Longitudinal Assessment of Child Welfare Privatization in Nebraska

Prepared for the Executive Board of the Nebraska Legislative Council

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PUBLIC CONSULTING GROUP

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I. EXECUTIVE SUMMARY

The purpose of this report is to provide a longitudinal assessment (2011 – 2021) of the privatization of case management functions in Nebraska's Eastern Service Area and to draw a conclusion about whether to continue privatized case management functions or return them to DHHS. The three criteria used for this retrospective analysis—quality, innovation, and cost—have revealed no particular advantage to privatization in the Eastern Service Area. Certainly, there have been advances in casework practice over the decade, but that can be said both for the State System as well as for the Eastern Service Area. The disruptions and resources expended in efforts to make the privatized system work do not measure up to the gains. This study concludes that case management in the Eastern Service Area should be returned to the Department of Health and Human Services, and the legislatively authorized pilot project should be terminated.

While the performance of the Eastern Service Area has improved to nearly match the rest of the State during this past decade, this cannot be attributed solely to privatization. The past decade was a period of federal emphasis on prevention and more family-friendly policies. For example, the Child and Family Services Improvement and Innovation Act, enacted September 30, 2011, required each state to describe activities to reduce the length of time children under age five spent without a permanent family. The legislation also established required monthly caseworker visits, targeted services to populations at the greatest risk of maltreatment and created new requirements for time-limited family reunification. Between 2012 and 2019, states were allowed to operate Title IV-E demonstration programs which permitted more flexible uses of federal funds without removing children from their homes to achieve better outcomes related to safety, permanency, and well-being. Nebraska DHHS took advantage of this opportunity by introducing Alternative Response, allowing families to receive services voluntarily in their homes.

Nebraska instituted important changes during the decade, moving Alternative Response from a demonstration to a statewide program, as well as expanding Structured Decision Making, which guides caseworker decisions at each stage of the process. While the private agencies have been instrumental in these changes, DHHS has managed them. Furthermore, in the Eastern Service Area, the Alternative Response program now constitutes more than half of the region's in-home cases and is already managed by DHHS.

The push toward preventive services continued with the passage of the Family First Prevention Services Act (FFPSA) on February 9, 2018, which amended Title IV-E of the Social Security Act to support evidence-based prevention efforts for 1) mental health and substance abuse prevention and treatment services and 2) in-home parent skill-based services. A sea change piece of legislation, FFPSA enabled Title IV-E to support not only the cost of foster care but also the cost of in-home prevention.

Nebraska has a strong sector of private provider agencies, and those agencies will continue to be necessary to provide an array of child welfare services in the State, regardless of whether case management is privatized. None of the reforms suggested by the new federal acts can be fully realized without the support and innovation of the private sector. The present issue is whether to continue delegating case management itself to these ends. Case management is governed by state and federal mandates such as monthly visits, caseload ratios, and time to achieve permanency. Regardless of whether the State or private sector delivers the service, it is a regulated service that will likely look very similar in either case. Further, the stability of the case managers themselves has been eroded by the contracting process. Turnover is far higher under privatization, to the detriment of children[1] Moving that function back to the

[1] Listening to the Voices of Children in Foster Care: Youths Speak Out about Child Welfare Workforce Turnover and Selection Jessica Strolin-Goltzman, PhD, Sharon Kollar, LMSW, Joanne Trinkle, LMSW, *Social Work*, Volume 55, Issue 1, January 2010, Pages 47–53,

State should not erode the capacities or resources of the private agencies to serve as partners with the public agency as it does in every other service area.

Many have argued that child welfare services in Nebraska are under-funded with some of the issues, such as agency closures, stemming from insufficient funding of privatized services. There is evidence to support this; between 2011 and 2021, Nebraska's statewide child welfare budget rose from $176.8 million to $196.6 million, an 11.2 percent increase. However, the consumer price index over the same period rose by 21.8 percent. A budget of equal value today would be $18.8 million more. While declining out-of-home caseloads could produce a reduction in that gap, child welfare funding has lost ground. Even so, funding changes were not equivalent by service area. Whereas the average service area budget allocation increased by 11 percent over the decade, the Eastern Service Area rose by 81 percent.

This report lays out the findings of a broad retrospective study conducted over six months, the second half of 2021. It illuminates the patterns in the child welfare practice over a decade, generally from 2011 to 2021, based on three criteria requested by the legislature: quality, innovation, and cost. It concludes with recommendations for moving forward.

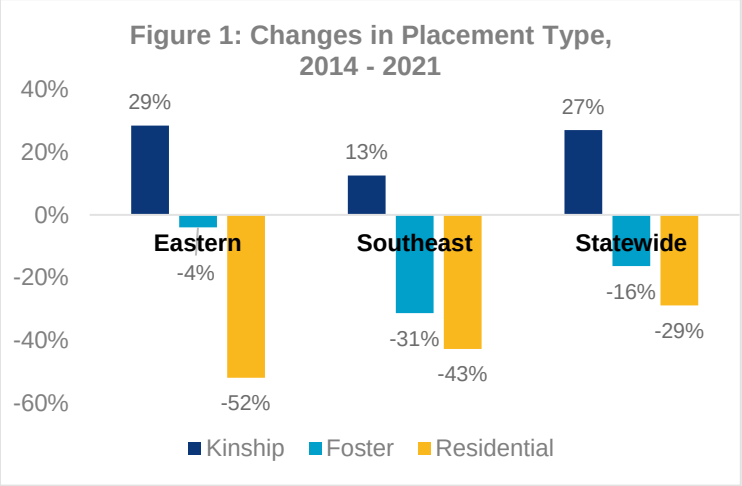
QUALITY

This section addresses how privatization has affected the quality of child welfare, with privatization generally being equated to performance in the Eastern Service Area. It employs ten criteria typically associated with quality.

Family Preservation: Placement Prevention

While the long-term trend over ten years has been to reduce the number of foster placements in Nebraska[2], this has not been the case in the Eastern Service Area, where there has been a **9 percent increase since 2014** compared to a **2.1 percent decrease** in the other service areas combined during those seven years. Children tend to stay in care longer in the Eastern Service Area, many in relative or kinship homes, producing a cumulative impact on the number in care on any given day.

Authorized by the legislature in 2014 for statewide implementation, Alternative Response has increased the number of families served in their homes; however, those cases are managed by the State. *The Eastern Service Area now has more families receiving Alternative Response, managed by DHHS, than other in-home services managed by the privatized contractor.*



Least Restrictive Placements

The rise in the use of relative and kinship homes statewide is to be applauded. Privatization has helped the State to achieve its efforts to move children and youth to kinship care and to reduce the use of residential care. Changes in juvenile justice policy contributed to the latter. The issue of licensing relative and kinship homes, however, is one that still needs attention as licensure rates are low, causing concern both for child safety and federal reimbursement of these placements.

[2] Foster placements encompass children in all out-of-home settings: kinship and relative care, foster family care and residential care.

Placement Stability

Privatization has had no discernible impact on placement stability as the entire State meets federal standards, and generally, the Eastern Service Area has brought down rather than boosted the statewide average.

Permanency for Children

The median length of stay for children in foster care tends to be higher in the Eastern Service Area than elsewhere in the State. The Eastern Service Area meets the federal standards for those in care for over one year, but its scores are below that of the State on permanency within 12 months.

Well-being of Children

In five of the six measures of well-being reviewed in this study, the Eastern Service Area performed below the State average. The exception was the physical health needs of the child, where the Eastern Service Area was comparable.

Independent Living

Outcomes such as level of education, employment, and homelessness for youth who reach the age of maturity while still in foster care in the Eastern Service Area are comparable to State averages. There is no perceptible impact of privatization.

Child Fatalities

Nebraska's rate of child fatalities is better than the national average. Because the incidence is rare and not reported by service area, we cannot say whether privatization has contributed to this result.

Practice Standards

Nebraska generally meets the federal standard for monthly visits of children in foster care, but there has been an erosion of that measure in the Eastern Service Area where the standard was not being met as of July 2021.

Service Array and Monitoring

While a wider array of services may be available at this point than in the past, the uptake as expressed by families engaging in services is lower in the Eastern Service Area.

Workload and Staffing

Child welfare agencies in general struggle with high turnover rates. The privatized system does not lend itself to job stability due to the uncertainties of the contracting process itself, regardless of provider High turnover produces vacancies and therefore high case ratios, thus violating workload mandates. While the caseload ratios have been met in the privatized Service Area in the past, overall privatization has not helped to sustain either caseload standards or a stabilized workforce and in fact has denigrated them, to the detriment of children and families.

INNOVATION

Occurrence of Innovation

Many new programs and services were initiated over the decade, some by the public agency and more by the private agencies. Some innovations such as Alternative Response and Structured Decision-Making represented the adoption of programs developed elsewhere in the country while others were unique to the local service area.

Impact of Privatization on Innovation

Privatization fostered a culture of innovation and creative thinking about family needs. Private agencies can be quicker in implementing new ideas. The impact of the changes has not been reflected, however, in the various measures of success such as timely reunification.

Factors Hindering Innovation

Many of the factors hindering innovation are exogenous to the agency and unavoidable. These include legal and regulatory factors associated with contracting for services and the case management function. Meeting the requirements of the current 855-page contract makes worrying about trying new approaches to serving children and families a secondary concern.

Motivating Innovation in the Future

Both public and private agencies are needed to foster innovation, preferably working as a team. Tangible steps can be taken by the public agency to invite and fund innovative programs through field-initiated procurements.

COST

How Privatization Affected Total Child Welfare Expenditures

Many have asserted that child welfare is an underfunded system in Nebraska and the failure of early privatized efforts in other service areas is a testament to that. Statewide funding for child welfare has declined significantly relative to inflation in the last decade but increased substantially in the Eastern Service Area.

How Privatization Affected Federal Claiming

While federal claiming increased during the period, it cannot be attributable to the Eastern Service Area which had the lowest percentage increase among the service areas. DHHS budget reporting has anomalies that make it difficult to sort out costs and claiming. As an example, any claims for Medicaid reimbursement for children in foster care are reflected in the Division of Public Health budget and could not be identified.

How Privatization Affected the Cost of Serving Each Family and Child

Out-of-home care costs per child are lowest in the Eastern Service Area, while in-home costs per family are highest there. The lower cost of relative and kinship care may be contributing, but the inability of the State to claim federal reimbursement for unlicensed kinship homes is an issue. It is therefore difficult to conclude the effect of privatization on the cost per case.

How Privatization Affected Cost Benefit

Privatization has not produced a lower cost of success, i.e., timely reunification or adoption, but quite the opposite. The three-year average cost of success in the Eastern Service Area is 27 percent higher than the average of all other service areas. Fewer children return home within 12 months or are adopted within two years in the Eastern Service Area compared to the rest of the State. Recent data from the Foster Care Review Office show a smaller percent of family members in the Eastern Service Area engaging in the services that would address factors which had caused the child to be removed. This mitigates savings in the annual cost of care as children stay longer.

RECOMMENDATIONS

PCG's recommendations are outlined below. For more detail, please see the recommendations section of the report.

Case Management

1. **Return Case Management in the Eastern Service Area to DCFS and end the pilot.**

   Nearly all the data in this 10-year retrospective study show that *at best* privatization has brought the Eastern Service Area up to state averages on some measures but has yielded no net benefit. Amid the under-performance is the angst and drama produced by privatization. DHHS has spent untold resources on efforts to respond to Request for Proposal (RFP) challenges, manage the contract, monitor corrective action plans, and engage in legal battles. The uncertainties of the contracting process itself have resulted in very high case manager turnover rates and ballooning case ratios, to the detriment of children and families. Through Alternative Response, DCFS is already managing over 50 percent of all the in-home cases in the Eastern Service Area and has been accepting new out-of-home cases until compliance issues with Saint Francis are resolved. Many of the community agencies contracting with Saint Francis are providing the same services under the same rules at the same costs in other parts of the State through contracts with DHHS. If there were to be a new RFP process to replace Saint Francis, what vendors could realistically manage a contract of this magnitude?

   While the transition of case management back to the State will not be easy, now is a better time than most. The return should be done in a phased-in manner that causes as little disruption to children, families, and staff as possible and maintains what is working well now. To create a smooth transition, PCG recommends the following steps:

   a. Develop a small Leadership Group including agencies outside DHHS to plan and manage the process.

   b. Determine how many FTEs need to be reinstated to DHHS including job type and pay grade and obtain authorization.

   c. Phase in the change of case management responsibilities as new cases come in and case managers leave.

   d. Provide employment offers to Saint Francis supervisory, casework, and administrative staff who would be considered assets to DHHS.

   e. Have the Leadership Group assess which staff units that have been developed at Saint Francis, such as transportation and clinical after hours, to maintain through a contract with Saint Francis or transfer to DHHS.

   f. Have the Leadership Group assess which contracts now managed by Saint Francis should be moved to the State (see also Recommendation 5) and modify or initiate contracts with those providers.

   g. Provide resources to DHHS to support the significant amount of work necessary to transition cases back to the State. Developing and implementing a successful implementation plan will require time, effort, and investment which far exceed current staff capacity.

Administrative Infrastructure and Financial Capacity

2. **Strengthen DHHS administrative capacity to handle the increase in case management, contracting, contract monitoring, and quality assurance.**

3. **Review federal claiming processes, particularly Title IV-E, including Nebraska's capacity to implement The Family First Prevention Services Act of 2018, which allows for reimbursement of qualified services to prevent placement.**

    a. Review Title IV-E claims to assure a portion of its case management costs is included in the claims. This is in addition to the administrative component of out-of-home care.

    b. Assure that claims are made for all qualified service costs, which are now reimbursable under The Family First Prevention Services Act of 2018.

    c. Review policies and procedures for licensing kinship homes to determine what changes are needed to get more homes approved and eligible for federal reimbursement.

    d. To understand the true cost of serving a child and family, determine how to capture information on Federal Medicaid claiming for children in foster care administered by the Division of Public Health, and case management or other claiming reflected in the DHHS Administrative Budget Program 033 but not in Child Welfare.

4. **Ensure adequate funding for child welfare services.** Increase the State budget for child welfare consistent with the consumer price index over the past ten years and the case counts for in-home and out-of-home care.

Service Maintenance and Innovation

5. **Examine programs and services initiated through privatized contractors over the past decade to determine which should be re-established or maintained.**

6. **Encourage continuing innovation by funding field-initiated projects and through contracting structure.**

    a. ***Field initiated:*** Twice a year, DHHS should call for proposals that will result in funding two projects for about $150,000 per year each for two years which are designed and proposed by people and or organizations in the community.

    b. ***Contract structure****:* This may be achieved by alternative payment methodologies that afford flexibility to the provider and financially incentivize achieving program goals.

Independent Living

7. **Enhance Independent Living efforts for youth in foster care who are age 14 and over.**

II. PURPOSE AND SCOPE OF ASSESSMENT

BACKGROUND

The purpose of this report is to provide a longitudinal assessment (2011 – 2021) of privatization efforts in Nebraska's Eastern Service Area, specifically the privatization of case management functions, and its impact on quality, innovation, and cost, and to draw a conclusion about whether to continue privatized case management functions or return case management to DHHS.

Nebraska has implemented major reforms within its child welfare system over the past two decades while transitioning toward a more privatized service model. Throughout these reforms, the State has experienced numerous obstacles to achieving optimal outcomes and assuring safety for its children. PCG has laid out several key developments that have taken place in Nebraska, starting with the first Child and Family Service Review Audit until the present.

Early State Efforts and Reforms

One of Nebraska's primary motivations to reform its child welfare system was the result of a federal audit called the Child and Family Services Review (CFSR), which began in all states in the early 2000s. Findings from the first CFSR showed that Nebraska failed to comply with federal standards on all the seven measured outcomes, encompassing metrics such as maltreatment, permanency, and placement stability. These scores are based on statewide data and from on-site reviews of 65 cases, about half were selected from the largest county, Douglas, in the Eastern Service Area. [3,4]

In response, Nebraska implemented a Program Improvement Plan (PIP) laying out steps it would take to achieve compliance with these standards. The central approach of Nebraska's first PIP was Family Centered Practice, which focused on realizing a child's needs through the family when possible and empowering families to reduce the number of children in out-of-home care.[5]

In 2003, then Governor Johanns created the Children's Task Force in response to a high number of violent child deaths. That same year, the Task Force released its report, *A Roadmap To Safety For Nebraska's Children,* which centered on issues of caseworker workload and staff retention.[6] In 2004, the State added $3.5 million funds to provide 120 additional social workers to support the child welfare case management system.[7] Despite this addition, however, caseloads were still reported to be too high among caseworkers, falling from 129 percent above state standards in 2004 to 114 percent in 2005.[8]

In 2005, The Supreme Court Commission on Children in the Courts was developed to ensure maximum responsiveness to children in the State Court system. One year later, the *Through the Eyes of the Child Initiative* created a forum for local child welfare and juvenile justice stakeholders to identify systemic barriers and drive solutions to issues within their communities' juvenile court systems.[9] After these changes, however, issues in the juvenile court system persisted. The 2005 Foster Care Review Office reported that

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[3] Office of Inspector General of Nebraska Child Welfare, *Special Report: Eastern Service Area Pilot Project and the Contract with* Saint Francis *for Child Welfare Case Management Services,* Jennifer Carter, Sarah Amsberry, Sharren Saf, (Lincoln, Nebraska: September 23, 2021)
[4] U.S. Department of Health and Human Services, Administration for Children and Families, Nevada Child and Family Services Review, 2002.
[5] Office of Inspector General of Nebraska Child Welfare, *ESA Pilot Project, and Contract with* Saint Francis, 5.
[6] Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office*, Committee Report, Vol. 17, No. 1 DHHS Privatization of Child Welfare and Juvenile Services (Lincoln, NE: Nebraska Legislature, 2011)*, 9
[7] Nevada Foster Care Review Board, *2006 Annual Report: Working Together to Improve the Lives of Nebraska's Children in Foster Care,* Carolyn K. Stitt (Lincoln, Nebraska: n.p., 2006).
[8], Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office*, DHHS Privatization of Child Welfare and Juvenile Services,* 10
[9] Nebraska Judicial Branch, Through the Eyes of The Child Initiative (Lincoln, Nebraska, n.p., 2019)

several status offender cases reviewed that year showed behaviors that were a result of unaddressed abuse or neglect.[10]

In 2007, three agencies were restructured into the Department of Health and Human Services (DHHS), encompassing the Division of Children and Family Services (DCFS). That same year, DHHS initiated a new social services safety model, the Nebraska Safety Intervention System (NSIS), to improve safety decisions, provide clarity of purpose for initial and continual family assessments, and improve the ability to support decisions in a professional manner.[11] The State also created more programs to improve outcomes for children, including the Children's Behavioral Health Task Force, which prompted DHHS to create a ‘‘true continuum of services" that reflected the Department's goal of serving children with the appropriate services "at the right level of care, in the right setting (and) for the right amount of time."[12] DHHS soon began expanding its service array.

Among these changes, DCFS experienced numerous shifts within its leadership, introducing different approaches to reforming child welfare. In 2007, then Governor Heineman appointed Todd Landry, former CEO of the Child Saving Institute, as director of the DCFS. Mr. Landry reported "he had a mandate to "reform the system." [13] After the Governor announced his priorities for the restructured Department, which encompassed an acceleration of children's services and improved performance in the upcoming CFSR, a Program Improvement Team was established at a Child Services Stakeholders Conference to identify various "action plans." The later release of the Team's action plan included a Request for Bid (RFB) from private agencies to provide safety and in-home services for youth.[14] Following the RFB, it was announced that Todd Reckling would replace Mr. Landry as DCFS Director and that DHHS also would get a new CEO, Kerry Winterer. It was under the leadership of Mr. Winterer that DHHS opted to transfer more case management responsibilities to lead agencies.[15]

During the several years where DCFS experienced significant shifts to an entirely outsourced model, the legislature sponsored various reports (see Table 3) to document the outcomes of these shifts and any fiscal impacts. One key report, LR 37, produced several legislative changes during the 2012 session. This included Legislative Bill (LB) 961, which mandated that child welfare case managers be employees of DHHS. However, sudden disruptions to contracts with lead agencies in the years following prompted special provisions to allow for "case management lead agencies" in the Eastern Service Region as a part of a broader privatization pilot project.[16] Subsequently, the State sought to clarify its stance on the privatization of child welfare services and case management to achieve better outcomes for children and a higher standing within the CFSR reviews.

DHHS' Progression to Privatization

From 2007 to 2009, DHHS began growing the array of services available to families and gave the service providers a more expansive role. After the 2008 RFB, DHHS began contracting out-of-home services, through which agencies provided child welfare services, while CFS retained case management responsibilities.[17]

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[10]State Foster Care Review Board, *Hope is on the Horizon for Nebraska's Foster Children:23rd Annual Report of The State Foster Care Review Board,* (Lincoln, Nebraska: n.p., 2005)
[11] Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office, *DHHS Privatization of Child Welfare and Juvenile Services,* 10
[12] Ibid, 11.
[13] Ibid., 5.
[14] Ibid,6.
[15] Ibid, 8.
[16] Office of Inspector General of Nebraska Child Welfare, *ESA Pilot Project, and Contract with* Saint Francis, 8.
[17]Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office, *DHHS Privatization of Child Welfare and Juvenile Services.*

During the shift to a more outsourced service model, members of the public expressed concern the transition was happening too fast. Some expressed apprehension that contract funding was insufficient as DCFS had inaccurate counts of the numbers to be served. [18] The Foster Care Review Office in its 2007 Annual Report states that "Because a number of safety issues have been identified with contracted placements and services, the Board recommends oversight of contracts for clarity of expectations, evaluation of accountability, and consequences for non-compliance."[19]

In the following years, the State began contracting large portions of services to "lead agencies" responsible for expanding the service array through sub-contracts and paying for the services with a predetermined lump sum rate regardless of the number of children needing service or their presenting problems. By 2009, six agencies were awarded contracts to serve as lead agencies to implement services for all five DCFS Service Areas (Western, Central, Northern, Southeast, and Eastern): Alliance for Children and Family Services; Boys and Girls Home; Cedars Youth Services; Nebraska Families Collaborative, later known as PromiseShip; KVC Behavioral Healthcare Nebraska (KVC); and Visinet. They were to be fully operational by April 2010.[20] The agencies agreed to develop infrastructure, staffing, and programs necessary to provide service coordination under one set of funding, $7 million, to be fully implemented by April 2010 as both service coordinators and service providers.[21]

By May of 2010, the Foster Care Review Office reported concerns about critical problems it attributed to the privatization effort, including inadequate case documentation, high staff turnover, payment delays to third parties, and child placement issues. Later that year, in a briefing by DHHS officials under LR 568, legislators expressed skepticism about the planned transfer of more case management responsibilities to the lead agencies.[22]

Not soon after the onset of the lead agencies, financial challenges disrupted Nebraska's child welfare system. Later in 2010, the Alliance for Children and Families serving the Central Service Area, opted out of its contract before it began.[23] The other lead agencies met their 2010 service initiation deadline, but Cedars Youth Services withdrew within days due to inadequate reimbursement. A week later, Visinet filed for bankruptcy and DHHS took over cases in the Eastern and Southeast Service Areas. In interviews, several agency executives stated the lack of State funding posed challenges to their operations.[24]

Financial and service-related issues continued. By October 2010, the Boys and Girls Home's contract was terminated within the first six months of implementation and DHHS reassumed service coordination in the West, Central, and North Service Areas. DHHS provided KVC and Nebraska Families Collaborative the two remaining agencies in the Eastern and Southeast Service Areas $6.3 million in supplemental funding.[25] Financial reports showed that KVC-Nebraska invested $5.5 million of its own money during the first eight months of its contract, while Nebraska Families Collaborative anticipated losing approximately $2.5 million.[26]

DHHS soon after decided to change its privatization model in response to these disruptions. Lead agencies would now be responsible for case management in addition to service coordination in the Eastern Service Area. By January of 2011, both KVC and Nebraska Families Collaborative were sharing case management

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[18] Ibid.
[19] Nevada Foster Care Review Board, 2007 Annual Report: 25 Years of Looking Out for Nebraska's Children in Foster Care, Carolyn K. Stitt (Lincoln, Nebraska: n.p., 2007).
[20] Hornby Zeller Associates, Inc., *An Assessment of Child Welfare Privatization in Nebraska: Final Report*, (Troy, NY: Hornby Zeller, 2014)
[21] Appendix E: Detailed TimeLine of Child Welfare Developments in Nebraska
[22], Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office*, DHHS Privatization of Child Welfare and Juvenile Services,*16.
[23] Hornby Zeller Associates, Inc., *An Assessment of Child Welfare Privatization in Nebraska.*
[24] , Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office*, DHHS Privatization of Child Welfare and Juvenile Services, 7.*
[25] Office of Inspector General of Nebraska Child Welfare, *ESA Pilot Project, and Contract with* Saint Francis*,*7.
[26] Nebraska Legislature, Health and Human Services Committee, *LR 37.*

responsibilities in the region. DHHS provided an additional $19 million between the two agencies [27] and eliminated 77 of its staff positions.[28]

Shortly after DHHS transferred case management responsibilities to the lead agencies, KVC ended its case management contract due to cost, ceding its Eastern Service Area cases solely to Nebraska Families Collaborative and its Southeast Service Area cases to DHHS. The Legislature then established a pilot project to privatize child welfare (LB 961), including case management, in the Eastern Service Area,[29] representing about 42 percent of the child welfare caseload.[30] The DHHS contract with Nebraska Families Collaborative ran until June 30, 2015, with a 12-month budget not to exceed $59,951,000. The budget included a fixed monthly payment and variable payments based on the numbers served and whether the case is court-supervised.[31]

In October of 2016, a new RFP for case management services in the Eastern Service Area was released. After it was decided the award would go to Nebraska Families Collaborative, Magellan Choices for Families filed a protest.[32] DAS eventually ended that RFP process, rejecting both NFC and Magellan's bids, choosing to extend its contract with NFC via a sole source contract valued at $143 million for 2 years. At the end of 2017, Nebraska Families Collaborative changed its name to PromiseShip.

