

National Quality Improvement Center on the Privatization of Child Welfare Services

Performance Based Contracts and Quality Assurance Systems



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EXECUTIVE SUMMARY

Overview

The overarching goal of the Quality Improvement Center on the Privatization of Child Welfare Services was to inform the field and the Children's Bureau about the most current research, knowledge, and practice related to how public child welfare agencies contract with private providers for some or all of their core services. After an initial comprehensive needs assessment and knowledge gap analysis conducted by the QIC-PCW team in 2005-2006, performance-based contracting (PBC) and quality assurance (QA) systems were selected as the primary focus of further in-depth study and evaluation. Through a competitive RFA process, three demonstration sites were selected, each of which were implementing PBC/QA through a public-private partnership in some aspect of their child welfare service system. In September 2007, the QIC-PCW and its partners began the national cross-site evaluation of these three demonstration sites. This executive summary highlights findings from the final report of that three year evaluation.

Performance-Based Contracts and Quality Assurance Systems: A Model for Delivering Child Welfare Services

Performance-based contracting is a mechanism by which public agencies can move toward a more quality and data driven monitoring approach with accountability built into it. In turn, private agencies are given the freedom to determine how services are best delivered to meet contract expectations while achieving fiscal goals. PBC is even more directly linked to contract monitoring and ongoing Quality Assurance (QA) efforts since private agency performance is tied to payment. Therefore, contracts are either being rewarded or penalized based on their compliance with performance standards. How this is done can vary greatly. Understandably, both the public and private agencies desire positive results as this translates to positive results for families and children.

A successful PBC that leads to improved outcomes for children and families requires more than just collaboration and a contract. The ways in which the public agency changes policies or procedures, such as contract monitoring, to adapt and support this new contractual relationship are important (Collins-Camargo, McBeath & Ensign, in press)ⁱ. Equally important are the ways in which private agencies create innovative strategies or systems to help them achieve their contract outcomes and provide quality services (McBeath & Meezen, 2010)ⁱⁱ. These kinds of supports may evolve over time as new data is used in a continuous quality improvement process.

Evaluating the implementation and impact of PBC/QA within a dynamic system is challenging; while no one approach to establishing these contracts within a public-private partnership is preferred, common themes and lessons learned may help inform the process for others. Data on performance adds valuable evidence to the examination of this model of service delivery and its impact on outcomes.

Demonstration Sites: Florida, Illinois Missouri

In January of 2007, three demonstration sites were selected to participate in the QIC-PCW. These three sites had previously privatized their child welfare service delivery system and were now implementing Performance Based Contracting and Quality Assurance (PBC/QA) systems within some aspect of their service system. These sites were asked to evaluate how public-private partnerships operate under a performance-based contract and quality assurance system. Each site conducted a formal local evaluation of their initiatives and participated in the national cross-site evaluation. A brief overview of the sites is shown below:

QIC-PCW Demonstration Sites		
Florida	Illinois	Missouri
<p>In 1996, the Florida Legislature mandated the privatization of child welfare services through the use of a lead agency design. Between 1999 and 2005, the Department of Children and Families (DCF) transferred the management and day-to-day operations of the child welfare system to 22 private community-based care (CBC) lead agencies. All ongoing case management services are delivered by lead agencies across the state, which may in turn delegate direct case management activities to community-based case management agencies under subcontracts. Florida's PBC contract under the QIC targets children in foster care. Judicial Circuit 5 (Ocala and surrounding counties) and Kids Central (CBC) selected four performance measures for its contracts with case management agencies:</p> <ul style="list-style-type: none"> • Accurate data entry within 2 days of case receipt • Face to face supervisory meetings within 4 days of case receipt • Face to face supervisory meetings again at 30-45 days • Contact with biological parents 	<p>Missouri's public child welfare agency, Children's Division, had a long history of partnering with the private sector to deliver residential and mental health services, foster care, adoption recruitment, and case management services. Missouri's Children's Division, under House Bill 1453 of 2004, was directed the state to use private agencies to provide case management services through incentivized contracts and began piloting performance based contracts for its out-of-home care population in 2005. The state has since focused on improving the long-term maintenance supports and quality assurance processes of its performance-based foster care case management contracts in three regions of the state (Kansas City, St. Louis, and Springfield). Missouri's foster care and adoption services contracts were developed to include outcomes tied to the CFSR after its first federal review:</p> <ul style="list-style-type: none"> • Safety • Foster care re-entry • Permanency. 	<p>Illinois began using state-wide performance based contracts in 1998 expanded statewide to all children in traditional foster care placements. The state sought to expand its use of PBC to providers of residential service in 2007, and Independent Living /Transitional Living Program (ILO/TLP) services in 2010. The overarching goals of the expansion of PBC/QA to residential care were to incentivize shorter lengths of stay in residential settings while improving client stability and functioning, allowing for expanded availability of residential care beds for children at earlier stages of their need. Piloted in 2007 and fully implemented in 2008, the new PBC contracts for residential care focus on two outcome measures:</p> <ul style="list-style-type: none"> • Sustained Favorable Discharge Rate (SFDR) • Rate of Treatment Opportunity Days (RTOD)

Planning Process: Public-Private Partnerships in Collaboration

The final report highlighted the efforts in each site to establish a collaborative dialogue about the design and implementation of PBC/QA between both private and public partners. Given the complex relationship between public and private partnerships within a performance-based contracting system, each site identified the collaborative planning process as one of the most important factors in the success or failure of their efforts. The structure of the decision making process was different across sites, but it was evident that the sites took an inclusive approach when negotiating performance-based contracts and designing quality assurance systems.

In Illinois, an existing public-private decision-making committee and data team was used to plan and implement PBC/QA. In Missouri, they used an existing meeting that included CEOs of the private providers and key public agency staff to plan and implement activities. And in Florida, they developed a supervisor roundtable between the lead agency and the private providers to work on PBC/QA activities together.

Survey data on perceptions of the collaborative nature of the private-public partnerships in each site showed that there was general agreement in all sites that the key stakeholder group involved in the planning and implementation of this initiative had the right level of collaborative communication structure, process, purpose, goal, environment, and partners. While some variations existed within and across sites over time and by domain, the results generally demonstrated that the public-private partnerships were collaborative in their initial planning process and maintained that over time as PBC/QA evolved and matured.

The collaborative nature of the partnerships was not always reflected on the frontline level, however, as some workers indicated in focus groups that they felt less included in the process. In all sites, many workers were unclear about some of the details of PBC and how decisions were made. However, sites showed an effort over time to use data to help assist staff in understanding best practices and how outcomes were measured. While each site identified pros and cons to involving frontline staff in all details of PBC/QA implementation, this could be an area where more targeted efforts are made to ensure that collaboration and communication extends from the higher decision-making levels down to the frontline.

Finally, undertaking this level of system change requires sufficient time to plan since it affects all levels of an organization or agency. Each site emphasized that sufficient time is needed to ensure that all parties understand the outcomes being measured, how they are measured, and how these contracts affect each side fiscally. Additionally, time is needed upfront to make sure the right data is available to measure each outcome or to make the necessary changes to guarantee accurate and reliable data to inform the system as a whole.

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Necessary Components: Finding What Works

While it is difficult to identify any one necessary component of a successful PBC/QA system, there were several common elements across the sites that emerged and were identified as being key to the successful implementation of PBC/QA. How those elements played out in an individual site or the level of significance each one played cannot be known. Instead, general themes emerged across sites.

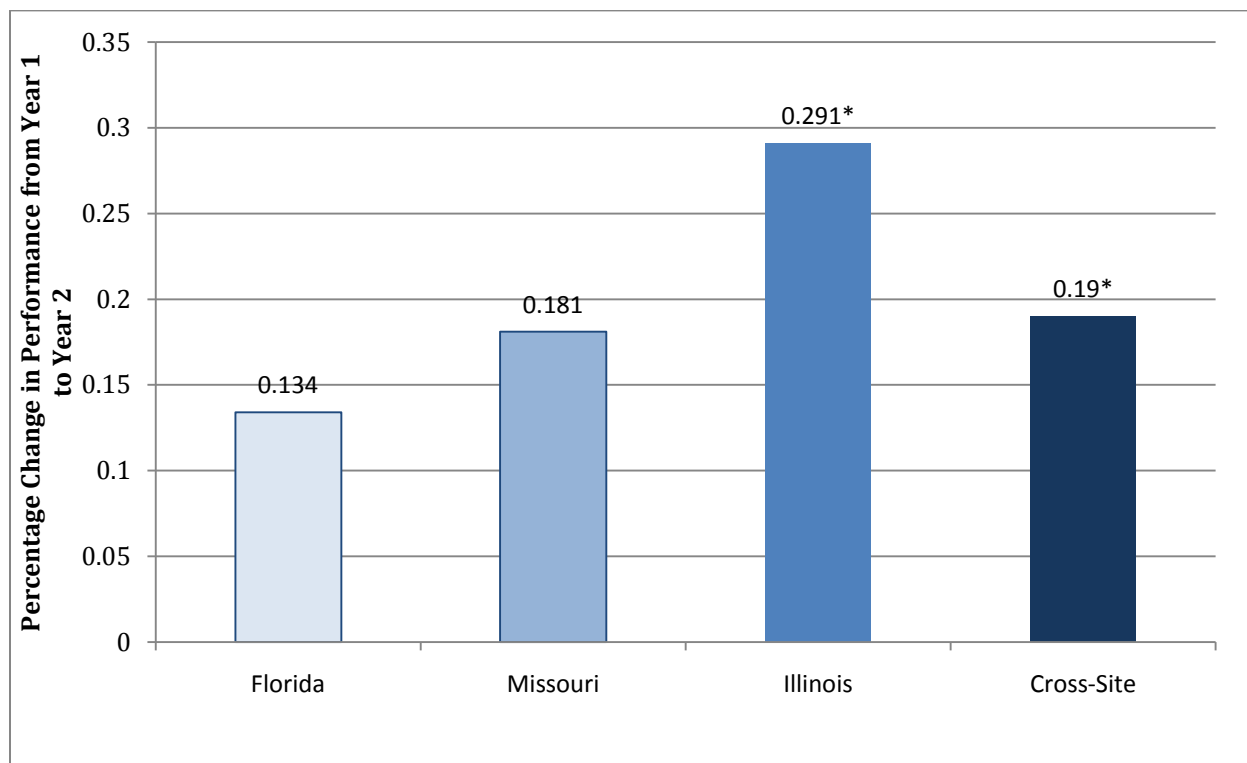
Common Elements for Success	
Political	Right Time and Support for Change
Leadership	Right Leaders Driving Change & Staying Involved
Collaboration	Inclusive Planning Process Between Public & Private
Planning	Sufficient Time to Plan
Communication	Formalized, Transparent Communication Structure
	Meaningful Feedback to All Levels
Practice	Support for Practice Change
Data	Having and Using Reliable Data
QA/QI	Restructuring QA/QI Process to Support PBC
Outcomes	Selecting Right Outcomes and Building a Contract Around Them

All sites noted that implementing this kind of service delivery model requires strong leadership, agency support, and political will for the kinds of systematic changes needed. All sites used an existing or newly formed public-private partnership structure to ensure that the right people were involved in the planning process and that there was enough time for all perspectives to be heard. This process was ideally transparent and that communication and feedback occurred at all levels of staff on both the public and private sectors.

Given the shift in emphasis on outcomes and performance, most sites developed new approaches or training to help

support the kinds of practice changes required to achieve the outcomes. Aligned with this shift, all sites needed to assess their existing data systems and procedures to ensure that they had the right data to measure performance and to inform quality assurance activities to support accountability and continuous quality improvement across the private providers.

Finally, each site used their public-private partnership and existing data to identify the right outcomes for what they wished to achieve collaboratively. Selecting these outcomes was noted as a critical piece of building a performance-based contract. Sites selected these outcomes based on the population and services to be provided and the alignment between the outcomes and the system-related goals of improving service and outcomes for children and families. These factors varied across sites so identifying a single or set of outcomes that is right for including in any given PBC is not feasible. Rather, the public-private partnership was used by all sites to jointly discuss, identify, and agree upon the right outcomes for each unique system.



Results showed that across all sites, the standardized change was positive and above the mean of 0. Regardless of the outcome or how it was measured, performance increased over time relative to 0 (mean/no change) in all sites. One-sample t-tests conducted within each site indicated that this change was significantly different from 0 only within the Illinois site ($t=30.45$, $p<.021$). However, across sites, the relative change in performance on all outcomes in all sites was significant ($t=3.197$, $p<.013$).

As agencies were able to make systematic changes to their organization and measure the impact of putting PBCs in place, their relative performance on the outcomes specified in their contracts showed a positive and significant increase overall. These results are promising in that the direction of agency or system change is positive and leading to improved outcomes at the organizational and child/family level.

Taken together, the data suggests that sites in this study who implemented PBC for this project (Illinois, Florida) or those that made changes to their existing PBC system (Missouri) were able to demonstrate some significant and positive changes in outcomes at the organizational and child-level. Future data beyond these two years is needed to determine if this impact is sustained.

Context: Outside Factors Influencing the System

While each site had unique state or local factors, four common variables appeared across the sites and were perceived to have an important role in influencing the implementation of PBC/QA, the public-private partnership, and the outcomes under consideration.

Leadership: In all sites, stakeholders believed that the changes necessary implement PBC and to the system as a whole were a function of key leadership at both the public and private level. System changes inherent in PBC require leaders who will drive those changes via a strong public-private collaborative partnership, leaders who will hold agencies accountable for performance, and leaders who will assume responsibility for the difficult decisions and compromise necessary for this work. Leadership at all levels can help drive practice and bring necessary resources to help improve outcomes for children. The level of involvement by key leadership at the beginning and throughout this process can greatly influence the future success and sustainability of changes made as a result of PBC/QA.

Resources, Budgets, and Political Climate: All sites discussed the challenges of PBC when resources are tight, budgets are cut, and the political climate makes change difficult. Fewer resources make it difficult for agencies to provide the range of services needed to ensure positive outcomes for the children they serve. Additionally, budget cuts impact the extent to which public agencies can incentivize contracts and support private partners. A robust cost analysis of PBC was not conducted for this evaluation, but such data is necessary for determining the effectiveness and efficiency of PBC within a foster care system. Given potential cuts to social services across the country, understanding the fiscal implications of PBC will be key for stakeholders in the legislature, the public child welfare agency, and the private provider community. Planning for a rigorous cost analysis in conjunction with PBC/QA can lend support to the overall fiscal impact of such initiatives.

Data Systems: One key factor stakeholders identified as affecting the implementation of PBC and effectively managing outcomes across diverse agencies is the data system used to monitor performance. Given the complexity of the outcomes measured in sites and the kind of data required for PBC, an unreliable or incomplete data system can be a huge barrier to overcome. State-wide data management systems are often not designed to easily generate the data needed for monitoring PBC. Duplicate agency data systems and work-arounds are common. All sites agreed that PBC requires a transparent, robust, and accurate data system. Data systems may not influence outcomes themselves, but they do impact the ability of the public and private agencies to monitor performance outcomes and identify necessary changes to improve services.

Concurrent Initiatives: In all sites, PBC did not operate in a vacuum within the child welfare system and service delivery agencies. Many concurrent initiatives designed to improve services and practice at the system and agency level occurred in all sites. These programs included programs to address the front-end of the child welfare system. Other initiatives

focused on changes to how practice and supervision occurred. As a result, it is impossible to attribute all outcomes achieved during the QIC project to PBC alone. Rather, complex systems such as those in place in the sites require complex explanations for the kinds of outcomes they produce.

Evolution over Time: Refining a Dynamic System

Within all three sites, staff noted that over the three-year period, emphasis shifted from compliance and direct oversight of practice and process, to technical assistance and developing a continuous quality improvement approach focused on outcome achievement. In support of this, communication emerged as key. The evolution of QA/QI systems to CQI in conjunction with PBC produced a greater understanding of the role of the public and private agencies involved.

Additionally, as sites implemented PBC and began monitoring outcomes, it became apparent that other adjustments were made during this project: 1) Outcomes selected were either refined, re-defined, or dropped all together from the contracts; 2) New quality assurance activities were designed and data was used to initiate joint private-public quality improvement changes; 3) Incentives and disincentives were re-negotiated, discontinued, or refined in response to fiscal factors or collaborative practices; and 4) Communication efforts began to more effectively target front-line case managers and supervisors.

All sites indicated that successfully implementing PBC in their individual sites was an on-going process rather than a static one-time change in the structure of the system and the way business was done. Much of the evolution over time in the sites was in response to data directly related to and generated by performance-based contracts. Additionally, all sites indicated that, while at times challenged and difficult, the public-private partnerships grew stronger due to the collaborative nature of the planning process and the on-going work together.

Lessons Learned: Tips for the Field

In keeping with the goal of the QIC-PCW of sharing information and knowledge with the field so that others learn from their experience, the demonstration sites identified several key lessons learned while developing and implementing PBC/QA within their public-private partnership. These take-away messages may assist other states or agencies as they study other models of service delivery or are in the process of planning and implementing PBC/QA.

Lessons Learned Across Sites	
Process	<ul style="list-style-type: none"> Planned collaboration and communication process structures are critical Performance-based contracting is an evolutionary process that takes time If phasing in, need structured plan for new sites using lessons learned from experienced Use a fidelity checklist for implementation
Public/Private Partnerships	<ul style="list-style-type: none"> Put equal emphasis on reform in both the public and private sectors All providers are different entities - they don't operate the same. May need to be more direct and prescriptive with the private sector
Contracts	<ul style="list-style-type: none"> Collaboratively choose right outcomes to match overall system goals Develop a longer term plan than the current contract Marry finance to outcome development at the start Need fluid peer record review across sectors Avoid a dual case management system across partners Be flexible in contracts and allow innovation
Data	<ul style="list-style-type: none"> Develop or modify data collection/tracking system that is robust Must have reliable and accurate data to measure outcomes/performance

Conclusion

This cross-site evaluation of three child welfare demonstration sites implementing performance-based contracts within their service systems is the first of its kind to examine this process in three different states in detail. While guided by ambitious research questions that were designed to address the effects of the planning process, the components of the contracts, and the outcomes associated, the challenge of conducting the kind of rigorous research needed to fully answer those questions illustrates some of the limitations of the current study. With that said, this evaluation did yield a great deal of valuable information about the challenges and successes each site had in implementing a PBC/QA model within their child welfare service system and how the public-private partnership worked to improve outcomes under this model. Taken together, data from this evaluation furthers our understanding of how collaborations between the public and private sector can be inclusive and supported by key organizational factors that improve performance and outcomes over time. The evolving nature of public/private child welfare partnerships requires constant collaboration on all aspects of contract development, refinement, monitoring, as well as systemic and practice improvements designed to foster better outcomes for children and families.

As federal and state entities move toward accountability and performance frameworks for distributing funds through grants or contracts, future research is necessary to rigorously design and evaluate these approaches to effectively assess the true impact of each change made within a performance-based system.

Future Research



Rigorous Evaluations Needed: Future research in this area should involve more rigorous evaluation designs and ensure that comparative data is appropriate and accessible. Limitations in this evaluation spoke to the need for experimental or quasi-experimental design to appropriately test whether outcomes under PBC are better than under the previous system. Evaluations are needed that select one or more key outcomes for which quality data exists and systematically identify, measure, and test the impact of organizational or system changes targeted on those outcomes. This will help identify and build the evidence base for promising approaches other states or systems may implement. Finally, in order to evaluate whether PBC/QA has a lasting impact on outcomes, more longitudinal research is needed to analyze the long-term outcome sustainability. This evaluation only covers a full two years' worth of outcome data and more time is needed to truly assess performance gains over time.

Best Practice and Staffing: Given that the contracts focus on the outcomes desired, there is less known about what kind of practice changes are necessary to drive those outcomes. Future research may wish to further explore the kinds of detailed practice changes made by front-line staff in response to PBC/QA and to assess the types of individual and agency-level practice models that have the most impact on outcomes. This level of analysis is better suited to determine what kinds of worker and agency-level practices best promote outcomes for children and families. Finally, future research may wish to further explore ways to improve staff buy-in evaluate its impact on organizational practice and outcomes. Front-line workers play a key role in driving agency policy and practice and their support for new initiatives such as PBC/QA is critical. Research is needed on how an organization or agency can best promote a culture of data-driven decision making and to use performance data at the front-line level to support practices and programs that work

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For more information or a copy of the final cross-site evaluation report, please visit this website:

<http://www.uky.edu/SocialWork/qicpcw/>

ⁱ Collins-Camargo, C., McBeath, B., & Ensign, K. (in press). Privatization and performance-based contracting in child welfare: Recent trends and implications for social service administrators. *Administration in Social Work*.

ⁱⁱ McBeath, B., & Meezan, W. (2010). Governance in motion: Service provision and child welfare outcomes in a performance-based, managed care contracting environment. *Journal of Public Administration Research and Theory*, 20, pp. 101- pp 123.

INTRODUCTION

Description of the QIC PCW

Overview

To promote knowledge development regarding contracting with the private sector for portions of the child welfare system in certain settings, the Children's Bureau funded the Quality Improvement Center on the Privatization of Child Welfare Services. The QIC PCW served as a resource for information on public/private partnerships, and child welfare privatization efforts and provided lessons learned from these efforts. Additionally, through subgrants funded by this initiative, research and demonstration projects tested the use of contracting and quality assurance approaches to improve organizational, practice and client outcomes. The information gained from these efforts will move the field forward and inform the ongoing process of child welfare enhancement and reform.

The research and demonstration projects tested models in **innovative performance-based contracting and quality assurance systems**. This topical focus fully integrates the *performance-based contracting* and *monitoring* practice areas, and successful strategies while infusing approaches to managing *partnership dynamics* and the *engagement of external entities* into the practice model.

The data and literature suggest that a number of practices throughout this process are promising and should be evaluated for their contribution to achieving positive organization, practice, and client outcomes. Each project incorporated the following promising practices within their models:

- the statement of a shared vision that drives the initiative and is grounded in desired outcomes;
- an inclusive planning and contract development process that involves both public and private providers, as well as administrative and practice level staff;
- the involvement of key external entities, particularly the courts, tribes, and community-based agencies, that play a critical role in the provider's achievement of performance indicators as well as the working relationship between public and private workers on the frontline;
- the implementation of a contract-monitoring process that balances appropriate levels of systemic and case-level review without micromanagement;
- quality assurance and positive-outcome-seeking utilization management systems that involve administrative and field staff in analyzing practice and outcome data, as well as the cost effectiveness of frontline evidence-based practice that best promotes desired outcomes for families and children; and

- on-going communication with and management of public and private sector relationships that strive for true partnerships in serving families and children, while recognizing the realities of the contractual relationship.

In addition to the subgrants and the related cross-site research, the QIC PCW focused significant efforts on facilitation of on-going knowledge development and dissemination related to public/private partnership in child welfare service provision to the broader child welfare community. These efforts were directed in three ways. First, the QIC promoted rigorous, comparative outcome evaluation of partnership and privatization initiatives. Second, it was the responsibility of the QIC to make evolving information available to the broader community through creating or disseminating materials of interest or reports related to evaluation studies as they emerge, conducting presentations and publishing related to this work. Finally, the QIC provided opportunities for on-going dialogue on both a face-to-face and technologically enhanced basis.

