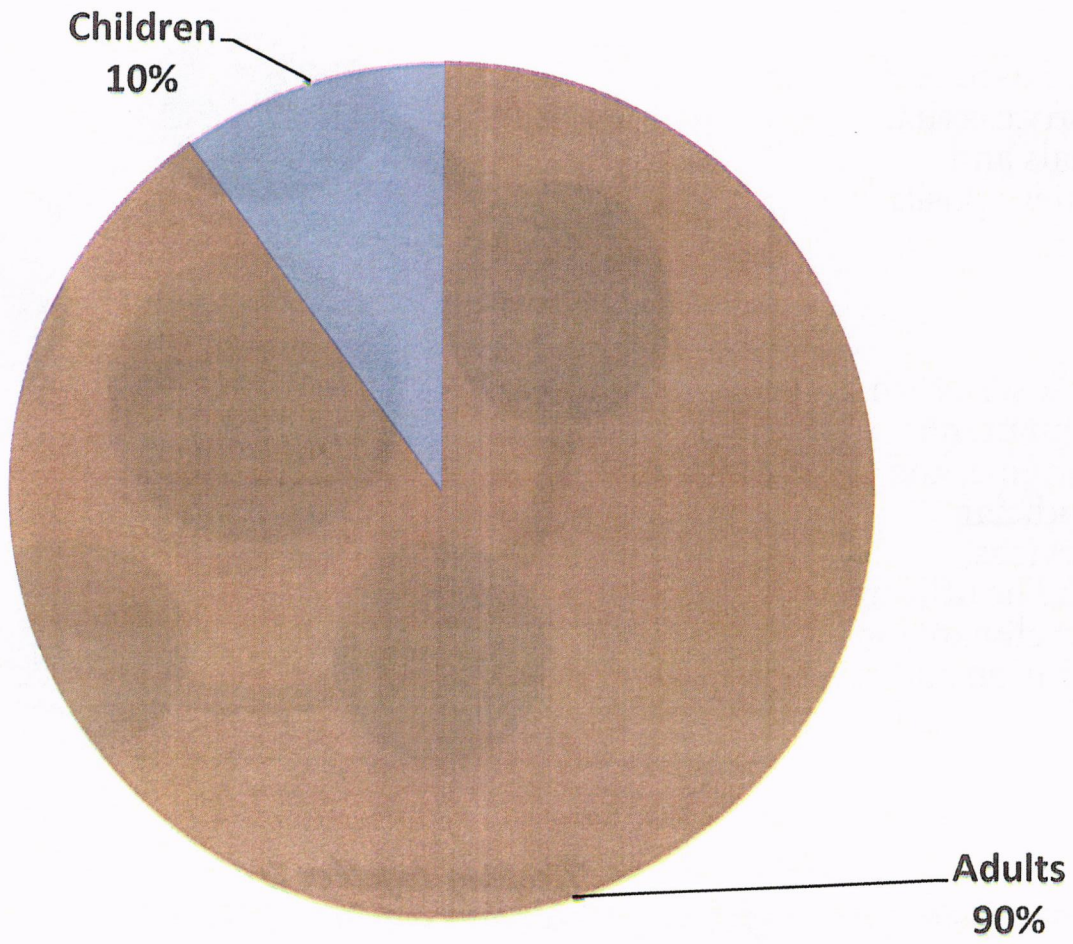
Strategic, strengths-based and Recovery focused process that empowers individuals and communities to achieve positive results.

The Regions work closely with Service providers, community leaders, consumer groups, and representatives of judicial, education, social services, law enforcement, and healthcare providers to create a climate for interagency collaboration and systems integration.



Coming together is a beginning. Keeping together is progress. Working together is success. ~ Henry Ford

Persons Served



Behavioral Health and Child Welfare Collaboration

STEP ONE

- CFS identifies **Transition Age Youth (TAY)** needing ongoing behavioral health services to ensure continuity of care
- CFS fills out TAY Behavioral Health Referral form and submits to Regional Transition Team by youth 17th birthday; CFS is responsible for providing all necessary information for transition planning to begin

STEP TWO

- Regional Transition Team acknowledges receipt of the request for consultation within 60 days. Regional Transition Team may make recommendations at this time. These recommendations may include: youth eligible or not eligible for transition team review, youth case review should be scheduled for target date, consideration of next steps for CFS, notation of potential Behavioral Health services, request for more information, etc.
- CFS retains responsibility for care coordination for youth, makes determination of next steps
- CFS initiates contact with Magellan for youth 18 year old that will need coordination for adult mental health services

STEP THREE

- CFS considers appropriate planning, proceeds with responsibilities as appropriate for youth and per State guidelines
- CFS may re-engage Regional Transition Team for transition planning partnership; continued contact as appropriate

STEP FOUR

- CFS initiates continued contact with Regional Transition Team , provides required and relevant information; retains responsibility for youth care. Submits Section B (and Section C if necessary) of the Referral Form
- Regional Transition Team collaboratively assists CFS with appropriate team to identify service availability and care coordination opportunities. May consider/recommend use of Magellan Youth Transition Planning Checklist Reference Guide

STEP FIVE

- CFS submits Referral Form Section C to Regional Transition Team . As appropriate CFS, youth and Regional Transition Team collaborate to create transition plan. Regional Transition Team responsible for facilitating their transition team process, for clarifying available programs/services via Regional Transition Team and potentially within community, but CFS retains responsibility for youth and care plan implementation
- CFS retains ultimate responsibility for youth care coordination until guardianship ends.

STEP SIX

- CFS assists and empowers youth to determine transition plan, utilizing Regional Transition Team to assist particularly with behavioral health care plan. As appropriate, services are initiated.
- Regional Transition Team provides recommendations for care regarding planning, action steps, resources, adult services, collaboration with providers, etc. Able to initiate when appropriate and agreed upon by CFS and youth.

Behavioral Health and Child Welfare Collaboration

From 2001 through 2009 the Regions partnered with Children and Family Services in the development and management of a public care coordination model to address the needs of children with behavioral health needs. These partnerships ended with the onset of Child Welfare Reform in 2010.

- **Integrated Care Coordination Units** which were designed to effectively manage, at the local level the care of youth who are in the custody of the state who experience multiple and complex needs utilizing wraparound principles and family-centered practices.

- **Early Integrated Care Coordination** which was designed to
  - Decrease the number of youth in the Child Welfare System.
  - Decrease the number of referrals to the County Attorney for legal action
  - Increase the parent's ability to adequately meet their children's needs through the wraparound process.
  - Develop intensive, early intervention strategies to prevent the child from being removed from their home and community.
  - For children in the state's custody to decrease the length of time they were in the child welfare system.