Recent Turbulence in the Eastern Service Area Contract

In 2019, CFS released an intent to award a contract to Saint Francis Ministries rather than PromiseShip, which was up for re-bid. In reviewing the scoring, the primary factor was cost. Soon thereafter, PromiseShip filed and ultimately lost a bid protest. The transition was further complicated by DHHS's decision to expedite the case transfer process. Originally set to begin in January 2020, case transfers now were to begin by October 2019. During this process, the Saint Francis contract was amended numerous times. On October 25, 2019, an amendment was signed to allow Saint Francis to earn up to $29.5 million during the first year of the contract, $11.5 million more than the $18 million allowed in the original contract, to account for the expedited transition. In December, the transition to Saint Francis was complete.

In mid-January 2020, less than one month into the full transfer of cases, emails between DHHS and Saint Francis showed that only 19 of the 38 contractors who received subcontracts from Saint Francis had executed them. Additionally, financial concerns manifested early in the contract. By spring of 2020, DHHS projected that Saint Francis*'s* monthly spending would exhaust budgeted funding before the end of the fiscal year. This same rate of over-spending was carried into the fiscal year 2021, despite DHHS's warning the agency would not be paid more than the do-not-exceed amount of its contract. [33]

In October 2020, Saint Francis announced it was suspending its CEO and COO pending an investigation into a whistleblower complaint alleging financial mismanagement at the organization. An internal investigative report at Saint Francis substantiated these allegations, including the revelations that Saint

[27] Office of Inspector General of Nebraska Child Welfare, ESA Pilot Project, and Contract with Saint Francis,7.
[28] Appendix E: Detailed TimeLine of Child Welfare Developments in Nebraska
[29]Chapter 68 1212: The department may contract with a Lead Agency for a case management Lead Agency model pilot project in the department's eastern Service Area as designated pursuant to section 81-3116. The department shall include in the pilot project the appropriate conditions, performance outcomes, and oversight for the Lead Agency , including, but not be limited to:
(a) The reporting and survey requirements of lead agencies described in sections 43-4406 and 43-4407;
(b) Departmental monitoring and functional capacities of lead agencies described in section 43-4408;
(c) The key areas of evaluation specified in subsection (3) of section 43-4409;
(d) Compliance and coordination with the strategic child welfare priorities determined by the Nebraska Children's Commission as provided in section 43-4204; and
(e) Assurance of financial accountability and reporting by the Lead Agency .
[30] Appendix E: Detailed Timeline of Child Welfare Developments in Nebraska
[31] Ibid.
[32] Office of Inspector General of Nebraska Child Welfare, *ESA Pilot Project, and Contract with* Saint Francis.
[33] Appendix E: Detailed Timeline of Child Welfare Developments in Nebraska

Francis had failed to bid the Easter Service Area (ESA) contract properly, despite warnings by staff to Saint Francis leadership that the bid was flawed.

In November 2020, under new interim leadership, Saint Francis presented its substantial budget shortfalls to DHHS, and DHHS began exploring options to support Saint Francis's expenses. In late January 2021, DHHS and Saint Francis testified to the legislature's Health and Human Services Committee that they were in the process of negotiating a new contract. The interim CEO of Saint Francis testified that Saint Francis needed an additional $25 million to keep operating in the current fiscal year, along with approximately $10 million to cover the shortfall for the fiscal year that ended June 30, 2020.

By the end of January 2021, DHHS finalized an emergency contract agreement with Saint Francis Ministries to continue providing case management services in the ESA through February 2023 via a reimbursement contract estimated at $68,890,448 in its first year, and $78,362,884 in the later 13 months. The new contract also reimbursed Fiscal Year 2020 expenses of $10.5 million. In addition, the Legislature authorized another study about the long-term viability of the pilot project authorizing privatization of case management services

At the same time, there was building evidence that Saint Francis was not fulfilling its contractual obligations. By the end of March 2020, DHHS produced a Corrective Action Plan (CAP) relating to Saint Francis' failure to complete case plans within 60 days of the transfer and to provide timely documentation of a child's transfer utilizing the N-FOCUS (Nebraska's SACWIS) data base. Throughout 2020, DHHS released three more CAPs relating to court performance, Saint Francis Ministries' failure to use the E-verify system, and background checks for new employees. In January 2021, DHHS issued another CAP regarding Saint Francis's caseload ratio and monthly face-to-face visits.

By August 2021, DHHS had approved only three of the seven CAPs issued to Saint Francis. Increasing concerns that Saint Francis was not prepared to meet its caseload ratio prompted DHHS to mandate it produce a Hiring Plan.[34] In September 2021, the Office of the Inspector General of Nebraska Child Welfare released a report concluding that Saint Francis was failing to meet the key terms of its contract in the Eastern Service Area.

Concurrent Review of Nebraska's Child Welfare Performance

As privatization was unfolding in Nebraska, the State continued to participate in the federal Child and Family Service Reviews. In the third (and latest) round in 2017, Nebraska still was not in substantial conformity on *any* of the child-specific outcomes. While DHHS has shown considerable improvement over the three federal review periods on specific items, the results were not sufficient to lead to a "strength" on the outcome itself. Throughout the country we see similar results, as shown in Table 1: no states had strengths in five of the seven outcomes. The exceptions were one safety measure and one well-being measure.

[34] Office of Inspector General of Nebraska Child Welfare, *ESA Pilot Project, and Contract with* Saint Francis.

Table 1: Percent of States Passing Casework Component of Child and Family Services Review, 2002 and 2017

	Safety		Permanency		Wellbeing		
	Protection from Abuse	Safety in-home	Permanency and Stability	Continuity and Connections	Enhanced Capacity to Provide Needs	Education	Physical and Mental Health
2012							
National	**13%**	0%	0%	**6%**	0%	**19%**	0%
Nebraska	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**
2017							
National	**9%**	0%	0%	0%	0%	**18%**	0%
Nebraska	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**	**0%**

In addition to casework practices, the federal review assesses *systemic factors*: statewide information system; case review system; quality assurance system; staff and provider training; service array and resource development; agency responsiveness to the community; and foster and adoptive parent licensing recruitment, and retention. Both in 2008 and 2017 (latest review) Nebraska had passed five of the seven factors, the outliers being case review system and service array.

In its statewide indicators, a separate set of federal measures, during the latest round of federal reviews, Nebraska scored better than the national average on three of the measures, comparable to the national average on three and worse on one as shown in Table 2.

Table 2: Nebraska Performance on Round 3 Federal Indicators Compared to Nation

Indicator	Nebraska Score Compared to the US
Maltreatment in foster care	**Same**
Recurrence of maltreatment	**Same**
Permanency within 12 months of entry	**Worse**
Permanency within 12 months for children in care 12-23 months	**Same**
Permanency within 12 months for children in care 24 months or more	**Better**
Reentry into foster care	**Better**
Placement stability	**Better**

Table 2 paints a picture of a system that generally does well; however, once a child enters foster care, the child generally will not leave for two years or more in Nebraska, generating a score of “Worse” on permanency within 12 months of entry. The pandemic seems to have reduced the length of stay in the past year or two, as evidenced by the most recent Foster Care Review Office Annual Report. While in care, children are less likely to experience repeat maltreatment than in other parts of the country or to move around a lot. The expanded use of kinship care in Nebraska may well be producing this scenario, with over half the children in the State’s child welfare system now in kinship homes.

These data suggest that the initial motivation for privatizing may have been ill-informed. If the standard is comparable to the rest of the nation’s performance on the global CFSR measures, every state did poorly at the beginning. Nebraska continues to fail on all seven measures as do most states. That said, Nebraska scores comparably to the rest of the country on more discrete federal indicators used for the statewide assessments and tracked by DHHS in Compass with the exception being permanency within 12 months.

Summary of Reports Evaluating Child Welfare Reform and Privatization

Much of the material in Table 3 was drawn, with permission, from the ***Office of Inspector General SPECIAL REPORT: Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services, September 23, 2021.***

Table 3. Summary of Child Welfare Reform and Privatization Reports

Report	Findings
Foster Care Review Office, "Report on Child Welfare Reform" (December 2010)	• Despite child welfare services reforms, the number of children in out-of-home care had not yet been significantly reduced. [35] • The Report called for a legislative review of DHHS reforms and that "DHHS concentrate efforts to address Lead Agency performance issues through contract management and oversight" as well as improved training and documentation of case plans within lead agencies "to assure the safety of system-involved children."
The Auditor of Public Accounts, "Attestation Report of the Nebraska Department of Health and Human Services Child Welfare Reform Contract Expenditures July 1, 2009, through March 31, 2011" (September 2011)	• DHHS failed to realize its stated goal of containing expenditures, whereby in the past two years costs have significantly increased. • There was a "critical lack of accountability" in the form of missing documentation on how public dollars were spent.
Legislative Fiscal Office, "Fiscal Overview of Child Welfare Privatization in Nebraska" (October 2011)	• Child welfare costs increased by about 27 percent between 2009 and 2011. DHHS failed to publicly bid multi-million-dollar contracts with private service providers, resulting in many amendments and increased costs with no effective oversight. • One service provider, Visinet, Inc., was overpaid by millions of dollars. DHHS expended thousands of dollars on both duplicate claims and payments to the wrong contractors. • DHHS failed to reconcile provider billings in NFOCUS. • Providers failed to meet client service coordination and delivery benchmarks required by their service contracts. • DHHS failed to approve subcontractors utilized by service providers, as well as to ensure that such subcontractors were appropriately compensated for their services. • DHHS failed to cooperate with the audit examination.[36]
Nebraska Legislature, Health and Human Services Committee, "LR 37: Review, Investigation and Assessment of Child Welfare Reform" (December 2011)	• Most notably, the LR 37 recommended: "that case management should be returned to the State." • The possibility of a private entity exiting a contract that encompasses case management poses a large risk to the entire child welfare system. • In addition, the HHS Committee provided recommendations for contract management and oversight, procurement, and case management.

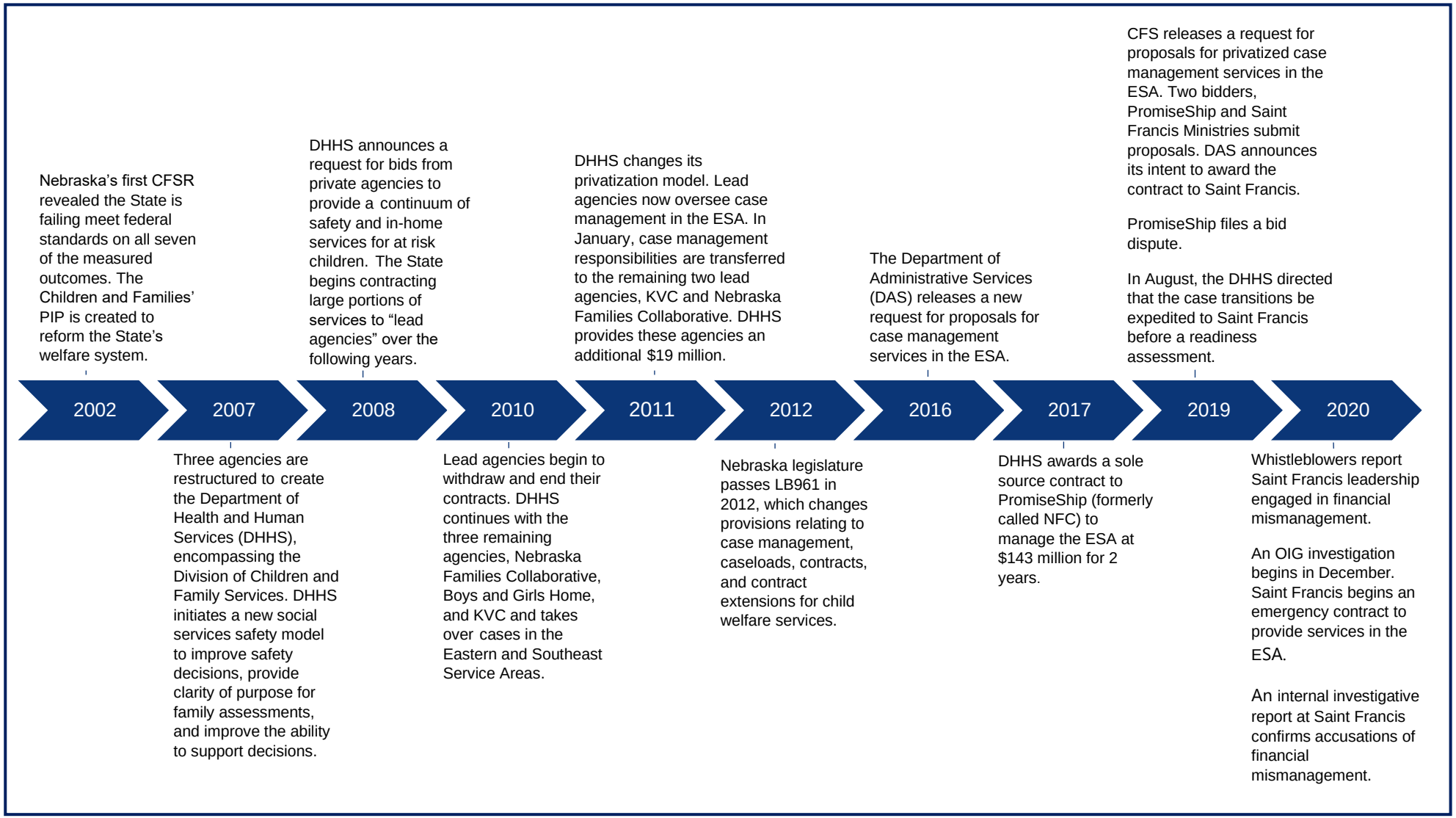
[35] Nebraska Legislature, Health and Human Services Committee, *LR 37*
[36] Nebraska Auditor of Public Accounts, *Executive Summary Attestation Report of the Nebraska Department of Health and Human Services Child Welfare Reform (Families Matter) Contract Expenditures July 1, 2009, through March 31, 2011, (*Lincoln, Nebraska: n.p., September 2011).

Report	Findings
Hornby Zeller Associates, Inc., "Assessment of Child Welfare Services in Nebraska" (November 2012)	• Due to the need for stability, DHHS should continue privatization in the ESA with the State providing case management for all other areas. • Child welfare outcomes had not improved under privatization and that both the Lead Agency and DHHS were equally capable of providing case management services in the ESA. • The costs of privatization could not be considered reasonable; the State should have expected to invest more money before seeing cost savings from privatization. • The level of upheaval caused by privatization had eroded the trust between private and public agencies and highlighted the need to develop valid measures of progress beyond those required at the federal level.
The University of Nebraska-Lincoln, Department of Psychology, "A Case Study of the Effects of Privatization of Child Welfare on Services for Children and Families: The Nebraska Experience" (October 2013)	• DHHS had unnecessarily rushed the large-scale initiation of privatization which resulted in a reduction in quality and availability of services, and an increase in costs. • The study found mixed support from stakeholders, lack of a cost-benefit analysis before implementation, limited or low competition for services due to a poor distribution of services across the State, lead agencies that lacked experience in managing large-scale contracts, a limited hiring pool of skilled workers, a poorly constructed procurement process, and unclear roles and responsibilities between public and private agents.
Hornby Zeller Associates, Inc., "An Assessment of Child Welfare Privatization in Nebraska" (December 2014)	• The State was still not experiencing any measurable benefits from having privatized child welfare case management, and that there was no measurable difference in the outcomes for children and families between the private and public agencies. Any cost savings were most likely a result of shifting costs to the clients and to Medicaid, where they still impacted the State budget but did not get counted as child welfare costs. What savings had materialized had been offset by the huge loss in federal funding. Three options going forward are: 1. Maintain privatization as currently structured in the ESA to avoid disruption. 2. End the Lead Agency contract and return all functions to DHHS. 3. Return case management to DHHS and use the privatization model to create a Lead Agency to manage services provided to children and families.
The Stephen Group, "Nebraska Department of Children and Family Services-Assessment of Outsource Model in Nebraska's Eastern Service Area" (May 2019)	• PromiseShip had been able to achieve comparable cost and performance outcomes relative to the other four service areas despite various obstacles including few financial incentives to encourage innovation or drive performance improvement. • If continuing with an outsource model, Nebraska should incorporate a performance-based contract with financial controls, require the agency to develop an array of services to meet the requirements of the federal Family First Prevention Service Act, develop a Stakeholder Engagement Plan, develop a contract oversight process that includes a Quality Assurance Team, and implement a Child Welfare Leadership Team consisting of representatives from all DHHS divisions. • The State should balance the desire to be prescriptive with the flexibility to allow the Lead Agency to be innovative.

Report	Findings
State of Nebraska, Office of Inspector General of Nebraska Child Welfare, "Special Report: Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services" (September 2021)	• The difficulties with Saint Francis' performance under the ESA contract have brought into starker relief the long-standing challenges and risks inherent in a privatized case management system. • Saint Francis has failed to meet key terms of the contract and the Eastern Service Area Pilot Project has demonstrated an unacceptable risk to children and families. • Further, the contract with Saint Francis should be terminated as well as the pilot project overall.

TIMELINE

Below is a high-level timeline reflecting 20 years of privatization. For a more detailed chronology of child welfare developments in Nebraska, please refer to Appendix E.



III. ASSESSMENT CRITERIA

To assess the question, over the past two decades but particularly in the past seven to ten years, has privatization been a service or a disservice to the citizens of Nebraska? A study would need to look at three aspects of child welfare services, quality, innovation, and cost. This study aimed to address the following questions:

1. What impact has privatization had on the quality of child welfare services?
2. What impact has privatization had on child welfare service innovation?
3. What impact has privatization had on the cost of child welfare services?

RESEARCH QUESTIONS

To determine the impact of privatization on quality, innovation, and cost of child welfare service. PCG developed the following research questions.

Quality

- How does Nebraska perform on standard measures of quality relating to placement prevention, foster care, and adoption services?
- How have the privatized Service areas, with a focus on the Eastern Service Area (ESA), compared to the rest of the State on the quality measures?
- Are there other relevant measures of quality such as National Youth in Transition Database (NYTD) surveys that can be employed?
- Are there plausible explanations of any disparities in quality measurement between the ESA and the rest of the State other than privatization?

Innovation

- What innovations in child welfare services have been seen in Nebraska over the past decade?
- Have any of those been spurred by privatization?
- If not originated in that way, have any been aided and abetted by privatization, for example through leadership or motivated staff?

Cost

- How has privatization affected total expenditures on child welfare?
- Has privatization enhanced or detracted from the State's ability to obtain federal reimbursement for its child welfare programs?
- Is the cost per child or family served greater or lesser in the Eastern Service Area than in other Service areas served by the public sector?
- Regardless of the answer to any of these, has privatization resulted in a cost-benefit?

These research questions drove PCG's analysis of the impact of privatization in Nebraska over the past two decades.

MEASURES

PCG developed quality indicators to measure the impact of privatization on quality, innovation, and cost of child welfare services. The following quality indicators guided PCG's analysis of the impact of privatization in Nebraska's Eastern Service Area.

Quality Indicators

- Placement prevention
- Use of least restrictive placement
- Placement stability
- Permanency for children in foster care
- Wellbeing of children
- Practice standards
- Child fatalities
- Independent living
- Workload and staffing

Innovations Indicators

- New services or approaches to serving families
- Sustainability of services
- Auspices of service provision (public, private)
- Factors affecting service development
- Impact of regulatory requirements and funding mechanisms

Cost Indicators

- The total cost of child welfare
- Use of federal funding and federal reimbursement
- Cost per case
- Cost benefit

IV. METHODOLOGY

To gain a deep understanding of the two decades of privatization in Nebraska and measure the impact of quality, innovation, and cost on child welfare service in the Eastern Service Area the following key tasks were completed:

Research Reports and Other Sources

To gain a historical perspective, PCG reviewed previous evaluations and investigative reports, child welfare data, provider contracts, legislation, State plans, and other relevant documents. Having a team member previously co-author two prior evaluations of privatization in Nebraska contributed to PCG's understanding of the history of Nebraska's child welfare system and the findings from recent investigations. Please see Appendix F for a full bibliography of all the sources PCG reviewed.

Innovation Focus Groups

During September, PCG conducted 6 Innovation Focus Groups with stakeholders, meeting with a total of 27 people. The meeting schedule is listed below.

- DCFS CFS – 9/13/21
- Saint Francis 9/24/21
- PromiseShip and Nebraska Family Collaborative/ Children's Home Society of Washington- 9/16/21
- Nebraska Children's Home Society/ CAFCON- 9/15/21
- Foster Care Review Office- 9/14/21
- Office of Inspector General of NE Child Welfare and State Ombudsman's Office- 9/10/22
- CW Provider Agency- 9/22/21

The Innovation Focus Group questions can be found in Appendix A.

In addition to holding stakeholder interviews, PCG administered a survey to all focus group participants, to *Assess Innovations Aided or Abetted by Privatization in the Eastern Service Area*. The survey identified programs and practices identified as having been initiated over the past ten years as part of privatization in the Eastern Service Area. It asked recipients to select the programs' current status and a recommendation for the future.

The survey was completed by 18 people from 10 organizations. Additional information from the stakeholder survey can be seen in section VI.

Data Synthesis

Once PCG had reviewed all the relevant reports and data sources and conducted innovation focus groups, we analyzed these sources to answer the research questions established for quality, innovation, and cost, as well as the general question of whether privatization has succeeded and should continue. The following sections present PCG's findings.

V. QUALITY

FAMILY PRESERVATION: PLACEMENT PREVENTION

Setting the Stage: Abuse and Neglect Patterns

Once families come to the attention of the child welfare agency through a report of abuse or neglect, the first goal is to stabilize the family to prevent the children from being removed from the home and placed into foster care. To do this, child welfare agencies assess threats to the child's safety and respond by helping families access needed services to ensure children can remain safe.[37] The goal is to keep children at home in a safe environment whenever possible, but if removal is needed it is to place the child in the least restrictive setting.

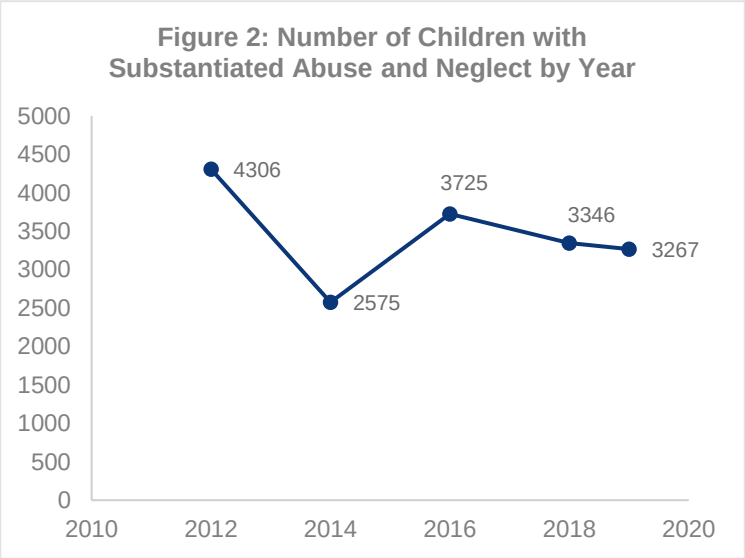


Figure 2 depicts the number of children who have substantiated child abuse and neglect cases over the past decade. In Nebraska, as elsewhere through federal mandate, child abuse and neglect investigations cannot be contracted to private agencies, they are handled by DCFS staff. This is the pool from which new foster care placements potentially are drawn. Therefore, the ability to prevent placements should vary by the size of the pool assuming the nature and severity of the reports are relatively constant.

There was a large dip between 2012 and 2014 in the number of children in Nebraska with substantiated reports of abuse and neglect with a rise in 2016 and then a modest decline since then. Overall, the decline in child victim numbers is 26 percent between 2012 and 2019. The rate per thousand child victims has shown a concomitant decline from a high of 9.1 in 2012 to a rate of 6.5 in 2019, in part due to the introduction of Alternative Response. The data suggest there should be a reduction or stabilization in both in-home families served and out-of-home placements as well.[38]

[37] Child Focus, Nebraska Child Welfare Blueprint Report, (Washington, D.C., n.p., March 2017) https://childrens.nebraska.gov/PDFs/Reports/NE%20Blueprint%20Report%2003.2017.pdf(Accessed October 2021)
[38] Both the numbers and the rates were accessed through KidsCount: https://datacenter.kidscount.org/data/tables/7625-victims-of-substantiated-child-maltreatment?loc=29&loct=2#detailed/2/any/false/1729,37,871,870,573,869,36,868,867/any/14770,2033

Impact of Alternative Response

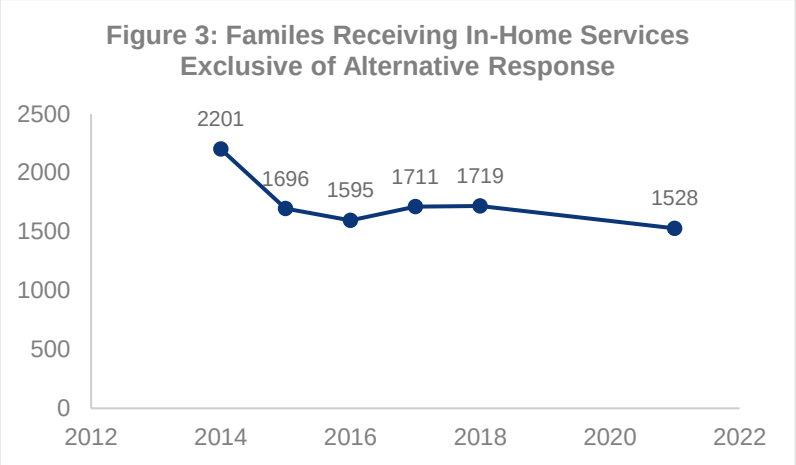
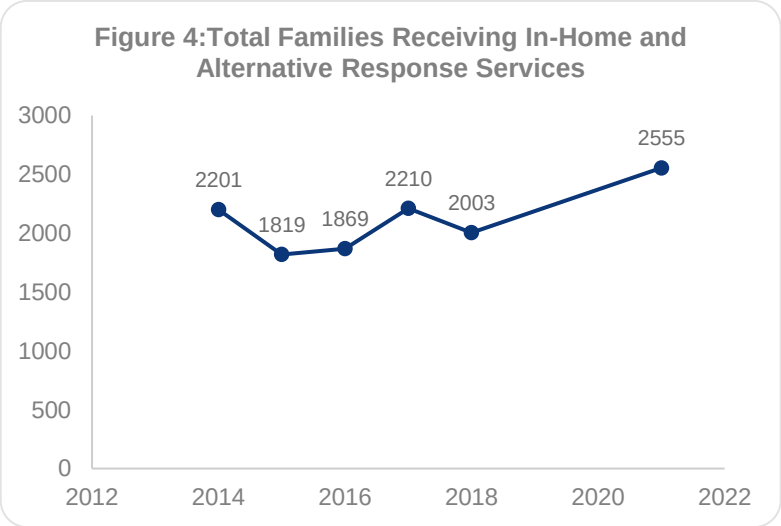


Figure 3 shows the number of families receiving services in their homes at points in time from 2013 to 2021. There has been a decline of 31 percent, which is somewhat higher than the number of abuse victims. However, the picture changes when Nebraska's Alternative Response is added to the mix, shown in Appendix D. Alternative Response allows caseworkers who are responding to a report of abuse and neglect to "assess," rather than investigate, the family. Additionally, caseworkers do not have to enter a finding in the central registry.[39]Therefore, the children will not appear as abuse and neglect victims while the families can receive services voluntarily in the home.