Description of the Program Model

Public child welfare agencies are required to demonstrate accountability and effectiveness in new ways. The results of the Child and Family Services Reviews, in conjunction with increasingly difficult caseloads and tight state budgets, have pressed states to assess alternative ways to meet service mandates. Some states are considering various forms of privatization of services or functions. There is a need to build a knowledge base of best practices in privatization efforts, and determine the effectiveness and efficiency of such approaches, and reaching consensus on appropriate reform models.

Both public and private agencies need to be able to demonstrate their effectiveness in promoting the safety, permanency and well-being of children and their families. There is an underlying assumption amongst some that privatization leads to increased accountability and competition in the provision of child welfare services, but this is untested. Privatization efforts require clarification of roles and responsibilities between the state agency and private contractor, coupled with a collaborative partnership. Using a participatory approach, rigorous evaluation strategies are necessary to compare efficiency as well as progress toward organizational and client outcomes.

The logic model for the QIC PCW program can be found in **Appendix A**. This was an evolving document encompassing both Phases of the QIC process, and was not specific as to the actual topical focus area of the subgrants themselves. Implementation objectives are based in a partnership model, in that our work with and among the QIC PCW subgrantees functioned through collaborative partnership both in the development and implementation of their interventions and local evaluations, in the development and implementation of the cross-site evaluation, and in the development and implementation of a dissemination and diffusion strategy related to the lessons learned and findings of the research. A key underlying assumption in our program model is that through partnership and collaborative problem-

solving, the work of the projects will be strengthened, the functioning of the QIC will be strengthened, and the overall knowledge development enterprise will be strengthened.

In Phase II, the intervention objectives and primary activities, in summary, included:

- Conducting the request for applications process
- Conducting the application review, selection, and award process
- Providing pre- and post-award technical assistance to grantees
- Managing and monitoring grants
- Facilitating a collaborative partnership among the QIC, and the grantees
- Conducting the cross-site evaluation
- Facilitating a national dialogue on partnership
- Providing technical assistance to the broader child welfare community
- Disseminating/diffusing information, lessons learned and study findings.

The activities of grantees and the QIC overall promoted improved national dialogue and information-sharing on public/private partnership in child welfare; increased collection and synthesis of emerging trends in child welfare privatization and evaluation efforts related to it, increased rigor in testing administrative processes through the establishment of methodologically sound evaluation designs in funded demonstration projects; increased collaboration among and evaluation of privatization projects through establishment of problem-solving networks at the grantee and national levels and improved and increased dissemination of process and outcome findings. The promotion of such activities has led to the following outcomes: 1) increased evidence on best practice in child welfare services, 2) increased evidence related to the development and impact of collaborative public/private partnerships in child welfare service provision, and 3) increased evidence base regarding the innovation, efficiency and performance (safety, permanency and well-being) related to activities involving contracting and quality assurance processes within a privatized context, and, ultimately, on a national level, lead to state and tribal child welfare agencies, community stakeholders and federal staff having the necessary knowledge to assist in sound decision-making regarding the effective and efficient provision of mandated child welfare services.

Specific to the topical focus area of the QIC PCW subgrantees, innovative performance-based contracting and quality assurance systems (PBC/QA), the program utilized a theory of change, which laid out the underlying conceptual framework linking the PBC/QA projects to child and family outcomes. This process involved administrative change, practice change, organizational change, and finally organizational or systemic, and client level change.

Overview of the Grantees

The **Florida Department of Children and Families** (DCF) in collaboration with Kids Central, Inc. (KCI) established and implemented a comprehensive demonstration project to

identify the impact of several promising privatization practices on child welfare related outcomes. Kids Central is the Community Based Care (CBC) Lead Agency responsible for organizing the network of care in Judicial Circuit 5, which includes Lake, Sumter, Marion, Citrus, and Hernando counties in central Florida. The evaluation was conducted by Jean K. Elder and Associates.

By establishing a strong tie between public and private service providers, they demonstrated that a comprehensive planning process in the development of performance-based contracts and inclusion of performance measures in our quality assurance process can lead to improved outcomes in some areas. The project focus included: 1) articulation of a shared vision driving practice and outcomes; 2) implementation of an inclusive planning and contract negotiation process involving private and public providers, administrative and practice staff; and 3) implementation of a comprehensive contract monitoring process and quality assurance and positive outcome-seeking systems of utilization management that engage administrative and field staff in creative analysis of practice and outcome data, linking cost effectiveness with evidence-base practice on the frontline that best promotes desired outcomes for families and children. ***See Florida Project Sheet in Appendix B.***

Illinois Department of Child and Family Services extended PBC/QA to residential programs currently serving approximately 2,500 children and youth in the child welfare system, many of whom have increasingly severe and complex service needs. The Illinois Department of Child and Family Services (DCFS), the Child Care Association of Illinois (CCAI) and the University of Illinois at Urbana formed a public-private partnership to lead this endeavor.

A core principle of the Illinois model was allowing all stakeholders to have meaningful input into the planning and design phase of this project. A Project Steering Committee comprised of representatives from the provider community and senior leaders from DCFS was established to provide oversight and policy direction for the project. The performance-based contracts were designed to: 1) emphasize *results* related to output, quality and outcomes; 2) have clearly defined objectives and timeframes; 3) use *measurable performance standards* and quality assurance plans; and 4) provide *performance incentives and penalties* and tie payments to outcomes. ***See Illinois Project Sheet in Appendix C.***

Missouri Division of Children's Services, in partnership with the University of Missouri-Columbia, examined the processes necessary for maintaining public and private partnerships in support of performance-based contracting of out-of-home services in child welfare beyond the initial contract implementation process. The Missouri Children's Division built upon their existing child welfare system that began contracting out case management for a select portion of the out of home care population in 1997. Since that time, the Children's Division has expanded contracting to multiple agencies that make up seven consortiums and operate in three circuits. In 2005, Missouri initiated its first performance based contracts with these seven consortiums with an emphasis on improving child welfare outcomes.

Using a mixed method design, the project expected to determine those public/private contracting and contract monitoring processes which provide a best-practice model for ongoing use of performance-based contracting in the delivery of out-of-home care that lead to the optimal positive outcomes for children needing such services.

Missouri's project tested this model of long-term maintenance of a Performance-Based Contracts and Quality Assurance System that supports public/private agency collaborations in meeting the long-term needs of children in out-of-home care both effectively and efficiently. It also provided an approach to expanding private/public collaboration across the child welfare service continuum and in human services in general. ***See Missouri Project Sheet in Appendix D.***

SECTION 2

Process Evaluation

Grantee Implementation Activities

All grantees were awarded contracts beginning January 2, 2007 and implemented their project within the required time frame. Implementation ended at varying times between September and December 2009.

Florida

Process of implementation

Implementation of the project was completed as of November 30, 2009 and their final report has been submitted. In January 2007, the Florida project laid the foundation for their work for the first six months by establishing several working groups: an Advisory Board, Intervention Group and a Supervisory Roundtable. These groups were established to guide the development of the new performance based contracting and quality assurance system that would be in place July 2007 as well as throughout the implementation of the new contract and monitoring system. Each groups' work will be described below. The project evaluators attended Advisory Board, Intervention and Supervisory Roundtable meetings in person to observe, document and evaluate the processes used to implement and sustain this project.

Advisory Board

This group had the following representatives: public agency leadership (DCF Central Office), statewide child welfare advocacy organizations, legislative, local community advocates, and courts. The original purpose of the Advisory Board was to provide oversight and input as well as to gain the support of state and community leaders regarding the work of the project in the hopes that lessons learned could be shared across systems. This group had great momentum in the beginning and there was a spotlight shown on this Circuit for their innovative work, however, as administrative and legislative leadership changes occurred, attendance dwindled. The Board became more of a group that was reported to rather than a place where input could be sought.

Intervention Group

Led by a neutral facilitator, executive and management staff of DCF, KCI, and CMAs met at least monthly in the beginning but then tapered off to bi-monthly nearing the end of the project. The purpose of this group was to discuss issues specific to the implementation, management and assessment of the performance based contracts and individual incentive measures. Decisions related to the contract and incentive measures were made during this time. Later in the intervention, a communication gap was identified between the CMA executive management and the frontline supervisors; therefore, a strategy to bridge this gap

was to conduct joint meetings between the Intervention Group and the Supervisory Roundtable. This allowed the supervisors to have more input into strategies to improve performance on the incentive measures.

Supervisory Roundtable

This group was formed after the Intervention Group determined early on that a forum was needed for frontline supervisors to share and discuss their own issues related to the performance based contract. A neutral facilitator led this group in looking at evidence-based practice and strategies for continuous quality improvement. Some key outcomes from these meetings include: 1) initiation of a collaborative review and negotiation surrounding the purpose and responsibilities of Job Coaches and 2) decision to expand the current model for collaboration, developed as a result of the QIC project, to include Legal staff.

Performance Measures

Four individual performance-based incentive measures were developed in collaboration with DCF, KCI and the CMAs. During the planning process, the group first had to decide whether they were to incentivize process or outcome measures. Building on the implementation work of Dr. Dean Fixsen and colleagues at the National Implementation Research Network, then at the University of South Florida, the project used implementation drivers as their guide to bring about system improvement. The identified performance measures were built around current social work practices that were believed to lead to improved permanency, safety and well-being for children and families. Three of the four incentive performance measures were process measures. The incentive measures that were agreed upon at the end of a very fast-paced six-month period were 1) face-to-face supervision within 4 days of case receipt and again at 30 to 45 days; 2) case information entered within two days, 3) contact with the (both) biological parents; and 4) permanency. A second, but very necessary step was to collectively define each of these measures so that all parties would know when a target had been met successfully. For example, the collective group had to agree upon what constituted 2 days (business, working, calendar) and what permanency outcome was incentivized.

These incentive measures were built into their existing contract that included already established deliverables specific to safety, permanency and child well-being. The new measures were designed utilizing a “shared risk” model. The intent of the shared risk was that KCI would provide technical assistance for CMAs that did not perform at or above the established targets for each performance measure for the first quarter and if performance did not improve, the CMAs would then have to pay for technical assistance provided by KCI until the target was reached. Despite being planned, KCI decided they would not impose this penalty when agencies were demonstrating that improvements were taking place as compared to the benchmark performance but they were not reaching established targets. There were outside variables that were believed to have impacted their performance, such as the delay of and untimely implementation of a new SACWIS impacted the frontline workers ability to enter data within the required time frame of two (2) business days. Additionally, retrospectively there was discussion around the setting the targets correctly. For instance, instead of setting a target of

100 percent when performance was very low at the beginning stage, it might have been easier to achieve success if targets would have been increased in a stepwise fashion throughout the intervention period. There was also speculation regarding the use of penalties and whether it would have impacted performance, if enacted.

Of the \$60,000 in incentive funds that were available to each of the four CMAs, less than 50 percent of the dollars were earned. Overall, there was improvement on all four incentive measures, so an interesting question comes from this research is whether or not incentives make a difference in moving agencies and frontline workers toward improved practice and improved outcomes.

Below is a description of each incentive measure and the status at the end of the intervention.

Incentive Measure: Face-to-Face Supervision within 4 days of Case Receipt and at 30 to 45 Days

Definition: Between two and four working days, all new cases transferred for services from investigation will receive a supervisory screening with worker and again between 30 – 45 days and quarterly thereafter. Incentive payments were received when both the supervisory review at two to four days and 30 – 45 days occurred 100 percent of the time. Meetings had to occur face-to-face and key case-related factors had to be discussed with the worker.

The intent was to incentivize quality direction and management of frontline workers through face-to-face supervisory meetings. When this takes place, it was believed that overall casework and related outcomes would improve. This measure was assessed by reviewing the Supervisory Review Tool (created by the Supervisory Roundtable representatives) that was to be used to document each supervisory meeting. The KCI Quality Assurance (QA) team reviewed all Supervisory Review Tools completed for out-of-home care cases to determine if a quality meeting took place. Over time, DCF, KCI and CMAs worked to hone the definition of a “quality” supervisory meeting so that all understood the necessary elements. The KCI QA Team also provided a detailed description when a supervisory meeting did not meet the standard so that the supervisor and worker would know specifically what necessary steps were needed to improve the quality of the supervisory meeting and gain compliance at the time of the QA review.

Status and Finding: Data indicated that while incentives were not consistently being earned by the CMAs, significant progress was made. Aggregate data showed that CMAs began the intervention period achieving around the 15 percent mark. While the target was set at 100 percent achievement of this measure, the CMAs ended with achieving nearly 80 percent, which is certainly considered remarkable improvement over a three-

year period. It would be important to consider whether the target established was too high or if this target should have been established with more reasonable expectations of achievement.

Incentive Measure: Case Information Entered within 2 Days

Definition: All case information will be entered into Florida Safe Families Network (FSFN), Florida's SACWIS, accurately and timely (within 2 days). The CMA shall input and update all required case management information into FSFN. Furthermore, the CMA shall correct all errors indicated on the AFCARS Error Report minimally on a monthly basis and also by request from KCI. CMAs received incentive payments when case information was entered in a timely manner 90 percent of the time.

The intent was to incentivize data entry, an activity that is already required by Florida Department of Families and Children and by Kids Central, Inc. with the expectations that it would increase KCI's overall performance within the statewide assessment of CBCs. Furthermore, by entering data accurately and timely, data analysis would be completed and used to inform management decisions likewise in a timely fashion. KCI assessed this measure through case review of data entry across a sample of out-of-home care cases for each CMA. The sample was selected based upon a formula that assures 90 percent confidence with a 10 percent margin of error and includes an appropriate oversample. This approach was based upon an established quality assurance standard developed and used within the statewide QA process.

Status and Finding: CMAs were not able to achieve the target for this incentive measure and performance fluctuated between the 70 percent and 80 percent mark. Since the CMAs struggled in meeting this target throughout the intervention, KCI decided to incentivize specific units that could sustain performance for a month. Though several units achieved this goal, no single unit sustained performance for more than one month beyond this period.

Incentive Measure: Contact with Biological Parents

Definition: Case managers of children in out-of-home care will have contact with both biological parents. Contacts with biological parents will increase by 12 percent during the fiscal year. It will be tracked on an ongoing basis utilizing an agreed upon set of questions used during the case review process: (e.g. describe your involvement with your case planning process, what is the hardest thing for you to achieve in the case plan, etc.). CMAs will receive incentive payments when contact with biological parents is made in a percentage of cases meeting the target. The target continually increased over the contract period.

It was expected that by incentivizing contact with biological parents, case progress would be expedited and case outcomes enhanced. Furthermore, contact with biological parents is already an expectation of DCF and KCI, and is measured by the statewide performance review.

Status and Finding: Performance continued to improve with some CMAs reaching 80 percent compliance in the last months of the intervention. While KCI has not achieved goals associated with the state comparable process measure, they do lead the state in efforts to contact biological parents. The state's measure is compliance only (yes/no) while DCF does not give credit for reasonable efforts made to reach or contact both biological parents. CMAs started achieving around 30 percent, with a peak of over 60 percent and ended around 50 percent.

Incentive Measure: Permanency

Definition: CMAs will work to achieve one of two permanency options (Return to Parent and Legal Guardianship/Kinship Care) for youth and maintain permanency for six months. In the original contract, Independent Living was considered a permanency option but was later dropped when the group agreed that it was not, in fact, a viable permanency option. CMAs received incentive payments for youth who reached one of the two permanency options. CMAs were asked to review caseloads to provide a count of the number of youth who had achieved permanency during the first six months of the current contract. This number was then used to create a baseline expectation for each CMA and to establish payment levels for reaching various outcomes. As this proved difficult to do, the methodology for receiving payment was modified to a self-report by the CMAs of youth who have achieved and maintained permanency for six months. CMAs received a payment of \$1000 for each child that maintained permanency in a legal guardianship/kinship care placement and \$1500 for each child who was able to maintain permanency when successfully reunited with parents for six months.

It was believed that by incentivizing maintenance of permanency, case planning will be enhanced and improved thereby reducing the likelihood that a child will return to out-of-home care.

Status and Finding: While the CMAs increased their incentive earnings over time, the data did not indicate a clear progression towards improved permanency rates since the potential pool of youth who could be achieving permanency was not known. Historical data and clear definitions of permanency might have aided in identifying a clear outcome.

Progress was made on each incentive measure, some more than others; however, progress ceased on a collective level in the last months of the intervention. When reviewing the progress and trend lines of the individual CMAs on meeting the incentive measures it should be

noted that KCI announced in mid-March 2009 that a rebidding process would take place and they would be reducing the number of contractors from four to two CMA. The announcement of the awards was made just prior to the end of the project. This will be discussed in more detail in a later section as it is possibly could have impacted performance and collaboration.

Did implementation occur as planned?

Overall, Florida implemented this project as planned. There were barrier and facilitators to the success of the project. The barriers to timely and successful implementation were communication issues, public agency SACWIS changes, lack of understanding of performance measures, evaluation obstacles and key leadership changes. The implementation facilitators were the willingness to have open and honest discussion, flexibility and adaptability to system barriers and quality assurance and quality improvement processes established to promote quality service delivery. It should be noted here that often the project implementation team would tout the value in the role of the external facilitator in creating a level playing field—so that DCF, KCI and the CMAs could sit on the same side of the table while the final focus group interviews yielded a different finding regarding the use of the external facilitator. The focus group participants, specifically the frontline supervisors, felt that facilitation was not valuable in bringing about the sharing of best practices. However, the supervisors who attended the roundtables did value the opportunity to come together with other supervisors and the opportunity to develop those relationships across agencies.

The performance based contract was in place by the target date, July 1, 2007. There were a number of issues identified by the Project Team that became apparent throughout the planning process and even throughout the implementation of the project.

The first and most pervasive barrier was a lack of communication at various times among the Project Team (DCF, KCI and CMAs), as well as internal communication within the CMAs from executive leadership to frontline staff members. The latter communication issue could be identified as the most impactful as it determined the success of the CMAs in achieving performance. During the work of the Intervention Group it became apparent that contractual outcomes and practice issues affecting these outcomes were not internally communicated from CEO-level to supervisors to frontline staff. This lack of communication affected the CMAs' ability to meet or exceed performance measures since supervisors and frontline staff was not receiving appropriate information about the performance measures.

Second, the implementation of a new version of Florida's SACWIS ("FSFN") in August 2007 was a barrier. The changes affected the Community Based Care Agency's (CBC) ability to monitor the contracts with the CMAs resulting in no incentives/disincentives being applied in July and August. FSFN did not have the capability of reporting data regarding the specific outcome measures of the CMAs. However, a solution was identified that resulted in turning this barrier into a facilitator of success. KCI developed a sampling process that provided for a quality review of cases with detailed suggestions in areas that CMAs needed improvement. Although

originally designed as a temporary fix for the database problems, KCI continued with this case review method since it appeared to be effective in providing each CMA with the specific documentation on which practice change could be made. These reviews were detailed and provided qualitative feedback rather than taking a strict “yes” or “no” compliance approach.

Third, there was not a clear understanding of the existing performance measures, especially in the beginning. Thus, communication, knowledge and understanding of the incentive measures, and the importance and impact of front-line practice and staff training were all identified as barriers to successful implementation of the first performance based contract. As a result, the project plan was modified to engage staff at supervisory and front-line levels in order to better inform them and provide necessary supervisory guidance and training surrounding the performance based contracting initiative.

Fourth, the evaluators experienced a couple of barriers: comparison site cooperation, comparison site data comparability, and IRB changes. A significant delay occurred in gaining the cooperation and involvement of the comparison site in the project even though they had originally provided written support. Through the evaluators’ persistence and the additional requests by DCF Judicial Circuit 5 and KCI leadership, the comparison site cooperated. However, as the evaluators began to explore the comparison of data, it became apparent that it was going to be a difficult task to retrieve data related to the specific KCI performance measures since their Circuit was not set up to track those particular measures (i.e. completion of supervisory review at four days and at 30 – 45 days). Additionally, the comparison site implemented a number of new initiatives that resulted in improved outcomes, therefore, making it hard to discern the differences between Circuits. As the evaluation was fully underway, they received notification from the Florida Department of Health that they would no longer serve as the IRB to the child welfare agency, and, therefore, all evaluation activities had to be suspended. The QIC staff and an Advisory Board member, Florida project evaluators and DCF leadership worked together to develop a partnership with the University of South Florida to provide IRB oversight of the local project.

And, lastly, there were two significant leadership changes within the project: public agency leadership and project management. The Judicial Circuit 5 Administrator, the key public agency leader in the project, advanced to a Regional Administrator position. From the beginning of the project, the partnership between the Circuit Administrator and Kids Central Inc.’s CEO, was the foundation for the work. The Regional Administrator had limited involvement and although it took some time for the new Circuit Administrator to fully understand and participate in the project, the partnership was still strong between DCF and KCI. The original project manager at KCI retired in 2008. Although the personality and communication style of the outgoing and incoming managers differed, the project’s work as a whole was not compromised.

One particular event occurred near the end of the project that can neither be identified as a barrier nor a facilitator to success but should be noted. Changes were made in conjunction

with KCI's Board of Directors while taking into consideration the current budget shortfall and other trends in out of home care. The most significant decision was made to put out a Request for Proposals for two (2) Case Managing Agency (CMA) contracts. Currently, there are five (5) contracts with four (4) CMAs. A few factors were identified that played a role in this decision. Most importantly to note is the fact that KCI has reduced the number of children in care by almost 50 percent over the last five years (as reported by DCF and KCI leadership). This was attributed to a couple of initiatives, the Diversion Project and Kinship Care/Family Finding. Also, a few other initiatives, such as the focus on family engagement and reunification as well as a supervisor to worker ratio of 5:1 and caseworker to family ratio of 10:1 have been factors in reducing the numbers in foster care. As a result of this reduction in numbers of children in care, caseloads have been significantly reduced. The rationale is that money can be saved and reinvested into supports for CMAs if they are able to reduce administrative overhead costs associated with managing five contracts with four CMAs to two CMAs.

There were some possible implications to the research and evaluation component of the QIC project at the time of the announcement. The primary concern was that two new CMAs would be awarded contracts, leaving all four CMAs to transfer all cases at the time when the QIC was to be completing the project. Another concern was the manner in which the information was shared with the CMAs about the RFP. This information was shared via email. The KCI and CMA partnership had built a strong foundation over the last fifteen months through open and honest dialogue and transparency. To share this kind of information via email rather than sharing it at an Intervention or Supervisory Roundtable meeting seems counter to the culture that had been created. KCI Management responded to our concerns by stating that as the decision had been made at a Board meeting where some CMA representatives were present, and they wanted to relay the information as soon as possible so as not to cause any undue harm or miscommunication in the CMA Community.

The RFP went out in late June and was due back in late August/early September, 60 days from issuance. This decision could have impacted the progress of the CMAs on the performance measures as evidenced by a drop in performance on some of these measures in the last several months of the intervention. Two of the existing four CMAs received contracts to provide case management services. It was anticipated that a majority of the supervisory and front line staff from the non-contracted agencies would be hired by the newly contracted agencies. It is unknown at this time as to whether that did, in fact, occur. Reportedly, the transitioning of cases and staff did not go as planned. The QIC Team planned to conduct a final site visit and cross-site focus groups in early October 2009, prior to the announcement of the contract awards for optimal participation and feedback. However, KCI staff determined that it was necessary to move up their announcement date to two weeks prior to the QIC site visit due to the staff time needed to prepare their proposal for re-procurement as the Lead Agency for Judicial Circuit 5 that would be due before the end of the year. Although there was good attendance by Directors and Supervisors at the focus groups, the frontline staff attendance was low. It is hard to determine if some of the participants' attitudes and perceptions were influenced by the recent contracting decisions as some staff was facing uncertainty in their

employment. It should be noted that, overall, agency staff felt that performance based contracting has benefited their system.