2012 Session

LR 37 CHILD WELFARE BILLS

- **LB 820** provides for the Title IV-E Demonstration Project Committee, a Foster Care Reimbursement Rate Committee, a monthly stipend for foster parents for the upcoming year and clarification regarding foster care licensing. (Senator Campbell Priority Bill)
- **LB 821** provides for the Nebraska Children's Commission and the Office of Inspector General of Nebraska Child Welfare Act (**LB 957**). (HHS Committee Priority Bill)
- **LB 949** introduced by the Performance Audit Committee requires reports relating to expenditures, changes or movement of funds in excess of $250,000, and progress toward key goals; a strategic plan that identifies the main purpose of programs, key goals, benchmarks and methods of quantification of progress by the Division of Children and Family Services of the Department of Health and Human Services in conjunction with appropriation request; and designate as a separate budget program the appropriation of funds for child welfare. (Legislative Performance Audit Priority Bill)
- **LB 961** addresses case management as a core function of government; allows for a pilot case management lead agency model project in the eastern service area; sets caseload limits and defines how cases are counted; requires the department to develop case plans for non-court, voluntary cases; requires realignment in the central, northern and western service areas with judicial districts; and prohibits lead agencies in the southeast, central, western, or northern service areas. (HHS Committee Priority Bill)
- **LB 1160** provides for the development of a web-based, statewide automated child welfare information system to integrate child welfare information; reports by the department and lead agency pilot project; evaluation of child welfare system by a national entity; coordination of all department reports regarding child welfare and juveniles and report on issues involving co-occurring conditions by the department. (Legislative Performance Audit Priority Bill)
  - Two additional LR 37 bills originally introduced at request of HHS Committee by other Senators (amended into above bills)
    - **LB 774** (Howard) Reporting requirements re child welfare (amended into LB 1160)
    - **LB 926** (Dubas) Provide for minimum payment rates for foster care payments and (amended into LB 820)

OTHER BILLS AMENDED INTO LR 37 BILLS

LB 837 (Howard) Create a Committee to review use of certain drugs by wards of the state (amended into LB 821);

LB 874 (Howard) Change licensure procedure (amended into LB 820)

LB 900 (Lathrop) Require a report concerning individuals in need of multiple division services from DHHS (amended into LB 1160) and

LB 1149 (McGill) Change provisions relating to child guardianships and child welfare caseloads (parts amended into LB 961)

OTHER BILLS INTRODUCED AS A RESULT OF INFORMATION FROM LR 37

LB 858 (Avery) Change state contracting requirements for services (Government, Military and Veterans Affairs Committee Priority Bill) Passed

LB 1072 (Business and Labor) Amended to include providers' Miscellaneous Claims against the State from Boys and Girls Home non-payments (Passed notwithstanding line-item objections of the Governor)

Summaries of LR 37 Child Welfare Bills
2012 Legislative Session

LB 820

Provides for the Title IV-E Demonstration Project Committee; theFoster Care Reimbursement Rate Committee; a stipend for foster care parents; and defines the exception to foster care licensing.

1) **Title IV-E Demonstration Project**
   - The application date is September 30, 2013 for the Department of Health and Human Services to apply for approval of a Title IV-E demonstration project.

   - The Title IV-E Demonstration Project Committee is created.
     - Members shall be appointed by Director of CFS-
       - Representatives of the department,
       - At least five child welfare stakeholder entities:
         - One advocate for legal and policy issues including child welfare
         - One advocate that singularly focuses on children's issues
         - Two child welfare service agencies
         - Lead agency
       - One ex-officio member representing the court system
       - Convene within thirty days by director
     - The committee shall review, report, and provide recommendations regarding the Title IV-E demonstration application.
     - The committee may engage a consultant with expertise in Title IV-E demonstration project applications and requirements.
     - The committee will review:
       - Nebraska's Title IV-E participation and penetration rates;
       - Review strategies and solutions for raising participation rates and reimbursement;
       - Recommend specific actions for addressing barriers to participation and reimbursement.
     - The committee shall provide an implementation plan and a time-line for applying for a Title IV-E waiver.
       - Within goals of strategic plan
       - Maximize federal funding
     - As the Nebraska Children's Commission is created the Title IV-E Demonstration Project Committee shall come under the commission's jurisdiction
       - The commission may appoint additional members and make any changes it deems necessary to comply with this act.
     - Committee shall report to the HHS Committee on its activities-
       - July 1, 2012
       - September 1, 2012
       - November 1, 2012
       - Final Report December 15, 2012
       - To include the status of the application by September 15, 2012
     - Committee's implementation plan regarding the demonstration project shall meet the requirements of 42 U.S.C. 1320a-9 including at least two of the child welfare program improvements policies described in 42 U.S.C. 1320A9 (a) (7)

2) LB 820 provides for the creation of the a **Foster Care Reimbursement Rate Committee**:

- To develop a standard statewide foster care reimbursement rate structure for children in foster care in Nebraska
- The Committee shall include:
  - The CEO of the department or his/her designee;
  - Representatives of an array of stakeholders involved in the foster care system.
- The committee shall use the 2007 national foster care compensation study as a beginning standard for setting reimbursement rates and adjust the standard to reflect the reasonable cost of achieving measurable outcomes for foster care in Nebraska.
- The committee shall:
  - Analyze consumer expenditure data for the costs of caring for children in Nebraska;
  - Identify and account for additional costs specific to foster children;
  - Apply a geographic cost-of-living adjustment for Nebraska;
  - Maximize the utilization of federal funds by supporting compliance with Title IV-E and TANF funding.

- The committee will develop a **statewide level of care assessment system** to standardize criteria to determine a foster child's placement needs to appropriately identify the foster care reimbursement rate.
  - Review other states' assessment models and reimbursement rate structures;
  - The state wide level of care assessment system will be research based, supported by evidence-based practices, and reflect the commitment to a systems of care, trauma-informed, child-centered, family-involved, coordinated process.
- The committee shall develop the statewide level of care assessment and foster care reimbursement rate structure to provide incentives to tie performance in achieving the goals of safety, maintaining family connection, permanency, stability, and well-being to reimbursements.
- The committee will report
  - to the Health and Human Services Committee of the Legislature on July 1, 2012; September 1, 2012; November 1, 2012 and
  - a final report will be provided to the HHS committee and the Governor with recommendations for the statewide level of care assessment system and the foster care reimbursement rate structure on December 15, 2012.
- As the Nebraska Children's Commission is created the committee shall immediately come under the commission's jurisdiction. The commission may change the members and make any changes necessary to comply with the act.

- **Foster Care stipend**
  - Nebraska foster parents make an essential contribution to the safety and well being of Nebraska's foster children, and
  - Additional compensation, during the determination of a standard state wide foster care reimbursement structure, is needed;
  - Beginning July 1, 2012 and continuing through June 30, 2013, foster parents will be provided an additional stipend.
- The stipend will be three dollars and ten cents per day per child and will be in addition to the current tiered rate paid to foster parents;
  - The stipend will be paid monthly through the agency or the department contracting with the

foster parent;

- The contracting agency shall receive an administrative fee
  - Twenty-five cents per child per day for processing the stipend,
  - Paid monthly by the state;
  - In addition to the stipend, not funded from it.

- **Licensing of foster parents**
  - No person shall furnish or offer to furnish foster care for one or more children not related to such person by blood, marriage, or adoption
  - Without having in full force and effect a written license issued by the department except as otherwise provided in the section.