Figure 4 shows the case volume when both in-home and Alternative Response cases are counted, producing a large spike in families served across the State. In the most recent *Point in Time Report* from DHHS, July 6, 2021, there was a total of 1,528 in-home cases without Alternative Response, and a total of 2,555 cases with it, a difference of 67 percent.[40] Instead of a decrease of 31 percent, Nebraska had an increase of 16 percent in families served in their homes.



This increase can be viewed as an overall expansion of Nebraska's system to meet the needs of families and children without alleging abuse and neglect, that is, to provide preventive and early intervention services, particularly with cases of neglect. While the University of Nebraska's evaluation of the Title IV-E Waiver Demonstration found that about 9 percent [41] of the cases were diverted to Alternative Response, Figure 3 suggests that the portion has grown significantly in recent years. The Nebraska Legislature permitted Alternative Response statewide in 2014.[42]

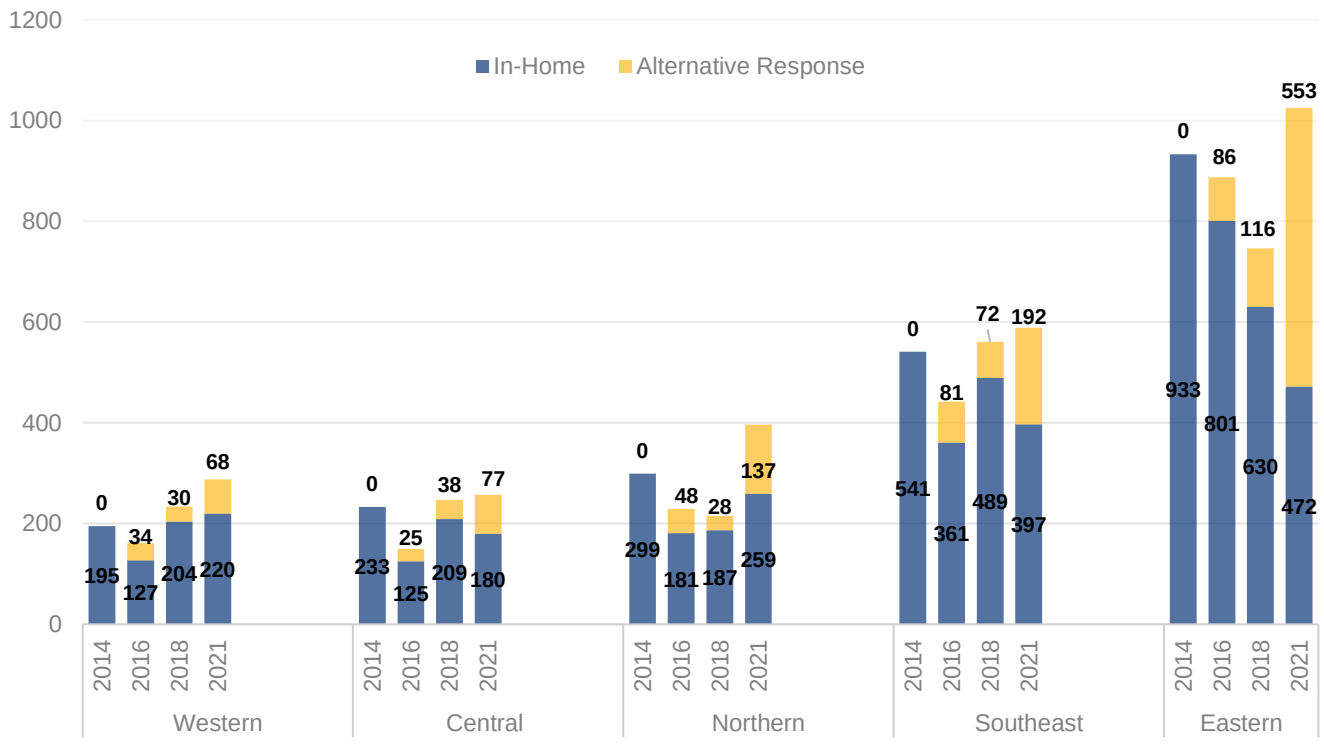
[39] The University of Nebraska Lincoln Center on Children, Families, and the Law, *Nebraska IV-E Waiver Final Report* (Lincoln, Nebraska, University of Nebraska, 2019).
[40]Nebraska Department of Health and Human Services, Division of Children and Family Services, *CFS Point in Time Dashboard Summary Report (Lincoln, Nebraska: n.p., 2017)*
[41]The most frequently selected exclusionary criteria were those related to use of controlled substances, domestic violence, and abuse/neglect of a child. Overall, 91 percent of CPS intakes were excluded during the waiver.
[42] 28-712.01. Reports of child abuse or neglect; alternative response assigned; criteria; Review, Evaluate, and Decide Team; duties; department; duties; Inspector General's review.

Figure 5 presents the picture of in-home service provision by Service Area including both traditional in-home and Alternative Response families. Information is portrayed in two colors, with blue reflecting the traditional in-home cases and yellow representing the Alternative Response cases.

The figure shows that the use of traditional in-home service cases in the Eastern Service Area fell by nearly half between 2014 and 2021, (from 933 to 472) as Alternative Response increased. Alternative Response has altered the case mix in the Eastern Service Area.

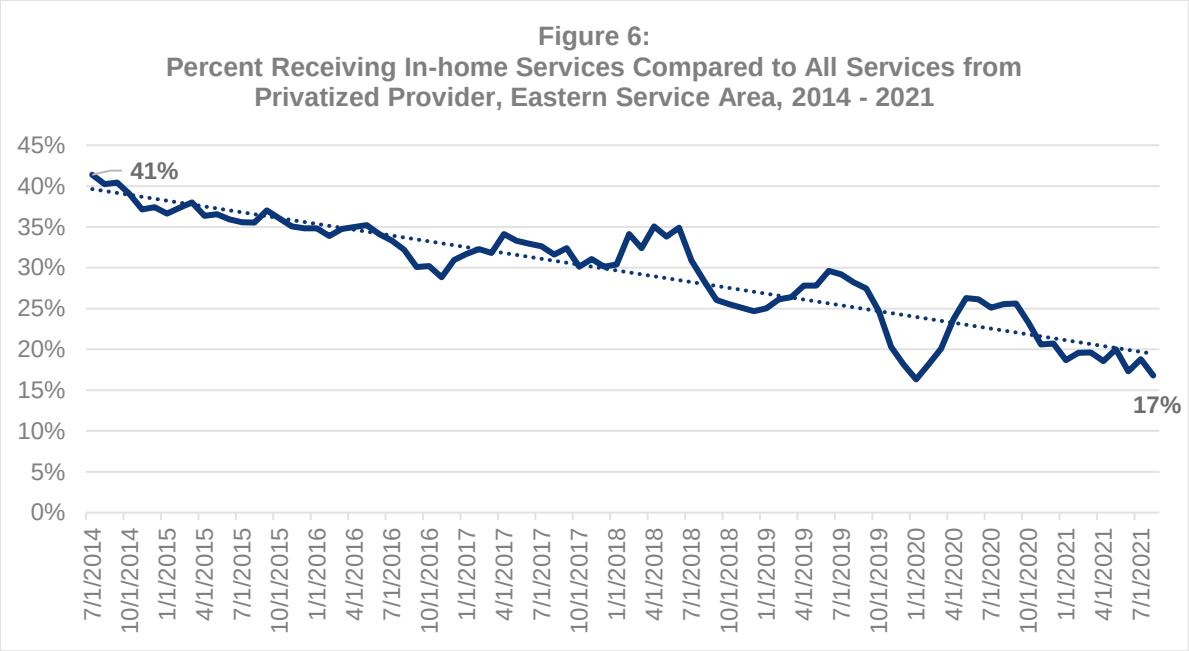
The University of Nebraska's evaluation of Alternative Response found that among the families who presented needs, the most common were for parenting skills, a child's emotional and behavioral adjustment, the mental health of a child, and material needs. DCFS has the ability to purchase various services such as parenting education and counseling to support the family and child, but those services do not come from the privatized case management agency.

Figure 5:
Families with In-Home and Alternative Response Cases by Selected Years, 2014 - 2021



What is notable for this study is that DCFS handles Alternative Response in all the Service areas; it is not part of the privatization effort. *By 2021, that caseload had grown to encompass more than 50 percent of all in-home cases in the Eastern Service Area.* However, the nature of the remaining in-home cases has presumably shifted to those posing more serious safety risks to the child(ren).

Figure 6 shows the percent of **in-home** cases handled in the Eastern Service Area in comparison to all cases, in-home and out-of-home including Alternative Response. Compared to all cases, the in-home cases handled by the privatized provider have declined from 41 percent in 2014 to 17 percent in 2021. *Contracted case management is now largely for placement cases in the Eastern Service Area.*



To answer the question of what impact privatization has had on the volume of families served in their homes, the answer is a reduction from the contractual perspective but an increase overall. The next question is whether serving more families in their own homes has resulted in a decline in the number of children removed.

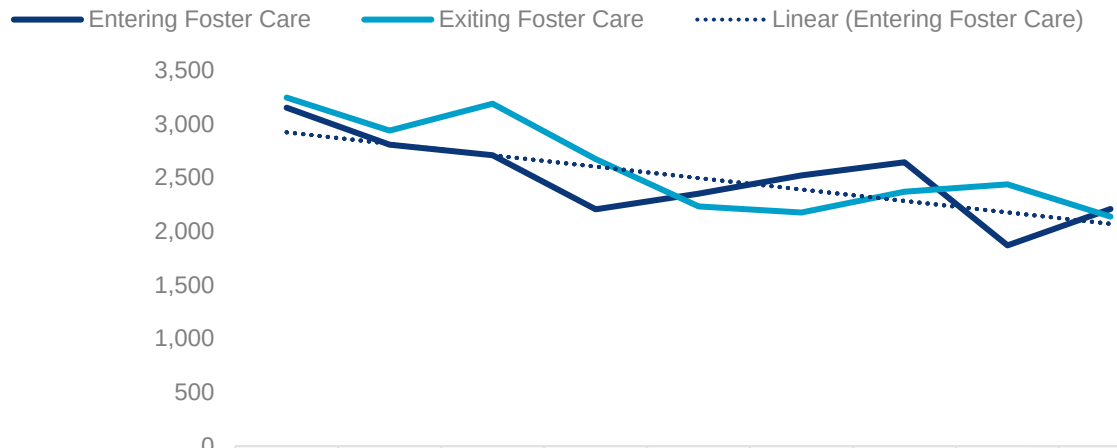
Total Placements and Placement Rate Per Thousand

The ten-year perspective does indeed show a decline in placements. Nebraska's out-of-home care population declined from 5,117 to 3,294, a 35.6 percent decrease (Appendix D) which exceeds the decline in child victims (over a shorter time period) of 26 percent. The federal out-of-home care census grew by 8.1 percent during that period (Appendix D) which makes Nebraska's performance more outstanding.

There was one anomaly during that period, however, identified in the 2015 Foster Care Review Office Annual Report (page 9), that affected both the numbers of placements and the types of placements: the movement of juvenile cases who were then counted as part of the DHHS' out-of-home caseload, to the Office of Probation. That transition was to be completed by July 2014 but the numbers of transferred cases increased after July 2015 when the Office of Probation hired additional case managers. As a result, the out-of-home case count decreased by nearly 900 cases between 2013 and 2014 and another 10.1 percent statewide between 2014 and 2021.

Placements can be affected both by the number of children entering care and the number of children exiting care. Figure 7 shows these patterns on a statewide basis from 2011 to 2019, again using the Adoption and Foster Care Analysis and Reporting System (AFCARS) data. The lines are running essentially in tandem, although there was a spike in entries in FY 2017 and a dip in FY 2018.

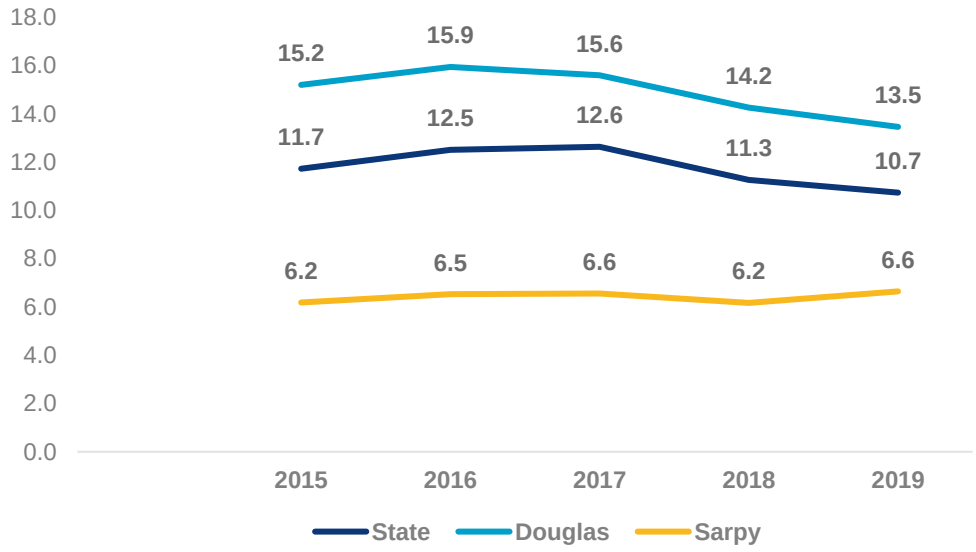
Figure 7:
Children Entering and Exiting Foster Care, Nebraska, 2011 - 2019



	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Entering Foster Care	3,151	2,806	2,708	2,204	2,351	2,521	2,644	1,869	2,209
Exiting Foster Care	3,245	2,939	3,188	2,673	2,231	2,174	2,369	2,438	2,137

The rate per thousand children in care statewide is shown in Figure 8 both for the State and for the two counties that constitute the Eastern Service Area: Douglas and Sarpy. [43]

Figure 8: Rate per Thousand of Children in Placement, 2015 - 2019

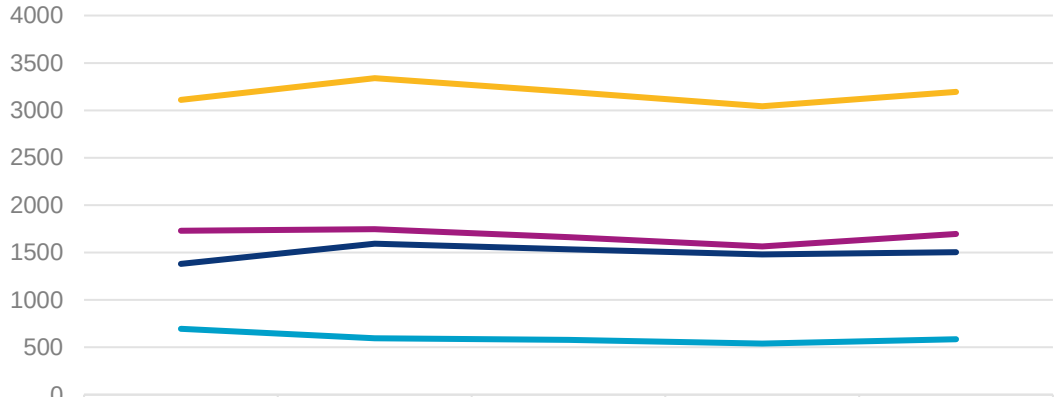


[43] Annie E. Casey KidsCount: rate per 1,000 children who are State wards and placed out do home during the calendar year, data drawn from Nebraska DHHS.

Fortunately, both the State and Douglas show declining placement rates, nearly in tandem. While Sarpy has a lower rate per thousand overall, its placement rate has increased by 6.4 percent between 2015 and 2019 compared to declines in Douglas County and the State.

The next question is how the Eastern Service Area's placements compare to the Statewide data. The Service Area-specific analyses that follow are drawn from a shorter period, 2014 to the first eight months of 2021, representing the data available by Service Area[44] which DCFS considers accurate. Figure 9 shows the combined use of out-of-home placements of all types (relative/kinship, foster homes, and residential care) by the Eastern and Southeast Service areas, all the Service areas excluding the Eastern region, and the whole State.

Figure 9: Average Annual Point in Time Count of Children in Placement, 2014-2021



	2014	2016	2018	2020	2021
Eastern	1380	1593	1532	1479	1502
Southeast	695	594	578	539	585
Statewide	3111	3339	3195	3043	3196
Areas-ESA	1731	1746	1663	1564	1694

The contrast between the Southeast and the Eastern Service Areas is large. In the Eastern Service Area, the census rose by 8.8 percent, in the Southeast, there was a decline of 15.8 percent and in all the service areas exclusive of the Eastern there was a decline of 2.1 percent. Eastern did not have the greatest proportional increase; that occurred in the Western Service Area as shown in Table 4, although they are virtually the same.

[44] DCFS provided the data monthly, which was averaged and therefore will differ somewhat from the 6-month AFCARS files which represent placements on the last day in the period.

Table 4: Percent Change of Children in Placement by Service Area and Year, 2014 to 2021

	2014	2016	2018	2020	2021	Percent Change
Central	355	371	318	326	370	4.2%
Western	291	346	348	375	317	8.9%
Northern	390	436	419	324	379	-2.8%
Eastern	1380	1593	1532	1479	1502	8.8%
Southeast	695	594	578	539	585	-15.8%
Areas minus Eastern	1731	1747	1663	1564	1651	-2.1%

Source: DHHS

The Foster Care Review Office reports a 1.4 percent statewide increase in daily population placements from June 2019 to June 2020, with increases in every Service Area except the Northern which saw a 13.4 percent decline.[45] The Eastern Service Area increase was 2.1 percent during that period and by the end of March 2021; it had 46.5 percent of the state's out-of-home care population, or 1,595 children in placement,[46] a higher proportion than expected (43 percent).

Thus, we conclude that despite the reduction in substantiated child abuse victims and despite the introduction of Alternative Response to bolster services to families in their own homes, there has not been an increase in placement prevention in the Eastern Service Area. Put another way, over the past seven years there has been a 9 percent increase in placements in the Eastern Service Area and a 2.1 percent decrease in the other Service areas combined.

USE OF LEAST RESTRICTIVE PLACEMENTS AFTER REMOVAL

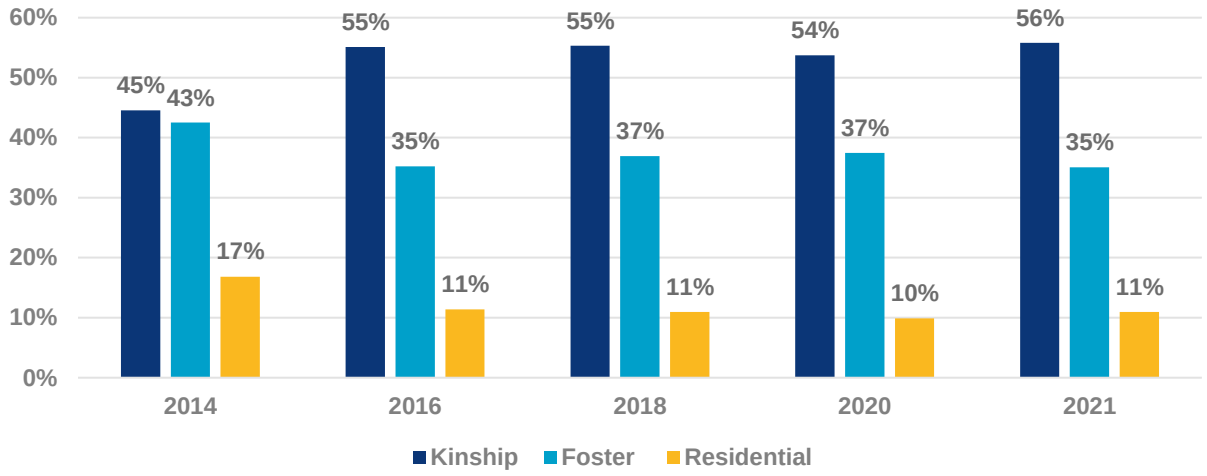
There is a consensus in the field that when children must be removed from home it is better to place them close to home, so they do not have to change schools and preferably with people they know including family. According to Childfocus

> *"A model child welfare system provides a range of family foster care placement options for children — kinship care, traditional foster care, and treatment foster care. Children do best when placed with relatives or other caring adults with whom they share a connection, referred to as kinship care. When kin are not available, traditional foster families are the most appropriate alternative and can provide nurturing environments for children until they can safely return home."*[47]

DCFS has strived to increase the proportion of children placed with relatives or kin (families known to the child who are not related by blood) while maintaining a licensing or approval standard. Figure 10 provides an overview of the change by placement type from 2014 to 2021, including kinship and relative homes, traditional foster family homes, and residential care. It shows that DCFS has succeeded statewide in increasing the use of kinship and relative homes by about a quarter.

[45]Foster Care Review Office, *Annual Report* (Lincoln, Nebraska, Neb. Rev. Stat. §43-1303(4), 2020),7.
[46]Ibid,20.
[47] Childfocus, *Nebraska Child Welfare Blueprint Report*, March 2017, 9.

Figure 10:
Changes in Out-of-Home Care Placement Types Statewide, 2014 to 2021



The use of kinship homes went from 45 percent in 2014 to 56 percent in 2021. Statewide, there has been a 24 percent increase in the use of kinship and relative care, offset by a 19 percent reduction in the use of foster family homes and a 35 percent reduction in the use of residential treatment.

Table 5: Proportion of Children in Kinship Care by Service Area and Year, 2014 to 2021

	2014	2016	2018	2020	2021
Central	32%	51%	63%	50%	55%
Western	56%	64%	64%	57%	59%
Northern	44%	58%	52%	54%	56%
Eastern	48%	55%	55%	53%	56%
Southeast	40%	50%	49%	54%	54%
Statewide	45%	55%	55%	54%	56%

Table 5 breaks down the use of kinship and relative homes by Service Area and year, showing the proportion of total placements that are with relatives. Note that in 2014 there was far more variation among the service areas than in 2021 where the range is 54 percent (Southeast) to 59 percent (Western). The Eastern Service Area is the same as the statewide average (56 percent).

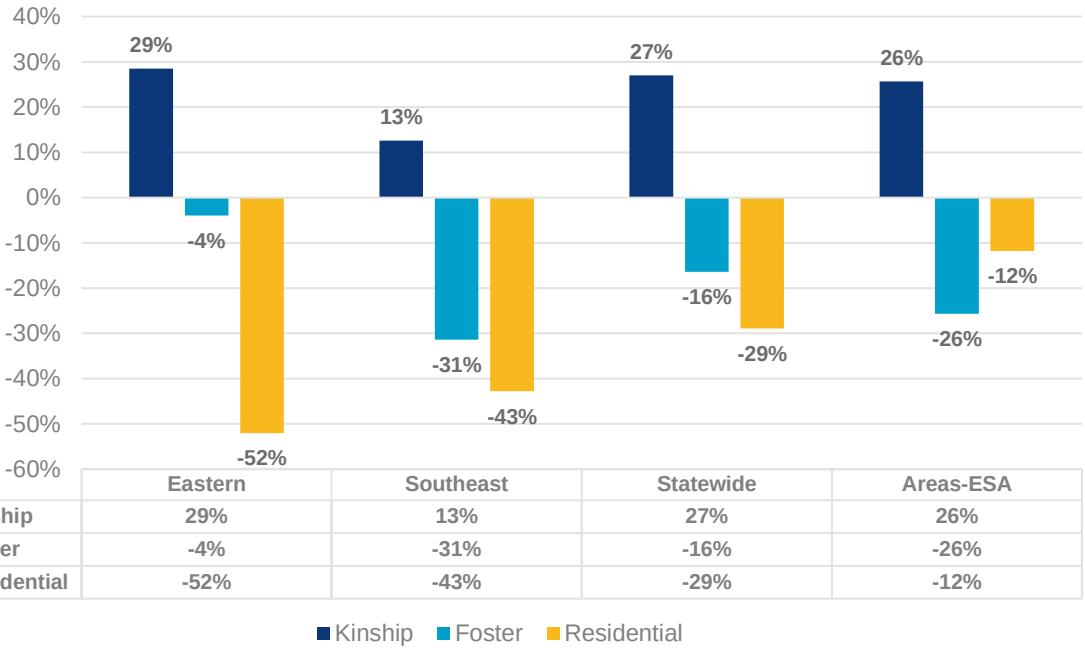
Table 6: Proportion of Children in Residential Care by Service Area and Year, 2014 to 2021

	2014	2016	2018	2020	2021
Central	4%	4%	6%	5%	8%
Western	6%	6%	6%	6%	6%
Northern	9%	8%	8%	8%	9%
Eastern	7%	6%	5%	3%	3%
Southeast	9%	9%	7%	7%	6%

Table 6 shows the proportion of children in residential care by Service Area and year. Residential care is the most restrictive and most expensive form of out-of-home placement. Some reductions may be a function of changes in the juvenile system in Nebraska, specifically the movement of case management of juvenile cases out of child welfare as well as the introduction of the Crossover Youth Practice Model (CYMP) developed by Georgetown University's Center for Juvenile Justice Reform. Nebraska has had four active CYPM sites. Douglas and Gage Counties were implemented in 2012, Lancaster and Dodge Counties in 2015, and Sarpy County commenced planning in 2015. The Office of Probation Administration is the Lead Agency coordinating CYPM throughout the State. The Eastern Service Area declined from 7 percent to 3 percent and is now below the statewide average of 5 percent.