There were also facilitators to the implementation of this project, the following are examples. Others will be contained in the section that addresses lessons learned.

As identified by the Project Team, the use of an external facilitator during the planning and implementation was believed to have been key to its rapid implementation and the successful development of incentive performance measures. The roundtable discussions were used to gain “buy-in” from the CMA leadership, program directors, supervisors and front line staff. The project team has worked diligently to make sure the right people are at the table. Again, it should be noted that there is a difference in the perceptions of the CMA supervisors, and DCF and KCI in this regard.

KCI’s openness to make changes in their contract process and strong cooperative leadership from both KCI and DCF Judicial Circuit 5 has facilitated the development and implementation of the performance based contracts. Because of this process, KCI has also received release from the State from completing the more traditional quality assurance reviews. This dispensation has given the QIC process additional credibility with the collaborative, sanctioning the work that has been completed to date. Furthermore, the State DCF has adopted the Project Supervisory Screening tool in large part, putting KCI months ahead in its implementation and acknowledging the comprehensive work done to date at the frontline level.

KCI has continued to utilize the collaborative model in developing the new performance based contract. Although progress in some areas was less than expected, the collaborative process improved their efforts in how they worked together on many other projects and there has been overall improvement in meeting outcomes. It is debatable whether this project’s model is a true shared risk model. Incentives were provided; however, KCI decided not to fully implement the penalties because of a number of contextual variables (most were due to new SACWIS and updates to SACWIS). Also, in the spirit of building a better partnership through collaboration and communication, KCI was hesitant to impose any penalties early in this relationship-building process. This may have been necessary as a show of good will as this partnership was in the very early stages of development.

Final Site Visit Focus Group Themes

The following themes in the areas of planning, communication/collaboration, PBC key components, and impact of PBC on outcomes were taken from the Final Site Visit Report located in **Appendix E**.

Planning Process

- **Agreement across both sectors that the planning process was inclusive.** However, it was also largely agreed that although for the most part the right people were at the table, representatives of frontline staff should have been included.

We assumed it was being driven down to the line and it wasn't. – Florida Private Provider

- **The timing of the initiative was favorable and this furthered the process.** In Florida, the lead agency had a history of undesirable child outcomes and a poor relationship between the public and private agencies, but new leadership set the stage for reform. It was noted that in all states a tremendous amount of planning meetings were held.

Communication and Collaboration

- **A lack of a communication plan or consistent structures presented a barrier but solutions were identified.** Florida's community board and provider CEO group was utilized but a neutral facilitator was added for planning and supervisor roundtables. When it was determined that the frontline was not engaged, town hall meetings were established to communicate at this level. The lack of a formalized communication plan was noted as a challenge.

The early meetings were purposeful. The measures weren't predetermined. We started fresh, and a lot of good discussion took place regarding defining measures. After several meetings we were more product-driven. — FL Public

Key Components to Implementation of the PBC

Quality of Data

- States experienced **challenges in their current data systems**, whether in reliability of the data or in use of historical data to forecast benchmarks.
- **A necessary component of the process was a system for reconciliation of data and indicator measurement** between sectors. Florida enhanced its use of data-driven decision-making and began connecting practice to child outcomes.

Decisions on use of incentives and disincentives

- Some form of **fiscal consequence focuses attention on outcome achievement** and virtually all believed improvement would be demonstrated over time.
- **Concessions may need to be made in order to enable providers to commit given the risk.**
- **Clarity regarding the outcome definition and how they would be measured is crucial.**

Selection of Contract Indicators

- Some of the **factors associated with selection of indicators were feasibility, accessibility, simplicity and timing.**

Overall I'm fine with them, but they are timing out. It is time to shift. We have been incentivizing this for a long time; probably have seen as much improvement as are going to. —FL Private

- ***Indicators may have time-limited impact*** and the approach should focus on incremental change.

Components of the Quality Assurance system

- ***Emphasis shifted from compliance and oversight to technical assistance*** and developing a continuous quality improvement approach.

Recommended Changes

- It is time to statistically ***assess whether the current practice drivers/indicators truly are linked to outcome improvement.***
- ***Some providers perceived their failure to earn an incentive as a penalty.***
- ***Should build a system based on incremental improvement*** rather than categorical improvement.

Impact of PBC on outcomes

- ***Progress was made toward practice change*** within the child welfare system as a result of the projects. Some CMAs demonstrated practice improvement and use of supervisor review in this regard. In addition their supervisory roundtables became more focused on practice solutions.

The supervisors talk more and share best practices. No longer just complaining, they are bringing up issues and developing solutions together. They know each other now. —FL

- Some providers made a conscious ***decision not to discuss the contract or its fiscal aspects with staff.***
- ***The collaborative process resulted in an improved child welfare system and outcomes for children.*** Relationships and understanding of the roles and strengths across sectors had improved. The combined performance based contract, and the use in a more integrated quality assurance and improvement process was believed to have resulted in enhanced evidence-informed practice and data-driven decision-making.

This CBC went from a bottom dweller to one of the top performers. —FL Public

- ***Collaboration and relationships across the sectors improved.***

[The] Project has strengthened the relationship with the local DCF. It was not this way when we started. —FL Private

- ***Project components were adopted statewide.***
- ***There was a sense of improvement in supervisory practice.***
- ***An evidence-based practice approach developed, although this project was seen to be one of several initiatives that contributed to this outcome.***

Other final thoughts from Project members:

Evaluation keeps you honest. We are typically good at planning and initial implementation and not so good at sustaining. —Florida

True public private partnership is a very rewarding way to work even though it is uncomfortable at first. —Florida

Lessons Learned

This section describes several key lessons learned throughout the project:

Continual focus on communication planning: Use of communication planning as a tool to reduce both anxiety and confusion for upper, middle and frontline staff is of critical importance. Answering staff questions in writing and sharing the questions and answers with all staff, utilizing a monthly newsletter and keeping clear minutes of all meetings is beginning to materialize as a critical function.

Ensure all necessary participants are included: Staff responsible for developing and implementing quality assurance measures and processes should be involved in planning all incentive measures and associated outcomes.

Use of joint meetings (between supervisors and intervention group): Communicating one message to both the group of supervisors and CEOs created an opportunity to clarify issues and reduce anxiety and miscommunication. Asking the group to submit questions that can be responded to in advance provided the project team an opportunity to discern what “major” issues are in need of discussion.

Consensus surrounding measurement processes, definitions and meanings must be established: Early in the process, it became clear that key participants had different definitions relating to primary concepts and measurements. Later in the process, as issues in data collection were discovered, building consensus on how to move forward was extremely important to the ongoing integrity of the process ultimately reducing anxiety of frontline staff on “how they are being graded”.

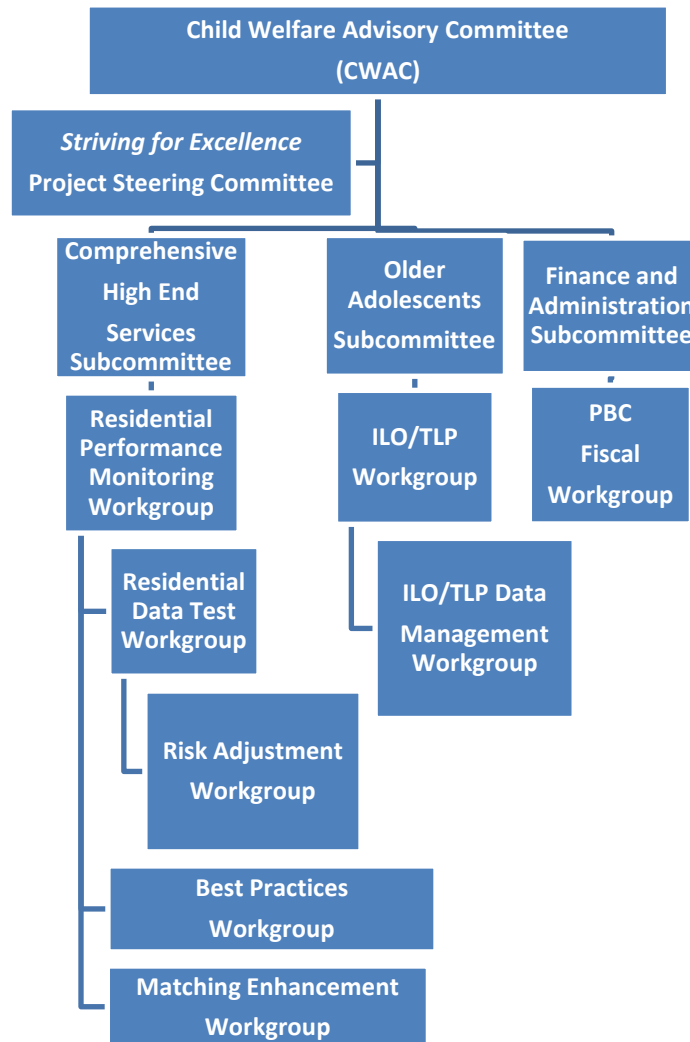
Incorporation of outcome expectations at a contractual level did not translate to specific expectations or activities at the practice level: Through the course of the project meetings, participants identified that there was not clear translation of outcome expectations

into daily practice expectations or improvements. Though CMA management staff were knowledgeable of contractual outcomes, these outcomes had not been broken down into core practice activities that would help meet the true intent of the measure. Such focus on practice is critical when looking at how an organization will best be able to meet contracted performance expectations. The Florida project team addressed required practice changes through the implementation of supervisory training and enhanced Continuous Quality Improvement (CQI) initiatives that clearly identify practices that will facilitate improved outcomes.

Illinois

Process of implementation

Implementation of the project was completed as of December 30, 2009 and their final report has been submitted. In January 2007, the Illinois Project created the Striving for Excellence Project Steering Committee as a part of the Illinois Child Welfare Advisory Committee (CWAC) structure to guide the work of this project. The internal DCFS Implementation Team and CWAC subcommittees and workgroups continue their work on this project to coordinate efforts in the public sector. See the Illinois Child Welfare Committee Structure below.



A number of these committees, subcommittees and workgroups have contributed to the project's work. Additionally, an annual Residential Provider Forum was used as a vehicle to discuss current PBC issues, assess progress, share best practices and communicate future directions in Residential PBC. These committees are described in more detail below.

Project Steering Committee

The Project Steering Committee was comprised of the CWAC Subcommittee and Workgroup Chairs with equal representation from the Department of Children and Family Services (DCFS) and private residential, Independent Living (ILO) and Transitional Living Program (TLP) providers. These committees continued to meet throughout the project period and after to provide policy guidance and project oversight. They closely monitored the progress of the residential performance outcomes throughout this period and collaboratively addressed potential fiscal problems created by the Illinois budget deficit.

Throughout the project, committee meetings were typically held bi-monthly, however, declined in frequency in the last months of the project and beyond. The project evaluator

attended all Project Steering Committee meetings in person to observe, document and evaluate the processes used to implement and sustain this project.

Residential Performance Monitoring Workgroup

This workgroup is comprised of the DCFS Residential Monitoring Director and a residential provider agency executive. Tasks for this workgroup have included the formation of a technical assistance or mentoring network to encourage the sharing of information between agencies currently using the identified best practices with those who are in need of assistance, identifying a new workgroup for Best Practices and .

Residential Data Test Workgroup

This workgroup is comprised of representatives from DCFS, private provider agencies, Northwestern University, Chapin Hall Center for Children, and the University of Illinois at Chicago. This group reports to the Residential Performance Monitoring Workgroup and the High End Services Subcommittee which was tasked with examining and refining the specific outcome measures, data sources, and recommendations for risk adjustment throughout the life of the project. They are the primary workgroup monitoring the data collection and analysis of the residential performance indicators developed for this initiative. It is co-chaired by a University of Illinois at Chicago representative and the DCFS Quality Assurance Manager for Residential Treatment. A residential provider agency executive, who co-chairs the High End Subcommittee and another residential provider agency executive, who co-chairs the Residential Performance Monitoring Workgroup serve on this Data Test Workgroup, which enhances the communication between all of the groups working on this project.

In the final stages of the project, this workgroup analyzed the variances in lengths of stay in like agencies (mild, moderate, severe) providing residential care. They determined that the Sustained Favorable Discharge Rate (SFDR) measure (described below), which contains length of stay in its statistical model, could be adjusted to further incentivize shorter lengths of stay. This was seen as preferable to adopting a third performance measure related to length of stay. They continued to look at potential variables for inclusion in the risk adjustment model. In addition to determining necessary changes to data collection in RTOS (Residential Treatment Outcomes System) and recommended elimination of items which were captured in other data bases to prevent duplication of effort.

The Finance and Administration Subcommittee & PBC/QA Fiscal Workgroup

This subcommittee is co-chaired by a private provider CFO and the DCFS Deputy Director of Budget and Finance. The work of this Subcommittee has tackled such issues as 1) rate re-structuring for the residential provider system using a three-tiered approach (mild, moderate and severe) to classifying programs and assigning rates, 2) underutilization of residential beds and waiting lists for severe beds which cost the Department almost \$1,000,000, and 3) assessing the impact of higher incentive payments than anticipated on the budget and the life of the performance based contract.

The Finance and Administration Subcommittee formed an expanded PBC/QA Fiscal Workgroup to review the financial aspects of this project and make recommendations to the Steering Committee. This expanded committee includes representatives from the Data Test Workgroup to ensure programmatic as well as financial expertise in the development of the fiscal structure.

Statewide Provider Forum

The Department and the Illinois provider association, Child Care Association of Illinois (CCAI) convened annual Statewide Provider Forums each spring at Governor's State University. All residential, ILO and TLP providers were invited to attend. Residential providers who were achieving success were often asked to share their practice models during the forum and were available for Q & A. Data Test Workgroup members, DCFS, residential providers and university partners often presented project performance data with an emphasis on the progress made in developing and implementing the ILO/TLP performance measures, residential performance trends and favorable discharge trends based upon an analysis of historical data from FY 2007 to date. Providers were given an opportunity to pose questions and provide feedback on the project.

Residential Performance Based Contracting Methodology

The following description of the PBC methodology was taken from a guide created by the Data Test Workgroup, *Residential Performance Based Contracting Guide, Fiscal Year 2009*. This guide was distributed to all residential providers at a Provider Summit in 2008, just prior to the actual PBC being put into place.

Capacity

Prior to the beginning of each contract year (July) the Department determines the capacity it will contract with each agency (if at all), based on the agencies' historic utilization adjusted for current Department needs. This will be the capacity that will be contracted for the coming fiscal year. This process takes place at least annually but possibly more often if the residential census changes dramatically (i.e. need for more severe residential beds).

Rates

Model rates for mild, moderate and severe residential programs were established in 2007, as well as a model group home rate. These baseline rates are subject to provider-specific review conducted by the Department. The agencies are paid 100 percent of their contracted capacity at the performance contracting rate (as of July 2008). All providers will have an additional contracted rate to serve any referral that is deemed to be beyond its program capacity. Youth in this category will also be considered exempt from performance calculations. No bed holds will be paid.

Referrals

All provider referrals are made through a Department centralized matching process to ensure intake matching. Providers will operate pursuant to a ***no decline*** provision subject to review by the DCFS Deputy Director of Placement and Permanency or the Associate Deputy for Residential Monitoring when there is a dispute. Providers will not be paid for contracted bed vacancies that are a result of declined referrals.

Risk Adjustment

Given that each residential provider serves a population of children with a different “mix” of characteristics to measure, *risk adjustment* is an effort to equalize the relevant differences between client populations. Certain factors have been identified that statistically affect the Sustained Favorable Discharge Rate and Treatment Opportunities Days Rate. Certain youth carry a greater risk for poor outcomes on these indicators because of their history or complexity of presentation. These youth are weighted so as to equalize their overall effect on SFDR and TODR, so that programs with proportionally more children at risk of poor outcomes will not be unfairly measured on these performance indicators. This will “level the playing field” so that outcomes can be compared across like programs.

Reconciliation

Agencies are expected to participate in data collection process as requested. Performance data will be regularly distributed and reconciled.

Agency Performance Ranking

Like agencies will be ranked annually using a multidimensional performance matrix of gauging their overall performance. This ranking will be used by the Department to determine its annual residential contracting and resource development plans.

Performance Measures

The risk adjusted performance benchmarks were provided to each provider prior to each contract year. Each provider will have an established individualized predicted ***sustained favorable discharge rate (SFDR)*** and ***treatment opportunity days rate (TODR)***. Below is a description of each performance measure and the status at the end of the intervention.

Sustained Favorable Discharge Rate

Definition: SFDR was determined by the number of youth who experience a positive or neutral discharge to a placement that remains stable, divided by the total number of youth served. The benchmark for the agency will be established based on a risk adjusted (*see explanation above for risk adjustment methodology*) SFDR that takes into account characteristics of the youth served and the agency’s historic performance.

Financial incentives were paid annually to agencies that exceeded their predicted SFDR. For every youth who was positively discharged above the predicted SFDR, the Department paid the difference between the residential per diem and the weighted average per diem of

statewide step down placements for every day up to 270 days that the youth remains stable in a positive discharge placement, provided that the agency maintains its baseline SDFR for at least 180 days.

Status and Finding: This outcome was incentivized in the contract and \$3,155,904 was awarded to private agencies in fiscal incentives with average award of \$45,227. At the system level, the overall percentage of spells in which youth remained in favorable discharge (step-down) for 180 days post-discharge across all providers increased by over 5 percent of the total population in care.

Private agencies surpassed performance benchmarks set for Sustained Favorable Discharge Rate for FY 2009 by \$2 million dollars. The Department had budgeted \$2 million dollars to provide incentive payments to agencies which exceeded their targets.

Problems were identified related to the performance measure itself, the time period in which data is measured post discharge, the risk adjustment model pertaining to length of stay, and the calculation of the incentive payment. Therefore, although it may be seen as a positive sign that agencies vastly exceeded their benchmarks, these results need to be interpreted with caution. Until adjustments and corrections are made to the SFDR measure and a second year of performance data analyzed, it is too early to assess the impact of this measure. (For more detailed analysis, see Cross-Site Evaluation Report).

Treatment Opportunity Days Rate

Definition: TODR was determined by dividing the total number of aggregated bed days during the residential spell by the number of days youth were at the facility, i.e. not on runaway, in detention or psychiatrically hospitalized. The benchmark for the agency was established based on a risk adjusted TODR that takes into account characteristics of the youth served and the agency's historic performance. Penalties equivalent to 25 percent of the rate will be assessed for the number of bed days out of the agency that exceed the number derived from the predicted rate of treatment opportunity days.

Status and Finding: Data is kept at the individual agency level by the Department for performance monitoring in the Residential Treatment Outcomes System (RTOS). Each agency could access their own data at any time. TODR was an outcome in which agencies were penalized for not achieving their contract target. Overall, twenty four agencies (out of 41) were penalized for a total of \$712,033 with median penalty of \$23,915.

From the first year PBC was in place to its second year, the raw number of days youth were kept in care increased by over 3000 total days across the system. This change resulted in fewer dollars spent on hospitalization or incarceration and resulted in more days for residential agencies to provide the appropriate level of care in their facility.

Significant improvement occurred in the rate of use of psychiatric hospitalization and preventing runs. Overall, residential providers decreased their psychiatric hospitalization usage by 15 percent in FY 2009 when compared to FY 2008. This resulted in a reduction of 2,400 hospital days. This has been calculated to be approximately \$2.4 million in savings, predominantly through Medicaid savings. Runaway rates decreased by 10 percent between FY 2008 and 2009 resulting in 800 more days in treatment statewide. Detention rates increased statewide by 9 percent with 350 more days spent in juvenile detention or the Department of Corrections by Illinois child welfare system wards who are placed in residential care.

There were significant differences noted across classification (i.e. mild, moderate, moderate group home, severe, and chronic) level. Overall, institutional care (severe and moderate levels) are trending up in TODR performance overall. Community based settings, (i.e. mild, moderate, and moderate group homes) trended down in TODR. Moderate group homes increased their use of psychiatric hospitalization overall by 9 percent. Severe providers decreased their use by 28 percent. Mild providers increased their runaway rate by 38 percent. Severe providers also improved their detention rates by 27 percent, while moderate programs increased theirs by 22 percent, moderate group homes by 29 percent and mild agencies by 64 percent. The performance differences between institutional and community-setting residential care is being looked at by a couple of CWAC subcommittees. Across the board, moderate group homes struggled the most in meeting or exceeding performance benchmarks. (For more detailed analysis, see Cross-Site Evaluation Report).

Did Implementation Occur as Planned?

Overall, Illinois implemented this project as planned, although the ILO/TLP performance based contracting was delayed and not included in the evaluation of this project. Below is a timeline of the rollout of the Residential PBC followed by a discussion of the barriers and facilitators to successful implementation. The identified barriers are the size and complexity of the project, initial data availability for ILO/TLP, consistent public agency leadership, disconnect between residential and step-down placements when transitioning youth, and occurrence of multiple reform efforts. Facilitators to success were history of strong public and private agency leadership and collaborative working relationship, commitment of university partnerships that provide ongoing technical assistance, utilization of multiple communication strategies, and commitment to joint problem solving.

The PBC contract period, originally scheduled for implementation on October 1, 2007 did not begin until mid-November, 2007 and only included the Residential providers. The delay allowed for more significant review of the proposed contract language by the relevant CWAC Subcommittees and Workgroups, but the contract demonstration period was shortened with limited data available for review by the Project Steering Committee prior to implementation of the FY 2008-09 contracts. Due to this fact, there were few changes in the terms and conditions of the demonstration contract and the FY 2009 contracts. Several Project Steering Committee

members expressed concerns about implementing the fiscal aspects of this initiative, particularly the penalties imposed for failure to meet “treatment opportunity days” standards, without a more in depth analysis of performance data obtained over a full year. The Data Test Workgroup’s work toward the development of its agency risk adjustment strategy was very detailed.

Penalties were imposed for the first time on residential treatment providers who failed to meet their Treatment Opportunity Days Rate (TODR) in FY 2009. The decision was made to finally allow the performance of all agencies “to go public” and be disseminated to agency executives. This was done via email by DCFS to agency chief executive officers. Three spreadsheets were sent to each agency:

1. A report showing Treatment Opportunity Days Rate (TODR) performance results for all residential performance based contracts sorted in four different ways: a) alphabetically; b) classification level; c) specialty population; and d) population density.

Each report contained contract-specific information regarding total spells, bed days, total absent days, total present days, actual TODR, benchmark TODR and the difference between the actual and benchmark TODR. Noted at the bottom of the *alphabetical report* is the percentage of absence days (out of total bed days accrued during FY 2009) for all contracts, and the average actual TODR, benchmark TODR and difference between actual and benchmark TODR. Similar information is subtotaled for the other reports by the sort type (i.e., classification, specialty population, population density).

2. A report graphically depicting TODR trends throughout FY 2009 for each agency, including:
 - a. A chart displaying the actual TODR achieved, the FY09 benchmark TODR and deviation from the benchmark (actual TODR – benchmark TODR) for each month and the end result for the fiscal year. The bottom row of the chart lists the number of youth absent out of the total number of spells (youth served) each month; and
 - b. A graph displaying the trend line of actual TODR performance each month in relation to the TODR benchmark for each contract.
3. A report summarizing historical agency TODR performance from FY 2006 through FY 2009.