LB 821

Provides for the Nebraska Children's Commission and the Office of Inspector General of Nebraska's Child Welfare Act

The Legislature finds and declares that:

- The Health and Human Services Committee of the Legislature documented serious problems with the child welfare system in its 2011 report on the LR 37 study;
- Improving the safety and well-being of Nebraska's children and families is a critical priority which must guide policy decisions in a variety of areas;
- To improve the safety and well-being of children and families in Nebraska, the legislative, judicial, and executive branches of government must work together to ensure:
  - The integration, coordination, and accessibility of all services provided by the state, whether directly or through contracting;
  - Reasonable access to appropriate services statewide, and efficiency in service delivery; and
  - Availability of accurate and complete data and ongoing data analysis to identify important trends and problems as they arise; and
  - As the primary state agency serving children and families, the Department of Health and Human Services must:
    - Exemplify leadership, responsiveness, transparency, and efficiency;
    - Program managers must strive cooperatively to ensure programs view the needs of children and families comprehensively as a system rather than individually in isolation, including pooling funding when possible and appropriate.

It is the intent of the Legislature that the Nebraska Children's Commission provide a broad restructuring of the goals of the child welfare system and provide a structure for the Commission that maintains the framework of the three branches of government and their respective powers and duties.

The Nebraska Children's Commission is created as a high-level leadership body to:

- Create a system-wide strategic plan for child welfare reform of programs and services;
- Review the operations of the department regarding child welfare and recommend as a part of the strategic plan either the establishment of a new division within the department or a new state agency; and
- Provide a permanent forum for collaboration among state, local, community, public, and private stakeholders in child welfare programs.

The Commission voting members shall include:

- The CEO of the department or his/her designee;
- The Director of CFS or his/her designee; and
- Sixteen members appointed by the Governor representing:
  - A director of a child advocacy center;
  - A regional administrator of a behavioral health authority;
  - Community members from each service area (the representative from the eastern service area may be from a Pilot Project lead agency or collaborative member);
  - A prosecuting attorney who practices in juvenile court;
  - A guardian ad litem;
  - A biological parent currently or previously involved in the child welfare system;

- A foster parent;
- A CASA volunteer;
- A Foster Care Advisory Committee member or a member of a local foster care review board;
- A child welfare services agency that directly provides a wide range of child welfare services, that is not a member of a lead agency collaborative;
- A young adult previously in foster care; and
- A representative of a child advocacy organization representing legal and policy issues that include child welfare.

- The Commission non-voting ex officio members shall include:
  - The Chair of the Health and Human Services Committee or a committee member designee;
  - The Chair of the Judiciary Committee or a committee member designee;
  - The Chair of the Appropriations Committee or a committee member designee;
  - Three persons appointed by the State Court Administrator
- Non-voting ex officio members may:
  - Attend meetings and participate in discussions of the commission
  - Provide information to the commission on the policies, programs, and process of each of their respective bodies;
  - Gather information for the commission; and
  - Provide information back to their respective bodies from the commission.
  - The non-voting ex officio members shall not vote on decisions or on the direction of the development of the strategic plan.

The Commission shall

- Meet within sixty days after the effective date of the act
- Select from its members a chairperson and vice-chairperson
- Meet not less than once every three months
- Meetings may be held at any time on the call of the chairperson
- Be within the CEO of the department office
- Hire a staff to carry out the responsibilities of the commission.
- Hire a consultant with experience in facilitating strategic planning to provide neutral, independent assistance in developing the statewide child welfare strategic plan
- Terminate June 30, 2014, unless continued by the Legislature.

The Nebraska Children's Commission shall work with:

- Service area administrators, the 1184 teams, local foster care review boards, child advocacy centers, the teams created pursuant to the Nebraska Supreme Court's Through the Eyes of the Child Initiative, community stakeholders, and advocates for child welfare services and programs to establish networks in each service area.
- Networks shall permit community collaboration to strengthen the continuum of services available to child welfare agencies and to provide resources for children and juveniles outside the child protection system.
- Each service area shall develop its own unique strategies to be included in the statewide strategic plan.
- The department shall assist in identifying the needs of each service area.

The Commission will create and/or oversee committees as it deems necessary to include, but not be limited to:

- A committee to examine state policy regarding prescription of psychotropic drugs for state wards;
- Title IV-E Demonstration Project Committee;
- Foster Care Reimbursement Rate Committee;
- Members of the committees may be
  - Members of the Commission or
  - May be a non-member of the Commission who is assigned, with the approval of the majority of the Commission, for their subject matter.
- Committee to examine the structure and responsibilities of the Office of Juvenile Services, the committee shall:
  - Review the role and effectiveness of the youth rehabilitation and treatment centers and
  - Make recommendations to the commission on the future role of the youth rehabilitation and treatment centers in the juvenile justice continuum of care.
  - Review the responsibilities of the Administrator of the Office of Juvenile Services, including
    - Oversight of the youth rehabilitation and treatment centers and juvenile parole, and
    - Make recommendations to the commission relating to the future responsibilities of the administrator.

The Commission will work with other child welfare and juvenile entities including, but not limited to:

- State Court Administrator
  - Facilitated Conferencing shall:
    - Be included in strategic plan discussion;
    - Continue to be utilized as determined by the court of jurisdiction;
  - Be funded and contracted through entities at least to the same extent as provided on the effective date of the act
- Douglas County Crossover Youth Practice Model; and
- Nebraska Juvenile Services Delivery Project.

The Nebraska Children's Commission shall create a statewide strategic plan for child welfare program and service reform in Nebraska considering, but not limited to:

- The potential of contracting with private, nonprofit entities as lead agencies in a manner that maximizes the strengths, experience, skills, and continuum of care of the lead agency.
- Any lead-agency contracts entered into or amended after the effective date of this action shall detail how the qualified licensed agencies, as part of their efforts to develop the local capacity for a community-based system of coordinated care, will implement community based care through competitively procuring either:
  - Contracting for specific components of foster care and related services or;
  - Comprehensive services for a defined eligible population of children and families.
- Intentional strategies for high-quality evidence-based prevention and early intervention services;
- Realignment of services areas to coterminous with the judicial districts;
- Identification of the type of information needed for a clear and thorough analysis of progress on child welfare indicators.

- A lead agency after the effective date of this act shall:
  - Have a board of directors of which a least fifty-one percent of the membership is comprised of Nebraska residents who are not employed by the lead agency or a subcontractor of the lead agency;
  - Complete a readiness assessment as developed by the department to determine viability
  - Not more provide more than thirty-five percent of direct services; and
  - Provide accountability for meeting the outcomes and performance standards related to child welfare services established by NE child welfare policy and the federal government.