Figure 11 shows the change by service area in all three placement types during the same period, 2014 to 2021**,** specifically the Eastern Service Area, the Southeast, the rest of the Service Areas grouped, subtracting the Eastern Service Area, as well as the statewide change which includes all the service areas.

Figure 11: Change in Placement Type by Service Area, 2014 to 2021



	Eastern	Southeast	Statewide	Areas-ESA
Kinship	29%	13%	27%	26%
Foster	-4%	-31%	-16%	-26%
Residential	-52%	-43%	-29%	-12%

Figure 11 attempts to answer the question of the degree that privatization drove the increase in the use of the least restrictive placement: relative and kinship homes. It certainly had a positive impact on the difference in change over the seven years between the Eastern Service Area (29 percent) and the rest of the service areas (26 percent). A particularly large change can be seen in its use of residential placements. That decreased in the Eastern Service Area by 52 percent and in the other service areas combined by 12 percent.

Privatization has helped the State to achieve its efforts to move children and youth to kinship care and to reduce the use of residential care. Changes in juvenile justice policy and resources helped the latter as well.

PLACEMENT STABILITY

It has been demonstrated that if children change homes multiple times while in out-of-home care their emotional health and well-being are damaged. Thus, the federal government measures the stability of placement through a composite measure, with a score deriving from several factors such as length of time in care and number of moves. The score reflects the number of children with two or fewer placements over specific periods, not counting children who experience brief hospitalization or who run away.

From June through October 2018 all the service areas, as well as the State, met the placement stability standard of no more than 4.12 moves per 1,000 days in care, although the Eastern Service Area's performance was the worse among the service areas.

The most recent measure in the Eastern Service Area, its 6/28/2021 Performance Scorecard, also shows the Eastern Service Area in compliance with the stability measure.

A long-term perspective on placement moves is provided in the 2021 Foster Care Review Office Report which shows lifetime placements by Service Area for cases reviewed in the past year. The percentage of children with four or more placements by the age of the child is shown in Table 7. [48] For each age range, the Eastern Service Area has the highest percentage of children with four or more moves, an unfavorable result.

Table 7: Percent of Children with Four or More Lifetime Placements Reviewed by 6/30/2021[49]

Age Group	Central	Eastern	Northern	Southeastern	Western
0-5	5.1%	14.5%	8.5%	8.4%	7.6%
6-12	20.4%	34.0%	20.0%	25.5%	23.9%
13-18	43.1%	62.0%	50.5%	46.9%	39.2%

ABSENCE OF MALTREATMENT OF CHILDREN IN FOSTER CARE

Regardless of the type of placement, an important measure of quality is whether children suffer abuse and neglect in their placement setting. This is a federal measure and reflects the number of children placed outside their home either in a foster home or in group care, and the percent who were *not* abused or neglected by a foster parent or facility staff. The federal standard is 99.7 percent.

Over the last decade, Nebraska showed improvements in this measure, showing 99.4 percent compliance statewide in 2012 and 99.89 percent compliance in 2016, exceeding the federal standard of 99.7 percent in 2016.

The most recent data in Compass, June 2021, shows the performance in the Eastern Service Area to be 99.52 percent with a target of 99.68 percent, even the target being slightly below the standard. This is comparable to the Southeast with scores of 99.58 percent compared to the target of 99.68 percent. The statewide average on this measure, considering the service areas out of compliance, is 99.68 percent. Thus, while the differences are infinitesimal, both the Eastern and Southeastern Service Areas are performing below the rest of the State.

PERMANENCY FOR CHILDREN IN FOSTER CARE

When children must be removed from the home, the goal is to achieve a permanent placement as quickly and as safely as possible, preferably with the family of origin.

Timeliness and Permanency of Reunification

This is a federal composite measure (meaning it is derived from more than one measure) and determines both the timeliness of reunification and whether the reunification lasted for a particular time period. The measures constituting the composite are reunification in less than 12 months, the median time to reunification, entry cohort reunification in less than 12 months, and permanence of reunification.

Over the last decade, Nebraska showed improvements in this measure, moving from a score of 106.2 in 2012 to 125.1 in 2016; the federal target is 122.7. Thus, the State met the standard by 2016.

The Compass data for June 2021 shows the Eastern Service Area with a score of 103.13, performing *well below the target* of 122.6. The Southeast Service Area was also below with a score of 113.23, while the statewide average including the ESA had a score of 109.33. Thus, the statewide average did not meet the national standard either, but with over 43 percent of its cases coming from the ESA, the region acts as an anchor to the statewide data. A year earlier, in July 2020, the ESA scored 108.15, meaning the performance has decreased in the past year. The State's Child Welfare Plan gives the following reasons for the shortfall,

[48] Ibid, 35.
[49] N=3535

but they are not particular to any Service Area: lack of efforts to transition the child to the parental home, not assisting the foster parents in understanding a child's behaviors for adoption to occur, and courts delaying guardianship due to advocating for the child to be adopted instead.

The Eastern Service Area Scorecard measures youth in care achieving permanency in 12 months. This is defined as the percentage of children entering foster care over 12 months that are discharged to permanency within that period. The goal is to meet or exceed 43.8 percent. However, the most recent Eastern Service Area Quality Performance Scorecard (6/28/2021) shows non-compliance on this measure now and in each of the past five months.

Additionally, from the cases it reviews, the Foster Care Review Office calculates the median length of stay in foster care of those who exited, about 4,000 each year. Last year it found that the Eastern Service Area had the longest median length, while the statewide median dropped to 528 days during FY2019-20 from 546 the previous year. The median length of stay in the Eastern Service Area was 615 in FY 2019-20.[50] The current Annual Foster Care Review Office report shows considerable improvement with a median of 337 days for all service areas and 359 for the Eastern Service Area, putting the region in third out of five among the service areas.

Permanency for Children in Foster Care, Composite Score

This federal composite measure addresses the frequency that permanency is achieved for children and youth who have been in care for *longer* periods. Permanency is defined as exiting care to reunification, adoption, or guardianship. The measures in the composite are exits to permanency before a youth's 18th birthday for children who have been in care for 24 months or more; exits to permanency for children who are free for adoption; and children emancipated who were in foster care for three or more years.

From June through October 2018, all the Service areas, as well as the State, met the permanency composite. The Eastern and Southeastern Service areas scored very similarly and while lower than the other service areas, still met the standard.

In June 2021, the Eastern Service Area was still exceeding the federal standard, with a score of 143.07 and a standard of 121.7. The Eastern Service Area scored 139.25, still marginally exceeding the standard, while the State scored 152.95, also exceeding the standard. A year earlier, all three jurisdictions exceeded the federal standard.

Re-entry into Foster Care within Twelve Months of Discharge

Once children leave foster care the goal is for them not to have to return, prompting the re-entry measure. This is a federal measure from the Child and Family Services Review with the goal of less than or equal to 8.3 percent of re-entries. The standard is met by the State. The most recent Scorecard report, referenced above, shows that the Eastern Service Area is currently meeting that goal and has done so for the past five months. This result is affirmed in the *ESA Full-Service Case Management Contract Monitoring Summary, Quarter 1 2021* which states that Saint Francis continues to meet the goal of reducing the percentage of children who re-enter foster care within 12 months.

Timeliness of Adoption

This is a federal composite measure that, as its name suggests, measures whether adoption is achieved in a timely manner depending on how long the children have been in care and whether they are legally free.

From June through October 2018, all the service areas and the State as a whole met the timeliness of adoption target of 106.4. In June 2021 the Eastern Service Area sustained this achievement, scoring 116.0.

[50] Foster Care Review Office, *Annual Report* (Lincoln, Nebraska, Neb. Rev. Stat. §43-1303(4), 2020),28.

The Southeast Service Area excelled during the recent period, achieving a score of 159.67 with the same target of 106.4 while the State achieved 146.01.

A year earlier the Eastern Service Area also met the standard with a score of 119.81, greater than this past year, while the Southeast Service Area exceeded the standard with a score of 147.5, but not to the same degree as its current year performance. A year earlier, the State exceeded the national average as well.

Tables 8 and 9 summarize Nebraska's passage of federal measures which are reported by Service Area in Compass on the DHHS website past the time of the federal review. By slight margins, both the Eastern Service Area and the Southeast do not meet the federal standard on two outcomes, whereas the entire State does. This result is generally typical of what has been found in past evaluations of privatization in Nebraska.

Table 8: Summary of Compliance with Federal Outcomes, June 2021

Measure	Eastern Service Area	Southeast Service Area	Statewide
Absence of Maltreatment Occurrence	**Noncompliant**	**Noncompliant**	**Compliant**
Absence of Maltreatment in Foster Care	**Noncompliant**	**Noncompliant**	**Compliant**
Timeliness of Permanency and Reunification	**Noncompliant**	**Noncompliant**	**Noncompliant**
Timeliness of Adoption	**Compliant**	**Compliant**	**Compliant**
Permanency for Children in Foster Care	**Compliant**	**Compliant**	**Compliant**
Placement Stability	**Compliant**	**Compliant**	**Compliant**

Table 9 compares results between 2012 and 2021 to see the long-term impact of privatization on these measures. The Eastern Service Area's compliance declined on two measures during that period. The Southeast remained the same while the State improved.

Table 9: Difference in Performance in Federal Outcomes, 2012 and 2021

Measure	Eastern Service Area	Southeast Service Area	Statewide
Absence of Maltreatment Occurrence	**Down, Noncompliant**	**Same, Noncompliant**	**Same, Compliant**
Absence of Maltreatment in Foster Care	**Down, Noncompliant**	**Down, Noncompliant**	**Improvement, Compliant**
Timeliness of Permanency and Reunification	**Same, Noncompliant**	**Same, Noncompliant**	**Same, Noncompliant**
Timeliness of Adoption	**Same, Compliant**	**Same, Compliant**	**Improvement, Compliant**
Permanency for Children in Foster Care	**Same, Compliant**	**Same, Compliant**	**Same, Compliant**
Placement Stability	**Same, Compliant**	**Same, Compliant**	**Same, Compliant**

WELL-BEING MEASURES

Mental and Behavioral Health of a Child

In Round 3 of the Child and Family Services Review, addressing the mental and behavioral health of the child was an area needing improvement, making it a subject to track. The change from the PIP baseline in 2018 to the PIP Quarter 1 Report shows three out of five service areas with improvement, including the Eastern Service Area. However, only the Western Service Area reached the target of 95 percent.

The Foster Care Review Office reports that in 2021 the mental health needs of the child were partially or substantially improving in 67.8 percent of the cases in the Eastern Service Area compared to 84.4 percent in the Southeast and 75 percent statewide, making the Eastern Service Area the lowest achiever. The result is comparable to 2018, where the Eastern Service Area had a score of 67 percent on completed mental health assessments and effort to assure appropriate treatment (however, not an improvement). The Southeast scored 78 percent, and the State, 67 percent. Both the Southeast and the State exceeded the Eastern Service Area's performance, which also had the highest proportion of children in foster care with a mental health diagnosis (50.6 percent, compared to 44.9 percent in the Southeast and 47.8 percent statewide).

The percent of children with psychotropic medications prescribed was lower in the Eastern Service Area for very young children, age 0 to 5, a good result, and comparable for those age 6 to 12 (about one in five) and those age 13 to 18 (about two in five).

Physical Health Needs of a Child

In Round 3 of the Child and Family Services Review, addressing the physical health needs of the child was an area needing improvement, making it a subject to track. The change from the PIP baseline in 2018 to the PIP Quarter 1 Report shows all but one Service Area stayed the same or showed improvement, including the Eastern Service Area, but none reached the target of 95 percent.

The Foster Care Review Office reports that in 2021 the medical needs of the child were met in 84 percent of the Eastern Service Area cases compared to 86 percent in the Southeast and 83 percent for the entire State. Consequently, the results are comparable across the State. This represents a small improvement from 2018, where 82 percent in the Eastern Service Area had their needs met, with 78 percent in the Southeast, and 79 percent statewide.

Foster caregivers need to receive information on the health and medical needs of the child. While this is achieved in nearly all the cases in three Services Areas, there are significant deficits in two, including the Eastern Service Area. According to the 2021 Foster Care Review Office Report, one-quarter of cases do not meet this requirement. [51] (See Table 10)

Table 10: Caregivers Receiving Information about Child's Medical Needs at Placement

	Central	Eastern	Northern	Southeastern	Western
Placement received information	95.2%	74.9%	75.9%	98.0%	96.4%

The Foster Care Review Office reports that in 2021 the medical needs of the child have been met in 84 percent of the Eastern Service Area cases compared to 86 percent in the Southeast and 83 percent of the State. This represents a small improvement from 2018.

Educational Needs of a Child

In Round 3 of the Child and Family Services Review, addressing the educational needs of the child was an area needing improvement, making it a subject to track. Two Service areas performed worse, including

[51] Ibid, 39.

Eastern, one stayed the same, and two improved as shown in the Foster Care Review Board Office Annual Report. Three of five met the 95 percent target, excluding the Eastern Service Area.

The Foster Care Review Office reports that in 2021 the academic performance is on target for males in 56.4 percent in the Eastern Service Area, 59.6 percent in the Southeast, and 60.4 percent statewide. For females, the scores are 57.6 percent in the Eastern Service Area, 73.3 percent in the Southeast, and 67.2 percent statewide. In 2018, the Eastern Service Area had the worst score, with 77 percent achievement compared to 100 percent in the Southeast and 84 percent statewide. In addition, the Foster Care Review Office in its latest report shows whether educational information was shared with the caregiver; the score was lowest in the Eastern Service Area, Table 11.

Table 11: Caregivers Receiving Information about Child's Education at Placement

	Central	Eastern	Northern	Southeastern	Western
Placement received information	97.4%	74.6%	78.9%	97.6%	96.6%

The Foster Care Review Office reports in 2021, 59.7 percent of children ages 5 to 18 in the Eastern Service Area participated in extra-curricular activities compared to 86.9 percent in the Southeast and 74.4 percent statewide. The Eastern Service Area had performed far lower on this measure.

Placement with Siblings

There is a discrepancy in results reported in the 2020-2024 State Plan and The Stephen Group report, although they use different samples. The State Plan shows CFS ensured siblings were placed together 97 percent of the time in a sample of 29 cases and that all six service areas surpassed the target goal of 95 percent for the most recent review. The Stephen Group reports data from 2016 to 2018 showing the percent with all siblings placed together and the percent with at least one sibling placed together.[52] The 2018 scores for the Eastern Service Area were 58 percent for all siblings placed together, compared to 68 percent for the Southeast and 65 percent average for the State. The Eastern Service Area also scored below all others on one sibling placed with the other at 81 percent, with the Southeast and statewide average both showing 82 percent. However, this is also a measure on the Eastern Service Area Quality Performance Scorecard which shows on 6/28/2021 that Saint Francis is close to meeting the goal of 79.5 percent.

INDEPENDENT LIVING

The John H. Chafee Foster Care Independence Program (CFCIP) aids foster care youth to achieve self-sufficiency. The program serves youth who are likely to remain in foster care until age 18, youth who, after attaining 16 years of age, have left foster care for kinship guardianship or adoption, and young adults ages 18-21 who have "aged out" of the foster care system. The Foster Care Review Office reported in 2021 that 16.4 percent of qualified youth had an Independent Living Assessment completed in the Eastern Service Area compared to 20.7 percent in the Southeast and 20.4 percent statewide. This reflects poor performance both in the Eastern Service Area and throughout the State. In its 2021 report the Foster Care Review Office shows worse performance in the Eastern Service Area than any of the others on the following (which were all the factors measured):

- Completed independent living assessment
- Current transitional living plan
- Youth involved in developing own plan

[52] The Stephen Group, *Assessment of Outsource Model in Nebraska's Eastern Service Area,* 37.

- Relationships with positive adults
- Receiving skills in preparation for adulthood

The federal government developed a National Youth in Transition Database (NYTD) survey for the states to administer to youth who have reached age 17 in foster care and during two follow-up periods, on their 19th and then 21st birthdays. The survey collects outcome information regardless of their foster care status. The outcomes include financial self-sufficiency, experience with homelessness, educational attainment, positive connections with adults, high-risk behavior, and access to health insurance.[53]

Table 12: Quality Measures from National Youth in Transition Database Survey

Quality Measure	Question	Successful Outcome
Employment	1 & 2	Yes
Education	7 & 8	Yes
Connection to an Adult	9	Yes
Homelessness	10	No
Incarceration	12	No

Table 12 shows the measures PCG evaluated from the NYTD survey, corresponding survey questions, and the responses that identified a successful outcome.

Table 13 presents the percentage of responses for each successful outcome by Service Area. For most, the Eastern Service Area scored similarly to the rest of the State. The largest gap can be seen in homelessness. While the Eastern Service Area scored comparably to the Southeast, with a quarter of the respondents reporting that they have been homeless in the past two years, only 13 percent in the Central Service Area and 11 percent in the Western Service Area had a comparable result.

Table 13: Quality Measures from NYTD Survey by Service Area

Quality Measure	Central	Eastern	Northeast	Southeast	Western
Currently employed full time	19%	20%	17%	17%	19%
Received High School Diploma/GED or Associate Degree	38%	33%	36%	33%	31%
Currently enrolled in education	64%	67%	63%	68%	73%
Connection to an Adult	94%	93%	95%	97%	93%
Homelessness (no)	85%	74%	83%	75%	86%
Incarceration (no)	62%	69%	62%	59%	72%

To obtain a statewide score on outcomes, PCG ranked each service area on each measure from 1 to 5, with 1 being the most favorable score. Table 14 shows each service area's score for each quality measure, as well as an aggregated ranking. The best potential score is 6 and the worst is 30. The Eastern Service Area has the median score of 18 while the Southeast has the worst median at 20.

Table 14: Service Area Rankings on NYTD Quality Measures

Quality Measure	Central	Eastern	Northeast	Southeast	Western
Employment (full time & part time)	3	1	5	4	2
Received High School Diploma/ GED or Associate Degree	1	3	2	4	5

[53] Administration for Children & Families, Children's Bureau "About NYTD: Fact Sheet"

Quality Measure	Central	Eastern	Northeast	Southeast	Western
Currently enrolled in education	4	3	5	2	1
Connection to an Adult	3	4	2	1	5
Homelessness	2	5	3	4	1
Incarceration	4	2	3	5	1
Total Score	**17**	**18**	**20**	**20**	**15**

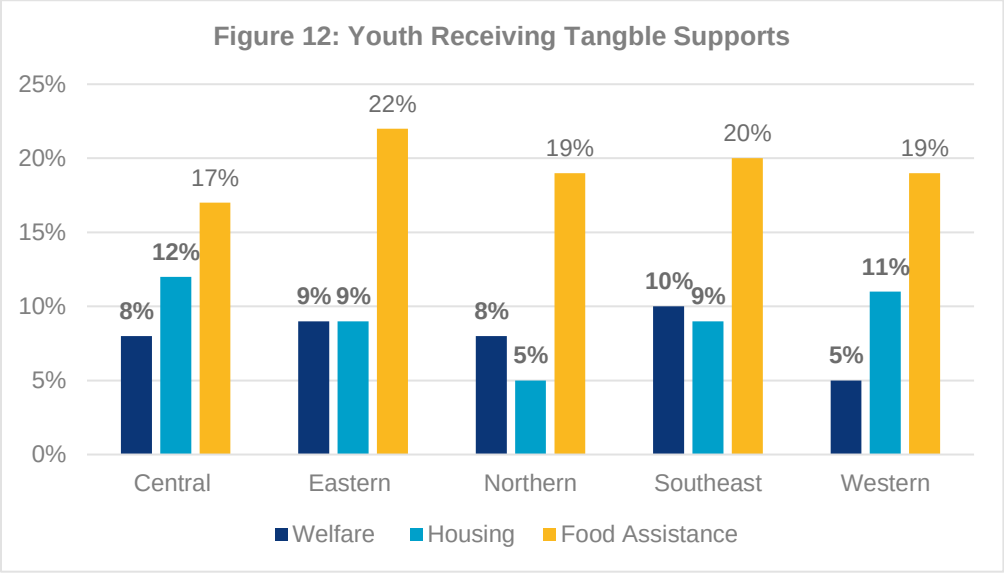
Table 15: Final Service Area Rankings

Quality Measure Ranking	Overall Ranking
Western	1
Central	2
Eastern	3
Northern	*4
Southeast	*4

Table 15 shows the result with the Western Service Area ranked highest, and the Eastern in the middle with the Northeast and Southeast tying for last.

Government Assistance Measures

Figure 12 presents information on receipt of welfare, housing, and food assistance. The most prevalent benefit is food assistance, with percentage of respondents receiving the benefit ranging from 17 percent (Central) to 22 percent (Eastern). Receipt of welfare varied from 5 percent (Western) to 10 percent (Southeast). Housing assistance ranged from 5 percent (Northern) to 12 percent (Central).



There are no large differences among the service areas in the receipt of tangible support, although the Eastern Service Area is highest collectively (40 percent) whereas the Northern Service Area is lowest (32 percent). The service most prevalently received is food assistance followed by housing assistance and then welfare.

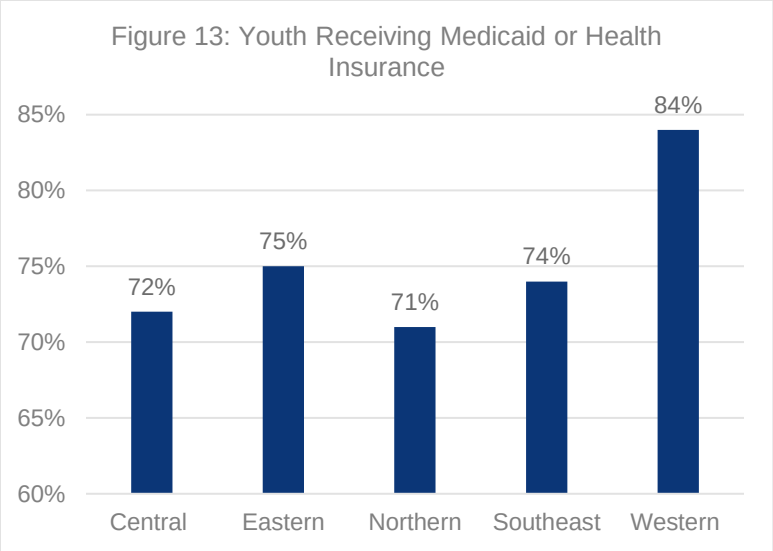


Figure 13 displays the percentage of youth who receive Medicaid or who have other health insurance, limiting the analysis to 19 - to 21- year-olds. The range is 71 percent (Northern) to 84 percent (Western). Between 84 percent and 93 percent of respondents receive their health insurance from a government entity or through another insurance provider with the Central Service Area being lowest and the Northern Service Area highest. The Eastern Service Area was second to best.

The following charts show respondents' use of government assistance programs: food assistance, housing assistance, and welfare payments. The most prevalent is food assistance, with just over 10 percent responding positively. Only 3 to 7 percent receive housing or welfare assistance. The Eastern Service Area is comparable to the others on these measures.

The NYTD data show that across the State of Nebraska the quality outcomes for youth exiting foster care are moderate. (Combine education and employment for those over 18) statewide employment outcomes are low, with 18 percent of youth across the State reporting employment either full-time or part-time. statewide education outcomes are moderate, 34 percent of youth responded that they have received a high school diploma, GED, or associate degree, and 67 percent reported that they are currently enrolled in educational courses. Statewide connection to an adult has a high outcome across the State, 94 percent of respondents reported a connection to an adult other than their social worker or caseworker. The statewide outcome for homelessness is high across the State, 81 percent of youth reported that they have not been homeless in the last two years. The statewide outcome for incarceration is moderate, 65 percent reported that they have not been incarcerated in the last two years. Compared to the statewide results, the Eastern Service Area's quality measures are in line with the other regions. When ranking each service region by the quality measures, the Eastern Service Area ranks in third place, with the Western in first place and Central in second.

PRACTICE STANDARDS

Face to face Contacts with Youth

The 2017 CFSR Final Report examines the frequency and quality of visits between caseworkers and children (Item 14 Well-being Outcome 1, Families have enhanced capacity to provide for their children's needs). This factor was ranked as an Area Needing Improvement not for the foster care cases, but for in-home and alternative response cases, which is why it passed in AFCARS (which strictly measures foster care).

Caseworkers are supposed to see children in foster care at least monthly. The federal target is that 95 percent of youth should have such visits, and this is a performance measure in the Saint Francis contract Scorecard. The federal AFCARS report shows that Nebraska has met the standard from 2015 to 2019, with the percent receiving a monthly visit ranging from 95 percent to 98 percent during that period. However, as of June 2021, the Eastern Service Area contractor was not meeting the standard based on a CQI review of 1,922 cases. In July 2021 there was improvement reported although the standard still was not being met.

Caseworker Visits with Parent

Caseworker visits with parents are measured by the Child and Family Services Review process, looking at both the frequency and quality of visits. Because the measure was quantified as part of the CFSR process, the number of cases reviewed was small. However, the Eastern Service Area had the lowest compliance among all the service areas (exclusive of Tribal) in the follow-up period and declined from baseline. No service area met the 95 percent target, although the Southeast was closest.