As mentioned previously, fiscal incentives for Sustained Favorable Discharge Rate (SFDR) performance actually almost doubled the projected budgeted amount (approximately \$2 million to \$4 million). The DCFS Director considered amending the contract for the current fiscal year to lessen the impact of these incentives on the Department’s budget but ultimately left

the contract and benchmarks as originally established prior to the 2009-10 contract. New benchmarks were established using current provider achievement in addition to utilizing a cap of \$2 million dollars for incentives to be earned.

There were a number of identified barriers to the successful implementation of the Illinois project. First, the complexity of a statewide project became apparent at the Data Summit held in March 2007 where university partners and data repository representatives described their current data sets to the Project Steering Committee. As the CWAC Subcommittees worked diligently to develop their recommended performance measures in time for the first Statewide Provider Forum in June 2007, the complexity of the issues presented caused delays in finalizing the measures. The Project Steering Committee also recognized the need to educate providers on the basics of performance based contracting at the first Statewide Forum as over half of those in attendance were not foster care case management providers and had no prior experience with the concept.

Related to the complexity of a statewide project, there are also some notable challenges to the collaborative process within a project of this size. This was a statewide demonstration project expanding performance based contracting to three distinct child welfare services: residential and group home services, independent living services, and transitional living services (although IL/TLP services were not included in this project). The providers of these services are located throughout the state. They vary in size from six-bed group homes to large residential campuses. The size and scope of this initiative has hindered collaborative efforts. Steering Committee members made great efforts to ensure that all providers, regardless of their size or geographic location, are given the opportunity to provide input in the development and design phases of the project, specifically through the Annual Provider Summits hosted by CCAI.

Secondly, data collection, monitoring and quality assurance systems in ILO/TLP programs were not as fully developed as those implemented in residential. Attempts were made to replicate residential outcome measures for ILO/TLP (e.g. Treatment Opportunity Days Rate) so that they could be adjusted for risk using the current residential model. The critical stakeholders recognized that the programs were too different and required a more in-depth analysis of what ILO/TLP data is currently collected and to what degree it is reliable before an ILO/TLP specific risk adjustment strategy could be built and implemented. Due to the fact that ILO/TLP was significantly different in the population it serves as compared to the residential population, the cross-site evaluation decided to focus on the residential intervention. Although the Illinois project continued with its work in ILO/TLP, it was not captured in the findings of this project.

Thirdly, as the work of this project continued to be carried out by the CWAC Steering Committee and CWAC sub-committees, members noticed the lack of Departmental leadership in attendance at some of these meetings. Initially, the Director or Executive Deputy Director always attended Steering Committee meetings and their input was valued by all Steering Committee members. Over time, their attendance was less consistent, which led to members

questioning the project's priority and viability over time. Similarly, the QIC recognized the inconsistency in Illinois project staff's ability to communicate with QIC Staff. The QIC did not doubt that much work was taking place regarding this project in Illinois; however, oftentimes the project evaluator was the only representative attending an All Project or individual project call. The evaluator always provided thorough information about the current status of the project though this should be the role of the project manager.

Fourthly, the Department's Residential Strategic Planning Workgroup looked closely at barriers to youth stepping down to and from residential treatment and how it relates to youth transitioning from residential placements to specialized foster care. Their analysis of the process identified similar systemic barriers related to the lack of knowledge of the Discharge and Transition Protocol on the part of other entities, such as foster care case management agencies. The recommendation was made that foster care agencies be made aware of funding for transition-related activities and services during Phase 2 of the discharge and transition planning process. The training of foster care case managers, both those employed in private agencies and by the Department has been sporadic throughout the life of this project. Although cross training opportunities have been made available in the past to allow residential and foster care agencies to be trained jointly, the residential providers recommend that the Department provide opportunities for cross training to develop a shared conceptualization of trauma informed care. They report that treatment gains made in residential care may be lost once a youth is discharged to a foster home placement if the foster parents are not made aware of the trauma-informed treatment approaches used in residential care. The providers are recommending that the Department consider creating an overall training approach which would be consistent across the entire system of care.

And, lastly, several major initiatives were underway at the same time. The implementation case studies conducted by the project evaluator in 2009 indicated that the impact of multiple reform efforts had a significant impact on frontline staff and supervisors in residential agencies, particularly the conversion of agencies to Medicaid at the same time as performance based contracting was being implemented. The extent and magnitude of work required of residential agencies to successfully convert to Medicaid billing and its impact on the delivery of services was not adequately planned for nor fully understood by the Project Steering Committee and DCFS leadership. Provider members of the High End Subcommittee and the Residential Provider Group continued to stress the impact of Medicaid conversion during every scheduled meeting.

There were also facilitators to the implementation of this project. The following are a few examples. Others will be contained in the section that addresses lessons learned.

First, and most critical to the success of the project, is Illinois' history of working in partnership and collaborating on systems issues. The partnership and collaboration that was first modeled by Illinois through the Child Welfare Advisory Committee is now being modeled through the work of this Steering Committee. Clearly, this is a mature system at work, in that

they are using higher level problem solving methods where all parties take immediate action to resolve the issues as well as take on the responsibility and accountability. The historical relationship of the public and private sectors provides a foundation for continued work and a place to address issues as they arise.

Secondly, the involvement of multiple university partners in providing technical assistance to the Project Steering Committee as well as the CWAC Subcommittees and Workgroups was instrumental in achieving the project objectives. By combining data contained in multiple university databases, the risk adjustment model was designed to analyze the factors that predict potential difficulties in successful completion of residential treatment. Data from the Chapin Hall's multi-state study, which was also used in the development of the National Youth in Transition Database (NYTD) outcomes, has been shared with the Project Steering Committee and Workgroups.

Thirdly, the use and availability of multiple communication strategies to disseminate information about this project statewide led to statewide provider involvement. CCAI provides a weekly *Monday Report* that updates all CCAI member agencies of the project's status and how to provide feedback to the Steering Committee. The Statewide Provider Forums hosted by CCAI allowed for face-to-face communication between attendees and project leaders. The Data Test Workgroup's electronic "base camp" was used to post minutes, reports, relevant research, and meeting notices. This tool is also useful during meetings where documents can be posted and reviewed by members who attend the meetings telephonically. Residential service providers continued to disseminate information about the project on their informal list serve which also provided information to non-CCAI members thereby increasing the project's outreach. The residential service providers met monthly in an informal setting.

And, lastly, the ability to solve problems collaboratively and rapidly put into place systemic changes to enhance project implementation was a facilitator of success. The Project Steering Committee continuously demonstrated its ability to identify problems as they surfaced and worked collaboratively to rapidly solve them so that project implementation was not hampered. The development of the Child and Youth Investment Team (CAYIT) Matching Team was a direct result of this rapid response. The Director's determination to implement a "no decline" policy in the performance based contracts led to a more in-depth assessment of the entire admission process.

The workgroup designed a centralized CAYIT admission and referral process which was facilitated by the electronic transmission of documents using the Department's D-Net web based information system. Private providers were given access to the D-Net for this purpose. Communication procedures were developed to facilitate the transmission of client histories and medical records to maximize the sharing of information thereby enhancing the decision-making process to ensure appropriateness of fit between the client and the treating agency. New protocols were developed to match children and youth with the agencies most appropriate to

meet their treatment needs. Each agency updated its program plan to provide more specific information about their treatment programs and ability to treat specific populations.

In addition to working on problems identified in the admission to residential care, the Project Steering Committee also identified problems related to discharge from residential care, particularly when stepping down youth to a less restrictive setting such as foster care. A new discharge and transition protocol was developed collaboratively by a workgroup under the direction of the Residential Monitoring Subcommittee.

Final Site Visit Focus Group Themes

The following themes in the areas of planning, communication/collaboration, PBC key components, and impact of PBC on outcomes were taken from the Final Site Visit Report located in **Appendix E**.

Planning Process

- Agreement across both sectors that the ***planning process was inclusive***.

When we walked in the room we tried to establish a collegial environment, and level the playing field. Some things were more negotiable than others, things wouldn't be written in stone and over time as an agency we would be willing to make adjustments. In the beginning they were more cautious, but as they worked in committee structures, and saw recommendations coming from group were actually the ones being incorporated, they became more open. I thought planning process went well.—IL Public

- ***The timing of the initiative was favorable and this furthered the process***. In Illinois, reform of residential care had been discussed for some time, committee work was ongoing but uncoordinated to this particular effort, and with the right leadership in place the timing was right.
- ***The timeframe required by the QIC project helped keep the progress moving***.

It helped that there were some external timelines that moved the process forward because it focused the efforts. We would have just stayed paralyzed if there weren't external deadlines – tolerance for ambiguity was good but so was a deadline.—IL Private

Communication and Collaboration

- ***Various communication structures and strategies were created to promote bi-directional exchange of information***. While CWAC served as the vehicle for planning and the state provider association served as a primary conduit, a more ad hoc group of residential providers was enlisted as a key vehicle for information exchange. Data and provider summits were also held to bring in providers statewide, and an implementation

team within the public agency was established to promote internal communication among units.

Presentations at summits were done by providers to help build buy-in because private providers were honest about where they were and demonstrated collaboration. They had to admit to their peers in a public forum that their outcomes were not good.
—IL Public

- ***Leadership in both sectors plays a critical role but cannot always devote enough time.***
- ***Some existing issues were never discussed in collaborative meetings,*** and trust issues and tension remained between sectors.

There are still elements of fear and suspicion that don't really come out in the Steering Committee. Even now, there is belief that the Department operates behind closed doors. Failing to know the full story of internal processes, some providers are suspicious.
—IL Private

We have had ups and downs with providers, but not a disconnection with them. They can say 'this doesn't feel like a spirit of collaboration now'. We were able to respond. The fact that they could say that says something.—IL Public

- There is an ***impact of the history of how prior administrations did not act in a collaborative manner*** as well as reactive rather than proactive planning at times.

Key Components to Implementation of the PBC

Quality of Data

- ***Integration of data housed in multiple universities and a system for reconciliation of data and indicator measurement between sectors*** was identified as necessary components.

Decisions on use of incentives and disincentives

- Some form of ***fiscal consequence focuses attention on outcome achievement*** and virtually all believed improvement would be demonstrated over time.
- ***Concessions may need to be made in order to enable providers to commit given the risk.***
- ***Clarity regarding the outcome definition and how they would be measured is crucial.***
- ***Thought should be given to how earned incentives could be used,*** and whether or not providers should be required to re-invest them in some way.

Selection of Contract Indicators

- Some of the ***factors associated with selection of indicators were feasibility, accessibility, simplicity and timing.***

I don't know. There are a number of ways to get at what we are trying to do. Whether there are better ways to get at this, I don't know. The ones we selected are too complex. Are we changing practice to the extent we can sustain practice over time? That will be the measure of whether these are the right outcomes.—IL Private

- **Established measures were complex** and did not necessarily measure whether kids were getting “better”.

Components of the Quality Assurance system

- **Emphasis shifted from compliance and oversight to technical assistance** and developing a continuous quality improvement approach.
- **There is value of data sharing** across providers to promote practice improvement.

Recommended Changes

- A shared vision needed to be developed regarding residential care as a part of an overall system of care.
- There was a need for emphasis on gaining buy-in from the frontline.
- Held harmless period should have been a full year.
- Accountability should be promoted in the public sector as well as the private.

Impact of PBC on outcomes

- Some providers were recognized for re-thinking their treatment process to focus on evidence-based methods.
- Practice protocols were created to address challenges such as centralized matching of youth to facilities and a transition protocol for stepping youth down into the community, as the achievement of outcomes required it.

I think these changes are for the better. They can look at similar providers and show the facilities that are doing a better job treating youth and stepping them down. One program is re-doing their entire philosophy and treatment process because of the data we have been able to provide them on length of stay and other indicators.—IL

- **Some providers made a conscious decision not to discuss the contract or its fiscal aspects with staff.**
- There was a **significant increase in the use of data within the system**. Data-driven decision-making had been implemented, and trust in the data had increased in the provider community.
- **The collaborative process resulted in an improved child welfare system and outcomes for children.** Relationships and understanding of the roles and strengths across sectors had improved. The combined performance based contract, and the use in a more

integrated quality assurance and improvement process was believed to have resulted in enhanced evidence-informed practice and data-driven decision-making.

Are we better now than when we started? Yes, we are much more active, we understand things more deeply, have common goal of the health of the child and family. The system is better off. It has uncovered a lot that we had to do, it is forcing us to move forward.—IL Private

- ***Collaboration and relationships across the sectors improved.***

For whatever missteps we might have made in judgment on the frontend, the good will that was bought as a part of the process, the flexibility we demonstrated, living up to what we committed to—over the long haul it will serve us well.—IL Public

- ***Increased understanding of performance data, and a data-oriented, accountable system.***

Other final thoughts from Project members:

The commitment everyone has shown to make sure it has been on a successful path. The public side was able to sit at the table and let go of a tremendous amount of control. There were lines drawn in the sand, and then smudged and re-drawn where people could come to consensus and agree not to step over it.—Illinois

There was a culture that existed where everyone could cut their own deals and a lack of transparency on how we worked with the provider community. To get the group to see we could be transparent, look at each other's rankings, and still come out a whole—we had to build trust and good will.—Illinois

I am supportive of the QIC model. It drives the amount of accountability ... There have been times I have been uncomfortable between demands for accountability but it gets a far better product. Technical assistance and consultation makes you modify what you are doing, be critical of what you are doing in a way you would do under normal funding.—Illinois

Lessons Learned

Need for a sustained, clear and consistent communication strategy between the public and private sector: Illinois learned from its past experience with the implementation of performance based contracting in foster care case management the necessity of providing meaningful opportunities for both the public and private agencies to engage in dialogue to develop a shared vision of success. Despite the challenges inherent in a project of this size, complexity and magnitude, these opportunities were provided through the use of the existing CWAC Subcommittee and Workgroup structure. This project's established communication strategies provided valuable information which the Project Steering Committee and

Workgroups used to adapt and modify their work processes to ensure additional opportunities for stakeholders to be heard.

Need for sustained and committed leadership dedicated to project implementation:

The DCFS Director remained in place throughout this project which has benefited project management and oversight. The Project Steering Committee members noted the importance of the full engagement of the Director in project activities and implementation during interviews conducted by the local evaluator following Year 1 and Year 2. They stressed his high level of commitment to this project and the level of trust invested in his leadership ability by both the public and private sectors. In the final year of the project, it became harder for the Director to attend Project Steering Committee meetings given other competing priorities. The lack of the Director's presence at Steering Committee meetings led to private provider members questioning his support and commitment to this project, although the Executive Deputy Director continued to attend meetings and co-chair.

The private agency executive leadership engaged in this project remained strong and consistent. The private agency leaders who served on the Project Steering Committee are viewed by the wider child welfare community as experts in performance based contracting. Their willingness to provide technical assistance and support to agencies struggling with implementation helped to allay anxiety and fear. They are perceived as advocates for the private sector, but also as strong partners of the public sector.

Need to effectively and efficiently manage utilization of residential treatment services:

This project highlighted the need to take a systemic and holistic approach to child welfare system reform. The use of performance based contracting in residential care would not have been possible without the changes made to streamline, automate and centralize the admissions process. The Centralized Matching Team (CMT) decreased the time from referral to admission. Providers reported that the youth now being referred to them are more appropriate.

The Department recognized the need to improve its forecasting of need. This project highlighted gaps in information and data needed to more effectively project from one fiscal year to the next the types of beds needed, particularly for specialty populations such as pregnant and parenting teens and sexually problematic behavior youth.

The Discharge and Transition Protocol was a valuable tool in helping to streamline the discharge process and heighten the likelihood of sustained stability in step-down placements. Its use highlighted gaps in service assessment and provision, especially for community-based services to support successful placements in less restrictive settings. It also helped to identify other systems, such as community mental health, education, and foster care case management, which impact residential agency performance. Agencies reported an increased awareness of the performance of other agencies, particularly those foster care or specialized foster care agencies to which youth could be stepped down, with strategies being developed at both the

state and regional levels to more fully engage case managers in understanding the Discharge and Transition Protocol and to use it as a tool to guide successful step-downs.

In these times of economic recession, when resources are scarce and the cost and duration of residential care continues to rise, it is imperative that services purchased by the state be of the highest quality and in the words of Director McEwen, “provide the right service, at the right time, at the right place and for the right price.” The forecasting of need continues to be more of an “art” than a “science”. While there will always be a certain percentage of residential beds open and unfilled to accommodate the best interest of children and youth who will either return to those placements or are transitioning to and/or from them, the Department is aware of the need to build better forecasting models to assist in managing capacity.

Need to establish clear definitions and consistent data collection: Although Illinois has a robust and reliable child welfare data system, with databases maintained by several university partners, definitional issues continued to arise. Definitions and the policies clarifying them should be fully developed prior to implementation. Without reliable data upon which to measure performance outcomes, performance based contracting cannot be an effective tool to drive system improvement.

Need for transparency in fiscal penalties and incentives: Transparency in the development of the fiscal structure for this project was critical. The DCFS Implementation Team continued to respond to questions related fiscal problems and concerns. The Department’s “Frequently Asked Questions” document has been useful in helping residential providers understand the relationship between their performance on the two residential outcome measures and their potential fiscal penalties and rewards. With the deployment of the RTOS reporting mechanisms, agencies have the ability to closely monitor their performance and calculate their potential penalties for failure to reach their benchmarks for Treatment Opportunity Days Rate and their potential reward for exceeding their benchmarked Sustained Favorable Discharge Rate.

More residential agencies reported that they tracked potential fiscal implications of a TODR penalty since they understood how the penalties were calculated, assessed and reconciled following the FY 2009 fiscal year. Agencies reported that the ability to calculate their potential penalty allowed them to make contingency plans for upcoming fiscal years. They also reported that they closely monitored the progress of youth post-discharge to increase the likelihood of a successful sustained placement which would entitle the agency to a bonus.

Importance of internal coordination of efforts in the public agency: The DCFS Implementation Team took the lead in coordinating efforts and overcoming internal bureaucratic barriers and silos within the Illinois Department of Children and Family Services. The organizational structure of the Department is complex. There are six different divisions with direct impact on this project: Placement/Permanency, Clinical Practice/Professional

Development, Service Intervention, Budget/Finance, Field Operations and Monitoring. Three other divisions have more indirect involvement: Child Protection, Planning/Performance Management and Communications.

Using a collaborative model, the Team analyzed the problem and worked with staff assigned to the division impacted to resolve the issue. This was particularly helpful in assessing the issues raised as a result of the underused capacity in residential care. The complexity of the problem could not have been identified without the full engagement of the Fiscal Office, Field Operations, Monitoring and Placement/Permanency. The Team continued to closely monitor bed capacity each week and regularly communicate on the status during the week.

Importance of determining the potential impact of multiple reform efforts being implemented simultaneously on both senior leaders in the public and private sectors and the frontline staff responsible for direct service delivery: Significant child welfare reform and innovation continued to occur in Illinois. The proposed merger of the Department of Juvenile Justice and the implementation planning process required by the Executive Order are by necessity requiring intense focus from the DCFS leadership team. Two large, multi-year new federal demonstration projects have been awarded to DCFS to implement enhanced efforts to diligently recruit foster families and implement an intensive trauma informed practice model to shorten length of stay in foster care for youth entering the child welfare system between the ages of 9 and 12. While the Department's administration remained firmly committed to child welfare system improvement, all of these efforts required significant staff time from senior leaders of the Department, most of which are also under a mandate to take unpaid furlough days two days per month. The impact of additional stress placed upon these essential public agency staff through their involvement in multiple change efforts, while experiencing forced furlough days at the rate of two days per month adding to workload impact, should be seriously considered.

On the private sector side, preliminary findings from the local evaluation over a two year period of implementation case studies in ten diverse residential agencies revealed the negative impact on frontline staff of rolling out performance based contracting, conversion to Medicaid fee for service and the Discharge and Transition protocol at the same time. While the Project Steering Committee and the Department were aware of the need and rationale for successfully certifying private agencies so that they could bill Medicaid for services rendered, the magnitude of the workload implications on agency staff was unanticipated. This highlighted the need for better coordination of reform and innovation efforts prior to implementation. It is critical that a high level of coordination – coupled with collaboration with the private sector to ensure their unique perspective is considered – take place as the new innovations are deployed.

Missouri

Process of Implementation

Implementation of the project was completed as of September 30, 2009. Missouri did not continue implementation of this project in the third funding year. Although local evaluation efforts were discontinued, public-private partnership work around performance based contracting and quality assurance continued. Assistance from the cross-site evaluation team was provided in order to complete evaluation activities.

The Missouri project built upon several years of public-private partnership work, specifically performance based contracting. Initial contracts were awarded June 2005 to seven consortiums to serve the St. Louis, Kansas City, and Springfield regions and were for a period of three years. The QIC project began mid-contract, therefore was able to look at current performance measures and the quality assurance systems and plan for the upcoming contracting period to begin late 2008. The Missouri Project established and enhanced several working groups to take on the PBC/QA work: Advisory Board, CEO Meeting, Program Managers Meeting, and Local/Regional CQI Meetings. These groups were to guide the implementation of the performance based contracting and quality assurance system. Each groups' work is described below. The project evaluator attended Advisory Board, CEO, Program Manager and Local/Regional CQI Meeting in person to observe, document and evaluate the processes used to implement and sustain this project.

Advisory Board

A QIC project Advisory Board was created in late 2007. Board members included the Missouri Children's Division (CD) managers, private provider CEOs and community stakeholders. The primary purpose of the group was to determine the information that was needed to explain the quantitative outcomes and how the information would be collected. This group met on a very sporadic basis, less than bi-annually, and was not used to advance the work of this project. This group was soon dissolved at the end of project funding.

CEO Meetings

CEO meetings are held on a quarterly basis and include all seven consortia CEOs and CD central office and regional management. Typically, contract and performance measure issues are discussed during these meetings. Other topics, such as contract amendments, outcome achievements and targets, SACWIS compliance and challenges, cost comparison, and specific regional performance issues (i.e. St. Louis' decrease in monthly referrals). As more and more practice issues arose during these meetings, it was determined that a separate Program Managers meeting would be held to include public and private agency program managers.

Program Manager Meetings

Program Manager Meetings are held quarterly and are facilitated by a private agency representative. The group creates their own agenda based on identified practice issues. Some

of the issues identified over time have been the following: adoptions, Another Planned Permanent Living Arrangement (APPLA) outcomes, outcome measures and target adjustments, SACWIS, worker visitation, critical incidents, working with children who run, replacement case protocol, and case selection for the rebuild process. This group was also responsible for organizing and setting the agenda for the statewide Public/Private Practice Summit.

Local/Regional CQI Meetings

Within the first six months of implementation of the PBCs in 2005, prior the QIC project, Continuous Quality Improvement (CQI) Meetings were implemented at the local and regional levels. These meetings were designed to address implementation issues at the lowest level possible. Issues which could not be resolved at the local level were referred to the regional CQI; issues which could not be resolved at the regional level were referred to the state level tier, CEO meetings. However, through the public/private partnership work of QA Managers, the Program Manager meetings now serve as the state level tier for the CQI process where ad hoc groups are created to address practice issues in a timely manner.

Over time, the CQI meetings evolved into a time to discuss quality assurance and best practice issues. Invitations for the regional CQI meetings are sent to the public and private QA and QI specialists. Staff are invited to set aside additional time at these meetings when necessary to ensure there would be time for the QA discussions.