The Commission shall review the operations regarding child welfare programs and services and recommend as a part of the strategic plan and make a choice regarding the establishment of a new division within the department or the establishment of a new state agency

The department shall, with direction from the Commission, within three months after the effective date of this act, contract with an independent entity specializing in medicaid analysis to conduct a cross-system analysis of current prevention and intervention programs and services provided by the department for the safety, health, and well-being of children and funding sources to:

- Identify resources that could be better allocated for services to at-risk children and juveniles transitioning to home-based and school-based interventions, and
- Provide info to expand services to reduce GF and expand federal funds;

The department shall:

- Fully cooperate with the Commission;
  - Provide info on child including reports, data, programs, process, finances and polices;
- Collaborate regarding the development of a plan for a state wide automated child welfare information system and
- Coordinate and collaborate with the Commission regarding the engagement of an evaluator to provide a child welfare system evaluation.

The Commission shall provide a written report the the Health and Human Services Committee of the Legislature on the status of its activities on or before:

- August 1, 2012, September 15, 2012, and November 1, 2012.
- The statewide strategic plan and written report shall be provided to the HHS Committee and the Governor on or before December 15, 2012.

The Office of Inspector General of Nebraska Child Welfare is created within the Office of Public Counsel.

It is the intent of the Legislature to:

- Establish a full time program of investigation and performance review to provide increased accountability and oversight of the Nebraska child welfare system;
- Assist in improving operations of the department and the Nebraska child welfare system;
- Provide an independent form of inquiry for concerns regarding the actions of individuals and agencies responsible for the care and protection of children; and
- Provide a mechanism for investigation and review to determine if individual complaints and issues of inquiry reveal problems in the system that necessitate legislative action for improved policies and restructuring of the child welfare system.

It is not the intent of the Legislature in enacting the Office of Inspector General of Nebraska Child Welfare Act to:

- Interfere with the duties of the Legislative Performance Audit, Legislative Fiscal Analyst, or
- Interfere with the statutorily defined investigative responsibilities or prerogatives of any officer, agency, board, bureau, commission, association, society, or institution of the executive branch of state government.

The Inspector General shall:

- Be appointed by the Public Council with approval from the Chairman of the Executive Board and the Chairman of the Health and Human Services Committee of the Legislature.
- Carry out the duties of the office within the amount available by appropriation through the Office of Public Council for the Office of Inspector General.
- Be subject to the control and supervision of the Public Counsel; however, removal of the Inspector General will require approval of the Chairmen of the Executive Board and Chairman of the Health and Human Services Committee of the Legislature.
- Be a person well equipped to analyze problems of law, administration, and public policy and during his employment not be actively involved in partisan affairs.
    - No former of current executive or manager of the department may be appointed Inspector General within five years of service to the department
    - Not later than two years after the date of appointment the Inspector General shall obtain certification as a Certified Inspector General

The Office shall investigate:

- Allegations of possible misconduct, misfeasance, malfeasance, or violations of statutes or of rules or regulations of the department by an employee of, or a person under contract with, the department, a private agency, a child care facility, a foster parent, or any other provider of child welfare services or which may provide a basis for discipline pursuant to the Uniform Credentialing Act; and
- Death or serious injury in foster homes, private agencies, child care facilities, and other programs and facilities licensed by, or under contract with, the department and death or serious injury in any case in which services are provided by the department to a child or his or her parents.
- Any case involving an investigation under the Child Protection Act, which case has been open for one year or less.
- The department shall report all cases of death or serious injury to the Office.

Investigations by the Inspector General shall be independent of and separate from an investigation pursuant to the Child Protection Act.

- Notwithstanding the fact that a criminal investigation, a criminal prosecution, or both are in progress, all law enforcement agencies and prosecuting attorneys shall:
    - Cooperate with any investigation conducted by the Inspector General;
    - Immediately upon request by the Inspector General, provide copies of all law enforcement reports relevant to the Inspector General's investigation;
        - All law enforcement reports provided pursuant to this section are not public records;
        - Shall not be subject to discovery by any other person or entity; and
        - Except to the extent otherwise provided in the Office of Inspector General of Nebraska

Child Welfare Act the confidentiality of all law enforcement reports shall be maintained
    - Collaborate with the Inspector General regarding all other information relevant to the Inspector General's investigation.
- If the Inspector General in conjunction with the Public Counsel determines appropriate, may suspend an investigation by the office until:
    - A criminal investigation or prosecution is completed; or
    - Has proceeded to a point that, in the judgment of the Inspector General, the investigation will not impede or infringe upon the criminal investigation or prosecution.
- Under no circumstance shall the Inspector General interview any minor who has already been interviewed by a law enforcement agency, personnel of the Division of Children and Family Services of the department, or staff of a child advocacy center in connection with a relevant ongoing investigation of a law enforcement agency.

The office shall have access to all information and personnel necessary to perform the duties of the office.

- A full investigation conducted by the Office shall consist of retrieval of relevant records through subpoena, compliance with a request of the Office, or voluntary production, review of all relevant records, and interviews of all relevant persons.

Complaints to the office may be made in writing. The Office shall also maintain a toll-free telephone line for complaints. A complaint shall be evaluated to determine if it is within the functions of the Office and whether a full investigation is warranted.

The Office shall not conduct a full investigation of a complaint unless:

- The complaint alleges malfeasance, misconduct, misfeasance, violation of a statute or of rules and regulations of the department, or there is a basis for discipline pursuant to the Uniform Credentialing Act;
- The complaint is against a person within the jurisdiction of the Office; and
- The allegations can be independently verified through investigation.

The Inspector General shall determine within fourteen days after receipt of a complaint whether it will conduct a full investigation.

- A complaint for discipline under the Uniform Credentialing Act shall be referred to the appropriate credentialing board under the act.

All employees of the department, all foster parents, and all owners, operators, managers, supervisors, and employees of private agencies, licensed child care facilities, and other providers of child welfare services shall cooperate with the office re full access to and production of records and information within the confidentiality and protection outlined in the act.

The office may:

- Issue subpoenas, enforceable by action in an appropriate court, to compel any person to appear, give sworn testimony, or produce documentary or other evidence .
- Allowed Counsel to be present; the same privileges and immunities are extended the individuals as in the district court.
- Access all relevant records through subpoena, compliance with a request of the office, and voluntary production.

All investigations conducted by the office shall be conducted in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution.

- Reports of investigations conducted by the office shall not be distributed beyond the entity that is the subject of the report without the consent of the Inspector General.
- Except when a report is provided to a guardian ad litem or an attorney in the juvenile court pursuant to subsection (2) of section 34 of this act, the office shall redact confidential information before distributing a report of an investigation.
- The office may disclose confidential information to the Chairperson of the Health and Human Services Committee of the Legislature when such disclosure is, in the judgment of the Public Counsel, desirable to keep the chairperson informed of important events, issues, and developments in the Nebraska child welfare system.
- Records and documents obtained or reports produced by the office in the course of an investigation are not public records.