Caseworker Contact with Parents: Monthly Family Team Meetings

The lack of regular monthly contact is cited as a concern in the 2020-2024 State Plan as well as in the most recent Eastern Service Area Scorecard, where this measure is grouped with other case management issues; 39.6 percent of the records reviewed were out of compliance. For monthly Family Team Meetings, it is not clear from the measure whether families are supposed to be present, although that is the understood model. The measure is, "Of all children in foster care, what percentage had a family team meeting *held on their behalf?"* While the goal is 95 percent, Saint Francis' scores are in the 60 percentiles for each of the last five months and this is another subject of a corrective action plan.

The lack of parent involvement in service planning has been a problem over the years. In the most recent Child and Family Services Review, no Service Area met the 95 percent standard. The Eastern Service Area was second to lowest in the follow-up period. While one of the selling points for privatization has been stronger engagement with families, these measures do not demonstrate that typically to be the case.

SERVICE ARRAY AND MONITORING

Privatized contractors have been required to outsource services to children and families. That is, they contract to sub-recipients and are responsible for monitoring and payment processes. They are allowed to retain up to 35 percent of service costs for themselves as service providers.

When thinking about service array, it is important to consider why families are in the child protective system in the first place. The 2021 Foster Care Review Office Report documents the reasons for removal in adjudicated cases. While there can be multiple reasons, even with the introduction of Alternative Response, neglect is the most prevalent and is present in more than half of cases.

The Stephen Group found that PromiseShip concentrated its services in too few providers, violating the concept that privatization is supposed to stimulate the competitive nature of services. Instead, 27 percent were sourced from a single provider while 96 percent of the providers billed less than $2 million over three years.[54] When asked about their satisfaction with referrals received now, all the providers PCG interviewed expressed satisfaction.

The Stephen Group found that 18 percent of the $129 million of contract payments over the three years studied has been to Kinship Foster Parents managed directly by PromiseShip. Boys Town (Father Flanagan's Boys' Home) received 10 percent of contract payments. Following is a list of the largest service providers over the three years, the amount received, and the percent of all contracts let by PromiseShip.

[54] The Stephen Group*, Assessment of Outsource Model in Nebraska's Eastern Service Area,* 6.1

Table 16: Contracted Providers to PromiseShip

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

Below is a list of Saint Francis contractors. When examining specific contracts, it became clear that they do not have dollar amounts or even the number of people to serve associated with them. Rather, they are based on the referrals made by the Lead Agency. Contractors expressed no dissatisfaction with the number of referrals they were receiving.

Contracted Providers to Saint Francis

- Adjudicated Youth Services
- AI Villarreal
- Apex Foster Care, Inc.
- Apex Youth Services
- ASL Interpreting
- Beneficial Behavioral Health
- Better Living
- Boys Town
- Buoyant
- Camelot
- Capstone
- Caring People of Sudan
- Cedars Youth Services
- Center For Holistic Development
- Child Saving Institute
- Children's Square
- Christian Heritage Children's Home
- Concord Meditation
- Family Development Services
- Family Support Advocates
- Heartland Family Services
- Heather Atwood Heredia
- KVC Behavior Healthcare
- Lutheran Family Support Network
- Nebraska Children's Home Society
- NOVA
- Omaha Home for Boys
- Owens and associates
- Paradigms Inc.
- Priority Foster Care
- ReConnect Inc.
- Rite Passage
- Youth Care & Beyond
- Youth Futures
- You Turn

The Saint Francis contract itself provides a specific dollar amount that must be contracted to other agencies, with Saint Francis determining the purpose of these contracts. Per the latest Scorecard (7/28/21), Saint Francis is working closely with DHHS to implement the Federal Family First Prevention Services Act (FFPSA) in the Eastern Service Area. During the most recent quarter (April-June 2021) the Saint Francis Contracts Team worked to implement new services based on reassessing gaps and needs as well as

including services supported within the Title IV-E Clearinghouse. Contracts for the following services have been issued: Intensive Family Preservation, Intensive Family Reunification with evidence-based practices that target different populations, Assessment Foster Care, Integrated Family Care and Resource Family Homes, Emergency Shelter, Family Support including Motivational Interviewing, Parenting Time/Supervised Visits, Respite Care/Short-term Foster Care. This list may not be complete.

Saint Francis implemented a file audit system to monitor subcontractor compliance with contract requirements. During the April-June 2021 quarter, it completed personnel file audits for seven contract providers. Though good, these are efforts duplicative of what the DHHS CQI unit could or would do in a fully public system. At this point, the scrutiny of Saint Francis contracts may well be higher than the agencies in the other service areas.

Examining the question from a micro perspective, the Foster Care Review Office reports for FY 2021 that in 79 percent of the Eastern Service Area cases the parents' services were offered, although the attendance was 47 percent for mothers and 23 percent for fathers. This compared to statewide averages of 88 percent offered, 52 percent delivered to mothers, and 29 percent to fathers. That is, efforts at getting families into services were less successful in the Eastern Service Area.

WORKLOAD AND STAFFING

Average Caseload Ratios

Nebraska law requires caseload ratio standards for ongoing cases of 12 to 17 cases. DHHS currently tracks caseload ratios on the Eastern Service Area Scorecard as well as for all service areas on its website.[55]

In the past, PromiseShip has met the State caseload standard; for example, in SFY 2018 caseworkers had an average monthly caseload of 11.1 with individual monthly caseloads ranging from 1 to 25 in the Eastern Service Area. The Stephen Group found that caseloads were somewhat lower in the Eastern Service Area.

There has been significant deterioration in the past few years, both in the Eastern Service Area and statewide, although the problem is far worse in the Eastern Service Area. With a goal of 100 percent, Saint Francis met the standard in about 40 percent of the cases over five months in a recent Scorecard report: 44.1 percent in April 2021, 35 percent in May 2021, 31.8 percent in June 2021. Staffing shortages exacerbated by the pandemic have affected caseload ratios.

Table 17: Ongoing Worker Caseload Status by Service Area, Average of June 20211

Service Area	Total Staff	Staff in Compliance	Percent in Compliance
Central	**33**	**26**	**78.8%**
Eastern	**90**	**28**	**31.1%**
Northern	**19**	**12**	**63.2%**
Southeast	**40**	**23**	**57.5%**
Western	**24**	**21**	**87.5%**
State	**206**	**110**	**53.4%**

For the job category of Ongoing, [56] which explicitly represents the privatized staff in the Eastern Service Area, the Eastern Service Area has the lowest percent in compliance by far at 31.1 percent compared to 57.5 percent in the Southeast and a statewide average of 53.4 percent. Problems of worker retention have

[55] Nebraska Department of Health and Human Services, *Children and Family Caseload Status* (Lincoln, Nebraska: Department of Health and Human Services, September 2021).
[56] This excludes investigation workers who are not covered by privatization.

been exacerbated over the past 18 months by the COVID pandemic. Yet as of June 2021, the manifestation was far worse in the Eastern Service Area.

Turnover Rates

Staff turnover is a perpetual problem for child welfare agencies and there have been many efforts over the years to address it such as paying for caseworkers to obtain additional degrees in return for their retention. National studies have demonstrated 20 to 50 percent attrition rates in child welfare with the highest rates occurring in the first three years. The average length of child welfare employment is less than two years and high turnover rates create a constant flow of recently hired child welfare workers.[57] These data are before COVID.

Nebraska DHHS has not been immune, and privatization has not abetted the problem over the years. The Stephen Group reports, for example, that the statewide turnover rate for caseworkers was 59 percent annually and 63 percent in the Eastern Service Area under PromiseShip. It found that 95 percent of DHHS workers and 100 percent of PromiseShip workers leave before 36 months on the job[58] and concludes that "PromiseShip has not done a better job at reducing turnover than DHHS."[59]

The problem continues and has gotten worse, in part due to the pandemic and in part due to the uncertainty of the contracting status of the current contractor. The drumbeat of bad news including public hearings, corrective action plans, and placing Saint Francis on probation as a child-placing agency have taken their toll. DHHS publishes information on Child Protective Services Children and Family Service Specialists (CFSS) case manager monthly turnover rates each month. Positions include CFS Specialists, Child Abuse Hotline, APS, B2i & Trainees within each category. Counts exclude Supervisors and Administrators. Turnover data are expressed as a count and proportion of CFS Specialists that are no longer in the position from the prior month. Those not in the position may have been promoted, accepted a different position, or separated their employment from DHHS or Saint Francis Ministries. Turnover rates presented here are limited to DHHS CFS Specialists and Saint Francis Ministries Case Manager positions because those are the relevant positions for this study.

Table 18: Case Manager Turnover Rate for DHHS and Eastern Service Area Staff, January – June 2021

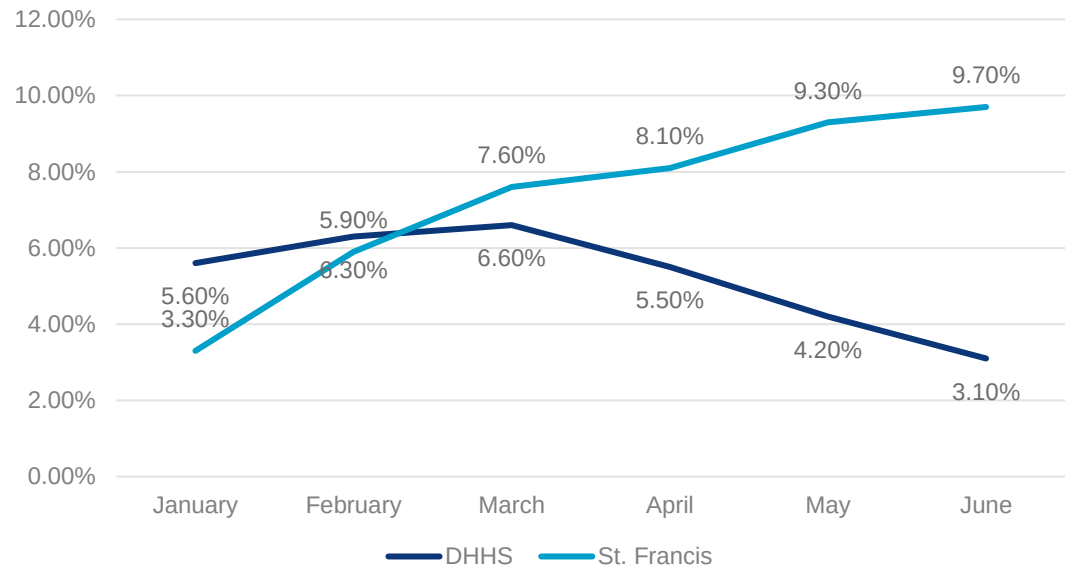
Month	Count at end of Month	Positions Separating During Month	Monthly Turnover Rate	Six-month Average
DHHS				
January	414	23	5.6%	**5.2% per month**
February	399	25	6.3%	
March	392	26	6.6%	
April	382	21	5.5%	
May	409	17	4.2%	
June	421	13	3.1%	
Eastern Service Area/Saint Francis				
January	121	4	3.3%	**7.2% per month**
February	118	7	5.9%	
March	119	9	7.6%	
April	111	9	8.1%	
May	108	10	9.3%	
June	113	11	9.7%	

[57] L. Schelbe, M. Radey, & L, Panish, *Satisfactions and stressors experienced by recently hired frontline child welfare workers*. (Children and Youth Services Review, 2017) 78, 56-63.
[58] The Stephen Group*, Assessment of Outsource Model in Nebraska's Eastern Service Area,* 61.
[59] Ibid, 61.

The recent trend in turnover shows that DHHS is on a decline (less turnover) whereas Saint Francis' rate is escalating month by month. (Figure 14) However, the situation is volatile due to the pandemic. In the first six months of the year, the average turnover rate per month was 5.2 percent for DCFS and 7.2 percent for Saint Francis, a 38 percent difference. If you multiply the monthly turnover rates by 12 to arrive at an annual rate, that would be 62.4 percent for DCFS and 86.4 percent for Saint Francis. These very large rates probably help to explain why most of the compliance measures discussed in the Practice Standards above are not being met.

By its very nature, regardless of vendor, privatization contributes to high turnover since the contracting process produces uncertainties unlike the stability of state employment. The instability of case managers hinders the ability to recruit and retain more, creating a cycle that has proven untenable. Turnover is difficult on children and families and does not promote permanency.[60]

Figure 14:
Case Manager Turnover Rate, January-June 2021



Large caseloads are perpetual problems in child welfare although the standards have greatly improved. If agencies were staffed at a rate to meet the 12 to 17 statutory ratio, the caseloads should be manageable. However, statewide compliance lies at 50 percent, but that is driven in part by the 30 percent compliance in the Eastern Service Area. High caseloads have been shown in many studies to lead to high turnover, and again the rates are worse in the Eastern Service Area. While staffing is an issue for virtually all employers at this time due to the pandemic, other reasons such as job insecurity have generated higher turnover in the Eastern Service Area as reported in past studies before the pandemic.

[60] Listening to the Voices of Children in Foster Care: Youths Speak Out about Child Welfare Workforce Turnover and Selection Jessica Strolin-Goltzman, PhD, Sharon Kollar, LMSW, Joanne Trinkle, LMSW, *Social Work*, Volume 55, Issue 1, January 2010, Pages 47–53,

VI. INNOVATION

INNOVATIONS IN CHILD WELFARE PRACTICE OVER THE PAST DECADE

What is Innovation?

For purposes of this study, innovation is a practice or a service introduced to Nebraska Child Welfare Agencies. Innovation does not have to be a new concept to the child welfare world, only to the child welfare system in Nebraska. For example, a practice might be widely used across the country but brought to Nebraska by a private provider. In some instances, it is difficult to know who suggested or initiated a service in Nebraska, but PCG is accepting the observations of those who provided testimony.

Practices and Services Introduced Over the Past Decade

Through interviews with stakeholders, the *Survey to Assess Innovation Aided or Abetted by Privatization in the Eastern Service Area,* and in reviewing contracts we have found that the following practices and services have been introduced over the past decade, many stimulated by privatization. It is not possible to verify the true origin of some since many factors, including national conferences and professional articles, stimulate the initiation of these practices. For other practices and services, the origin tied to privatization is far clearer, an example being the assignment of case managers to specific courts so they can develop and maintain smoother working relationships. Most of these services are widely used across child welfare agencies in the U.S. but were introduced in Nebraska during privatization.

In the listing below, *practices* refer to ways of handling cases while *services* refer to what families and children receive.

Practices

- Alternative Response (both a practice and a service)
- Structured Decision Making
- Family Team Decision Making
- Assignment of Case Managers to specific courts to develop and maintain relationships with judges
- Mobile workforce, aided by technology
- 24-hour “after hours” unit to respond to intakes and emergencies after hours
- Community Partnership

Services

- Pathway to Permanency Program
- Intensive In-home I and II
- Family Finding
- Professional Foster Parents
- Integrated Family Care
- Incorporation of evidence-based practices such as motivational interviewing, trauma systems theory, and cognitive behavioral therapy into service delivery

PCG’s *Survey to Assess Innovation Aided or Abetted by Privatization in the Eastern Service Area* included the 33 service initiatives from PromiseShip’s 2020 report, *A Decade in Review: 2009-2019*, in addition to other services introduced by Saint Francis to determine if they were still being delivered, by whom, and what respondents would recommend for future delivery. According to the results, all the programs are still being delivered with 94 percent of the innovative initiatives being delivered by the private sector, although not necessarily the privatized Lead Agency itself; they are all recommended to be continued through contracts with private agencies, although respondents acknowledged that all staff, public and private, should embrace some of the practices and services. Examples are Alternative Response, Structured Decision Making, and Motivational Interviewing. In addition, many of the providers testified in focus groups

that they are delivering the same services in other parts of the State, only under contracts directly with DHHS. Alternative Response is a case managed by DHHS, although some of the services families receive are provided by agencies under contract with DHHS.

FACTORS STIMULATING INNOVATION

Role of privatization in the initiation of practices and services

Privatization appears to have played a role in the initiation of practices and services across the Eastern Service Area. Many have testified that privatization fostered a culture of thinking creatively about how to meet families' needs. During the innovation focus groups, PCG heard that the Lead Agency structure allowed for private providers to propose creative new services to meet the needs of the families and communities they were servicing. They were able to adapt their services without going through an extensive procurement process that the State requires. The creative thinking that drove new programs can be demonstrated through the Integrated Family Care Program, which addressed the needs of homeless or virtually homeless families by putting the entire family into a mentor home for up to 90 days followed by providing rental assistance. Another example is Pathways to Permanency, a type of one-stop shopping service model developed by the Lead Agency and another contractor that is replicated elsewhere as an all-inclusive model where families can receive multiple services through one provider.

Privatized lead agencies are focused on localized, rather than statewide solutions. PCG found in focus groups that the privatized lead agencies worked closely with the local community. The local community connection created a space for collaboration between private providers and the Lead Agency, which was said to benefit families and youth in foster care. However, what gives cause for concern is that other sections of this report show the benefits of these innovations were not demonstrable. At best, the Eastern Service Area was brought up to match the performance level of the other service areas. If there are other metrics to demonstrate community connection, they have not been clearly articulated.

Structure of Contracts and Payment Mechanisms

The privatized lead agency model allows for flexibility to meet the needs of families through provider contracting. They are not restricted to the State procurement process, and providers attested that led to new service development. In addition, the private sector has more flexibility in staffing and wages. They can create different positions than those available under DHHS management to serve the needs of families and can create payment incentives to retain staff. Privatization can also lead to some flexibility in contract management, especially if the provider agency has independent resources to fund services.

After reviewing Saint Francis's contracts with the private providers, the contracting structure does not allow for flexibility of services. They are structured similarly to DHHS contracts for comparable services across the State, with a fee for service and payment rate. Although the Lead Agency does not need to follow the same RFP process as DHHS, their procurement process looks similar. Saint Francis puts out an RFP requesting services, private providers respond to the bid, then contracts are awarded. The contracts written by Saint Francis are prescriptive on the services provided, the staff required for each service, reporting requirements, performance outcome measures, and established payment rates (fee for service).

FACTORS HINDERING INNOVATION

Through research and focus groups, PCG learned that the following factors were perceived as hindering innovation during the decade of privatization in the Eastern Service Area.

Short-Term Contracting. During the decade of privatization, DHHS often authorized contracts and funding for one to two years at a time. That poses challenges for a provider agency to staff a workforce when it is unknown if the funding for their services will still be available in 12 months. Caseworkers and

supervisors question the long-term commitment to sustaining their efforts which may have ramifications for implementing new and innovative services.

Contract Terms. The contract with the current Lead Agency is highly regulated and has many performance requirements for service delivery and performance-based contracting. The complicated 855-page contract with numerous performance indicators results in the vendor focusing on meeting the basic requirements of the contract rather than worrying about trying new approaches to serving children and families.

Time to Implement a Large and Complex Contract. The contract with the Lead Agency is large and complex; this type of contract takes time to develop a working system and to track the results of that system. PCG heard in focus groups and the survey that it can take up to seven years, including two years for the transition and planning and the following five years to look at the results of the system. To allow for innovative services, the Lead Agency needs to be given enough time to build the system of care and track its results.

Federal Reimbursement for Services. Federal reimbursement requirements can constrain innovation. The Title IV-E Waiver demonstration projects were a way to mitigate that. This is generally not the foremost concern of providers unless there are contractual reasons for aligning what they deliver with federal reimbursement requirements. Of particular interest is Title IV-E and the Family First Prevention Services Act (FFPSA). Title IV-E does not reimburse for kinship care if the families are not licensed and many in Nebraska are not. For example, in the fiscal Year 2018, only 7.4 percent of the $7.7 million spent on relative foster care was for children in licensed relative placements.[61] The Family First Prevention Services Act (FFPSA), authorized through the Bipartisan Budget Act of 2018, significantly changed how Title IV-E funds could be spent by states. Title IV-E funds can now cover the cost of prevention services to support youth at imminent risk of placement to remain at home. Since only authorized evidence-based services are included in reimbursement, the law may inhibit true innovation. However, it supports our definition of innovation being new to Nebraska.

MOTIVATING INNOVATION IN THE FUTURE

Through conversations with stakeholders in the innovation focus groups, survey responses and research review PCG identified ways that innovation can be fostered in the future with or without privatization.

Foster a Solid Commitment from the State. A shared vision on child welfare must be developed between the private providers, the courts, and DHHS. With a shared vision, DHHS and private providers can work together collaboratively to serve families and children. Through a solid commitment from the State, there would be equitable and adequate funding for in-home and safety-based services. In addition, the State would provide funding for capacity building and program development with community-based partners.

Engage with the Community, Providers, and Stakeholders. DHHS and private providers need to communicate and collaborate with different groups to foster innovation and cater to local needs. This can be done through hosting an advisory committee composed of diverse stakeholders and through listening sessions with the community. In addition, developing an Innovation Review Board composed of community stakeholders, private providers, and DHHS partners will provide a forum to introduce and discuss innovative practices and services.

Provide Funding for Innovation. Whether by DHHS or the privatized provider, some mechanism is needed to encourage creative thinking about practices, services, support, and testing innovative ideas with merit.

[61] Ibid, 108.

Allow Time for Pilot Programs to Take Shape. It takes time to develop, implement and test a pilot program. When developing a new service or administering a contract, allow sufficient time to test and evaluate those services which may foster innovation.

Allow for More Flexibility in Hiring and Retention. Allow for flexibility in the public sector for personnel management like under the private system. This would allow DHHS to create new positions and to have flexibility with salaries and bonuses. The flexibility would give the State more leeway to recognize and support state workers to improve worker retention and to move or redefine positions based on family needs

Use of Data. To continue to foster innovation the State should continue to utilize data in program evaluation, utilization, and reporting in real-time. In addition, the State should share this data with private providers.

VII. COST

While the initial motivation for the privatization of child welfare in Nebraska was the State's poor performance in the first federal Child and Family Services Review, the belief that the private sector can perform more *efficiently* than the public sector also played a role. To determine whether that belief has been validated in this instance is, however, complex. PCG has examined the issue concerning the questions in PCG's assessment criteria.

These questions will be addressed by comparing what has happened in the Eastern Service Area with the rest of the State. Where possible, a ten-year perspective is used. Where not, data from the available years are presented.

To conduct this analysis, DHHS provided ten years of expenditure data as well as case counts and some program-specific expenditure data, such as for out-of-home care. The State's budget designates child welfare as Program 354. The budget categories and their funding source (State, Federal) within Program 354 are shown in Table 19.

Table 19: Budget Categories for Program 354

Category	Funding Source	Purpose/Classification
Protection and Safety	State	Contracts/Child Advocacy Centers
Child Welfare	State	Aid to Individuals
		Accounting adjustments
		Contracts
IV-E Child Welfare	Federal	Aid to individuals
		Accounting adjustments
Adoption and Safe Families	Federal	Contracts
Subsidized Adoption	State	Aid to Individuals
		Accounting adjustments
IV-E Adoption	Federal	Aid to individuals
		Accounting adjustments
Post-Adoption Guardianship	State	Contracts
IV-E Guardianship	Federal	Aid to individuals
		Accounting adjustments

TOTAL CHILD WELFARE EXPENDITURES

How Privatization Affected Total Child Welfare Expenditures

The total Child Welfare Budget rose from $176,847,751 in SFY 2011 to $196,606,319 in SFY 2021 as shown in Table 20. This is an 11.2 percent increase. However, the consumer price index over the same period rose by 21.8 percent. Therefore, a budget of equal value to 2011's in 2021 would be $215,400561 or $18.8 million more. In constant dollars, i.e., dollars adjusted for inflation, **total child welfare expenditures not only did not rise during the privatization period but declined**.

That result does not imply, however, that privatization was the factor leading to lower costs. Virtually the entire decrease in inflation-adjusted dollars occurred in a single category: *State* (as opposed to Service Area) contracts for child welfare (non-federally reimbursed) services. These are contracts administered by DHHS' central office and they *decreased* by nearly $68 million over the ten years. The funds the State-administered through that budget category in 2011, $73,467,130, were subsequently allocated to Service

Area contracts. As the central office contracts declined, the services became the responsibility of or at least were attributed to each Service Area over the decade and, predictably, expenditures in every Service Area increased. They did not, however, increase to the same extent as the reduction of the central office contracts and they increased the most in the Eastern Service Area.

Table 20 presents the changes in spending by service area between 2011 and 2021 for all the categories that can be allocated to service areas in the budget figures. These are: Title IV-E Child Welfare, Title IV-E Adoption, State Subsidized Adoption, and State Child Welfare. Guardianship was not an expenditure in 2011 and therefore is not included.

Table 20: Total Child Welfare (Program 354) Expenditures, 2011 and 2021

	2011 Expenditures	2021 Expenditures	$ Difference	Percent Difference
Eastern	$53,848,037	$97,571,107	$43,723,070	81%
Central	$10,927,796	$18,484,630	$7,556,834	69%
Northern	$11,563,196	$19,114,120	$7,550,924	65%
Southeast	$23,627,766	$36,909,003	$13,281,237	56%
Western	$13,125,460	$19,753,905	$6,628,445	51%
Areas Minus Eastern	$59,244,218	$94,261,658	$35,017,440	59%
State Contracts	$73,467,310	$6,006,508	-$67,460,803	-92%
Accounting Adjustments[62]	-$9,711,816	-$1,232,954	$8,478,862	-87%
Statewide	$176,847,751[63]	$196,606,319	$19,758,569	11%

The largest increase in expenditures was attributed in the budget to the Eastern Service Area, 81 percent over the decade. Its increase was 30 percent higher than that of the Southeast Service Area and 27 percent higher than the combined service areas outside the Eastern Service Area. Note that the overall percentage difference statewide in expenditures that can be attributed to service areas, 11 percent, is reflective of the 11.2 percent increase in the entire child welfare budget discussed in the first paragraph of this section above.

As Table 20 above includes State and Federal payments for subsidized adoption, which are positive costs from the child welfare perspective, the following table shows the changes in the budget category *State contracts for child welfare* only.