Performance Measures

Missouri worked extensively in collaboration with private agency contractors in creating the performance measures as well as the targets for each measure. The measures were based on required measures for the Federal Child and Family Services Review. Targets were reassessed prior to each new contract year, however, until the recent contract year, targets had remained unchanged. This was in part due to the lack of data available to assess performance measure achievement. Each performance measure is discussed below. For evaluation purposes, mirror units were set up in two counties within two regions within the public agency. They were to serve as the control group. These mirror units were designed to have similar characteristics of private agencies, such as supervisor to worker ratio and a cap on the number of cases per case manager.

Permanency

Definition: Permanency achievement is defined as the number of children achieving permanency within the contract year. Target rates for permanency were set using public agency historical data with a 2 percent increase, as agreed upon by the private providers. Each of the three regions had unique and individualized targets for this particular performance measure. A built-in incentive or disincentive is inherent in the case assignment model. If an agency achieves permanency and sustains permanency prior to the 12-month period, then that agency continues to receive the case rate for that case. However, the agency does receive a replacement case at the end of the contract year. So, financial gain is minimal.

It was expected that by establishing a reasonable target and offering an incentive for moving children to permanency more efficiently and expeditiously that agency would be able to achieve higher rates of permanency than in previous year.

Status and Finding: The design of the contract necessitated the transfer of cases annually and every three years. A change in case managers often delayed permanency. The Children's Division and the CEOs came to an agreement that in order to improve permanency and minimize case transfers which disrupt continuity of the case manager—a redesign of the contract was necessary.

Local level variables also impacted permanency achievement. For example, a court's view on terminating parental rights and a reduced rate of children entering care. The most drastic decline in the number of children entering care occurred in a major metropolitan area, which is 64 percent privatized. The number of children who entered care in 2002 was 659 and was then reduced to 249 children in 2009. The permanency measure was based on historical data from prior to 2002; therefore, the permanency target was likely too high as none of this region's providers met the goal the first three years of the contract. In the fourth year, two of the three contractors met or exceeded the permanency expectation. The permanency target for Year 5 was renegotiated with all providers.

Stability

Definition: The stability target was based on total number of moves for a population (total number of cases for which a consortia is responsible) which is active during a specified time period with the expectation that each child would experience two or fewer moves.

The CD and consortia used the CFSR target established for stability as a guide. The goal was to achieve two or fewer moves for each child in out-of-home care.

Status and Finding: The outcomes for Years 1, 2, and 3 (Performance Based Contract years: 2005-06, 2006-07 & 2007-08) reflect an artificially inflated performance for Year 1 with overall performance declining each year. Each year cases were transferred in order to equalize caseload numbers across consortia; therefore, when the number of moves were calculated in a cumulative manner, new contractors were then penalized for prior instability—even though the instability did not occur during the time they were providing case management. Although it is in the best interest of the child to measure stability in this way, it was not reasonable to penalize contractors for the previous contractor's inability to stabilize a child's placement. Therefore, penalties or incentives cannot be tied to this measure when agencies cannot be held responsible for prior moves in the same contract year that took place in another agency.

Re-entries into Care

Definition: Re-entries were defined as any child re-entering out-of-home care within six months after achieving permanency through reunification with the birth parent, relative or adoptive placement.

The CD and consortia use the CFSR target established for re-entries as a guide. Although some re-entries are anticipated, the goal is to have as few re-entries as possible.

Status and Finding: Although a trend of decreasing performance was evident, the contractors still met the performance target in Years 1 through 4. One possible explanation for declining performance (i.e. increased numbers of children who re-entered care) could be that as the number of children served increased, the amount of time increased as well between Year 1 and Year 4, increasing the likelihood or possibility of re-entry.

Safety

Definition: This is measured by the number children who experience abuse or neglect while placed in out-of-home care with a contractor.

The CD and consortia use the CFSR target established for safety as a guide, although in the last year, the group did decide to raise the target in order to emphasize the importance of safety while in out-of-home care.

Status and Finding: Trends in performance on the safety measure are also difficult to evaluate as three contractors and one mirror unite group had no children who were abused/neglected by their alternative caregiver in Year 1. In Year 2 five contractors and one control group achieved 100 percent on this performance measure. In Year 3, all contractors and control groups met the performance expectation. In Year 4, only one contractor failed to meet the performance standard.

Resource Development

Definition: This is the number of licensed resource homes for each contractor.

A performance standard was not developed for this performance measure. Contractors indicated in their proposal the number of resource homes they planned to develop. In Year 3, two of the contractors did not develop the number of homes they indicated they would in their contract proposal. However, these providers did develop more homes proportionally when compared to contractors serving twice the number of children. As this measure was not designed in a manner to be indicative of performance it was not evaluated for Year 4.

Did implementation occur as planned?

Missouri encountered a great number of obstacles during implementation of its project. Although the current status of their public/private partnership is strong, findings for this project will be limited. The identified barriers are significant changes in project management, public agency leadership and project evaluation; data reliability and access, budgetary shortfalls, caseload assignment/equalization and outcomes. Facilitators to success were history of strong public and private agency leadership, collaborative working relationship and commitment of middle managers to improve practice through the sharing of practices across sectors.

Most significantly, project management and evaluator changes impacted the project's ability to stay focused and maintain momentum. The co-author of the original application, the person having the most institutional knowledge about Missouri's public/private partnership and the planning and implementation of the PBC, left the agency prior to the start of the project. The new project manager had little to no experience in public/private partnership work at the Children's Division. Public agency leadership, especially in the beginning, was disengaged in this project; therefore, the key interventions were in jeopardy of not being implemented because of the lack of authority present to push the project's initiatives. There were four different project managers over the course of the project, and a change in the lead evaluator after the first year. Due to many missed deadlines regarding evaluation activities, the Children's Division worked with the University of Missouri-Columbia to have another evaluator assigned. Until the return of the original project manager (co-author of the application) in late 2008, the QIC consistently pushed towards the implementation of their interventions and at times were very concerned about the lack of progress. However, when the original project manager returned to the agency, the project received the leadership it needed and momentum began.

It was understood from the beginning of the Missouri Project that their performance based contract and quality assurance system was in place the prior year. This project's intervention was to involve adaptations to the current contract and quality assurance system. This project would also be looking at the maintenance of the public/private partnership over time. The University of Missouri completed an evaluation in July 2007 that would inform the Children's Division and the project on future directions. The project's work was to utilize the knowledge learned from this report in order to make improvements, adaptations, and revisions in current practice; however, the Children's Division did not use this report's recommendations—which provided feedback from multiple stakeholders in the PBC. There were also early plans to revise the current quality assurance system as it was believed that the private providers were not using Children's Division data regarding outcome performance to understand practice trends occurring at individual agencies. This could have been due, in part, to private providers' belief that they have reliable data management systems on which to rely regarding accurate outcome achievement data. Significant quality assurance and quality improvement adaptations did take place late in the project. Anecdotal feedback suggests that these adaptations are moving the partnership forward in their system improvement but occurred too late in the project to know how they impacted outcomes.

Initially, the project team did not buy into the inclusion of a private provider serving on the project team even though all consortium members supported to application. It was apparent that the private provider community was supportive of the QIC work but due to lack of leadership in the beginning and the newly appointed project manager's lack of experience in working with the private providers, the private sector was left out of early QIC project planning.

There was also a significant delay in pulling the Project Advisory Board together. This Board was made up of representatives from the Children's Division, private child welfare services community, legal system, foster care providers and a faith-based organization but was disbanded shortly after the termination of the project. The Board was not utilized in its fullest capacity.

Delays were experienced because of significant issues with the data management system and the capability of the public agency to retrieve accurate and timely data. This caused a delay in the release of the Request for Proposals in 2008. The plan was to revise the outcome targets after examining performance for the third and final year of the first performance based contract. Due to the conversion to a SACWIS compliant system, those outcome measures were unavailable. As there were only two one-year renewal options for the first contract, a decision was made to release the RFP with the initial outcome targets. This data took over a year to receive.

Barriers to implementation are as follows:

As was discussed above, the most significant barrier to the successful implementation of the Missouri project was the ***early and frequent change in project management***, change in project evaluators after the first year and the inconsistent involvement of Children's Division leadership, especially in light of the inexperience of the project manager in the beginning.

There were also significant barriers to ***obtaining accurate and timely data throughout the project***. This has inhibited their efforts in being proactive with practice change but they believe this will improve over time as improvements are made to FACES, Missouri's newest SACWIS. Providers have had to wait over a year to receive accurate data regarding their performance measures. Fortunately, all providers are required to have their own Quality Assurance department and it appears that many of these agencies track their own performance.

Another major issue related to data and data management systems occurred in 2009. Up until this point in time, Missouri Children's Division and contractors had multiple data management systems. Private agencies were allowed to enter data into their own management systems as well as upload data into FACES, the Missouri SACWIS. Missouri met with the Children's Bureau for the AFCARS exit conference and later, Administration for Children & Families (ACF) visited Missouri Alliance. Federal dollars were at risk if contractors did not begin to utilize the SACWIS case management system as it was intended. Some contractors had data

entry staff entering information into FACES whereby case managers were not utilizing the system to guide practice as it was intended. The RFP did not clearly outline expectations related to the SACWIS system. The PBC contract renewal for Year 5 (fifth year of PBC between Children's Division and contractors) contained an amendment which required the contractors to discontinue data entry into their system once an input file has been created to allow daily updates of information to be provided from the state's system to the contractor's information system.

And, finally, another key decision that impacted the QIC evaluation was to disband the mirror units, or pilots. The pilots that were established to assist with the evaluation of this contract through establishing units within the Children's Division that replicated some of the conditions in the private sector were difficult to set up and maintain. Most importantly, the new regional directors were not in support of continuing the pilots due to the difficulty of maintaining the staffing ratios. Often they had to make sure these units were fully staffed to meet supervisor to staff ratio, often at the detriment of another nearby county who also needed staff. In addition, they allowed for comparisons which were viewed by the Children's Division to be harmful to the partnership because public agency staff views this as "us" vs. "them".

There was a ***proposed budget cut for contracted case management services***. This reduction has been removed from the budget but could be reintroduced. The St. Louis providers did agree to a reduction of 80 cases. There have been staffing reductions for Children's Division. When the project director resigned, the position was not replaced which ultimately resulted in Missouri not applying for the final year of QIC funding.

As the contracts were introduced the new (fourth) region and during the rebuild process at the end of each contract year a child/family had the potential to be assigned a new worker resulting in an inadvertent adverse event for the family due to a contractual procedure. As the result of the shift of cases from St. Louis City to other counties in the region 31 additional children were transferred to a new case manager. ***Attempts to provide caseloads which are equitable have, at times, also resulted in a change of case management providers***. A change in case managers can delay permanency for a child.

Cases transferring between agencies often created barriers for outcome calculations. For the baseline information and the comparisons across the three groups for Year 1 and Year 2, the case was assigned to the case management agency which served the child for the longest period of time during the reporting period. The outcomes were calculated for the time the child was assigned to that case management entity for an unduplicated count. For the cases which transferred at the beginning of the fourth year from one contracted agency to the other two contracted agencies within the region a decision was made to utilize the same methodology for an unduplicated count.

Facilitators to the success of project implementation are as follows:

A history of strong public and private agency leadership helped to build a foundation for the current performance based contracting and quality assurance system improvement work. The consortium of contract providers include a number of CEOs and directors who have also worked in the public agency. The relationship between the public and private leaders grew stronger over time and both sectors are now committed to working through issues that arise related to the contract, data management and practice. Open and honest communication is now valued by the partnership and has begun to take root throughout the middle and frontline staff in both the public and private sectors.

Collaborative working relationships are necessary in order to address system-wide issues. For example, one of the greatest achievements was the work accomplished during the statewide QA/QI Summits. These Summits brought together Quality Assurance staff from both the public and private agencies, and, for the first time, they were able to discuss such important issues as what role QA directors/staff play in their own agency as well as defining common terms. The local evaluator viewed this meeting as a real starting point for both public and private agency staff who serve in these capacities, either formally or informally, to build consensus and role clarity. After the first Summit, this group met quarterly at the regional level and at least yearly as a state group.

Commitment of middle managers to improve practice through the sharing of practices across sectors has moved the system forward. The Program Managers established themselves as a permanent body through the Program Managers' meeting and took on the role of a top level Continuous Quality Improvement (CQI) structure. They provide leadership to the various ad hoc work groups and serve as the organizing body when new issues arise. A private agency represented was elected serves as Chair for this group.

Final Site Visit Focus Group Themes

The following themes in the areas of planning, communication/collaboration, PBC key components, and impact of PBC on outcomes were taken from the Final Site Visit Report located in Appendix E.

Planning Process

- ***Agreement across both sectors that the planning process was inclusive.***

*This process has been pretty inclusive. Not always agreement, but inclusion.—MO
Private*

- ***The timing of the initiative was favorable and this furthered the process.*** Missouri had completed a pilot using PBC, was already seeking accreditation, and was looking to improve practice.

[The former director] helped shaped vision with pilot sites and comparison— his vision was bigger than just using PBC for accreditation; saw that the privates had expertise and thought that this would move CW forward and to push best practice forward with privates and public partnership.—MO Public

- ***A tremendous amount of planning meetings were held.***

I went to all meetings, lots of meetings and there was a sense that you couldn't afford not to be at meetings; there was a lot of meetings beyond what was needed.—MO Private

Communication and Collaboration

- ***Various communication structures and strategies were created*** to promote bi-directional exchange of information. CEO meetings and regular program manager meetings that focused on practice improvement rather than administrative issues were helpful.
- ***A new process for collaboration among quality assurance staff*** was created to promote integration of use of data and practice change.

Program managers meetings have been very positive and real partnership. We can bring up anything that may challenge a practice/policy – very cooperative, useful – all CD Regional Directors attend the meetings too. The CEO meeting is facilitated by CD – The Program Manager meeting is co-facilitated. This is a difference.—MO Private

- Some existing issues were never discussed in collaborative meetings, and trust issues and tension remained between sectors.

I wish we could focus more systemically and strategically about how the partnership is functioning, data trends, and how we can address the resource issues. There are bigger issues that don't get on the table.—MO Private

Key Components to Implementation of the PBC

Quality of Data

- A crucial component was the quality of the data system, both in terms of ability to measure outcome indicators as well as in continuous quality improvement. Challenges were experienced in their current data systems, dealing with the reliability of the data and the use of historical data to forecast benchmarks.

Decisions on use of incentives and disincentives

- Some form of ***fiscal consequence focuses attention on outcome achievement*** and virtually all believed improvement would be demonstrated over time.
- ***Clarity regarding the outcome definition*** and how they would be measured is crucial.
- ***Transition processes*** such as case transfer decisions need further examination.

- ***The system needs to use data regularly*** to revisit benchmarks, examine the relationships between the contract indicators and other desired practice and client outcomes, and identify unintended consequences such as certain types of providers or children who may be disproportionately impacted.

Selection of Contract Indicators

- Some of the ***factors associated with selection of indicators were feasibility, accessibility, simplicity and timing.***

We have been talking about this for 5 years but there has been no change in the contract to address [outcomes for older youth] or other issues we agree need to be tracked. As a state our system should support other outcomes than the federal outcomes. We have a cookie cutter approach.—MO Private

- ***Established measures*** did not necessarily measure whether kids were getting “better”.
- ***Lack of buy-in*** from judges, frontline complaints regarding emphasis on numbers, and the fact that some measures were impacted by the passage of time were challenges to the system.

Components of the Quality Assurance system

- ***Emphasis shifted from compliance and oversight to technical assistance*** and developing a continuous quality improvement approach.
- ***There is value of data sharing*** across providers to promote practice improvement.

Recommended Changes

- The state decided to directly incentivize permanency, and build a truer linkage between outcomes and payment; however, their ***case transfer process needed revision***, so their original system for re-building caseloads for agencies annually needs to be abandoned.
- ***The role of business decisions on the part of private providers needs to be explored.***
- Some indicated the ***contract was overcomplicated and included excessive oversight.***

Impact of PBC on outcomes

- ***Program managers, Practice Summits and QA meetings focused on collaborative sharing of best practice across agencies*** based on their review of outcome data.

Although there is competition among consortia, there is coordination and cooperation of practice at the program manager level. The QIC process can take credit for setting up the program managers as a body for CQI—these program managers do share openly on practice.—MO

- There was an ***increase in the use of data within the system***. They experienced a linkage between data and outcomes for children, and an emphasis within the system to determine what is working to improve outcomes.

Learning from the outcomes, meaning when there are good outcomes, what is helping that occur and sharing that. We recognized the need to bring the private agencies in on the CQI process. Action plans develop from that.—Missouri Public

- ***The collaborative process resulted in an improved child welfare system and outcomes for children***. Relationships and understanding of the roles and strengths across sectors had improved. The combined performance based contract, and the use in a more integrated quality assurance and improvement process was believed to have resulted in enhanced evidence-informed practice and data-driven decision-making.

Our system is stronger and we have better outcomes for kids. We think more critically about our work.—MO Private

- ***Collaboration and relationships across the sectors improved***.

Moving from ‘us vs. them’ to ‘they are us.’—MO Public

Other final thoughts from Project members:

You need robust data, outcomes, and evaluation to determine what it means and how to use it because you need it to improve practice.—Missouri

Lessons Learned

Important to inform community stakeholders of the intended purpose of the partnership and the contract: A large group was assembled to develop the contract. However, community stakeholders at the local level were not informed of the contract as they should have been. When the Springfield region expanded in Year 2, stakeholders were invited to attend local meetings in preparation of the contract. As the contract expanded to three new regions in Year 4 there were not enough time allotted for implementation, and, as a result, stakeholder involvement was limited and there have been court collaboration issues. The Children’s Division and contractors have worked with judges and GALs in order improve relationships.

Need for dialogue with public child welfare agency staff regarding PBC: Only those staff who would be directly involved with the contracts were provided detailed information initially. Case carrying staff will experience loss as their cases are transferred to the private agencies. They need to understand the contract so they can be supportive of the case transfers.

An increase in communication and support is needed during the transition: All CD staff needed information regarding the PBC. Only staff who were directly involved with the contracts were provided detailed information initially. Case carrying staff experienced not only the physical loss but an emotional loss as their cases were transferred to the private agencies. The public agency staff needed the opportunity to learn more about the public/private partnership work and the PBC so they could be supportive of the case transfers.

Planning and preparation needed for staff transitioning to contract monitoring role: The transition of case-carrying staff to contract Oversight Specialists was a long process. Missouri did not study turnover rates for these staff which may have been a complicating factor as the initial training for these staff was never been repeated. Local supervisors are relied upon to provide the initial training for these staff. Consequently, Oversight Specialists were taking on a varied role from providing technical assistance related to public agency policy to providing consultation regarding individual practices at the private agencies. It became clear that it would be important to provide a uniform training to all Oversight Specialists regarding their roles and responsibilities.

Important to designate staff for the analysis required throughout the caseload equalization process: The ongoing difficulty and complexity of calculating the case assignment process was not planned for. Due to the mobility of children in out of home care, this remains a challenge to date and the next iteration of contracts will address this issue in order to lessen the impact on children in care (i.e. stability in placement and worker stability).

Specialty services require additional training: The specialization of adoption services was an issue which presented shortly after implementation. CD provided training in Year 1. Subsidy issues continue to arise. As a result, an adoption workgroup was established in 2008. Subsidy training is now ongoing.

Unintended consequences of rebuilding the contractor caseloads each year: Annual case rebuilds and re-bids resulted in a change in case managers. A change in case managers can result in delayed permanency. The structure of the contract needed to be examined to determine if a performance based contract can be developed which will not require ongoing case transfers. This will be a priority over the next one to two years.

Unintended consequences in setting up the mirror units: The pilots that were established to assist with the evaluation of this contract were difficult to set up and maintain. In addition, they allow for comparisons which can be harmful to the partnership when individuals view this as us (public) vs. them (contractors). The mirror units were dissolved near the end of the project.

Difficulty in calculation of outcomes: At the end of each contract year, cases were sometimes transferred to different agencies in order to maintain the equal caseload. Changes

in case management agencies complicated the outcomes calculations. In addition, performance targets are difficult to establish. Local variables can impact outcome measures such as permanency. As such, longitudinal data is needed to clearly identify trends.

Necessary to include private agency in quality assurance activities: Joint QA activities were not occurring until recently. This was a major oversight by the public/private partnership. Both the public and private sectors are vested in Missouri's outcomes for children but the greatest impact will occur when both work together to improve service delivery to all of our children and families.

More emphasis on open communication between partners: Missouri has ongoing, open communication with its private partners at all levels. This has served as a solid foundation for the partnership. From the beginning, Missouri has utilized a solution-focused model which has allowed for timely adaptation to address areas of concern.

QIC PCW Projects in Contrast

While each project was charged with testing innovative performance based contracting and quality assurance systems, the three QIC PCW projects were unique in a variety of ways. For example, Florida and Missouri focused on foster care case management while Illinois focused on youth in residential care. There were differences between Florida and Missouri in how those contracts worked. Florida used a lead agency model and contracted with individual agencies that served a county or multiple counties while Missouri contracted with consortiums in three regions. These consortiums shared one contract and were responsible for outcome achievement as a whole, even though there were multiple agencies within one consortium.

Each site approached the setting of outcome targets very differently, although all did use historical data in their decision making. Illinois used historical data in addition to a risk adjustment model that was to equalize risk across agencies regarding the characteristics of the youth in each program. Missouri used historical data in addition to the current CFSR performance measure targets. Specifically regarding permanency, the private providers collectively set a goal that added 2 percent to the current rate of permanency achievement. Florida utilized historical data and current state performance measure expectations. Instead of focusing purely on outcomes, they decided to incentivize practice or process outcomes such as quality supervisory meetings, timely data entry and quality birth parent contact. Targets were set during their Intervention group meetings and were established according to the group's desired expectations (i.e. 100 percent achievement on supervisory review at 4 and 30 – 45 days).

QA/QI interventions varied greatly. Most of the focus of the projects' work was spent on the planning, development and implementation of a new performance based contract (i.e. selection of measures and targets). There were new QA/QI activities but the impact of these

innovations on the new PBC is a bit unclear (see Cross-Site Evaluation report for findings related to QA/QI).

Although Florida encountered significant issues with the SACWIS conversion, their QA adaptations appeared to have actually enhanced the agencies' performance on the contract measures. By bringing the QA in-house to KCI, they were able to provide detailed and quality reviews of cases each month. Feedback was provided within the following month as to the compliance in meeting performance measures. KCI provided on and off-site technical assistance related to improving performance on the measures. Over time, KCI increased the number of QA staff in order to meet the demand of conducting these monthly reviews and the timely feedback remained important to the ongoing improvement on the performance measures. Unfortunately, this process will unlikely continue past the project period.