The Inspector General's report of an investigation shall be in writing to the Public Counsel and shall contain recommendations. The report may recommend:

- Systemic reform or case-specific action, including a recommendation
  - For discharge or discipline of employees or
  - For sanctions against a foster parent, private agency, licensed child care facility, or other provider of child welfare services.
- All recommendations to pursue discipline shall be in writing and signed by the Inspector General.
- A report of an investigation shall be presented to the director within fifteen days after the report is presented to the Public Counsel.
- Any person receiving a report under this section shall not further distribute the report or any confidential information contained in the report.
  - The Inspector General, upon notifying the Public Counsel and the director, may distribute the report, to the extent that it is relevant to a child's welfare, to the guardian ad litem and attorneys in juvenile court in which a case is pending.
- The report shall not be distributed beyond the parties except through the appropriate court procedures to the judge.

Within fifteen days after a report is presented to the director under this act, he or she shall determine whether:

- To accept, reject, or request in writing modification of the recommendations contained in the report.

The Inspector General may consider the director's request for modifications, but is not obligated to accept such request. Such report shall become final upon the decision of the director to accept or reject the recommendations in the report or, if the director requests modifications, within fifteen days after such request or after the Inspector General incorporates such modifications, whichever occurs earlier.

In accordance with the Public Counsel statutes, no report or other work product by the Inspector General shall be reviewable in any court. Neither shall the office be required to testify or produce evidence.

The act does not require the office to investigate all complaints. The Inspector General with input from the Public Counsel shall prioritize activities as necessary to further the intent of the act and assist

legislative oversight of the Nebraska child welfare system.

On or before September 15 of each year, the Inspector General shall provide to the Health and Human Services Committee of Legislature and the Governor a summary of reports and investigations made under the Office of Inspector General Act for the preceding year.

- The summaries shall detail recommendations regarding issues that will increase accountability and legislative oversight of the Nebraska Child welfare system and improve operations of the department.
- The summaries shall not contain any confidential or identifying information concerning the subjects of the reports and investigations.

LB 949

Require reports relating to expenditures, changes or movement of funds in excess of $250,000, and progress toward key goals; a strategic plan that identifies the main purpose of programs, key goals, benchmarks and methods of quantification of progress by the Division of Children and Family Services of the Department of Health and Human Services in conjunction with appropriation request; and designate as a separate budget program the appropriation of funds for child welfare.

LB 949 requires that the DCF shall report in writing to the Appropriations Committee and the Health and Human Services Committee:

- On or before July 30, 2012:
  - Expenditures between January 1, 2012 and June 30, 2012;
  - Outcomes of such expenditures; and
  - Changes or movement of funds between child welfare subprograms within Budget Program 347 in excess of two hundred fifty thousand dollars.
- Beginning the third calendar quarter of 2012, within thirty days after the end of the quarter:
  - Expenditures and outcomes of such expenditures; and
  - Changes or movement of funds between child welfare subprograms within Budget Program 347 in excess of two hundred fifty thousand dollars.

As a part of the appropriations request process for bienniums ending June 30, 2015 and 2017, CFS shall include a strategic plan that identifies:

- The main purpose of each program; and
- With the assistance of the DAS CFS shall include:
  - Verifiable and auditable key goals that are fair measures of progress in meeting each program purpose;
  - Benchmarks for improving performance for the state and each service area and
    - Report regarding success meeting benchmarks;
    - Time-frames for meeting benchmark.
    - Not later that September 15, 2012 and 2015, the CFS shall report on the progress of key goals for the prior twelve months to the Appropriations Committee and Health and Human Services Committee.

Child welfare aid will be changed from a subprogram in Budget Program 347 and designated as a separate budget program.

LB 961

Case management; Pilot Case Management Lead Agency Model Project; caseloads; Non-Court, voluntary case plan requirements; service area realignment with judicial districts; prohibition of lead agency model;

- **Legislative findings**
  - State has responsibility for children in its custody;
  - Substantial cost to the state in privatizing case management,
  - Unsustainability of the financial costs of private case management; and
  - Importance of training for case managers and caseworkers.
- Returns case management to the state of Nebraska
  - Beginning April 1, 2012,
  - Except for the Pilot Case Management Lead Agency Model Project.
- The **Pilot Case Management Lead Agency Project**
  - The department may contract with a lead agency for a Pilot in the Eastern service area.
  - Shall include appropriate conditions, performance outcomes, and oversight for the lead agency
    - The reporting, monitoring, capacity, and evaluation as specified in LB 1160 for the department shall include the pilot project.
    - Compliance and coordination with the Nebraska Children's Commission development of the strategic plan as outlined in LB 821;
    - Assure financial accountability and reporting by the lead agency;
  - Prior to April 1, 2013, the HHS Committee shall
    - Review the pilot project and
    - Provide to the Legislature and the department recommendations, with legislative options necessary to enact the recommendations
    - Regarding the adaptation or continuation of the pilot HHS Committee will utilize:
      - The system evaluation and Children's Commission strategic plan in LB 821
      - The assessment of the department
      - The reports, surveys, information and data provided to the Committee;
  - If the pilot project continues past April 1, 2013, the lead agency shall comply with the requirements in LB 821 Section 4 (2) regarding future lead agencies:
    - Board of directors with at least fifty-one percent
      - Nebraska residents,
      - Not employed by the lead agency or a subcontractor of the lead agency;
    - Complete a readiness assessment, developed by the department, to determine the lead agency viability and evaluate organization, operational, and programmatic capabilities and performance;
    - No more than thirty-five percent of direct services may be provided by lead agency;
    - Provide accountability for meeting the outcomes and performance standards
- The department and pilot project caseloads shall range between 12-17 cases per case manager
  - Compliance with caseload range shall be completed by September 1, 2012.
    - Department and pilot will use the same criteria and standard specified in the bill
    - The department shall include, beginning September 15, 2012, in its annual report required in 68-1207.01:

    - A report on the progress toward the caseload standards in compliance with the act and according to the Child Welfare League of America, or its successor.
    - An annual report of the Child Welfare League of America or its successor, caseload standards.
- Caseload size determined by:
    - If children are placed in the home, the family shall count as one case regardless of how many children are placed in the home;
    - If a child is placed out of his or her home, the child shall count as one case;
    - If, within one family, one or more children are placed in the home and one or more children are placed out of the home, the children placed in the home shall count as one case and each child placed out of the home shall count as one case; and
    - Any child receiving services from the department or a private entity under contract with the department shall be counted as provided, whether or not such child is a ward of the state.
    - A child is considered to be placed in the home if the child is placed with his or her biological or adoptive parent or a legal guardian and
    - A child is considered to be placed out of the home if the child is placed in foster care, group home care, or any other setting which is not the child's planned permanent home
- DHHS shall develop case plans with specified services and actions for non-court and voluntary cases;
- After Sept 1, 2012, reconfigures Central, Western, and Northern Service areas so that no judicial district is included in more than one service area.
- Provides that lead agencies shall not be reinstated in the Southeast, Central, Western, and Northern Service areas.

LB 1160

Provides for the development of a web-based, statewide, automated child welfare information system to integrate child welfare information; reports by a national entity; and coordination of all department reports regarding child welfare and juveniles.