[62] These adjustments undoubtedly had varying reasons and sometimes exhibit large changes. It is not clear that either the adjustments themselves or the changes from year to year have a single overall significance, but they are included to show how the totals are calculated.
[63] Totals may be different than the sum of the items added due to rounding; all figures were provided in dollars and cents, not just in whole dollars.

Table 21: State Child Welfare Expenditures, 2011 and 2021

	2011 Expenditures	2021 Expenditures	$ Difference	Percent Difference
Eastern	$38,641,649	$66,980,762	$28,339,113	73%
Central	$7,531,356	$11,793,675	$4,262,318	57%
Northern	$8,701,765	$13,087,784	$4,386,019	50%
Southeast	$15,141,026	$20,504,456	$5,363,429	35%
Western	$10,060,420	$13,638,894	$3,578,474	36%
Areas Minus Eastern	$41,434,568	$59,024,809	$17,590,241	42%
State Contracts	$69,252,704	$1,446,990	-$67,805,714	-98%
Accounting Adjustments[64][1]	$38,641,649	-$5,246,127	$4,844,755	-48%
Statewide	$139,238,020	$122,206,433	$17,031,586	-12%

The largest increase in the ten years is still in the Eastern Service Area, 73 percent followed by Central at 57 percent. Its increase was 52 percent higher than the Southeast and 34 percent higher than the combined service areas outside the Eastern Service Area. Still, the statewide costs after accounting adjustments declined by 12 percent when the shifts from State contracts to service area contracts are calculated.

Given the timing of the largest reduction in State contracts, from $69.2 million to $2.1 million between 2011 and 2012 and with confirmation from the State, the change reflects the termination of the initial privatization experiment outside of the Eastern Service Area. That occurred because the providers found that they could not provide the services with the funds allocated by their contracts.

Privatization was not responsible for the reduction in inflation-adjusted child welfare spending. When the service areas were given back the responsibility to provide the services which had been privatized, they were able to do so at a lower cost than the privatized provider contracts deemed already to be too low. That combined with the largest increase in expenditures in the Eastern Service Area, 81 percent, suggests that privatization did not save the State money.

FEDERAL CLAIMING

How Privatization Enhanced or Detracted from the State's Ability to Obtain Federal Reimbursement

Before examining the effects of privatization, it is useful to understand Nebraska's history in federal claiming for child welfare overall.

According to a report issued in March 2021 by *Child Trends* based on SFY 2018 data[65], Nebraska is far behind other states in its use of federal reimbursement. As shown in Figure 15, the federal portion of Nebraska's child welfare funding was 19 percent that year compared to a national average of 44 percent, that is, less than half of the national average.

Concurrently, 81 percent of Nebraska's child welfare funding comes from State and local sources compared to 55 percent nationally. This disparity has not always been the case. A far earlier Urban Institute report covering SFY 1996 says that approximately 70 percent of the State's spending of $102,963,964 came from federal funds, "a proportion significantly higher than the national average." The explanation: Nebraska

[65] Child Trends, *Child Welfare Financing Survey SFY2018, State Profiles: Nebraska (*Bethesda, MD: n.p., March 09, 2020). Child Trends is a nonpartisan, 501(c)3 organization dedicated to producing objective, unbiased research.

relied far more heavily on Medicaid, Title IV-B and Emergency Assistance funds for child welfare than the nation.[66]

The data table in Figure 15 shows that the largest source of the discrepancy between Nebraska's and the rest of the country's use of federal funds in recent years is in Title IV-E. In addition, Nebraska did not report Social Services Block Grant funding for child welfare whereas nationally that consumes 5 percent of other states' sources. Also, Nebraska shows no Medicaid reimbursement for children in custody but, upon inquiry, the State says that any Medicaid reimbursement for children in foster care can be found in the Medicaid Budget (Program 348): all costs for Medicaid are either handled by the Managed Care Organizations (MCOs) and are paid by the monthly capitation rate or paid via a Fee-For-Service Model by the DHHS MMIS system. CFS does not have access to that data which is why it is not included in the tables above.[67]

Figure 15: US vs Nebraska Child Welfare Funding by Source

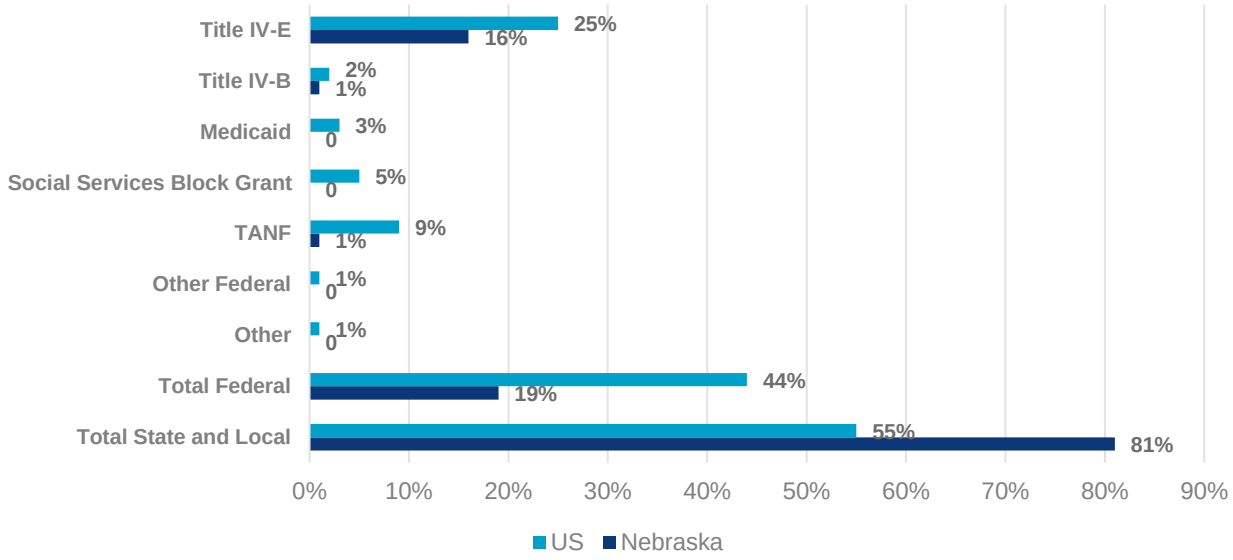
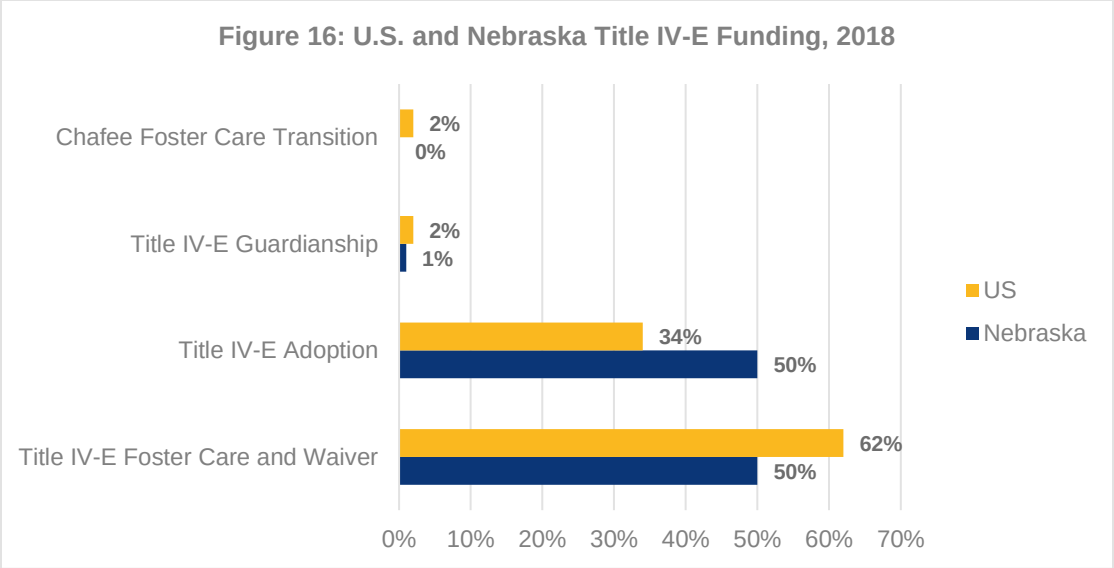


Figure 16 displays the use of various components of the Title IV-E program, comparing Nebraska to the U.S. Notably, Nebraska makes a larger use of Title IV-E Adoption Subsidies than the US average, 50 percent, versus 34 percent, a positive result. However, Nebraska's foster care and waiver funding is less, and shows no use of the Chafee Foster Care allocation to assist youth in State custody who are over the age of 16 to gain skills for independent living.

[66] The Urban Institute, *Assessing the New Federalism, State Child Welfare Spending at a Glance,* Shelley Waters Boots, Rob Geen, Karen C. Tumlin, Jacob Leos-Urbel (Washington D.C.: The Urban Institute ,1999).

[67] The problem of CFS' inability to report Medicaid costs is exacerbated under Family First where much of the service provision is done through a Healthy Families America contract with the Division of Public Health which does not use NFOCUS to track service provision or costs.



Between 2011 and 2021, Nebraska doubled the percentage of its federal child welfare reimbursement from 15 percent to 30 percent. The privatized Eastern Service Area, however, showed the smallest percentage increase (15 percent), just over half of the Northern and Central Service Areas' 29 percent and just over one-third of the 44 percent increase in the Southeast.[68]

There are several items of interest from this data. First, the Eastern Service Area began the period in 2011 with the second-highest percentage of federally reimbursable expenditures, 24 percent, compared to Southeast Service Area's 26 percent, and the non-Eastern Service Area figure of 22 percent.

Second, within the ten years, the Eastern Service Area's federally reimbursable expenditures for Title IV-E foster care dropped dramatically between 2012 and 2013 from $10.9 million to $2.6 million and did not begin to recover until 2020, when the State started to claim administrative (i.e., case management) costs for Saint Francis[69] yielding an administrative claim of $9,180,817. Data supplied by DHHS shows no other Title IV-E administrative claims for any service area from 2017 to 2021. However, DHHS reports that its Title IV-E administrative costs for the other service areas can be found in the DHHS Administrative Budget, Program 033.

Thirdly, in 2013, juvenile justice cases moved from child welfare to probation, which should have increased the percentage of child welfare costs that were federally reimbursable; far fewer juvenile justice than child welfare cases tend to be eligible for Title IV-E reimbursement due to both late eligibility determinations and the questionable applicability of federal child welfare requirements to the juvenile justice population. Removing this population from child welfare should have increased the percentage of costs that were

[68] This discussion assumes that the only federally reimbursable costs are related to Title IV-E: Title IV-E Foster Care, Title IV-E Adoption Subsidy and Title IV-E Guardianship. While other federal funds such as Title IV-B, TANF and the Social Services Block Grant may be used for the child welfare system, the caps on their allocations to the State mean that they cannot be maximized, i.e., the State cannot increase how much it gets. Only Title IV-E and Medicaid (Title XIX) provide that opportunity and the latter is limited in Nebraska to medical services as traditionally understood.

[69] While DHHS requested a cost allocation plan of PromiseShip to assist in making federal claims for administration, it appears not to have been used. The situation may have been complicated, however, by Nebraska's participation in the federal Title IV-E waiver which was implemented outside of privatization.

reimbursable. It is possible that the Title IV-E waiver reduced some of this impact, but it would not have reversed it.

While the Eastern Service Area had the largest increase in spending over the ten years, some of those costs represent services provided by the public agency and therefore cannot be attributed to privatization. That is because many of the in-home cases, particularly in the Eastern Service Area, have shifted to Alternative Response, which is managed by DHHS. There is no way to break out the cost of that program from other child welfare costs in the Eastern Service Area.

COST OF SERVING EACH FAMILY AND CHILD

How privatization affected the cost per child or family served in the Eastern Service Area and elsewhere

The cost of serving each family and child reveals the efficiency of services. If the privatized provider can serve the same number of children and families at a lower cost, it can be said to provide services more efficiently. In child welfare, this requires two analyses because in-home cases are counted by the number of **families** served whereas out-of-home cases are counted by the number of **children.**

There are two issues in calculating the cost per case in in-home cases. The first is determining the cost of the in-home services themselves and the second is determining the number of cases. Of the budget categories for Program 354 shown in Table 21 above, Child Welfare (State) is the major source to pay for in-home services. However, it is a large category and the only element we can safely deduct is the State costs of out-of-home care, which DHHS has provided for SFY 2017 to 2021.

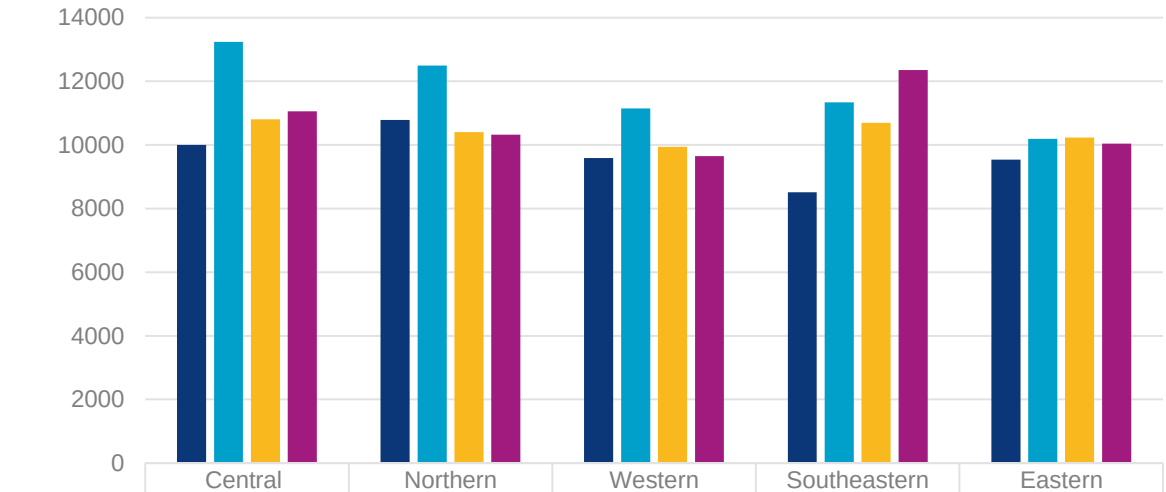
The second issue lies within counting the number of cases. In-home services now encompass both traditional cases and Alternative Response cases. Our team has the counts for both, although, the privatized provider is not responsible for Alternative Response cases. While we have calculated the cost per in-home case, the result is so large, and the variations in Service Area so great, that the result may not sound credible. The annual cost ranged from a low of about $17,000 in the Southeast to a high of about $57,000 in the Eastern Service Area when Alternative Response cases are included in the case count. Table 22 shows the cost per in-home and alternative response case by Service Area for three years. The average for the State is $43,376.

Table 22: Average Annual Cost for In-home and Alternative Response Cases

	2017	2018	2020	Average
Eastern	$48,115	$67,863	$57,323	$57,767
Central	$56,267	$44,916	$28,649	$43,277
Northern	$58,141	$66,961	$31,152	$52,085
Southeast	$18,456	$17,884	$15,008	$17,116
Western	$55,022	$43,815	$41,063	$46,634
State Average				$43,376
State Average Excluding the ESA				$39,778

Looking now at the cost per case for out-of-home care, Figure 17 shows the information for four years, SFY 2017 to SFY 2020. In one year, SFY 2018, the Eastern Service Area has a lower cost per case than any of the Service areas. The cost per case per year tends to be steadier in the Eastern Service Area, showing less variation.

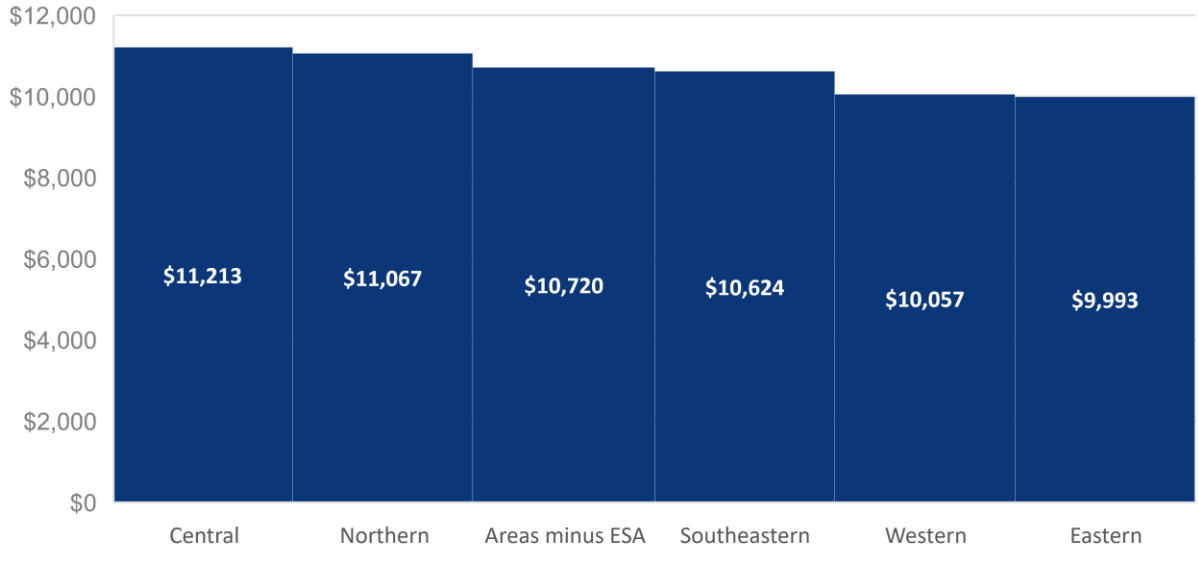
Figure 17: Cost per Out of Home Care Case, SFY 2017-SFY 2020



	Central	Northern	Western	Southeastern	Eastern
SFY 2017	9997	10788	9591	8515	9539
SFY 2018	13237	12495	11147	11339	10195
SFY 2019	10801	10403	9936	10694	10236
SFY 2020	11061	10321	9652	12349	10041

Figure 18 presents the average annual out-of-home care cost by Service Area, averaging SFY 2017 to SFY 2020 cases and costs.

Figure 18: Average Cost Per Out-of-Home Case, SFY 2017-2020



At $9,993, the Eastern Services Area has the lowest average cost per out-of-home case, 7 percent lower than the statewide average of $10,720 when the Eastern Service Area is subtracted. However, it had the highest average cost of in-home cases which includes Alternative Response, managed by DCFS. PCG compared its results with that of the Stephen Group (TSG). In broad terms, TSG found an average monthly cost per case combining in-home families and out-of-home children to be $3,100. That equates to $37,200 per year compared to PCG's average cost of an in-home case ($43,376) and the average cost of an out-of-home case, ($10,736) and a combined weighted cost of $25,228. The discrepancy may be a function of disparate methodologies. TSG combined both in-home and out-of-home cases even though the former serves the whole family and the latter only the individual child. By calculating those separately PCG could weigh the number of in-home vs. out-of-home cases. In addition, kinship and relative care are cheaper and their use has increased over the years, yielding a lower cost.

COST BENEFIT

How Privatization Affected a Cost Benefit

The ideal method for calculating cost benefit is to calculate a cost of success. This can be done by dividing the total expenditures of a program by the number of *successful* cases. The cost of success needs to be viewed in tandem with the cost per case. In this evaluation, our team used the out-of-home care costs because they are more reliable and pairs them with permanency outcomes.

The cost per case is a straightforward measure of efficiency. Cost of success, on the other hand, combines efficiency and effectiveness by asking how much must be spent to achieve the desired result for a single case. An agency can have a low cost per case, but if its success rate is also low, it will have a high cost per success. Assume, for instance, that a provider serves 100 cases, spends $10,000 per case, and achieves a positive outcome for half of those cases. To achieve 50 successful cases the agency must serve 100 cases at a per case cost of $10,000 but a per success cost of $20,000. If another provider also serves 100 cases but spends $12,500 per case and achieves a positive outcome for 70 percent of its cases, its cost per success is $17,857. Although it spends more on each case served, its higher success rate means that it could achieve 50 successful cases at a lower cost than the first agency.

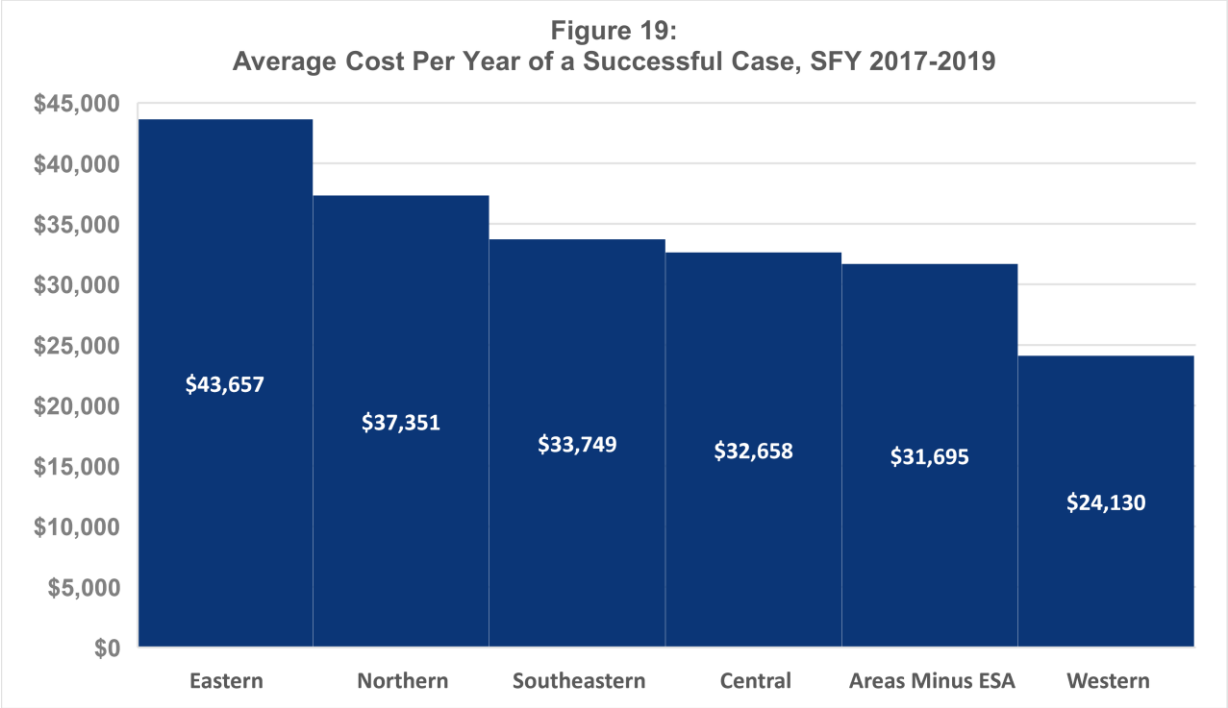
Finding permanent homes for children either through timely reunification or adoption is a hallmark for success in child welfare. Success for children in foster care, for instance, may be defined as reunification within 12 months or adoption within 24 months. That would take dividing the total foster care costs by the sum of the number of children reunified with their families within 12 months plus the number of children adopted within 24 months of entering care. DHHS provided data for these two simple outcomes by tracking children who entered care for 12 and 24 months respectively. Using the out-of-home cost data, this analysis, therefore, focuses on two critical measures, the timeliness of reunification and of adoption and the cost of achieving those results when only *successful* cases are counted.

The results by service area are shown in Table 23, with the data on both the numbers of children served and the numbers either returning home within a year or being adopted within two years.

Table 23: Cases with Timely Permanency Outcomes

Region	Case Outcome	SFY 2017	SFY 2018	SFY 2019	Average
Central	Total Cases	382	318	315	
	Successful Cases	140	99	111	
	Percent Successful	**37%**	**31%**	**35%**	**34%**
Northern	Total Cases	439	419	352	
	Successful Cases	138	111	116	
	Percent Successful	**31%**	**26%**	**33%**	**30%**
Western	Total Cases	399	348	344	
	Successful Cases	188	137	136	
	Percent Successful	**47%**	**39%**	**40%**	**42%**
Southeastern	Total Cases	655	578	535	
	Successful Cases	248	153	128	
	Percent Successful	**38%**	**26%**	**24%**	**29%**
Eastern	Total Cases	1620	1532	1464	
	Successful Cases	404	354	297	
	Percent Successful	**25%**	**23%**	**20%**	**23%**

Figure 19 presents the cost per successful case by service area by averaging three years of costs and three years of successes, 2017 to 2019. The analysis could not go past 2019 because 24 months had to pass before the adoption success could be counted.



The Eastern Service Area has the highest cost of success, $43,657. The region's cost per success is $9,908 more than the Southeast, and $11,962 or 27 percent more than the average of all the other service areas.

Even with a generally lower out-of-home care cost, the lower proportion of children achieving permanency drives up what it costs to achieve success.

Summary

This section of the report has looked at four issues related to cost: whether privatization has reduced costs compared to publicly provided services, whether it has increased the availability of federal reimbursement for those costs, whether it is more efficient on a per-child served basis, and whether it has produced a cost benefit by generating better outcomes.

While State child welfare spending has not kept up with inflation over the past decade, the portion allocated to the Eastern Service Area is the highest of all the regions. Federal reimbursement has doubled over the decade, but the proportion captured in the Eastern Service Area has had the smallest increase. The cost per out-of-home care case is lower in the Eastern Service Area than the rest of the State but higher for in-home cases. The results on this item are murky, however, because DHHS handles the in-home Alternative Response cases whose costs cannot be easily separated.

The cost per success is far higher in the Eastern Service Area than elsewhere, which is a negative finding. Even when the cost per out-of-home care case is less, the overall cost is greater because it takes longer to achieve permanency. Thus, the cost analysis does not result in favoring privatization as being more cost effective. However, the widespread concern that child welfare is under-funded given that the overall costs have not kept up with inflation should be considered concerning future funding. In addition, Nebraska spends a far higher share of state versus federal dollars to fund child welfare compared to the rest of the country. Efforts should be continued or enhanced to claim case management costs under Title IV-E.