Early changes to Illinois' QA program were not instituted with intent to be an innovative intervention, despite the fact that this was a requirement of the QIC PCW RFP to which they responded, but occurred as a result of a public agency and union issue. When Illinois began its project, the (QA) residential monitors were all contract employees through Northwestern University. Through union negotiation, all positions were brought into the DCFS Residential Monitoring Unit. It is through these changes that innovation took place. The CWAC subcommittee on Residential Monitoring aided in the redesign of the monitoring role. Changes were made in such things as daily hours of operation, monitor-to-youth ratios and types of activities conducted by the monitors. Hours of operation shifted from the typical morning to early evening to afternoon to later evening hours in order to accommodate on-site monitoring needs. The original goal for monitor to youth ratio was 35:1. Due to hiring and budget issues, this goal has not been realized but it still remains the goal. The role of the monitors has evolved over the last four years from a compliance-driven to a quality-driven process. Monitors spend more time on-site conducting safety assessments, reviewing cases and attending case staffing. They are working towards developing a partnership relationship versus a typical "compliance" monitoring relationship in order to work through improving performance, especially as youth are being transitioned to step-down placements.

Missouri's late start on enhancing their QA system did not allow for significant findings related to its impact on their PBC. However, considerable adaptations were made in the last year and are continuing past the project's implementation. Their three-tiered QA/QI system was enhanced by adding private providers at each level (in the regions where foster care case management was contracted)—local, regional and statewide. Peer reviews now involve both public and private agency staff in the review of public and private agency-managed cases. There is also a cross-purpose: frontline and supervisory staff learn about best and promising practices from their colleagues. These reviews have led to important discussions and practice improvement, according to those involved. Another improvement in QA practices is the quarterly Program Manager meetings where discussions of performance and practice issues are not only discussed but workgroups are created to develop protocols, strategies and recommendations for the system (public and private sectors). And, finally, the Children's

Division Contract Oversight Specialists (QA staff) received more clarification regarding their role with the private agency contractors. There were often misperceptions on behalf of the Oversight Specialist (OS), other CD staff and private agency staff regarding the role of the OS. Issues often would arise regarding how they provide technical assistance versus policy interpretation. It is anticipated that this will still take some time to work through.

The following table provides a contrast of the projects in the areas of intervention, project design and outcomes:

QIC PCW PROJECTS FLORIDA, ILLINOIS & MISSOURI	
Different PBC/QA Interventions Across Sites	<ul style="list-style-type: none"> • Case management – FL & MO • Residential - IL • Public/Private Structure • Contract Specifications – Incentive/Penalties • Quality Assurance Systems • Organizational or System Supports
Different Designs Across Sites	<ul style="list-style-type: none"> • Multi-county contractors vs. comparison - FL • State-wide private contractors – IL • 3 Regional private contractors vs. public mirror sites vs. public agency + random case assignment – MO
Different Outcomes Across Sites	<ul style="list-style-type: none"> • Process & Practice outcomes – FL • CFSR outcomes – MO • Treatment & Discharge outcomes - IL

QIC PCW Implementation Activities

The role of the QIC PCW was to support, monitor and evaluate the three PBC/QA projects. It was intentional from the beginning to build a supportive network among the sites as well as a strong partnership between the sites and the QIC. The following were used to successfully support the work of the QIC: National Advisory Board, Individual and All-Project Conference Calls, Site Visits, and All Project Meetings. The QIC also used its resources for knowledge development and dissemination.

National Advisory Board

The QIC used its National Advisory Board (NAB) as a place in which the QIC and project staff could draw upon for significant technical support when needed. The NAB included representatives from the following: state-level public child welfare agencies (operating in both a public-administered and privatized system), private child welfare agencies, national public and private child welfare organizations, a national court and judges association, university and non-profit organization researchers, and child welfare expert consultants. The NAB met annually and the purpose of the meeting was two-fold: to provide a status report regarding the work of the QIC and to pose issues that required specific input and guidance. In the beginning, the QIC NAB helped to shape the final topic—PBC/QA and also assisted in the refinement of the research questions for the project. Throughout the life of the project, board members were instrumental in providing technical assistance not only to the QIC Team but to individual project sites and staff. Their time, expertise and guidance have been invaluable and continued to be of importance through the end of the QIC.

Conference Calls

The QIC held monthly conference calls with individual projects and then quarterly project calls with all projects. The individual conference calls later were reduced to bi-monthly as the need to hold such frequent calls had lessened. These calls provided an opportunity for each site to share not only an update as to its most recent intervention and evaluation activities but for brainstorming around barriers. The All Project calls were intended to provide additional opportunities for each site to offer their ideas on others' barriers as they might have had prior experience with such an issue. In the beginning, it was difficult for sites to see the value in these calls as they felt their projects were so different that they could not relate each others' experiences; however, over time, they realized how similar the issues were and how they did have strategies and suggestions for one another. For example, Illinois had more than ten years' experience with PBC in foster care case management and had many lessons learned to share with the other sites.

The cross-site evaluation team also conducted conference calls at the request of the local evaluators as a way to discuss evaluation related issues as they would arise, brainstorm solutions, and promote efficient data collection and transfer from the local to the cross-site evaluation. These calls tended to occur individually rather than as a group so that each site could discuss in more detail the local evaluation issues.

Conference calls between the University of Kentucky, University of Louisville and Pal-Tech occurred monthly, at first, then quarterly, to address site-specific issues and plans for continued implementation and cross-site evaluation activities.

Site Visits

Site visits took place bi-annually with the purpose of developing greater understanding of each project's implementation and evaluation, monitoring project activities, and providing technical assistance. Final site visits occurred with all three projects in the months of October 2009, March and April 2010. The University of Kentucky, University of Louisville and Pal-Tech staff jointly conducted the site visits. See Final Site Visit Themes report in **Appendix E**.

All Project Meetings

All Project meetings were held bi-annually to provide the QIC Team and project staff the opportunity to meet face-to-face. Projects provided updates, worked through issues in implementation and local evaluation worked on cross-site evaluation planning. Towards the end of the project, significant time was spent on identifying appropriate venues for dissemination of the QIC project findings.

Knowledge Development

The QIC PCW continued to facilitate an information-sharing network and providing broad-based technical assistance to states, private agencies and other national organizations/entities. Presentations (listed in later section) at national meetings continue in addition to the submission of publications to peer-reviewed journals (listed in later section). A professional display enables distribution of QIC PCW materials when exhibition costs are reasonable and over 3,000 CDs have been distributed at national meetings and conferences.

A listserv is maintained to facilitate communication among the network of individuals involved since the early stages of the QIC PCW, which currently has over 350 participants. This listserv has been used to pose questions related to innovative ways that states are engaging in public/private partnerships to address budget shortfall, prevention data and dissemination of information, case assignment based on severity, and performance based contracting in regards to the recruitment, licensing and retention of foster homes. A second listserv for the QIC PCW Study Team and the Project Staff was utilized so that information can be shared more easily as they worked towards the implementation of their projects.

Awareness of the QIC PCW as a source of information and consultation regarding privatization and public/private partnership has grown throughout implementation. Throughout the project, QIC staff provided technical assistance, information or consultation to a total of 137 entities including states, national organizations, private agencies, and universities via email, telephone and/or face-to-face contact outside of day-to-day technical assistance provided to the individual projects. Specifically, the QIC staff worked with 23 states, 8 of those being in the last six months. We have seen considerable interest in performance based contracting. The number of contacts with states has increased most significantly during the last

six months during the No Cost Extension period. The contacts with each state/organization were also more in-depth than in previous reporting periods. This is due, in part, to a couple of states in particular going through child welfare reform and developing performance based contracts. The QIC is bringing in five states for a Public/Private Partnership (PPP) Strategic Planning event in May 2011 and, in partnership with the National Resource Center on Organizational Improvement, we will bring in five more states for PPP Strategic Planning in September 2011.

QIC Staff, Project Staff and Advisory Board members have spent a considerable amount of time during this reporting period in planning and developing dissemination materials. A committee was developed comprised of Advisory Board members, Project staff and QIC Team members. Plans specifically targeted peer-reviewed journals, national organizations and their publications and national conferences. The QIC Director and manager collaborated with key Advisory Board members who represent such organizations as Alliance for Children and Families, Child Welfare League of America, and National Association of Public Child Welfare Administrators in identifying opportunities within their organizations for dissemination. A listing of publications is provided in the ***Section 4, Sustainability and Dissemination***.

Summits on Public/Private Partnership

One of the important dissemination and technical assistance opportunities has been the Summits on Public/Private Partnership. Summits have been held in Chicago, Illinois (2007), Lexington, Kentucky (2008), St. Louis, Missouri (2009) and San Antonio, Texas (2010) in conjunction with the annual National Advisory Board meetings. In 2007, 2008, 2009 and 2010, there were 30, 30, 27, and 31 states that were represented, respectively. Over 525 participants attended the last four Summits combined and there were a great number of repeat attenders—many attended all four Summits. States attending were required to send a representative from both the public and private sectors to participate in the discussion. The QIC has published Summit Proceedings documents detailing the presentation summaries and themes from the roundtable discussions. These are housed on the QIC PCW Web site and have been distributed via the listserv.

The Summits' format remained constant throughout the four years: panel discussions were convened on particular public/private partnership topics and then roundtable discussions were convened on the specific panel discussion topic. The roundtables addressed a range of issues: creating and sustaining a shared vision, developing authentic partnerships, using data in decision making, contracting for outcomes, and using public and private agency strengths during tough economic times. Notes were taken during the roundtable sessions and were published as Proceedings reports for each year. The Summits received positive feedback regarding the usefulness of the information shared and learned and participants also expressed a desire to see the Summits become annual events so states may have the opportunity to problem-solve and information-share at the national level.

Cross-Site Process Evaluation

A synthesis of the similarities and differences has been discussed earlier in the report. Common to all three sites were the type of intervention (PBC/QA), intervention targeted families and children in the out of home care system, and planning phase preceded implementation of new PBC and QA system. Sites did diverge in the PBC and QA components, specificity of out-of-home care population and length of planning phase.

The QIC PCW Team conducted site visits to the three project sites regularly throughout the study period to develop a deeper understanding of the unique aspects of each project's intervention, monitor the progress of implementation and site-specific evaluation, observe relevant project activities, and collect data for the cross-site evaluation. During the final year, closing site visits were administered with a more structured format to enable conducting semi-structured key informant interviews and focus groups with individuals directly involved in the project planning and implementation (Appendix E). The process was structured in order to enable collecting the perspectives of people in various roles (e.g. public agency staff, private agency staff, evaluators) separately to allow contrasting points of view upon analysis as well as promote free expression without concern of the comments made impacting future contracts or relationships. The discussion guide requested respondents reflect on the following: the planning process; issues around project administration; communication and collaboration; practice change; use of data; the performance-based contracting (PBC) and quality assurance systems (QA); system impact; lessons learned; and the impact of having been involved in a multisite project. This report in its entirety is included within this Final Report in **Appendix E**.

The charts below will display the common elements for success and site-specific supports for success and a discussion will follow on the facilitators and barriers to success, lessons learned across sites.

Common Elements for Success	
Political	Right Time and Support for Change
Leadership	Right Leaders Driving Change & Staying Involved
Collaboration	Inclusive Planning Process Between Public & Private
Planning	Sufficient Time to Plan
Communication	Formalized, Transparent Communication Structure & Meaningful Feedback to All Levels
Practice	Support for Practice Change
Data	Having and Using Reliable Data
QA/QI	Restructuring QA/QI Process to Support PBC
Outcomes	Selecting Right Outcomes and Building a Contract Around Them

Site-Specific Supports for Achieving Success			
	Florida	Illinois	Missouri
Collaboration Support	<ul style="list-style-type: none"> • Neutral Facilitator • Supervisory Roundtable 	<ul style="list-style-type: none"> • Provider Forums & Info Dissemination • Issue-Specific Workgroups 	<ul style="list-style-type: none"> • Program Manager Meetings • Issue-Specific Workgroups
Outcome Support	<ul style="list-style-type: none"> • Supervisory Review Tool • Family Finders 	<ul style="list-style-type: none"> • Discharge & Transition Protocol • Child Youth Investment Teams (CAYIT) & Centralized Matching 	
Practice Support			<ul style="list-style-type: none"> • Statewide Practice Summits
Decision Making Support		<ul style="list-style-type: none"> • Child Welfare Advisory Committee (CWAC) 	<ul style="list-style-type: none"> • CEO Meetings
Organizational/System Support		<ul style="list-style-type: none"> • University Research Partnerships 	
Data Support		<ul style="list-style-type: none"> • Residential Treatment Outcome System (RTOS) • Data Test Workgroup 	<ul style="list-style-type: none"> • Random Case Assignment
Quality Assurance Support	<ul style="list-style-type: none"> • Detailed Agency & Worker Specific QA Reports 	<ul style="list-style-type: none"> • Monitoring Shift to Quality vs. Compliance 	<ul style="list-style-type: none"> • Joint Public/Private QA Alignment

Implementation Barriers

Although each project went about the work of building a performance based contracting and quality assurance model, there are similarities within the system that can be shared with the child welfare field at large. The statements below represent the barriers identified by the QIC and across all three projects:

The intervention being attempted is inextricably tied to the entire organizational structure and functioning of the agencies, it cannot be easily set apart and defined. Projects have struggled with what the innovative QA model will be--separate from existing QA/QI activities. Additionally, they have struggled with how to create strategies to get the data to the frontline worker so that practice change can take place.

There are a number of political issues that affect the implementation and outcome of these projects. The success may truly depend on the capacity of the leadership within the state or region to maintain focus on this effort while also balancing other priorities as the state and local level (i.e. CFSR).

Comparability of sites for the cross-site evaluation is a tremendous challenge, given the complex nature of the implementation model and the variance across states in the stage of implementation of performance based contract, and how their systems work. Even within projects there is tremendous difficulty in establishing realistic within project comparison.

While all projects have recognized the importance of the involvement of the judicial system, none have been successful in getting them to the table to understand the impact of this project on child welfare practice as well as outcomes for children and families.

Obtaining accurate and reliable data has been difficult for the Florida and Missouri projects. In order to hold providers accountable for their performance, it is necessary to have accurate data. The SACWIS for each state is either a new implementation (Missouri) or a new version. Additionally, Missouri is not currently in compliance with SACWIS and the costs associated with coming into compliance were not built into the PBC.

Economic challenges have had a direct impact on all three projects. Missouri did not request continuation funding due to positions being cut within their Division which restricted their ability to continue the specific work of the project. In Illinois, the QIC PCW nearly lost this project due to the Executive Branch cutting all contracts, even those supported by external funding from outside sources. The contracts and services were only "saved" due to the requirements of a current consent decree.

Perception by private provider agencies that the public agency is not attentive or supportive of their needs may have impact on the collaborative nature during the project and on the partnership work moving forward. How each project continues to collaborate, problem-solve, compromise, and share information will determine the success of their continued

partnership work. Each project's provider constituency has raised the issue from time to time as to whether the public agency (or contracting agency in Florida's case) truly is supportive and understanding of the private agencies' needs, especially in light of a difficult economic environment which has caused some agencies to reconsider how they provide care in the child welfare system. In Missouri, the public agency has demonstrated support when an agency was failing financially. In Illinois, the Director took a controversial stand in the face of possible extreme budget cuts to child welfare providers. These acts have created good will between the public and private agencies but this can easily be erased with several counter acts that could be made in the future that would disregard private agency needs—especially needs that are seen as critical to the private sector in order to continue doing business.

Implementation Facilitators

Each project has brought a high level of motivation from within their own public agencies and their private partners, and has utilized this initiative to make the system achieve better outcomes. It is clear from the contrast between Florida, Illinois and Missouri how important this is to achieving progress.

In specifically looking at all three projects, it becomes clear that a ***legitimate inclusive planning process*** can yield significant benefits including buy-in regarding very controversial topics, and well thought out performance indicators and incentive/disincentive systems. Being inclusive requires a ***top-down and side-to-side approach*** when thinking about implications of policy and practice. Oftentimes line staff was brought in far later than they should have been but it was understood that their input was invaluable to the success of achieving any defined outcome measures.

Active participation by public agency leadership throughout the planning and implementation phases sends a message to others involved that this initiative is important and is not going away. If system change is to occur, all within the system must see that it is the mission of the public agency. Although private agency leaders are instrumental in partnering and collaborating, it is up to the public agency to set the example.

The willingness of public and private partners to put tremendous hours into the planning and negotiation process has not only strengthened their partnership but enabled the partnership to build upon their strengths to create a contract that not only rewards success but ***reinforces best practices in child welfare***.

The ***use and availability of multiple communication strategies*** to disseminate information has been especially effective in the Illinois and Missouri projects. Creating opportunities for regular, consistent, face-to-face meetings, as well as conference calls, newsletters, and listservs appear to enhance collaboration.

And lastly, all three projects emphasized the ***use of data to track performance and tie it to practice change***. Leaders in both the public and private agencies began to understand the

importance of pushing data out to the field in a timely manner to be used to improve practice. It also became clear, especially in Florida and Illinois, that agencies that embraced using data in this way were more successful in showing improvements in their performance. Florida and Illinois shared agency performance on a regular basis using up-to-date data.

Coordination/Collaboration

A high level of commitment and collaboration has been present within and among the projects. Each project embraced the QIC model for working in partnership to create the cross-site evaluation plan and was willing to attend additional joint project meetings to accomplish their goal. The QIC emphasized inter-project communication and consultation. Fortunately, there were funds allocated in the budget to allow face-to-face meetings. These meetings allowed the QIC to collaboratively identify challenges and solutions, review cross-site activities and findings, and build a strong foundation of partnership among subgrantees and the QIC for all future years of the project. Individual project staff developed the trust and camaraderie necessary to facilitate this type of collaboration and partnership.

Dr. Crystal Collins-Camargo, Project Director, accepted a faculty position at the University of Louisville (UL) in July 2008. Due to the nature and importance of her role within the QIC PCW, the Children's Bureau decided that no changes should occur in the QIC Study team, therefore, the University of Kentucky entered into a partnership with UL for Dr. Collins-Camargo to remain in her role as Project Director and continue her leadership of the QIC. This transition continued to run smoothly and the Project Director and Manager continued to communicate via frequent emails, phone calls and in-person meetings to address day-to-day issues.

Dr. Teri Garstka, lead evaluator of the cross-site evaluation at Planning and Learning Technologies, Inc. left the agency to join the University of Kansas. Through a coordinated effort between UK, UL, Pal-Tech and Dr. Garstka, the QIC was able to retain her expertise as the lead evaluator of the cross-site evaluation. Dr. Garstka joined the QIC Team in conducting the final site visits in Missouri and Illinois and presented at the National Summit in September. Dr. Garstka will also remain the lead in analyzing the final data submitted by the projects and preparing the final cross-site evaluation report.

Over time, collaboration and partnership was enhanced in each project extending to other public and private agency partners and community stakeholders. Due to the increased level of collaboration and success achieved by working in this manner, agencies partnered on numerous other initiatives, including other federal grants.

Service Outputs

Outputs	Florida	Illinois	Missouri
Number of collaborative planning meetings held	<ul style="list-style-type: none"> • 46 meetings total • 20 Intervention Group Mtgs. • 15 Supervisory Roundtable Mtgs. • 4 Joint Intervention/Supervisory Roundtable Mtgs. • 4 Advisory Group Mtgs. • 3 Supervisory Trainings 	<ul style="list-style-type: none"> • 493 meetings total • 43 Project Steering Committee • 23 CWAC High End • 32 Residential Monitoring • 140 Data Test • 10 Best Practices/Safety (began in April 2009) • 25 Discharge & Planning Advisory Council (began in August 2008) • 61 Older Adolescents • 24 Finance & Administration • 33 Residential Provider Group (began capturing in September 2007) • 94 DCFS Implementation Team (began May 2008) • 8 DCFS Strategic Planning (began April 2010) 	<ul style="list-style-type: none"> • A total number of meetings or individual meeting numbers cannot be provided due to inconsistencies in tracking. Types and frequency (when known) are provided • Project Team Mtgs: fluctuated between weekly- in beginning of project- to bi-monthly • Advisory Board Mtgs: held infrequently but at least annually • CEO Meetings: held quarterly • Program Manager meetings: held quarterly, began in 2009 • APPLA Workgroup: met for specified period of time to provide recommendations to larger group • Adoptions Workgroup: met for a specified period of time to provide recommendations to the larger group • Regional/Local CQI Mtgs: quarterly • Oversight Specialists Meetings: varied frequency and varied whether in-person or through conference calls since OS were statewide

Number of performance indicators in place	<ul style="list-style-type: none"> • 4: Supervisory Review @ 4 days and 30 – 45 days; Data Entry within 2 days; Contact with birth family; and Permanency achievement through reunification or relative guardianship 	<ul style="list-style-type: none"> • 2 : Treatment Opportunity Days Rate and Sustained Favorable Discharge Rate 	<ul style="list-style-type: none"> • 5: Permanency, Safety, Re-entry, Stability and Resource Development
Length of PBC	<ul style="list-style-type: none"> • 1 year 	<ul style="list-style-type: none"> • 9 month “hold harmless” period • 1 year thereafter 	<ul style="list-style-type: none"> • 3 years
New QA/QI processes established	<ul style="list-style-type: none"> • Supervisory review process developed and supervisors trained. • Supervisory roundtable meetings occur at least bi-monthly to discuss practice issues. • KCI staff conducts intensive case reviews and provides qualitative feedback to CMAs on a monthly basis. • Technical assistance around family engagement provided beginning June 2009. 	<ul style="list-style-type: none"> • RTOS monitoring system for all residential providers to view current status of TODR and SFDR and Unusual Incident Reporting System (UIRS) to view agency-specific UIRs • Residential monitors continue to review files and attend case staffings on-site 	<ul style="list-style-type: none"> • *CFSR Readiness Assessment Planning continues in nine circuits • *Local/Regional CQI Mtgs. • Program Managers quarterly meetings serve as State level CQI meeting • Joint Peer Record Review • Practice Development Reviews • All out of home care investigations reviewed by OSS Supervisors • Plan of Change developed by Regional QA and supervisor/front line worker to address areas of concern in CD <p>*was not developed as part of this project but were new procedures as a result of the PBC</p>

Lessons Learned

Lessons Learned Across Sites	
Process	<ul style="list-style-type: none"> • Shared vision development and inclusivity is important in planning and on an ongoing basis • Planned collaboration and communication process structures are critical • Performance-based contracting is an evolutionary process that takes time • If phasing in, need structured plan for new sites using lessons learned from experienced • The role of the frontline is important, involve them early in the process • Use a fidelity checklist for implementation
Public/Private Partnerships	<ul style="list-style-type: none"> • Put equal emphasis on reform in both the public and private sectors • All providers are different entities - they don't operate the same. • May need to be more direct and prescriptive with the private sector
Contracts	<ul style="list-style-type: none"> • Collaboratively choose right outcomes to match overall system goals • Develop a longer term plan than the current contract • Marry finance to outcome development at the start • Need fluid peer record review across sectors • Don't have dual case management system • Be flexible in contracts and allow innovation
Data	<ul style="list-style-type: none"> • Develop or modify data collection/tracking system that is robust • Must have reliable and accurate data to measure outcomes/performance

SECTION 3

CROSS-SITE EVALUATION

QIC-PCW Cross-Site Evaluation Semi-Annual Report

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PAL-TECH[®]
Planning and Learning Technologies, Inc.

QIC-PCW Cross-Site Evaluation Semi-Annual Report

I. Overview

In September 2006, Planning and Learning Technologies (Pal-Tech) was awarded a subcontract under the Quality Improvement Center – Privatization of Child Welfare (QIC-PCW) to conduct the national cross-site evaluation. Three state grantees were selected as demonstration sites for the QIC-PCW. These three sites had previously privatized their child welfare service delivery system and were now implementing Performance Based Contracting and Quality Assurance (PBC/QA) systems within some aspect of their service system. This final report provides a culminating summary of activities and outcomes resulting from the QIC-PCW from September 2006 through September 2010.