The Legislature finds that:

- NE does not have the capacity to collect and analyze data required to inform policy decision, development and evaluation of the child welfare system-wide
- N-FOCUS does not provide data in a manner that
  - Allows for the monitoring of the system;
  - Allows for integration of other computer systems resulting in silos of operation and information;
- The department needs leadership in developing a uniform electronic data collection system for child welfare

It is the intent of the Legislature to provide:

- Legislative oversight of the child welfare system through an improved electronic data collection system;
  - Integrate child welfare information into one system to more effectively manage, track and share information, especially in case management
- Improved outcome measurements and increased reporting; and
- An independent evaluation of the child welfare system.

Web-based, statewide, automated child welfare information system
The department shall develop and implement a web-based, statewide, automated child welfare information system to:

- Integrate child welfare information into one system;
- Improve efficiency and effectiveness by reducing paperwork and redundant data entry allowing case mangers to spend more time working with families and children;
- Improve access to information to support policy and practice standards;
- Facilitate timely and quality case management decisions through information;
- Provide consistent and accurate data management to improve reporting, accountability, workload distribution, and case review requirement;
- Improve payment and service tracking;
- Improve case management;
- Utilize business intelligence software to track progress of dashboards;
- Access real time data to take supportive and corrective actions in cases;
- Expedite identification of foster homes and community resources available to meet children's needs; and
- Improve reporting and tracking capabilities for accuracy, transparency, and oversight of the child welfare system.

The capacity of the web-based, statewide, automated child welfare information system shall include:

- Integration of social services through automated interfaces with the courts, medicaid eligibility, child support, etc.

- Ease implementing future system modifications;
- Compatibility with multiple vendor platforms;
- Additional capacity if system volume requirements increase;
- Protection at each tier of system in the event of component failure;
- Vendor portals for direct entry of case information;
- Key automated process analysis for supervisor and management to include cell or other mobile communication devises for administration of cases;
- Web access 24-7;
- Automated application of child welfare policy and procedures;
- Automated prompts and alerts for case management assistance; and
- Compliance with federal regulations re child welfare and Title IV-E

On or before December 1, 2012, the department shall report to the Legislature a plan for a statewide automated child welfare information system. The report shall:

- Be developed with assistance from other agencies as necessary to include the data coordinator for the Foster Care Review Office;
- Include the design, development, implementation, and cost of the system;
- Review available options and compare costs of the options including:
  - System functionality,
  - Shared services re intake, rules, financial information and reporting,
  - Integration,
  - Maintenance costs,
  - Application architecture to ensure flexibility and scalability,
  - Maintenance costs,
  - Deployment costs,
  - Licensing fee,
  - Training requirements, and
  - Operational costs and support needs.
- Report shall compare costs and benefits of a custom-built system and a commercial off-the-shelf system including
  - Total cost of ownership,
  - Direct and indirect costs.
- In conjunction with the report, the department shall prepare the advance planning document required to qualify for federal funding
  - The advance planning document shall describe the plan for managing the design, development, and operations that meets federal requirements and state needs in an efficient, comprehensive and cost effective manner.

Reporting

The department shall report information regarding children served by the pilot project and the department to the HHS Committee on or before September 15, 2012 and each September 15 thereafter:

- Percentage of children served and allocation of child welfare budget by service area and pilot project including:
  - Percentage of children served by service area and corresponding budget allocation and
  - Percentage of children who are wards of the state and corresponding budget allocation.
- Number of siblings in out-of-home care placed with siblings by service area and by pilot project.

- Information updating the previous report of the Children's Behavior Health Task Force including:
  - Number of children receiving mental health and substance abuse services annually by the Division of Behavioral Health;
  - Number of children receiving behavioral health services annually at the Hastings Regional Center;
  - Number of wards receiving behavioral health services as of September 1;
  - Funding sources for children's behavioral health services for the fiscal year ending prior to report;
  - Expenditures of immediately preceding fiscal year for behavioral health services by region and category of service; and
  - Medicaid and CHIP expenditures for mental health and substance abuse services for all children and wards of state.
- Information from each service area and pilot project:
  - Case manager education including college degree, major and level of education beyond a bachelors;
  - Average caseload per case manager;
  - Average number of case managers per child during the preceding twelve months;
  - Average number a case manageers per child for children in system for three, six, twelve and eighteen months, and consecutive yearly average for children until the age of majority or permanency is attained;
  - Monthly case manager turnover;
  - Monthly face-to-face contacts between each case manager and parents of child on case manager caseload;
  - Case documentation of monthly consecutive parent contacts per quarter;
  - Case documentation of monthly consecutive child contacts with case manager per quarter;
  - Case document of monthly consecutive contacts between child welfare service providers and case mangers per quarter;
  - Timeliness of court reports; and
  - Non-court involved children, including the number of children serviced, types of services requested, specific services provided, cost of services provided and the funding source;
- All placement in residential treatment settings made or paid for by the child welfare system, OJS, the State Department of Education, or local education agencies, any lead agency or the pilot project through letters of agreement, and the medical assistance program, including, but not limited to:
  - Child variables;
  - Reasons for placement;
  - The percentage of children denied medicaid-reimbursed services and denied the level of placement requested;
  - With respect to each child in a residential treatment setting:
    - If there was a denial of initial placement request:
      - The length and level of each placement subsequent to denial of initial placement request and
      - The status of each child before and immediately after placement; six months and twelve months after placement;
    - Funds expended and length of placements;

        - Number and level of placements;
        - Facility variables; and
        - Identification of specific child welfare services unavailable in the child's community that, if available, could have prevented the need for residential treatment; and
    - Identification of child welfare services unavailable in the state that, if available, could prevent out-of-state placements;
- From any pilot project:
    - The percentage of its accounts payable to subcontracted child welfare service providers that are thirty days overdue, sixty days overdue, and ninety days overdue; and
- For any individual involved in the child welfare system receiving a service or a placement through the department or its agent for which referral is necessary:
    - The date when such referral was made by the department or its agent and
    - The date and the method by which the individual receiving the services was notified of such referral.
    - The date the individual began receiving such services; the department or its agent shall document such date.
- Each service area administrator and pilot project shall annually survey children, parents, foster parents, judges, guardians ad litem, attorneys representing parents, and service providers involved with the child welfare system to monitor satisfaction with:
    - Adequacy of communication by the case manager,
    - Response by the department, any lead agency, or the pilot project to requests and problems,
    - Transportation issues,
    - Medical and psychological services for children and parents,
    - Visitation schedules,
    - Payments,
    - Support services to foster parents,
    - Adequacy of information about foster children provided to foster parents, and
    - The case manager's fulfillment of his or her responsibilities.
    - Summary of the survey shall be reported to the Health and Human Services Committee of the Legislature on September 15, 2012, and each September 15 thereafter.
- Each service area administrator and pilot project shall provide monthly reports to the child advocacy center that corresponds with the geographic location of the child regarding the services provided through the department or the pilot project when the child is identified as a voluntary or non-court-involved child welfare case. The monthly report shall include:
    - The plan implemented by the department or the pilot project for the child and family, and
    - The status of compliance by the family with the plan.
    - The child advocacy center shall report to the Health and Human Services Committee of the Legislature on September 15, 2012, and every September 15 thereafter, or more frequently if requested by the committee, a summary of these reports.
- On or before September 15, 2012, and on or before each September 15 thereafter, the department shall provide a report to the Health and Human Services Committee of the Legislature on the department's monitoring the pilot project, including the actions taken for:
    - Contract management,
    - Financial management,
    - Revenue management,
    - Quality assurance and oversight,

- Children's legal services,
- Performance management, and
- Communications.
- The report shall also include review of the functional capacities of each pilot project for:
  - Direct case management,
  - Utilization of social work theory and evidence-based practices to include processes for insuring fidelity with evidence-based practices,
  - Supervision,
  - Quality assurance,
  - Training,
  - Subcontract management,
  - Network development and management,
  - Financial management,
  - Financial controls,
  - Utilization management,
  - Community outreach,
  - Coordination and planning,
  - Community and stakeholder engagement, and
  - Responsiveness to requests from policymakers and the Legislature.