VIII. RECOMMENDATIONS

The analyses presented coupled with PCG's experience with privatization in other states led to the following recommendations.

Case Management

1. **Return Case Management in the Eastern Service Area to DCFS and end the pilot.** Nearly all the data in this 10-year retrospective study show that *at best* privatization has brought the Eastern Service Area up to State averages on some measures but has yielded no net benefit. Amid the under-performance is the angst and drama produced by privatization. DHHS has spent untold resources on efforts to respond to RFP challenges, manage the contract, monitor corrective action plans, and engage in legal battles. The uncertainties of the contracting process itself have resulted in very high case manager turnover rates and ballooning case ratios, to the detriment of children and families. Through Alternative Response, DCFS is already managing over 50 percent of all the in-home cases in the Eastern Service Area and has been accepting new out-of-home cases until compliance issues with Saint Francis are resolved. Many of the community agencies contracting with Saint Francis are providing the same services under the same rules at the same costs in other parts of the State through contracts with DHHS. If there were to be a new RFP process to replace Saint Francis, what vendors could realistically manage a contract of this magnitude?

   While the transition of case management back to the State will not be easy, now is a better time than most. The return should be done in a phased-in manner that causes as little disruption to children and families as well as staff as possible and maintains what is working well now. To create a smooth transition, PCG recommends the following steps:

   a. Develop a small Leadership Group to plan and manage the process. Include representatives of DHHS, Saint Francis, other private providers, and a party with a statewide perspective such as the Foster Care Review Office Director or State Ombudsman.

   b. Determine how many FTEs need to be reinstated to DHHS including job type and pay grade and obtain authorization. Determine what pay incentives such as signing bonuses need to be instated to attract and maintain a viable workforce, even if such practices are contrary to normal State hiring and retention policies.

   c. Phase in the change of case management responsibilities by: 1) assigning all new cases to DCFS for case management purposes; 2) when a case manager at Saint Francis resigns assigning his or her caseload to someone at DCFS; 3) in three months from the start of the process assigning half of the balance to DCFS; 4) in six months assigning the remainder of the balance.

   d. Provide employment offers to Saint Francis supervisory, casework, and administrative staff who would be considered assets to DHHS. The Leadership Group should review all staff working under the contract at Saint Francis and extend job offers to worthy candidates for any job opening.

   e. Have the Leadership Group assess what staff units have been developed at Saint Francis to maintain through a contract with Saint Francis or to transfer to DHHS. These include for example: clinical after hours; transportation; provider relations and utilization; foster and kinship care; and family permanency.

   f. Have the Leadership Group assess which contracts now managed by Saint Francis should be moved to the State (see also Recommendation 5 and Appendix C) and modify or initiate contracts with those providers. Many of the agencies are already providing the same services

in other service areas; their current state contracts would need amending to encompass the Eastern Service Area. Contracts for services unique to the Eastern Service Area would need to be initiated if they are to be maintained to complete the current RFP cycle. DHHS could then determine whether to rebid that service in the future.

g. Provide resources to DHS to support the significant amount of work necessary to transition cases back to the State. Developing and implementing a successful implementation plan will require time, effort, and investment. Existing DHHS personnel will not have the bandwidth to manage this transition in addition to their current workload.

Administrative Infrastructure and Financial Capacity

2. **Strengthen DHHS administrative capacity to handle the increase in case management, contracting, contract monitoring, and quality assurance.** DCFS has made efforts to build its capacity to manage the Saint Francis contract with more staff performing functions such as contract monitoring. These functions should be reviewed considering its new responsibilities by a mix of internal and external partners to determine how the DHHS infrastructure should be enhanced. For example, contract monitoring should entail the proper amount of oversight that can be sustained on a statewide basis and be applied to all contracts without micro-managing. Continuous Quality Improvement efforts should continue for both contractors and the public agency, focusing on the most important factors. Human resources may need temporary enhancement to manage new hiring.

3. **Review federal claiming processes, particularly Title IV-E including Nebraska's capacity to implement The Family First Prevention Services Act of 2018, which allows for reimbursement of qualified services to prevent placement.** A disproportionate amount of Nebraska's child welfare budget is drawn from state, as opposed to federal funding. It needs a thorough review to determine what steps are needed to increase reimbursement of the federal share.

   a. Review Title IV-E to assure a portion of its *case management* costs is included in the claims. This is in addition to the administrative component of out-of-home care.

   b. Assure that claims are made for all qualified *service* costs which are now reimbursable under The Family First Prevention Services Act of 2018.

   c. Review policies and procedures for licensing kinship homes to determine what changes are needed to get more homes eligible for federal reimbursement. Nebraska has already instituted a kinship waiver. Other viable options are reflected in the attached link: https://www.casey.org/adapting-home-studies-for-kin/

   d. To understand the true cost of serving a child and family, determine how to capture information on federal Medicaid claiming for children in foster care administered by the Division of Public Health, and case management or other claiming that is reflected in the DHHS Administrative Budget, Program 033 but not in Child Welfare.

4. **Ensure adequate funding for child welfare services.** Increase the State budget for child welfare consistent with the consumer price index over the past ten years and the case counts for in-home and out-of-home care. Between 2011 and 2021, Nebraska's child welfare budget rose from $176.8 million to $196.6 million, an 11.2 percent increase. However, the consumer price index over the same period rose by 21.8 percent. A budget of equal value today would be $18.8 million more. Declining out-of-home care caseloads could produce a reduction to that figure but over the past decade, child welfare funding has lost ground by millions of dollars in Nebraska whose reinstatement could be used to fund the recommendations in this study.

Service Maintenance and Innovation

5. **Examine programs and services initiated through privatized contractors over the past decade to determine which should be re-established or maintained.** The Leadership Group should review the service list in Appendix C which represents initiatives developed by PromiseShip and Saint Francis to determine: 1) which are being delivered now; 2) which should be strengthened; 3) which should be curtailed; 4) which should be added through contract, and 5) which should be delivered by DHHS as part of its new responsibilities. In PCG's survey, respondents thought they all should be retained, generally by contracts to private providers. This recommendation would preserve prior innovations.

6. **Encourage continuing innovation by funding field-initiated projects and through contracting structure.**

    a. ***Field initiated:*** Twice a year, DHHS should call for proposals that will result in funding two projects for about $150,000 per year each for each of two years which are designed and proposed by people and/or organizations in the community. In addition to private providers, these could be kinship parents, youth in foster care, or others directly impacted by child welfare. These projects should be innovative in the sense that they are new to the field in general and/or new to Nebraska but do not have to be proven effective. The proposer should suggest how their work will be evaluated on a micro-level such as changes in children and families' ability to cope with stress or gain job training or employment. Validated self-assessments such as the Brief Parental Self-Efficacy Scale or the Child Adjustment and Parent Efficacy Scale (CAPES) could be used in measuring change.

    b. ***Contract structure****:* While many DCFS contracts are structured through fee for service, others should provide more latitude for staff to innovate how they serve families. This may be achieved by alternative payment methodologies that afford flexibility to the provider and financially incentivize achieving program goals. Once the Leadership Team examines programs and services consistent with Recommendation 5, it can suggest the appropriate contract payment structure to DHHS for those that will be initiated or maintained.

Independent Living

7. **Enhance Independent Living efforts for youth in foster care who are age 14 and over.** The Foster Care Review Office reports in 2021 that only one in five qualified youth (14- to 18-year-olds) statewide had an Independent Living Assessment completed. PCG's analysis of National Youth in Transition Database (NYTD) independent living data, though representing a 10-year timeframe, found that one in five reported homelessness in the past two years and one in three reported having been incarcerated in the past two years. DCFS has amended its Title IV-E plan to extend foster care which permits youth to get benefits longer under federal Chafee Funding for independent living and educational support (ETV). Nebraska's allocations under the Pandemic Act now equate to $2.79 million for Chafee services and over $400 thousand for tuition assistance. At a minimum, DCFS should step up its monitoring and enforcement of independent living assessments and service provision in accordance with these results.

APPENDIX

APPENDIX A: INNOVATION FOCUS GROUP QUESTIONS

Nebraska Legislature

Child Welfare Privatization Study Interviews
September 2021

INTERVIEW QUESTIONS

The Nebraska State Legislature is working with Public Consulting Group (PCG) to conduct a study of child welfare privatization over the last decade to assess quality, innovation, and cost of services. A critical part of this process is gathering information from agencies and providers about innovation in child welfare services during this time. Through interviews, PCG can gain a better understanding of how privatization may have contributed to innovative child welfare practices in Nebraska.

1. In your opinion, what has gone well with privatization and what hasn't gone well?

2. Have there been process-based or philosophical shifts in approaches to families and services?
    a. Have there been changes in assessment processes or case planning?
    b. Is there a document(s) that summarizes this approach?
    c. Have there been changes in the types of services offered that were particularly valuable?

3. What model(s) would you recommend going forward overall? (e.g., changes to the current model, more privatization, all via the State, etc.) How would innovation and flexibility continue under the model?

4. If the Eastern Service Area were to be put under public management, what suggestions do you have for initiating and preserving innovations in the future?

5. Are there or were there incentives in contracts that particularly encouraged innovation?

6. Are there any responses from the survey that you'd like to discuss or expand upon here?

APPENDIX B: NYTD SURVEY DATA QUESTIONS

PCG received Nebraska's NYTD survey data from 2011 to 2012 broken down into the following service regions: Central, Eastern, Northern, Southeast, and Western. The table below outlines the questions that are asked in the NYTD Survey.

#	Question
1	Currently are you employed full-time?
2	Currently are you employed part-time?
3	In the past year, did you complete an apprenticeship, internship, or other on-the-job training, either paid or unpaid?
4	Currently are you receiving social security payments (Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or dependents' payments)?
5	Currently are you using a scholarship, grant, stipend, student loan, voucher, or other type of educational financial aid to cover any educational expenses?
6	Currently are you receiving any periodic and/or significant financial resources or support from another source not previously indicated and excluding paid employment?
7	What is the highest educational degree or certification that you have received?
8	Currently are you enrolled in and attending high school, GED classes, post-high school vocational training, or college?
9	Currently is there at least one adult in your life, other than your caseworker, to whom you can go for advice or emotional support?
10	In the past two years, have you been homeless at any time?
11	In the past two years, did you refer yourself or has someone else referred you for an alcohol or drug abuse assessment or counseling?
12	In the past two years, were you confined in a jail, prison, correctional facility, or juvenile or community detention facility, in connection with allegedly committing a crime?
13	In the past two years, did you give birth or father any children that were born?
14	If you responded yes to the previous question, were you married to the child's other parent at the time each child was born?
15	Currently are you on Medical Assistance (MA)/Medicaid?
16	Currently do you have health insurance, other than Medical Assistance (MA)/Medicaid?
17	Does your health insurance include coverage for medical services?
18	Does your health insurance include coverage for mental health services?
19	Does your health insurance include coverage for prescription drugs?
20	Currently are you receiving ongoing welfare payments from the government to support your basic needs?
21	Currently are you receiving public food assistance?
22	Currently are you receiving any sort of housing assistance from the government, such as living in public housing or receiving a housing voucher?

APPENDIX C: NEBRASKA PROGRAM AND SERVICE INITIATIVES OVER PAST DECADE

PROGRAM INITIATIVES

1. **Intensive In-Home I and II.** Promotes family stabilization/preservation through intensive interventions to help children/families develop skills to achieve safety and stability. Level I (90 days) is used for in-home families and Level II (120-160 days) for either in-home or reunifying.

2. **Pathways to Permanency.** Encourages timely reunification by providing holistic care to the family system. Uses formal and informal assessment, as well as family and stakeholder input to develop the family service plan. Services include parenting time, skill-based support and education, and clinical consultation and minimized the number of providers engaging with families.

3. **Placement Stability Calls.** Requires a placement stability call prior to accepting notice of placement change absent an immediate safety concern in the current foster home.

4. **Professional Foster Care.** Pays foster parents a higher rate so one of the parents is available to meet the youth's needs.

5. **5 Day Bed.** Provides emergency agency-supported family foster care beds for up to five days allowing the youth to be placed in a family-based, consistent, short-term placement while coordinating for an appropriate longer-term placement.

6. **Better Together.** Family-centered intensive outpatient substance abuse treatment program for parents and their children that allows families to stay together.

7. **Permanency Contracts: Family Finding and Family Network Development.** Child placing agencies (CPA) establish lifelong connections using the Family Finding model and provide options for long-term permanency, including adoption. Serves children who have been in foster care for over three years and have been identified as hard to place or having complex needs. Contracts are outcome-based, thus holding providers to an identified standard.

8. **Fund Hope.** Instills hope in older foster youth and helps them build positive self-worth by fulfilling holiday and birthday wishes. Educates the community about the needs of older youth in foster care including the need for permanency after age 19.

9. **Duffels 4 Dignity.** Provides youth in care a duffel bag for their belongings through both monetary and tangible donations. (Transferred to Boys Town and Child Saving Institute)

10. **X-Treme Recruiters (XTRs).*** Locates and engages family connections when a child is not placed with relatives or kin at the time of referral.

11. **The Resource Family Program.*** Provides resources to enable foster parents to establish a mentorship role, help facilitate visitation between the biological parents and child, provide transportation for the child to appointments, school, and school activities, and thus maintain a level of normalcy for the child by preventing disruption of service delivery. Facilitates a co-parenting model where the resource parent and the biological parent share in as much of the parenting of the child as possible while ensuring the safety and well-being of the child,

12. **Placement Matching System.*** Uses algorithms to measure a child's needs against a provider's ability to meet them to select the best possible placement for the child.

CASE MANAGEMENT INITIATIVES

13. **Complex Case Team.** Serves families with exceptional needs using Family Permanency Specialists (FPS) with lower caseloads (N = 10), higher education, and specialized training in the areas of developmental disabilities and persistent mental illness.

14. **Non-Court Teams.** Focuses on the unique needs of families receiving services voluntarily. Specifically created for Family Permanency Specialists, Caseloads were intentionally kept low (N=12 families) so that FPSs could devote more time per family.

15. **Judge-Specific Teams.** Meets consistently with the same judge to provide Family Permanency Specialists an opportunity to understand the individual style of each courtroom. Teams meet at least quarterly with their assigned judge to share information to improve the process and overcome system barriers.

16. **Triage Team.** Purpose: Allows case management staff more time to be with their own families, minimize time on calls, and prioritize self-care and work/life balance create an after-hours triage team. Highly skilled in crisis management and de-escalation of high-needs situations.

17. **RED Teams.** Review, Evaluate, and Direct (RED) Team staffing using the Safe & Connected model to identify a child's areas of safety and belonging, strengths and protective capacities, complicating factors, and any gray areas to identify appropriate next steps.

18. **Douglas County Crossover Youth Practice Model (CYPM).** Purpose: Statewide effort to identify dual system-involved children—child welfare and juvenile justice--and improve the coordinated case planning process.

EVIDENCE-BASED SERVICES

19. **Nurturing Parenting.** A family-centered trauma-informed initiative designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices.

20. **Shared Family Care.** Places parent(s) and children together in the home of a host family who is trained to mentor and support the parents as they develop the skills and supports necessary to care for their children independently.

21. **Teaching Family Model.** Philosophy and practice of treatment that prioritizes therapeutic relationships with caregivers in supportive family-style settings; strength-based, comprehensive, and trauma-informed model of care that builds positive change while remaining focused on the holistic development of the person served.

22. **Common Sense Parenting.** Group-based class for parents comprised of 6 weekly, 2-hour sessions led by a credentialed trainer who focuses on teaching practical skills to increase children's positive behavior, decrease negative behavior, and model appropriate alternative behavior.

23. **Bridges Out of Poverty.** A program aimed at eliminating economic, cultural, and societal hurdles that will jump-start families in poverty.

24. **Trauma Systems Theory.** Model of care for traumatized children that addresses both the individual child's emotional needs as well as the social environment in which he or she lives.

25. **Safe and Connected.** Provides a structured way to make decisions with and for the children and families served by the child welfare, juvenile justice, and related systems. The model emphasizes organizing information to promote critical thinking and collaboration with the family and other stakeholders.

26. **Motivational Interviewing.*** Method to support families who may be ambivalent or hesitant about support from the child welfare system; helps to engage individuals and assist them in exploring and resolving their ambivalence about change.

27. **Cognitive Behavioral Therapy.** Helps children, adolescents, and their parents (or other caregivers) overcome trauma-related difficulties, including child maltreatment. Helps children address distorted or upsetting beliefs and learn skills to help them cope with ordinary life stressors.

28. **Family-Centered Treatment (FCT).*** Prevents the need for out of home placement through an evidence-based trauma treatment model of home-based family therapy.

COMMUNITY, FAMILY, AND STAFF ENGAGEMENT

29. **Engage Families Informally.** Hosts Quarterly Family Open Houses for families to participate in fun events (e.g., Trunk or Treat, Family Picnic).

30. **Engage Community Members and Stakeholders.** Community Advisory Board, Kinship Advisory Board, Parent Advisory Board, Foster Parent Advisory Board, listening sessions and table talks, Quarterly Community Partner Meetings Quarterly Provider Meetings.

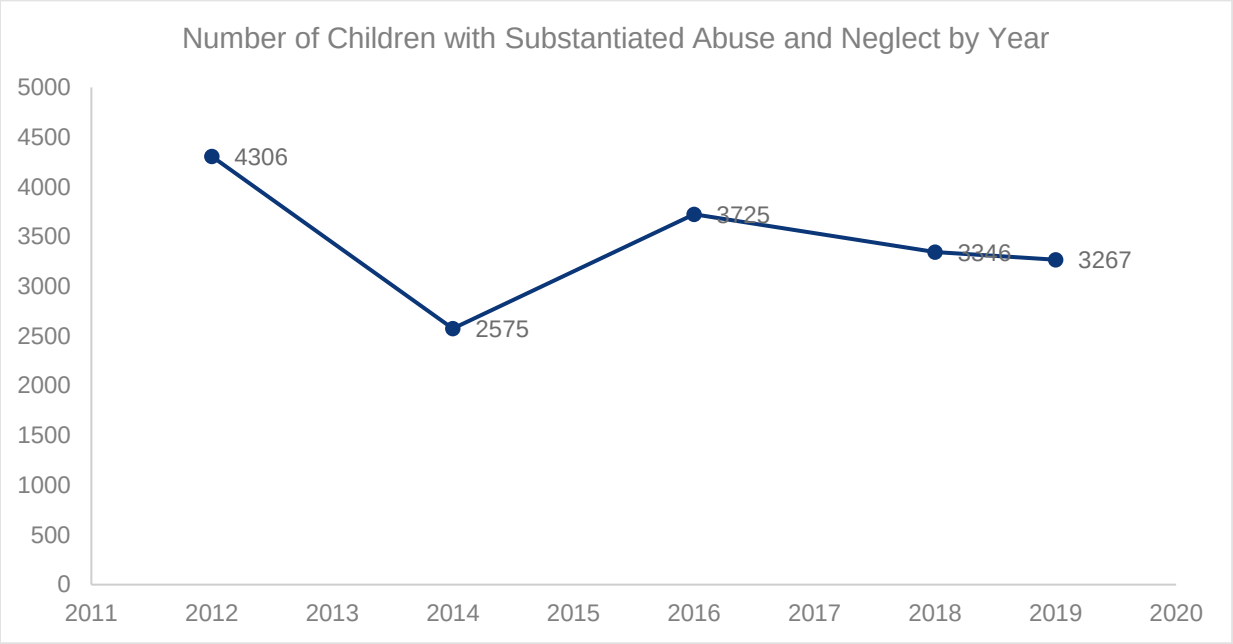
31. **Annual Foster Parent Appreciation Event.** Supports foster caregivers and youth through recognition and celebration.

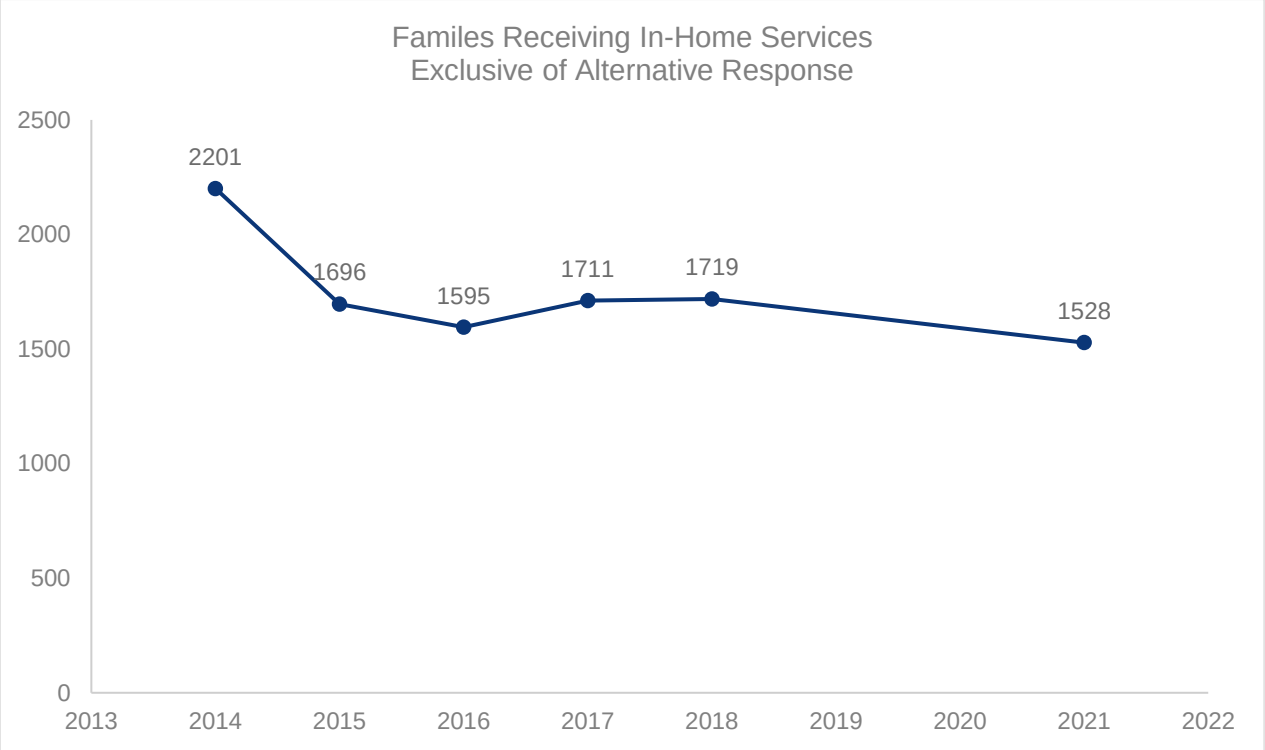
32. **Annual Kinship Family Holiday Party.** Annual party for kinship families and children

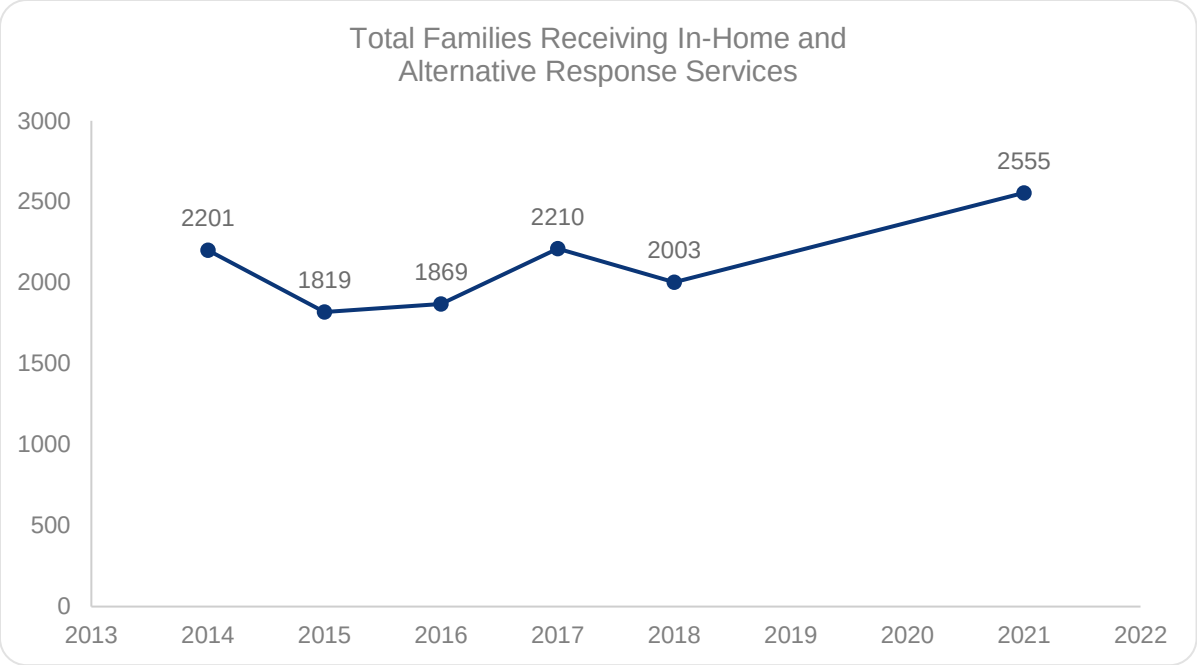
33. **MSW Program.** Enrolls five employees from DHHS and Project Harmony in a pilot MSW cohort program with the University of Nebraska-Omaha School of Social Work, to obtain an advanced degree in the child welfare field.