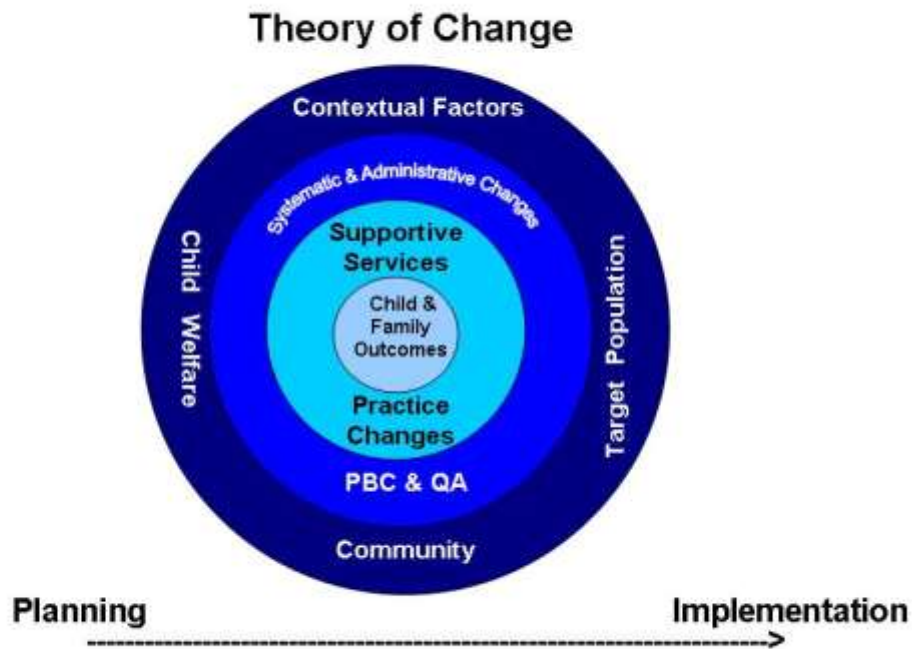
The cross-site evaluation team was tasked with documenting the PBC/QA implementation process and impact on outcomes in those three sites: Florida, Illinois, and Missouri. Through mixed methodologies, the cross-site evaluation accomplished the following activities:

- Documented and measured the intent of PBC/QA in each site
- Tracked PBC/QA implementation and evolution over time
- Assessed perceptions of key informants, front-line staff, supervisors, and QA directors on training, supervision, collaboration, and quality improvement/quality assurance activities
- Measured the impact of PBC/QA on contract performance measures and on child outcomes such as safety and permanency

The cross-site evaluation plan outlines data sources, methodologies, cohorts, and timelines for both a process and outcome evaluation of all three sites. This report provides a comprehensive synthesis of the planning and implementation process of each site's PBC/QA, the components and features of each site's PBC/QA systems, and the evolution and impact of these systems over time.

The conceptual framework guiding the cross-site evaluation lays out a theory of change within systems and across domains. As shown in the diagram below, broader factors such as important environmental contextual variables, the child welfare system in each state, the target population, and the community were be tracked over time to provide

important context. Moving further in, it was important to understand and measure systematic and administrative factors and the specific PBC/QA in each site to document how that drives change in supportive services and practice. Documenting and measuring changes in all of these factors was critical for understanding the child and family outcomes achieved in each site.



II. Methodology

The cross-site evaluation is guided by five broad research questions linked back to the conceptual framework guiding this evaluation.

Cross-Site Research Questions	
RQ 1	Does an inclusive and comprehensive planning process produce broad-scale buy-in to clearly defined performance-based contract goals and ongoing quality assurance?

RQ 2	What are the necessary components of performance-based contracts and quality assurance systems that promote the greatest improvements in outcomes for children and families?
RQ 3	When operating under a performance-based contract, are the child, family and system outcomes produced by private contractors better than those produced under the previous contracting system?
RQ 4	Are there essential contextual variables that independently appear to promote contract and system performance?
RQ 5	Once implemented, how do program features and contract monitoring systems evolve over time to ensure continued success?

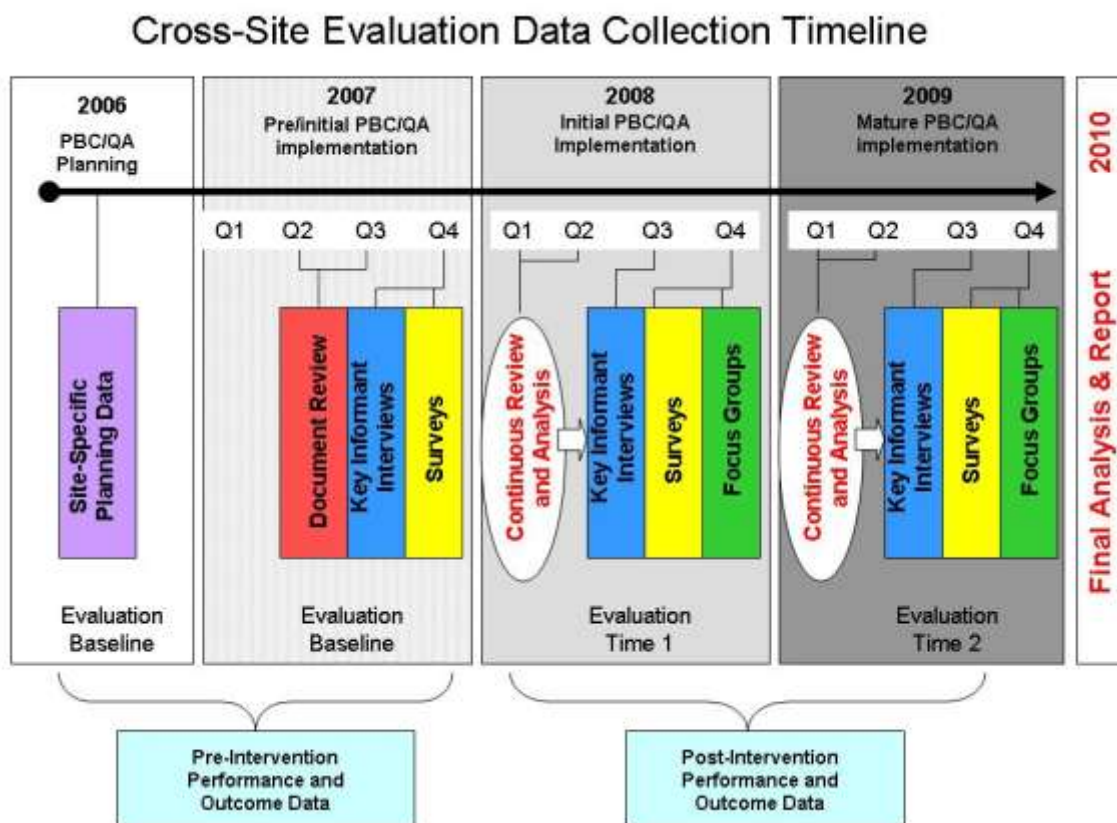
These five questions have been further deconstructed into a series of sub-questions, each seeking to provide the specificity, breadth, and clarity necessary for fully describing and evaluating the intent and impact of PBC/QA systems across sites. The complete list of cross-site research questions and a data source identification table are available from the cross-site evaluation team.

The cross-site evaluation involves a mixed methods approach and focused heavily on triangulation of data. For each research question guiding this evaluation, the cross-site team sought to synthesize data from multiple sources. Through triangulation, the team examined existing data to strengthen interpretations. By examining information collected by different methods, by different groups and in different populations, the team was able to corroborate findings across data sets, reducing the impact of potential biases that can exist in a single study. Triangulation combines information from quantitative and qualitative sources and is ideal when consistently reliable data does not exist to answer a specific research question.

In order to address the above five broad cross-site evaluation research questions, the team developed an evaluation plan and protocols that collected information in a systematic way across the three study sites. Four main data collection approaches were utilized over the course of the three time periods:

- Document review
- Focus groups and key informant interviews
- Surveys
- Agency and child outcome analysis

Each approach ensured that the team was able to obtain consistent information in a structured manner across the sites. Additionally, the cross-site design established consistent data collection timeframes to compare information and data over time in yearly intervals at Baseline, Time 1, and Time 2 intervals. The diagram below provides the overall timeline used for the cross-site data collection process:



This structured timeline provided a degree of rigor in data collection efforts across sites. Each site had its own type of quasi-experimental design, target populations, and scope and focus. Each site was also at different stages within the PBC/QA implementation process. Establishing consistent baseline and discrete time intervals for data collection and analysis was a key component of this design.

Finally, the collaborative development and refinement of cross-site surveys, focus group questions, and key informant interviews provided qualitative perceptions of the intent

of PBC/QA and the adjustments made as it increasingly impacted a broader array of personnel.

III. Cross-Site Analysis Plan

The analysis and synthesis strategies used in this evaluation were tailored to the appropriate source of data or information. The cross-site evaluation team developed an analysis strategy for each site and for each type of qualitative or quantitative data.

As with all analyses, interpretation and additional insight were added as qualitative process evaluation components were tracked over the course of the project. The following sections outline the challenges associated with this cross-site evaluation and the approaches the team undertook to evaluate three sites that have different models of private/public partnerships in the delivery of child welfare services.

A. Cross Site Challenges and Limitations

Several challenges existed within the context of the cross-site evaluation. It is important to acknowledge these challenges upfront as they each had an impact on the interpretation of the findings presented within this report. In light of these challenges, the cross-site team designed a comprehensive multi-method evaluation to ensure that issues were addressed in a sound methodological manner. This cross-site evaluation considered and planned for the following challenges:

- Different intervention designs across sites
- Different outcomes measured across sites
- Varied evaluation designs utilized In each site

Briefly, the issues associated with each challenge are outlined below. Detailed descriptions of each site's intervention, design, and outcomes are included in later sections of this report.

Different Interventions Designs across Sites

In all cases, what constitutes the “intervention” within the three sites was loosely defined. For inclusion in this demonstration project, sites were required to be involved in a private/public partnership between the child welfare agency and private care providers in some capacity. Specifically, they were required to be implementing performance-based contracts and quality assurance systems to support those contracts. How this was done varied greatly across sites in terms of the scope (e.g., county, region, state-wide), the contractual performance timeframes, the focus of the services (e.g., case management, residential treatment), the structure of the contracts themselves,

and the programs put in place to support PBC/QA. For cross-site purposes, the intervention was broadly defined as implementing PBC/QA within each site. Given the inherent differences in how each intervention was applied within each site, caution should be exercised when broadly attributing cross-site outcomes to PBC/QA. Additionally, in all sites, many other programs and initiatives were operating in tandem with the intervention which makes it difficult to tease out the relationship between the PBC/QA intervention and outcomes.

Different Outcomes Measured across Sites

Similarly, each site chose different performance measures to include in their PBC intervention. Evaluating performance under these interventions must take into account that what is being evaluated differs across the sites. Some contract performance measures were process-oriented (such as direct practice behaviors), while others were child outcome-oriented (such as safety or permanency). Additionally, because the focus of the interventions differed, common child-level outcomes typically measured in child welfare via AFCARS or CFSRs such as safety or permanency were not applicable in all sites. Some PBC interventions focused on traditional case management activities for which these child outcomes are relevant, while another PBC intervention focused on services to older youth in residential care.

The outcomes under evaluation differed in their proximity to the intervention and thus, some may require greater lengths of time for the intervention to have an impact on them. In other words, the three sites included both short-term and long-term outcomes and some were linked directly to the intervention while others were hypothesized to result from a broader change in the system under which the intervention was operating. Thus, there is no single outcome that is consistently measured in all three sites. Thus, caution should be exercised when drawing conclusions about the impact of PBC/QA.

Varied Evaluation Designs Utilized in Each Site

Finally, the way in which the intervention was designed for local evaluation differed across all three sites. One site utilized a pre-post design, another used a quasi-experimental design, and one originally began with a randomized control-treatment design. Because of the differences in the existence or type of comparison group available in each site, it was difficult to broadly determine if the outcomes under the PBC intervention were “better than” those that were not. In addition, not all outcomes were available in all comparison groups. It is possible to make comparisons of PBC intervention versus no intervention on some outcomes in some sites, but caution should be used in extrapolating from these varied designs which limit the kinds of conclusions that can be drawn.

Limitations

In addition to the above issues, conducting applied research and evaluation within real word systems inherently poses limitations on even the most rigorous methodologies. Often initial designs and protocols can change within the course of a project due to unforeseen influences such as budget cuts, a redirection of services, a change in leadership, and difficulties in obtaining accurate data. As with any evaluation conducted on large programmatic initiatives within existing organizational system, many variables that cannot be controlled can exert influence on the outcomes under assessment. Causal inferences are not possible given that experimental designs were not utilized consistently across sites.

This cross-site evaluation instead provided a rich description of the programs and processes implemented in each site and drew appropriate conclusions about relationships between those elements and their intended outcomes. Importantly, this evaluation sought to document the intent and evolution of an ever-changing intervention over time; this required acknowledging that it may not be possible to directly attribute change in outcomes due to one intervention. Many other important variables outside the scope of this evaluation may have influenced the types of outcomes under consideration in the child welfare system. Thus, while the evaluation team has designed a methodologically rigorous approach to evaluating the efforts undertaken by these three sites, it is important to acknowledge the limitations present.

B. Document Review Procedures and Analysis

The cross-site evaluation team began requesting contracts, agency forms, meeting agendas, attendee lists, meeting minutes, memos and letters from each site in June 2006. A large number of documents were received from each site, which formed the core of the materials used to review the planning and implementation process.

The cross-site evaluation team imported all documents into the qualitative data analysis software *Atlas.ti* and created a data extraction protocol. Initial document review analysis was completed in April 2007 and the information was captured in informal site briefs. The briefs were organized by research question and contained information gleaned from the collection of documents. After the initial draft of the information was created, each site was able to review the information and provide clarification and additional documents when appropriate. In addition, the cross-site team conducted follow-up phone call discussions with key informants to ensure the information was accurate and comprehensive.

Throughout the project, the cross-site evaluation team continually requested relevant documents as the implementation of PBC/QA matured and adjustments were discussed and made. From this document analyses, information has been synthesized into this report as it relates to each research question for each site.

C. Focus Group and Key Informant Interview Development and Analysis

In order to supplement cross-site data on qualitative perceptions of the planning and implementation of PBC/QA, focus groups and key informant discussions have been conducted. As previously noted, the cross-site evaluation involved triangulating data sources and methods for fully describing PBC/QA implementation; focus groups and key informant discussions provided valuable qualitative data on perceptions of stakeholders and staff members.

Initial focus groups were conducted in Q4 of 2008 or Q1 of 2009 by the local evaluators in conjunction with their own evaluation efforts. The cross-site team conducted all follow-up key informant interviews, and in the final year of the project (2009- 2010), conducted a final round of focus groups and key informant discussions.

Time 1 Focus Groups

For the initial set of focus groups and key informant interviews, the cross-site team and local evaluators collaboratively developed the set of questions. The cross-site team developed a standard protocol for conducting focus groups that was requested by the site evaluators. The purpose of this protocol was to provide a written document on conducting the focus groups and analyzing the data. This was to ensure fidelity of data collection and analysis across sites and to help local evaluators explain and expedite their work with program staff about the requirements of the cross-site evaluation.

During the course of collaborative work and review of the research questions, the team centered the focus group questions on stakeholders' perceptions of the PBC planning and collaboration as well as on any adjustments that had been made in contracts or QA processes. The intent of these initial questions was to collect perceptions after the intervention had been implemented and to have participants reflect on that process and any changes that had been made.

The following steps were taken:

- A total of 22 cross-site questions were identified for use in either focus groups or key informant interviews and these are included in Appendix A.
- Site evaluators also requested that the cross-site team draft a series of focus group questions that draw on the work of Dr. Dean Fixen's implementation drivers - six questions were developed by the cross-site team and adapted by the local evaluators for use in their local evaluation focus groups.

- Working collaboratively with the cross-site team, the site evaluators reviewed the questions and identified the most appropriate group of stakeholders and key informants for conducting groups and interviews
- Each site evaluator submitted a matrix for their sites to match each question with the appropriate stakeholder groups (i.e. steering committee, CEOs of private provider agencies, etc)

Given that the questions focused on the work of higher level personnel directly involved in creating, negotiating, and implementing PBC/QA, the level of analysis across the sites was at the director and program manager personnel level. In all cases, both public and private agency staff was included in these groups. The focus of the questions and the early implementation timeframe made it less likely that supervisors and front-line staff would be involved or knowledgeable. As a result, the cross-site team included these staff members in the second set of focus groups (Time 2 Focus Groups) designed to capture their experiences as the implementation of PBC/QA solidified in those sites.

An advantage of the local evaluators conducting the focus groups and doing the analysis was that the local evaluators included their insights of the local site context in their analysis. The evaluators used the analysis for their local evaluation and sent the cross-site evaluation team their analysis organized by question. The cross-site team used this information to look qualitatively at how the PBC/QA planning and implementation changed over time at each site.

Local evaluators conducted focus groups using the identified cross-site questions in the Fall 2008 and Spring 2009. The cross-site team analyzed and synthesized the qualitative information by research question both within and across sites. This information has been incorporated into the report under Research Question 1: Planning Process and Research Question 2: Necessary Components of PBC to further expand on perceptions by site personnel involved in the PBC/QA initiatives. State-specific findings were inserted throughout the text in areas where the findings provide additional insight regarding the implementation of PBC/QA at that site. Across-site focus group findings, if common themes were observed, are recorded at the end of each section.

Time 2 Focus Groups & Key Informant Interviews

For the final round of qualitative data collection, the cross-site evaluation team developed a series of questions suitable for both focus groups and key informant interviews. Specifically, the questions were designed for three levels of personnel: agency directors, supervisors, and front-line caseworker staff. Because each of these levels of personnel have very different experience working under PBC/QA in each site, it was important to develop questions that were reflective of their roles while also seeking information about their own unique perspectives. The focus groups were designed to assess supervisors and front-line staff separately.

Additionally, the cross-site team designed their data collection in accordance with the unique structure of each site. In all cases, focus groups were held with a sample of the private agency staff in the counties, regions, or state operating under PBC. This varies for each site and the cross-site team worked to ensure that representative samples of workers from all sites were solicited for inclusion in focus groups. The level of analysis remains the same across sites with the private agencies as the higher order of grouping followed by the personnel level addressed above.

The questions encouraged staff members to reflect on the following major themes:

- Roles and experiences in the decision making or planning process regarding establishing and maintaining PBC
- Understanding the goals of the contract
- Changes in daily casework practice as a result of PBC
- Supports that assisted in their work
- Understanding/using performance data and QA activities
- Unintended consequences due to PBC
- Recommendations for improvement to PBC

The evaluation team staff members conducted 8 to 12 final focus groups at each site in the Fall of 2009 for Florida (due to major intervention changes occurring during this time period) and in the Spring of 2010 for Missouri and Illinois. Convenience sampling was used to accommodate the needs of the participating agencies during the recruitment process. Participants were requested to have a minimum of 1 year of experience with a preference given for those with experience prior to the implementation of Performance Based Contracting. All participants were informed of their rights and gave written consent to participate. The following table provides a breakdown of the sample sizes of these focus groups.

Time 2 Focus Group Participants			
	Position	Sample Size	Time
Florida	Frontline	16	Fall 2009
	Supervisor	15	
Missouri	Frontline	36	March 2010
	Supervisor	25	
Illinois	Frontline	43	April 2010
	Supervisor	42	

Evaluation team members digitally recorded the sessions and took detailed notes on the information shared. This qualitative information was synthesized and analyzed at all

personnel level for major themes within sites and across sites. Again, these findings were inserted in the appropriate sections of this report under Research Question 1: Planning Process and Research Question 2: Necessary Components of PBC. State-specific findings were placed throughout the texts in areas where the findings provide additional insight regarding the implementation of PBC/QA at that site. Across-site findings, if common themes were observed, were inserted at the end of each section.

The focus group and key informant interviews developed for the final round of data collection are found in Appendix A.

Key Informant Interviews

As described in the larger QIC-PCW report, the QIC PCW Team conducted site visits to the three project sites regularly throughout the study period to develop a deeper understanding of the unique aspects of each project's intervention, monitor the progress of implementation and site-specific evaluation, observe relevant project activities, and collect data for the cross-site evaluation. During the final year, closing site visits were administered with a more structured format to enable conducting semi-structured key informant interviews and focus groups with individuals directly involved in the project planning and implementation (Appendix). The process was structured in order to enable collecting the perspectives of people in various roles (e.g. public agency staff, private agency staff, evaluators) separately to allow contrasting points of view upon analysis as well as promote free expression without concern of the comments made impacting future contracts or relationships. The discussion guide requested respondents reflect on the following: the planning process; issues around project administration; communication and collaboration; practice change; use of data; the performance-based contracting (PBC) and quality assurance systems (QA); system impact; lessons learned; and the impact of having been involved in a multisite project.

Across the three states, 55 individuals participated in the semi-structured interviews and focus groups, 21 of which were administrators and program management-level staff from private agencies, and fifteen public agency staff in similar positions. The remaining participants were evaluators (4), university collaborators (3) and a representative of a provider association. Overall, eight interviews were conducted in Florida, 15 in Missouri, and 22 in Illinois, which was roughly commensurate with the size of the overall project and the individuals involved in the planning and implementation of the interventions. The study team relied on each project director to assist in scheduling the interviews. This factor as well as the overall number of individuals engaged in the intervention and size of the project impacted the number of individuals participating in the interviews. For example, despite repeated requests, no subcontracting private case management agencies were scheduled to participate in interviews in Florida. The study team did observe a meeting with administrative staff from the case management agencies facilitated by an external individual and where appropriate their expressed perceptions

are included herein, but it should be noted that the study team did not conduct these interviews and questions asked of them did not follow the interview guide.

In addition, timing of the interviews is important to note. Final site visits were planned for spring 2010; approximately three months following completion of the official intervention in each state, recognizing that in truth the contracts and systems developed would remain in effect and continue to evolve. In the final year of implementation in Florida, local officials decided to go from four subcontractors to two during their annual rebidding process, the results of which were hypothesized to have a significant impact on perceptions unrelated to the implementation of the project. The site visit was scheduled to be conducted six months early so it could occur as late as possible in the intervention while just prior to the announcement of subcontract awards; however, awards were actually announced within a short time prior to the visit. In addition, six months prior to the site visit in Missouri, the state agency decided not to renew its contract with the QIC for a number of reasons, thereby terminating the external site specific evaluation while the actual contracts and quality assurance-related activities continued without the financial support of the QIC; the site agreed to facilitate final data collection for the cross-site evaluation as planned despite termination of the contract. Therefore, it is difficult to ascertain how these factors in these two states may have impacted data collected.

Focus Group and Interview Analyses
<ul style="list-style-type: none">• The cross-site team developed standardized questions and protocols for local evaluators to use when conducting focus groups held in each site.• After receiving the qualitative focus group data from each site, the cross-site team synthesized this information and organized perceptual data by focus group question.• Focus groups complemented existing data collection and triangulation efforts and provided targeted subjective perceptual information from specific groups of stakeholders.• The team identified areas where the subjective focus group data does or does not corroborate existing data and results obtained from other methods.• The cross-site team identified and refined follow-up efforts to clarify discrepancies, including key informant interviews or further documentation requests.• The key informant interviews were analyzed by Dr. Crystal Collins-Camargo and findings are included in the larger QIC report. For cross-site purposes, general themes around lessons learned and elements for success are included in the Conclusion section of this report.