- On or before December 31, 2012, the department shall provide an additional report to the committee updating the information on the pilot project contained in the report of September 15, 2012.

Child Welfare System Evaluation

The department shall engage a nationally recognized evaluator to provide an evaluation of the child welfare system.

- The evaluator shall:
  - Be a national entity that can demonstrate direct involvement with public and tribal child welfare agencies; partnerships with national advocacy organizations, think tanks, or technical assistance providers; collaboration with community agencies; and independent research; and
  - Be independent of the department and any lead agency or the pilot project:
    - Shall not have been involved in a contractual relationship with the department, any lead agency, or the pilot project within the preceding three years, and
    - Shall not have served as a consultant to the department, any lead agency, or the pilot project within the preceding three years.
- The department shall give consideration to evaluator candidates who have experience in:
  - Outcome measurement, including, but not limited to:
    - Measuring change for organizations, systems, and communities, with an emphasis on organizational assessment, child welfare system evaluation, and complex environmental factors;
    - Assessing the quality of child welfare programs and services across the continuum of care, with differential consideration of in-home and foster care populations and advanced research and evaluation methodologies, including qualitative and mixed-method approaches;
    - Use of data, including, but not limited to:

        - Using existing administrative data sets, with an emphasis on longitudinal data analysis;
        - Integrating data across multiple systems and interoperability;
        - Developing and using data exchange standards; and
        - Using continuous quality improvement methods to assist with child welfare policy decision making;
    - Intervention research and evaluation, including, but not limited to:
        - Designing, replicating, and adapting interventions, including the identification of counter factuals; and
        - Evaluating programmatic and policy interventions for efficacy, effectiveness, and cost; and
    - Dissemination and implementation research, including, but not limited to:
        - Measuring fidelity;
        - Describing and evaluating the effectiveness of implementation processes;
        - Effectively disseminating relevant, accessible, and useful findings and results; and
        - Measuring the acceptability, adoption, use, and sustainability of evidence-based and evidence-informed practices and programs.
- The evaluation shall include the following key areas:
    - The degree to which privatization of child welfare services in the eastern service area has been successful in:
        - Improving outcomes for children and parents, including, but not limited to,
            - Whether the outcomes are consistent with the objectives of the Families Matter program or
            - The pilot project and
        - Whether the cost is reasonable, given the outcomes and cost of privatization;
    - A review of the readiness and capacity of any lead agency or the pilot project and the department to perform essential child welfare service delivery and administrative management functions according to nationally recognized standards for network management entities, with special focus on case management. The readiness review shall include, but not be limited to:
        - Strengths,
        - Areas where functional improvement is needed,
        - Areas with current duplication and overlap in effort, and
        - Areas where coordination needs improvement; and
    - A complete review of the preceding three years of placements of children in residential treatment settings, by service area and by any lead agency or the pilot project. The review shall include
        - All placements made or paid for by the child welfare system, the Office of Juvenile Services, the State Department of Education, or local education agencies;
        - Any lead agency or the pilot project through letters of agreement and the medical assistance program.
        - The review shall include, but not be limited to:
            - Child variables;
            - Reasons for placement;
            - The percentage of children denied medicaid-reimbursed services and denied the level of placement originally requested;

- With respect to each child in residential treatment setting:
  - If there was a denial of initial placement request, the length and level of each placement subsequent to denial of initial placement request and the status of each child before and immediately after, six months after, and twelve months after placement;
  - Funds expended and length of placements;
  - Number and level of placements;
  - Facility variables;
  - Identification of specific services unavailable in the child's community that, if available, could have prevented the need for residential treatment; and
  - Percentage of children denied reauthorization requests or subsequent review of initial authorization;
- Identification of child welfare services unavailable in the state that, if available, could prevent out-of-state placements; and
- Recommendations for improved utilization, gate-keeping, and community-level placement prevention initiatives and an analysis of child welfare services that would be more effective and cost efficient in keeping children safe at home.

- The evaluation required pursuant to this section shall be completed and a report issued on or before December 1, 2012, to the Health and Human Services Committee of the Legislature and the Governor.

Health and Human Services Committee Report
On December 15 of 2012, 2013, and 2014, the Health and Human Services Committee of the Legislature shall provide a written report to the Legislature, Governor, and Chief Justice of the Supreme Court with respect to the progress made by the Department of Health and Human Services implementing the recommendations of the committee contained in the final report of the study conducted by the committee pursuant to Legislative Resolution 37, One Hundred Second Legislature, First Session, 2011.

Coordination of reporting dates of child welfare statutory mandated reports (LB774 amended into LB 1160))
In order to facilitate the HHS Committee report, the department shall provide to the committee by September 15 of 2012, 2013, and 2014 the reports required pursuant to sections 43-296, 43-534, 68-1207.01, 71-825, 71-1904, and 71-3407 and subdivision (6) of section 43-405. The Children's Behavioral Health Oversight Committee of the Legislature shall provide its final report to the Health and Human Services Committee of the Legislature on or before September 15, 2012.

- 43-296 All associations receiving juveniles under the Nebraska Juvenile Code shall be subject to the same visitation, inspection, and supervision by the Department of Health and Human Services.
  - Every such association shall annually, on or before September 15, make a report to the department showing its condition, management, and competency to adequately care for juveniles as are or may be committed to it.
  - The department shall provide a copy to the Health and Human Services Committee of the Legislature on or before September 15 of 2012, 2013, and 2014.
- 43-405 The administrative duties of the Office of Juvenile Services shall monitor commitments, placements, and evaluations at facilities and programs operated by the office or through contracts with providers and report its findings annually to the Legislature.