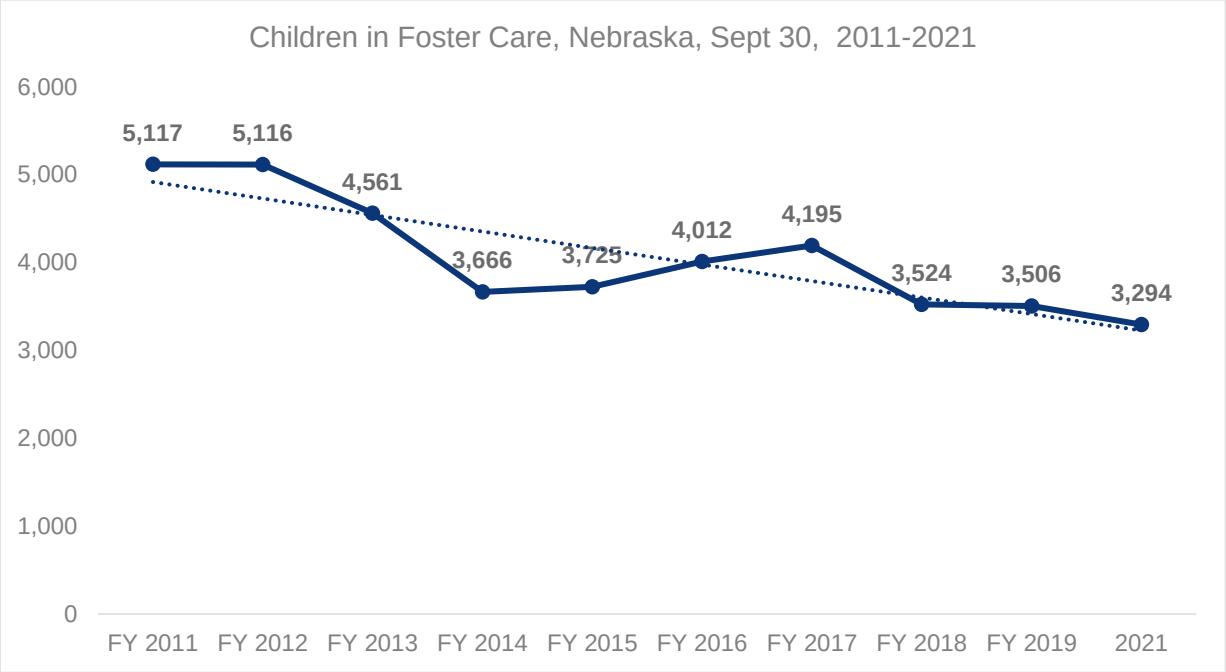
**These identified programs and service initiatives were introduced by Saint Francis Ministries. All other programs were introduced by PromiseShip.*

APPENDIX D: ADDITIONAL CHARTS AND GRAPHS






Total Families Receiving In-Home and Alternative Response Services
3000
2500
2000
1500
1000
500
0
2201
1819
1869
2210
2003
2555
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022


Children in Foster Care, Nebraska, Sept 30, 2011-2021
6,000
5,000
4,000
3,000
2,000
1,000
0
5,117
5,116
4,561
3,666
3,725
4,012
4,195
3,524
3,506
3,294
FY 2011
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FY 2015
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FY 2017
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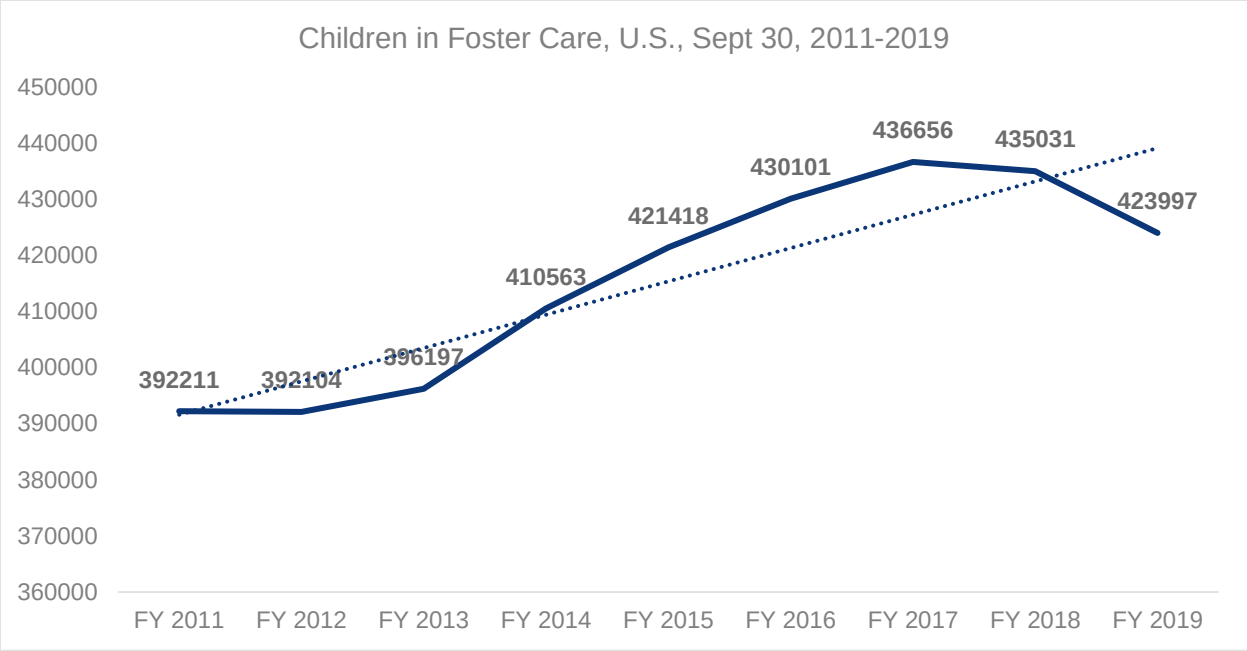
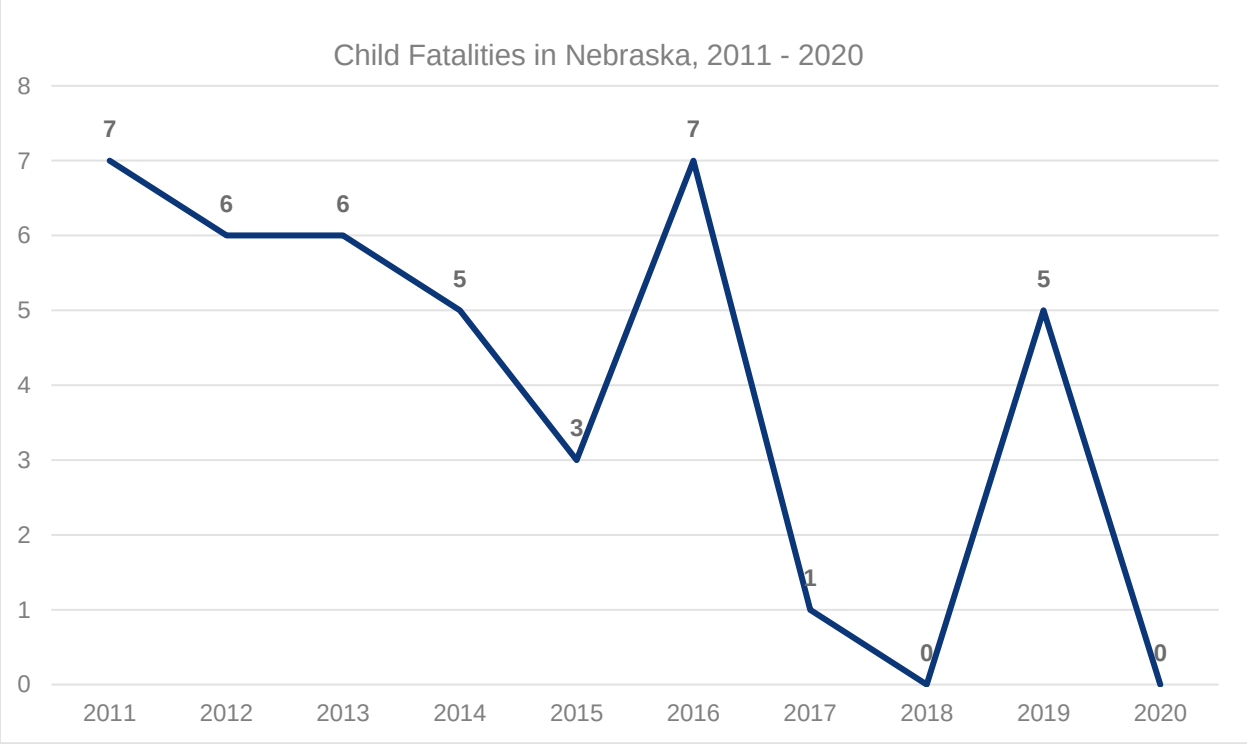
2021





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[70] Based on the data submitted by Nebraska to US DHHS using the federal National Child Abuse and Neglect Data System (NCANDS).

APPENDIX E: DETAILED TIMELINE OF CHILD WELFARE DEVELOPMENTS IN NEBRASKA

Date	Details	Category
2002 to 2007	Various efforts at reform both internal and external to the state agency responsible for child welfare were undertaken, largely in response to the state's scores on the first federal Child and Family Services Review (CFSR).	State efforts and reforms
2004	The first phase of reforms included adding funds for 120 additional social workers.	State efforts and reforms
2005	The Supreme Court Commission on Children in the Courts was developed to ensure maximum state court responsiveness to children in the court system.	State efforts and reforms
2006	The Through the Eyes of the Child Initiative[71] was developed, to create a forum for local child welfare and juvenile justice stakeholders to collaborate to improve issues in their communities' juvenile court systems as well as to identify systemic barriers and work on solutions.	State efforts and reforms
2007	Three agencies were restructured into the Department of Health and Human Services (DHHS) including the creation of the Division of Children and Family Services.	State efforts and reforms
2007	DHHS initiated a new social services safety model designed to improve safety decisions, provide clarity of purpose for family assessments, and improve the ability to support decisions in a professional manner.	State efforts and reforms
2007 to 2009	DHHS began growing the array of services available to families and giving the providers of these services a more expansive role.	State efforts and reforms
2007	Governor Heineman appointed Todd Landry, then CEO of the Child Saving Institute in Omaha, to head the newly created division. Mr. Landry was charged with reducing the number of	State personnel and division appointments

[71] Nebraska Judicial Branch, Through the Eyes of The Child Initiative (Lincoln, Nebraska, n.p., 2019)

Date	Details	Category
	children in foster care and (over 5,000 in 2007), reducing the number of times they moved from home to home.	
2007	Todd Landry appointed a Partners Council to monitor outcomes and program improvements while the Legislature established the Children's Behavioral Health Task Force.	State personnel and division appointments
2008	DHHS announced a request for bids from private agencies to provide a continuum of safety and in-home services for at-risk children.	DHHS RFP
2009 to 2010	The State contracted large portions of services to "lead agencies" who would be responsible for expanding the service array through sub-contracts and paying for the services with a predetermined lump sum rate regardless of the number needing service or their presenting problems.	DHHS contracting
2009	Todd Laundry left DHHS. Six agencies' contracts were signed, with the agencies now responsible to coordinate child welfare and juvenile services. The agencies agreed to develop infrastructure, staffing, and programs necessary to provide service coordination under one set of funding, $7 million, to begin operations late in 2009 and be fully implemented by April 2010 as both service coordinators and service providers.	DHHS contracting
2010	The *Alliance for Children and Families* serving the Central Service Area, opted out of its contract before it began.	DHHS contracting
2010	The lead agencies met their 2010 service initiation deadline, but *Cedars Youth Services w*ithdrew within days due to inadequate reimbursement; a week later *Visinet* filed for bankruptcy and DHHS took over cases in the Eastern and Southeast Service areas.	DHHS contracting
2011	Only two lead agencies remained, one stopped functioning as such just over a year later. By all accounts, this was a period of great turmoil and confusion about roles and responsibilities. In addition, instead of creating more service options for families, it caused existing services in rural parts of the State to disappear.	DHHS contracting
2011	Both case management and service delivery functions were contracted to the remaining lead agencies in the largest	DHHS contracting

Date	Details	Category
	Service areas using both a fixed monthly rate and a daily rate based on the number of children and families served.	
2011	*Nebraska Families Collaborative* (NFC) and *KVC* were given case management responsibility in the areas where they had previously provided service coordination. The two agencies shared responsibility for the Eastern Service Area, while KVC also managed cases in the Southeast. DHHS eliminated 77 FTEs as a result of the transfer of case management.	DHHS contracting
3/2012	*KVC* ended its case management contract, ceding its Eastern Service Area cases to *NFC* and its Southeast Service Area cases to DHHS.	DHHS contracting
2012	The Legislature (LB961) established a pilot project to privatize child welfare, including case management, in the Eastern Service Area (Douglas and Sarpy counties) representing about 42 percent of the child welfare caseload. As the provider, the *NFC* contract was amended many times to accommodate the changes in responsibility and payment.	Legislative oversight/ DHHS contracting
2014-2015	The Legislature (LB660) authorized the pilot project to continue in the Eastern Service Area and provided for an evaluation to be conducted. The DHHS contract with NFC ran until June 30, 2015, with a 12-month budget not to exceed $59,951,000. The budget included a fixed monthly payment and variable payments based on the numbers served and whether the case is court-supervised.	Legislative oversight/DHHS contracting
2017	DHHS awarded a Sole Source contract to *PromiseShip* (formerly called NFC) at $143 million for 2 years.	DHHS contracting
Fall 2018	CFS released a request for proposals for privatized case management services in the Eastern Service Area.	CFS RFP
1/2019	DAS released an RFP to identify a qualified bidder to provide full services case management for child welfare services in the Eastern Service Area.	DAS RFP
4/2019	Two bidders, *PromiseShip* and *Saint Francis Ministries* submitted proposals.	DAS RFP
5/2019	*Stephen Group* Report Published: Assessment of Outsource Model in Nebraska's Eastern Service Area.	State Reporting

Date	Details	Category
6/2019	Intent to award the contract to *Saint Francis* is issued.	DHHS contracting
6/2019	P*romiseShip* filed a bid protest with DAS. - Bid Violates statutory ratios, other requirements - Material undisclosed performance failed in Kansas (children sleeping in corporate offices) - History in Kansas of underbidding demanding more funding after contract award *PromiseShip* requests the DAS hold off on executing the contract pending the final protest meeting and DAS decision (no response)	Bid Protest
6/2019	Division of Children and Family Services received final approval of a Program Improvement Plan (PIP) created in response to a federal report assessing Nebraska's child welfare system.	CFS Corrective Action
6/2019	DHHS held clarification meetings with St; Francis in response to allegations.	Bid Protest
7/2019	DAS upholds the award, and the five-year contract with *Saint Francis* is executed. DAS dismisses initial protest from *PromiseShip.*	DAS Contracting
7/2019 to 9/2019	*PromiseShip* requested a “protest meeting” with DAS Director (DAS ignores); filed a taxpayer lawsuit and pursued various measures to stop the *Saint Francis* award.	Bid Protest
8/2019	DHHS directed that the case transitions be expedited (transfer cases starting 10/1 not 1/1) before readiness assessment.	Bid Protest
9/2019	Nebraska Appleseed filed a lawsuit in Lancaster County District Court, claiming that privatization is “special legislation.”	Bid Protest
10/2019	Judge McManaman denied *PromiseShip’s* request for a temporary injunction to stop the transition of cases.	Bid Protest

Date	Details	Category
10/2019	Case transfers to Saint Francis, originally contemplated to begin in January 2020, began early. A contract amendment is signed on October 25, 2019, to allow Saint Francis to earn up to $29.5 million during the first year of the contract, up from the $18 million allowed in the original contract.	DHHS Contracting
12/2019	Transition to *Saint Francis* was completed.	DHHS Contracting
1/2020	Judge McManaman dismissed the *PromiseShip* lawsuit with prejudice, upon agreement of the parties.	Bid Protest
Spring 2020	DHHS began to see that *Saint Francis* monthly spending would exhaust budgeted funding before the end of the fiscal year 2020. This same rate of over-spending carried into the fiscal year 2021, despite DHHS's warnings it would not be paid more than the do-not-exceed amount of their contract.	DHHS Contracting monitoring
10/2020	DHHS CEO Dannette Smith met with *Saint Francis* CEO Rev. Robert Smith and reiterated the do-not-exceed amount of the contract. He assured Smith that *Saint Francis* will not need to request more funds and that it will "eat" the expenses in excess of their contract amount for the fiscal year 2020.	DHHS Contract Monitoring
10/2020	*Saint Francis* confirmed to media that its board of directors had suspended CEO Rev. Robert Smith and COO Tom Blythe, pending an investigation into a whistleblower complaint alleging financial mismanagement with four basic allegations: 1) Financial mismanagement or neglect of the organization. 2) Improper use of company credit cards. 3) Failure to report *Saint Francis*'s true financial position to the board of directors. 4) Improper payment of $11 million for questionable IT services.	Saint Francis whistleblower complaint/ financial mismanagement
11/2020	*Saint Francis* Interim CEO William Clark met with DHHS CEO Dannette Smith, CFS Director Stephanie Beasley, CFO Mike Michalski, and General Counsel Bo Botelho. Mr. Clark outlines budget shortfalls and options for DHHS to consider.	Saint Francis whistleblower complaint/ financial mismanagement

Date	Details	Category
	By mid-November, DHHS began exploring options to support *Saint Francis's* actual expenses for case management.	
11/2020	*Saint Francis* removed CEO Rev. Robert Smith and COO Tom Blyth.	Saint Francis whistleblower complaint/ financial mismanagement
1/2021	William Clark, *Saint Franc*is Interim CEO, testified to the HHS Committee that *Saint Francis* needs an additional $25 million to keep operating this year, along with about $10 million to cover the shortfall for the Fiscal Year 2020.	Saint Francis whistleblower complaint/ financial mismanagement
1/2021	DHHS finalized an emergency contract agreement with *Saint Francis Ministries* to continue providing case management services in the ESA. A reimbursement contract through February 2023, the contract estimate was $68,890,448 the first year and $78,362,884 the second (13 months). The new contract also reimbursed Fiscal Year 2020 expenses of $10.5 million.	DHHS Contracting
6/2021	The Legislature passed an Act to conduct another study of privatization pilot.	Legislative oversight

APPENDIX F: BIBLIOGRAPHY

Administration for Children & Families, Children's Bureau "About NYTD: Fact Sheet," n.d., https://www.acf.hhs.gov/cb/fact-sheet/about-nytd (accessed October 2021)

Administration for Children & Families, Children's Bureau, *Adoption and Foster Care Analysis and Reporting System (AFCARS)* https://www.acf.hhs.gov/cb/data-research/adoption-fostercare

Annie E. Casey Foundation**,** *Funding Permanency Services: A Guide to Leveraging Federal, State, and Local Dollars, (2010)* http://childwelfaresparc.org/wp-content/uploads/2015/09/AECF-Funding-Permanency-Services-.pdf (Accessed September 2021).

Child Focus, *Nebraska Child Welfare Financing Primer and Nebraska Child Welfare Blueprint, (*Washington, D.C., n.p., April 2015) https://www.childfocuspartners.com/tools-publications/nebraska-child-welfare-financing-primer-2015-and-blueprint-2017 (Accessed October, 2021).

Child Focus, *Nebraska Child Welfare Blueprint Report, (Washington, D.C., n.p., March 2017) https://childrens.nebraska.gov/PDFs/Reports/NE%20Blueprint%20Report%2003.2017.pdf(Accessed October 2021)*

Child Trends*, Child Welfare Financing Survey SFY2018, State Profiles: Nebraska (*Bethesda, MD: n.p., March 09, 2020) https://www.childtrends.org/wp-content/uploads/2021/01/Nebraska_SFY2018-CWFS_03.03.2021.pdf (Accessed October 2021)

Child Trends*, Child Welfare Financing SFY 2014: A Survey of Federal, State, and Local Expenditures,* Kristina Rosinsky and Dana Connelly (Bethesda, MD: n.p., 2016) https://www.childtrends.org/wp-content/uploads/2016/10/2016-53ChildWelfareFinancingSFY2014-1.pdf (Accessed October 2021)

Hornby Zeller Associates, Inc., *An Assessment of Child Welfare Privatization in Nebraska: Final Report*, (Troy, NY: Hornby Zeller Associates, 2014)

Hornby Zeller Associates, Inc., *Assessment of Child Welfare Services in Nebraska* (Troy, NY: Hornby Zeller Associates, November 2012)

Martha Stoddard, *Nebraska inks $147 million emergency contract with Omaha-area child welfare contractor,* (Omaha, Nebraska: Omaha World-Herald, Jan 29th, 2021) https://omaha.com/news/state-and-regional/govt-and-politics/nebraska-inks-147-million-emergency-contract-with-omaha-area-child-welfare-contractor/article_8873d74c-627c-11eb-a4db-2fc6f3586efb.html (Accessed September 2021)

Nebraska Auditor of Public Accounts, "*Attestation Report of the Nebraska Department of Health and Human Services Child Welfare Reform Contract Expenditures July 1, 2009 through March 31, 2011"* (Lincoln, Nebraska: n.p., September 2011)

Nebraska Auditor of Public Accounts, *Executive Summary Attestation Report of the Nebraska Department of Health and Human Services Child Welfare Reform (Families Matter) Contract Expenditures July 1, 2009, through March 31, 2011, (*Lincoln, Nebraska: n.p., September 2011).

Nebraska Department of Administrative Services**,** *Request for Proposals (Lincoln, NE: Nebraska Department of Administrative Services, n.d.).* https://das.nebraska.gov/materiel/purchasing/5995/5995.html (Accessed October 2021)

Nebraska Department of Health and Human Services, Division of Children and Family Services, *CFS Point in Time Dashboard Summary Report* (Lincoln, Nebraska: Department of Health and Human Services, 2017) CFS Point in Time Dashboard Summary Report (ne.gov) (Accessed October 2021)

Nebraska Department of Health and Human Services, *Children and Family Caseload Status, (Lincoln, Nebraska: n.p., 2021* https://dhhs.ne.gov/Reports/Children%20and%20Family%20Services%20Running%20Caseload%20Report%20-%202021.pdf (Accessed October 2021).

Nebraska Foster Care Review Board, *2006 Annual Report: Working Together to Improve the Lives of Nebraska's Children in Foster Care,* Carolyn K. Stitt (Lincoln, Nebraska: n.p., 2006).

Nebraska Foster Care Review Board, *2007 Annual Report: 25 Years of Looking Out for Nebraska's Children in Foster Care,* Carolyn K. Stitt (Lincoln, Nebraska: n.p., 2007).

Nebraska Foster Care Review Board*, 2005 Annual Report: Hope is on the Horizon for Nebraska's Foster Children,* (Lincoln, Nebraska: n.p., 2005).

Nebraska Foster Care Review Board*, Hope is on the Horizon for Nebraska's Foster Children:23rd Annual Report of The State Foster Care Review Board,* (Lincoln, Nebraska: n.p., 2005).

Nebraska Foster Care Review Office, *The Nebraska Foster Care Review Board 2010 Annual Report: With additional information on the Child Welfare System Reform's Effects on Children and Youth January-June 2011*, (Lincoln, Nebraska: n.p., December 2010).

Nebraska Foster Care Review Office, *Annual Report 2019-20: Issued September 1, 2020, Pursuant to Neb. Rev. Stat. §43-1303(4),* (Lincoln, Nebraska: n.p., September 2020).

Nebraska Judicial Branch, Through the Eyes of The Child Initiative (Lincoln, Nebraska, n.p., 2019) https://supremecourt.nebraska.gov/programs-services/court-improvement-project/through-eyes-child-initiative-0 (Accessed October 2021).

Nebraska Legislative Fiscal Office*, "Fiscal Overview of Child Welfare Privatization in Nebraska" (Lincoln, Nebraska: n.p., December 15, 2011).*

Neb. Rev. Stat. §43-1303(4), 2020),28. https://nebraskalegislature.gov/laws/browse-chapters.php?chapter=43

Neb. Rev. Stat. §68-1207.01. Department Of Health and Human Services; *Caseloads Report* https://nebraskalegislature.gov/laws/statutes.php?statute=68-1207.01

Nebraska State Legislature, Performance Audit Committee and Legislative Audit Office*, Committee Report, Vol. 17, No. 1 DHHS Privatization of Child Welfare and Juvenile Services (Lincoln, NE: Nebraska Legislature, 2011)* Microsoft Word - 1CW Front Cover (nebraskalegislature.gov) (Accessed October 2021)

Nebraska State Legislature, Health and Human Services Committee, *"LR 37: Review, Investigation and Assessment of Child Welfare Reform"* (Lincoln, Nebraska: n.p., December 2011).

Office of Inspector General of Nebraska Child Welfare, *Special Report: Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services,* Jennifer Carter, Sarah Amsberry, Sharren Saf, (Lincoln, Nebraska: September 23, 2021).

Social Work, *Listening to the Voices of Children in Foster Care: Youths Speak Out about Child Welfare Workforce Turnover and Selection,* Jessica Strolin-Goltzman, PhD, Sharon Kollar, LMSW, Joanne Trinkle, LMSW: *Work*, Volume 55, Issue 1 (January 2010) Pages 47–53,

State of Nebraska, Office of Inspector General of Nebraska Child Welfare, "Special Report: Eastern Service Area Pilot Project and the Contract with Saint Francis for Child Welfare Case Management Services" (September 2021)

The Stephen Group*, Nebraska Department of Children and Families: Assessment of Outsource Model in Nebraska's Eastern Service Area: Findings and Recommendations* (Manchester, NH: n.p., May 2019)

The University of Chicago, Chapin Hall*, House Bill 1 Study Group: Privatization of Child Welfare Services Recommendations*, (Chicago, Illinois: Chapin Hall, 2019), kyhb1privatizationrecommendationreport62819.pdf (Accessed October 2021**).**

University of Nebraska-Lincoln, Department of Psychology, "A Case Study of the Effects of Privatization of Child Welfare on Services for Children and Families: The Nebraska Experience" (October 2013).

The Urban Institute, *Assessing the New Federalism, State Child Welfare Spending at a Glance,* Shelley Waters Boots, Rob Geen, Karen C. Tumlin, Jacob Leos-Urbel (Washington D.C.: The Urban Institute ,1999).

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, *Child and Family Services Review, Nebraska, 2002*.

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, *Child Welfare Information Gateway: Privatization (n.p., n.d.)https://www.childwelfare.gov/topics/management/funding/fiscal-reform/privatization/ (Accessed October 2021)*