- For 2012, 2013, and 2014, the office shall also provide the report to the Health and Human Services Committee of the Legislature on or before September 15.
- The report shall include an assessment of the administrative costs of operating the facilities, the cost of programming, and the savings realized through reductions in commitments, placements, and evaluations;

- 43-534 Every department, agency, institution, committee, and commission of state government which is concerned or responsible for children and families shall submit, as part of the annual budget request of such department, agency, institution, committee, or commission, a comprehensive statement of the efforts such department, agency, institution, committee, or commission has taken to carry out the policy and principles set forth in sections 43-532 and 43-533.
  - For 2012, 2013, and 2014, the Department of Health and Human Services shall provide a copy of its statement to the Health and Human Services Committee of the Legislature on or before September 15.
  - The statement shall include, but not be limited to:
    - A listing of programs provided for children and families and the priority of such programs,
    - A summary of the expenses incurred in the provision and administration of services for children and families,
    - The number of clients served by each program, and
    - Data being collected to demonstrate the short-term and long-term effectiveness of each program.
- 68-1207.01 The Department of Health and Human Services shall annually provide a report to the Legislature and Governor outlining the caseloads of child protective services.
  - For 2012, 2013, and 2014, the department shall also provide the report to the Health and Human Services Committee of the Legislature on or before September 15.
  - Such report shall include:
    - A comparison of caseloads established by the department with the workload standards recommended by national child welfare organizations
    - The fiscal resources necessary to maintain such caseloads in Nebraska;
    - Statistics regarding those child welfare workers employed by the State of Nebraska, under contract with the State of Nebraska or employed by a private entity under contract with the State to include:
      - The number of child welfare services caseworkers and case managers;
      - The average length of employment;
      - The average caseload;
      - The outcomes of such cases, including the number of children reunited with their families, children adopted, children in guardianships, placement of children with relatives, and other permanent resolutions established and
      - The average cost of training
- 71-825 The department shall provide an annual report to the Health and Human Services Committee and to the Governor for 2012, 2013, and 2014, on the operation of the Children and Family Support Hotline established under section 71-822, the Family Navigator Program established under section 71-823, and the provision of voluntary post-adoption and post-guardianship case management services under section 71-824.
- 71-827 The Children's Behavioral Health Oversight Committee of the Legislature shall monitor the effect of implementation of the Children and Family Behavioral Health Support Act and

other child welfare and juvenile justice initiatives by the department related to the provision of behavioral health services to children and their families.
    - The committee shall provide a report to the Governor and the Health and Human Services Committee of the Legislature on or before September 15, 2012.
    - The report shall include, but not be limited to, findings and recommendations relating to the provision of behavioral health services to children and their families.
- 71-1904 The department shall be responsible for the issuance, suspension, and revocation of licenses to provide foster care and the provision of training in foster care, which training shall be directly related to the skills necessary to care for children in need of out-of-home care, including, but not limited to, abused, neglected, dependent, and delinquent children.
    - The training required may be waived in whole or in part by the department for persons operating foster homes providing care only to relatives of the foster care provider.
        - Waivers shall be granted on a case-by-case basis
        - Upon assessment by the department of the appropriateness of the relative foster care placement.
    - The department shall report annually for 2012, 2013, and 2014, to the Health and Human Services Committee of the Legislature on or before September 15 the number of waivers granted under this subsection and the total number of children placed in relative foster homes.
- 71-3407 The purposes of the team shall be to develop an understanding of the causes and incidence of child deaths in this state, develop recommendations for changes within relevant agencies and organizations which may serve to prevent child deaths, and advise the Governor, the Legislature, and the public on changes to law, policy, and practice which will prevent child deaths.
    - The team shall provide the Governor, the Legislature, and the public with annual written reports which shall include the team's findings and recommendations for each of its duties. For 2012, 2013, and 2014, the team shall also provide the report to the Health and Human Services Committee of the Legislature on or before September 15;
    - Undertake annual statistical studies of the causes and incidence of child deaths in this state. The studies shall include, but not be limited to:
        - An analysis of the records of community, public, and private agency involvement with the children and their families prior to and subsequent to the deaths; and
        - Recommended changes to any law, rule, regulation, or policy needed to decrease the incidence of preventable child deaths;

Individuals with co-occurring conditions report
(LB 900 amended into LB1160)

A report:

- To the Health and Human Services Committee of the Legislature and the Developmental Disabilities Special Investigative Committee of the Legislature;
- On or before December 1, 2012;
- By the Directors of:
    - Children and Family Services,
    - Developmental Disabilities
    - Behavioral Health and
    - Medicaid and Long-Term Care;
- Concerning the access of individuals with co-occurring conditions of an intellectual disability

and mental illness to the full array of services needed to appropriately treat their specific conditions.

- The report shall include, but not be limited, to:
  - A summary of how these individuals are currently served, including eligibility determinations;
  - An identification and further defining of individuals who currently fall in the gap between the divisions or who move from one division to another in a search for appropriate services;
  - Information on the individuals currently receiving services from more than one division who have these co-occurring conditions, including the:
    - Costs of the services,
    - Types of services provided,
    - Unmet demand for such services, and
    - An estimate of the number of individuals served by one division who would also qualify for services through another division;
  - An explanation of the differences and similarities in funding for services provided by the divisions and how funds from each division are being blended or can be blended to best serve these individuals;
  - A plan that could be implemented by the divisions that would provide more integrated and coordinated treatment for these individuals by the divisions; and
  - Any recommendations for potential legislation that would assist the Division of Children and Family Services, the Division of Developmental Disabilities, the Division of Behavioral Health, and the Division of Medicaid and Long-Term Care in carrying out the plan.

2012 Interim Studies Regarding Child Welfare in HHS Committee				
LR	**Introducer**	**One Liner**	**Referenced to**	
LR 529	Campbell	Interim study to provide for review and assessment and make recommendations relating to the entry of children into the child welfare system	HHS Com	
LR 525	Coash	Interim study to examine how Nebraska's system for screening, assessing, and investigating reports of child abuse and neglect contributes to Nebraska's rates of out-of-home care	JOINT reference to *Judiciary* and HHS Coms	
LR 537	McGill	Interim study to gather data and develop recommendations on the unmet needs of and gaps in services available to youth who transition or "age out" of Nebraska's foster care system	HHS Com	
LR 578	Bloomfield	Interim study to assess the State of Nebraska's compliance with both the federal Indian Child Welfare Act of 1978 and the Nebraska Indian Child Welfare Act, and to make recommendations for improvements	JOINT reference to HHS Com and *State-Tribal Relations*	
LR 521	Larson	Interim study to evaluate whether the courts are utilizing the provision which provides that a court may order a parent to pay a reasonable sum to cover support, study, and treatment of a juvenile in the custody of the Dept. of Health and Human Services	JOINT reference to *Judiciary* and HHS Coms	

2012 Interim Studies HHS Committee regarding Children (not including Child Welfare)				
LR	**Introducer**	**One Liner**	**Referenced to**	
LR 533	McGill	Interim study to examine whether there are enough resources currently present in schools to detect and treat mental illness in school-age children	HHS Com	
LR 532	Schumacher	Interim study to assess mechanisms in place for school districts to detect any cause and correlation of unusual health patterns among staff and students arising during construction, renovation, or other school projects in public school buildings	HHS Com	
LR 465	Smith	Interim study to examine the impact of the pulse oximetry procedure in testing for critical congenital heart disease in newborns	HHS Com	
LR 479	Haar	Interim study to examine Nebraska's laws and regulations on radon gas exposure, particularly the effect of radon gas on children	HHS Com	