D. Cross-Site Survey Development and Analysis

The QIC PCW study team and the subgrantees worked in small collaborative groups via conference calls to develop surveys and instruments that captured information about the implementation process. From May 2007 – July 2007, these small groups finalized their instruments and presented them at the all-project meeting in Lexington. At that meeting and in the week following, changes were made to the surveys and instruments and finalized for each site to submit to their IRB. The sites agreed to include three main surveys for the cross-site evaluation: Wilder Collaboration Survey; Staff Survey on Training, Supervision and Evidence Informed Practice; and Quality Improvement Survey.

Wilder Survey

The first survey used in the cross-site evaluation was the Wilder Survey which examines perceptions of several dimensions of collaboration. The original instrument is a 41-item 5-point Likert scale developed by Mattessich, Murray-Close, and Monsey (2004). Scale development and factor analysis identified 6 main domains:

- Collaborative structure, purpose, common mission and communication
- Human and financial resources
- Existence of a collaborative “attitude” evidenced by history of collaboration in a community, trust, and respect among collaborative members
- Environmental conditions in which the collaboration operates, such as the respect and hope of others in the community, timing and political/social climate
- Characteristics of the collaborative members
- Communication dynamics

In subsequent factor analysis of this survey, Bryan and colleagues (2006) found five dominant domains in a population similar to the current study. The communication dynamics factor was subsumed under the collaborative structure factor.

The team and sites elected to use these five domains for this project given the similar population targeted and the small sample size which made factor analysis impractical. In addition, the team and sites agreed to add three PBC/QA-specific questions to the survey to capture more specific PBC/QA collaboration issues for a total of six domains. Further discussion of the Wilder survey, the items included, and results are found in the section: *Research Question 1: C. Collaborative Environment*.

Staff Survey on Training, Supervision, and Evidence Informed Practice

Demonstration Sites: Florida, Illinois Missouri

In January of 200, three demonstration sites were selected to participate in the QIC-PCW. These three sites had previously privatized their child welfare service delivery system and were now implementing Performance Based Contracting and Quality Assurance (PBC/QA) systems within some aspect of their service system. These sites were asked to evaluate how public-private partnerships operate under a performance-based contract and quality assurance system. Each site conducted a formal local evaluation of their initiatives and participated in the national cross-site evaluation. A brief overview of the sites is shown below:

QIC-PCW Demonstration Sites		
Florida	Illinois	Missouri
<p>In 1996, the Florida Legislature mandated the privatization of child welfare services through the use of a lead agency design. Between 1999 and 2005, the Department of Children and Families (DCF) transferred the management and day-to-day operations of the child welfare system to 22 private community-based care (CBC) lead agencies. All ongoing case management services are delivered by lead agencies across the state, which may in turn delegate direct case management activities to community-based case management agencies under subcontracts. Florida's PBC contract under the QIC targets children in foster care. Judicial Circuit 5 (Ocala and surrounding counties) and Kids Central (CBC) selected four performance measures for its contracts with case management agencies:</p> <ul style="list-style-type: none"> • Accurate data entry within 2 days of case receipt • Face to face supervisory meetings within 4 days of case receipt • Face to face supervisory meetings again at 30-45 days • Contact with biological parents 	<p>Missouri's public child welfare agency, Children's Division, had a long history of partnering with the private sector to deliver residential and mental health services, foster care, adoption recruitment, and case management services. Missouri's Children's Division, under House Bill 1453 of 2004, was directed the state to use private agencies to provide case management services through incentivized contracts and began piloting performance based contracts for its out-of-home care population in 2005. The state has since focused on improving the long-term maintenance supports and quality assurance processes of its performance-based foster care case management contracts in three regions of the state (Kansas City, St. Louis, and Springfield). Missouri's foster care and adoption services contracts were developed to include outcomes tied to the CFSR after its first federal review:</p> <ul style="list-style-type: none"> • Safety • Foster care re-entry • Permanency. 	<p>Illinois began using state-wide performance based contracts in 1998 expanded statewide to all children in traditional foster care placements. The state sought to expand its use of PBC to providers of residential service in 2007, and Independent Living /Transitional Living Program (ILO/TLP) services in 2010. The overarching goals of the expansion of PBC/QA to residential care were to incentivize shorter lengths of stay in residential settings while improving client stability and functioning, allowing for expanded availability of residential care beds for children at earlier stages of their need. Piloted in 2007 and fully implemented in 2008, the new PBC contracts for residential care focus on two outcome measures:</p> <ul style="list-style-type: none"> • Sustained Favorable Discharge Rate (SFDR) • Rate of Treatment Opportunity Days (RTOD)

The resulting survey contained 30 items total, some of which included sub-items with further specification and additional follow-up information. In terms of scaling, there was a mix of 5-point Likert type items, categorical items, and a few open-ended responses. The use of data, outcomes, and evidence informed practice was a primary focus of the majority of the questions. The following domains are included in the survey:

- Demographic Information
- Measuring and promoting client outcomes
- Supervision
- Training
- Quality assurance and improvement activities
- Intent to remain employed

Further discussion of the survey and results is found in the section: *Staffing Under PBC/QA: Perceptions of Evidence-Informed Practice, Supervision and Training in Front-line and Supervisors*.

Quality Improvement Survey

The final cross-site survey developed collaboratively in a workgroup focused on measuring quality improvement (QI) activities in public/private partnerships. After debating the topic internally and presenting recommendations, the full project agreed that the QI survey should assess a broader sample of individuals in both public and private agencies. In other words, the survey would be administered not only to management in public and private agencies, but those responsible for designing and implementing the systems, those who make use of the information it generates, and those who participate directly in the process itself. This would allow for a more representative perspective of whether the QI activities were pursued and implemented at all levels as well as how effective those activities were perceived to be in meeting the PBC/QA goals.

The workgroup identified 10 QI activities and 4 QA activities to be evaluated for the QI survey. The initial questions focused on the extent to which sites have implemented these activities. The full project team reviewed the scale and recommended the inclusion of a measure of the efficacy of the QI activities in implementing the stated PBC/QA goals. This also required follow-up questions linking the QI activities in the survey to the PBC goals and to their effectiveness in improving practice and client outcomes.

The final instrument was a 14-item survey, each with 3 sub-questions for each QA/QI target activity. These items were rated on a 5-point Likert type scale, with an additional Not Applicable response. Further discussion of this survey, the items, and results are

found in the section: *Research Question 2: C. Cross-Site Quality Improvement Assessments.*

Survey Analysis Methodology
<ul style="list-style-type: none">• Repeated measures general linear model analyses were used to examine change in subscale responses over time.• General linear modeling (GLM) provided a robust analysis that allows for examining the appropriate main effects (e.g., treatment, participant group, agency) and all interaction effects. With repeated measures, changes in the same conceptual variable over time can be examined as well as any interactions of time, treatment, and site variables.• Basic analyses such as correlation and cross-tabs were performed as appropriate.• Site-specific analyses were performed as needed to further clarify important within-site differences.• Given the differences in the intervention across site, care must be taken to include contextual information when interpreting the results from this analysis.

E. Agency Performance and Child Outcome Data Collection and Analysis

In addition to the above, the cross-site team worked with the sites to collect agency performance and child outcome data to measure the impact of PBC/QA. The cross-site evaluation analysis plan called for examining both the outcomes incentivized in each sites' contract (e.g., agency performance on specific performance indicators) and site-relevant child outcomes (e.g., safety, permanency).

Initial discussions were held in Quarter 2 of 2007 at an all-project meeting to identify and agree upon the outcomes to be collected. From that discussion, it became clear that, as previously noted in the challenges and limitation section, identifying consistent outcomes across sites was not feasible. Instead, it was necessary to work with the outcomes that were relevant within each site and devise a methodology for evaluating change across different outcomes.

Over the course of the project, the cross-site team worked with each site to further clarify, define, and identify performance measures and outcomes. The team developed an overview cross-walk of outcomes by site and this information is described in more detail in the site-specific descriptions further in this report.

In addition, the cross-site team developed site-specific data tables that identify timeframes, nesting variables, cohorts, and other relevant information needed to guide

the data requests and analysis for each site. As data has been sent to the cross-site team, much time is spent on assessing data reliability, trouble-shooting issues, formatting data for each site, and developing the analysis models.

Technical assistance with the sites on this issue revolved around working through their own unique data acquisition issues and state reporting systems. As data was received, it was formatted and prepared for analysis depending upon each site's design.

Agency Performance and Child Outcome Analyses
<ul style="list-style-type: none">• The cross-site team conducted both site-specific analyses and cross-site analyses on each type of performance and outcome component.• T-tests were done on any child-level outcomes for which an appropriate comparison group was available to determine if there are differences between agencies operating under PBC and those not.• Trend analyses were conducted to analyze performance over time.• Change scores were conducted to analyze effect size of change over time in performance.• Descriptive statistics were calculated on the proportion of agencies able to meet specified contract targets on outcomes.

Summary

The mixed methods and analyses presented above constitute the means used to address each of the cross-site evaluation research questions. For each question, data and information from multiple sources was used as appropriate; each question had multiple sub-questions requiring the integration of data and information from varied sources. The triangulation of methodology, data, and analysis in this cross-site evaluation enabled a comprehensive depiction of PBC/QA where similarities and distinctive features in the study sites are highlighted.

IV. Study Sites: Background and Context

Prior to addressing each research question, the background and context for each study site is provided below. The three sites differ in target population served, size, scope, and to some extent in project goals, but all used similar approaches to plan and oversee their efforts. Information for these descriptions came from document reviews and discussions with each site.

Florida

In 1996, the Florida Legislature mandated the privatization of child welfare services through the use of a lead agency design. Between 1999 and 2005, the Department of Children and Families (DCF) transferred the management and day-to-day operations of the child welfare system to 22 private community-based care (CBC) lead agencies. Under this design, Florida's public agency retains all child abuse/neglect hotline, intake and investigation functions. All ongoing case management services are delivered by lead agencies across the state, which may in turn delegate direct case management activities to community-based case management agencies under subcontracts.

Kids Central Inc. (KCI), the lead agency in Florida's Judicial Circuit 5 (formerly District 13) is one of three sites participating in the QIC PCW. KCI is the lead agency for Lake, Sumter, Marion, Citrus, and Hernando counties. At the time of the proposal, Kids Central was serving approximately 3,300 children. KCI has relied on case management agencies (CMAs) to deliver all-day-to-day services for its children in foster care. The four CMAs participating in the PBCs during the time of this evaluation were: Lifestream Behavioral Center (Lake County), Camelot Community Care (Marion and Hernando Counties), the Centers (Marion and Citrus Counties), and Children's Home Society of Florida (Sumter County).

Performance Based Contracts

Kids Central initially implemented performance based contracts during 2007 fiscal year (July 1, 2006 – June 30, 2007) prior to participating in the QIC. CMAs were offered incentives for achieving specified performance and outcome goals (largely related to CFSR measures) during this period. Under this contract, each CMA had the opportunity to earn up to \$60,000 in additional funds for meeting these targets. Overall, less than 50% of the available contractual incentives were earned by the CMAs. This poor performance led KCI to consider other ways of designing contracts and to look for other measures to incentivize in order to better meet system goals.

Florida's PBC contract under the QIC targets children in foster care (adoption services are conducted by a separate contractor). Judicial Circuit 5 selected five performance measures for its contracts; four of which are "process" measures – measures over which

workers have direct control. KCI wanted to incentivize things that CMAs could easily influence as a way to increase CMA buy-in to the PBC. These practice measures were also expected to impact the one outcome measure – more timely permanence. The five initial outcomes in the PBC are:

- Earlier and more accurate data entry into state’s administrative system.
- Face-to-face supervisory meetings within 4 days of case receipt
- Face-to-face supervisory meetings within 30-45 days of case receipt
- Increased contacts with biological parents
- Improved rates of maintained permanency for children

QA/QI System

Between 1999 and 2005, the Department of Children and Families (DCF) transferred the management and day-to-day operations of the child welfare system to 22 private community-based care (CBC) lead agencies. In 2003, Kids Central was chosen as the CBC in Circuit 5 (covering the five counties of Marion, Lake, Sumter, Citrus, and Hernando). Kids Central, in turn, contracts with case management agencies (CMA) that provide direct services to clients.

Prior to its participation in the QIC, the Circuit’s quality assurance activities were largely driven by state oversight procedures. These oversight procedures were somewhat fluid at that time due to DCF adjusting from being a state run child welfare system to a privatized child welfare system that included 22 lead agencies. The QA/QI that DCF completed was focused on the performance of the Circuit as a whole. Lead agencies such as Kids Central in turn had the responsibility and flexibility to set up and monitor their contracts with case management agencies. In addition, DCF reviewed the performance of each CBC lead agency on an annual basis on a variety of outcomes. DCF was operating a three tiered approach to monitoring its lead agencies:

Tier 1 – Lead agencies developed and implemented a Quality Management Plan that involved minimum requirements established by DCF. Lead agencies reviewed their in-house and subcontracted services and reported the findings back to DCF.

Tier 2 – DCF staff approved lead agency Quality Management Plans and validated findings through case reviews from lead agency Tier 1 monitoring. The approach involved several monitoring processes that were conducted on-site, simultaneously: contract oversight, case reviews and licensing of lead agencies.

Tier 3 – DCF staff conducted statewide Child and Family Services Reviews to check for compliance with federal reviews, providing technical assistance to assist lead agencies in their quality assurance activities and maintain Florida’s Program Improvement Plan (OPPAGA, 2006). These reviews were conducted

every six months. The results from the reviews were reported back to the CBC leadership team and eventually to the CMAs. These reviews were largely compliance driven; the primary goal was to verify if certain activities had taken place or to monitor aggregate outcomes.

DCF Central Office also had the ability to conduct different types of reviews as needed. In practice, the tiered monitoring system was not as effective in tracking lead agencies and subcontractors' performance as planned (OPPAGA, June 2008). For instance, lead agencies were not completing their Tier 1 quality assurance reviews in a timely manner which resulted in significant delays between Tier 1 and Tier 2 reviews. This delay made it difficult for DCF to validate earlier findings – that is, match the quality assurance data collected by the lead agency with what was currently being reported in case records.

Illinois

Illinois began using performance based contracts in 1997, initially with children in the care of relatives residing in Cook County and in 1998, expanded statewide to all children in traditional foster care placements (Kearney and McEwen, 2007).

Performance Based Contracts

Under the QIC-PCW project, the state sought to expand its use of PBC to providers of residential services, and Independent Living /Transitional Living Program (ILO/TLP) services. In Illinois, all residential, ILO and TLP services are provided by private agencies.

Due to several implementation challenges, the state decided to implement the new residential care contracts in FY2008 and the new ILO/TLP contracts in FY2010. This delay prevents an analysis of outcome data for the new ILO/TLP contracts. For this reason, the cross-site evaluation will focus primarily on the state's implementation of the new residential care contracts.

In Illinois, as in other states, children in residential settings have greater needs and challenges, are often older and have experienced multiple moves. The overarching goals of the expansion of PBC/QA to residential care are to incentivize shorter lengths of stay in residential settings while improving client stability and functioning, allowing for expanded availability of residential care beds for children at earlier stages of their need.

Prior to their involvement with the QIC, residential service contracts used per diem payments and individual rates were negotiated between each provider and the Department of Children and Family Services (DCFS). Prior attempts to standardize rates for residential service using a tier or level system (e.g. mild, moderate, or severe) had not been successful.

Piloted in 2007 and fully implemented in 2008, the new PBC contracts for residential care focus on two outcome measures: Sustained Favorable Discharge Rate (SFDR) and Rate of Treatment Opportunity Days (RTOD). Provider agencies can earn incentive pay through SFDR, or, through a “positive” or “neutral” discharge to a placement that is stable post-discharge for 90, 180, or 270 days. Provider agencies can lose money if they do not achieve a high enough Rate of Treatment Days which is the percentage of days children are in an agency’s care (i.e. not on runaway, placed in detention or DOC, or psychiatrically hospitalized) divided by the total number of beds in the residential stay.

Unique to Illinois, shared risk is built into the system in two ways. First, DCFS has agreed to a guaranteed bed purchase for a fiscal year for each facility based on capacity and need. In return, the Department implemented a ‘no-decline’ policy such that if a facility had the capacity and services to treat a given youth, they were not able to decline placement of that youth into their facility. In this way, risk is shared across the public and private partners.

QA/QI System

Residential care in Illinois has historically been provided by private agencies that are contracted to provide specific services for children needing a ‘higher’ level of care. DCFS first began providing QA/QI on these programs by evaluating contracts, conducting 384 reviews at facilities, and reviewing profiles submitted by residential providers (profiles were the pre-cursor to program plans in residential care- these documents provided an overview of the program, the treatment provided, and types of clients served). The Department began to review and rate the profiles which helped to provide the background information that eventually was needed to implement PBC in residential care.

In 2004, Illinois established a Residential Performance Monitoring Unit (RPMU) to provide oversight and technical assistance to residential service providers. The RPMU monitored both the quality of care and the appropriateness of the level of care and was charged with the identification of weaknesses in the overall system of care. This Unit provided a non-adversarial process that focused on improving practice through quality assurance and monitoring. The Department contracted with Northwestern University to run the RPMU. In 2007/2008 the Department discontinued the contract with Northwestern University for this Unit and brought it “in house”. The monitors for the unit were hired from within DCFS. Many of the monitors assigned to this unit had experience with the residential programs through their prior role as case managers but did not have extensive experience working in residential programs. As a result, the unit became less focused on technical assistance and more focused on monitoring. The Department hired and trained the monitors in the first half of calendar year 2008. The DCFS monitors received eight weeks of training focused on assisting providers improve clinical outcomes. In addition to their focus on clinical outcomes, the monitors were charged with ensuring that providers remained in compliance with DCFS Rules and

Procedures. The caseload for the monitors was decreased once it was moved 'in house' to allow increased time on site at the facilities.

In addition to the monitors, the Department has an Associate Director that is over the RPMU along with Field Services Managers in Cook County and downstate, as well as, a Statewide Quality Assurance Manager. Much of the QA/QI work is done in collaboration with the residential providers. Jointly, the Department and the provider community define goals for residential providers and the outcomes that will be monitored as part of their contract. The Child Welfare Advisory Council (CWAC) has a High End Residential Committee that focuses on residential care. Under this Committee are the Residential Subcommittee and the Data Test Subcommittee- both of which are involved with QA/QI efforts.

Missouri

Missouri's public child welfare agency, Children's Division, had a long history of partnering with the private sector to deliver residential and mental health services. In the 1980's and 1990's, this expanded to foster care, adoption recruitment, and case management services. These contracts were not performance based and public agency staff continued to participate in limited aspects of the case management process, including court hearings and licensing. Contractors were paid on a fee-for-service (or per diem basis), there were no outcomes to achieve, and providers were required to use the Division's foster homes.

During the 1990s, the Children's Division began exploring alternative contracting methods to better enable them to measure and improve on performance. Between 2002 and 2004, the Division collected extensive information about performance based contracting from several sources to design its own system.

The final major catalyst for the conversion to performance based contracts was House Bill 1453 of 2004 that directed the state to use private agencies to provide case management services through incentivized contracts. The legislation also required the Children's Division to evaluate this process. The University of Missouri-Columbia was selected to conduct an independent evaluation of the initiative, beginning in 2005.

Performance Based Contracts

Missouri's Children's Division began piloting performance based contracts for its out-of-home care population in 2005 prior to this QIC initiative. Under the QIC, the state has focused on improving the long-term maintenance supports and quality assurance processes of its performance-based foster care case management contracts.

In addition to improving performance on select outcome measures, the Division had several other goals for its new contracts. While the previous case management

contracts utilized approximately 26 contracted providers, the Division sought fewer contract. This reduction led to the development of provider consortiums to pool resources and partner within their respective systems to provide a broader continuum of services. The state also sought to become fully accredited and these new contracts would also work to reduce caseloads in the public sector and thereby meet accreditation standards.

Effective June 1, 2005, the contracts were awarded to seven consortiums in three regions comprised of several counties and circuits per region (St Louis, Kansas City, and Springfield). Case assignment and tracking did not begin until September 1, 2005. From July to September, the consortiums set up offices, hired and trained staff.

Piloted in three regions, St. Louis, Kansas City and Springfield, Missouri's foster care and adoption services contracts were developed to include outcomes tied to the CFSR. Missouri had its first federal CFSR prior to PBC being implemented and as a result of the state's performance, the Children's Division decided to incorporate child outcomes into the contracts with the consortiums. Specifically, the contracts included the outcome measures of safety, stability, and permanency. Of those outcomes, only permanency is directly incentivized such that each consortium is given a set caseload and a permanency rate which drives the number of random referrals consortiums will receive each year. The other outcomes are used for more QA/QI purposes by the CD.

QA/QI Systems

The Children's Division began contracting with private agencies to provide case management services for clients in the late 1980's and 1990's. When Missouri originally contracted with these agencies, the Children's Division continued to participate in limited aspects of the case management services. The private contractors were paid on a fee-for-service (or per diem basis), there were no outcomes to achieve and providers were required to use the CD's foster homes. It was not until 2005 that Missouri moved to a privatization model that included a performance based model that allowed the contracted agencies to have more responsibility and oversight of the cases.

The QA/QI that was provided to private, contracted agencies prior to Performance Based Contracting was limited primarily because the Children's Division maintained the primary oversight of the cases. Contracted agencies were involved with aspects of the case management but CD was the primary entity that provided services to the clients. The state opened a quality assurance unit in its state agency in 2004 but like many states, QA activities focused more on directly provided services by the public agency than on contracted services (ASPE, 2008). Prior to PBCs, outcomes described in the foster care contracts had no targets and were considered "goals" rather than expectations that would drive contract renewal (and in some cases, payment) decisions.

Over time, Missouri has worked to integrate the QA/QI systems of the Children's Division with that of each private consortium's internal QA/QI processes. The CD has established regional QA oversight specialists who work at the regional and local level to coordinate efforts between the private and public entities. Issues are typically addressed first at the local level and moved to the regional or state level as needed. In addition, for the private contractors under PBC, monthly CEO and program manager meetings held with the Children's Division have a portion of their time focused on reviewing performance data and identifying QA/QI strategies to address deficiencies or identify emerging issues.

Summary

This initial description of each site's history regarding performance-based contracting and quality assurance systems provides the framework for the additional work accomplished through the QIC-PCW. Subsequent sections in this report describe the planning process in each site which led it to adopt the public-private partnership model, discussing the specifics of each site's PBC and QA systems, the contextual variables that played out over the course of this evaluation, and the laying of groundwork for describing the evolution of these systems and processes over time.

V. Research Question 1: Does an inclusive and comprehensive planning process produce broad-scale buy-in to clearly defined performance based contract goals and ongoing quality assurance?

This section describes how each site designed its PBC/QA model, the structure of the planning process, and who participated in that process. These descriptions were drawn from document review from each site and are enhanced with information from focus group discussions and key informant interviews which include stakeholder perceptions of how inclusive and collaborative the planning process felt to various members.

Additionally, cross-site results from the Wilder Collaboration survey are presented. Key staff members in each site who were involved in the planning and decision making process were surveyed on their perceptions of collaboration and inclusiveness at the initial stages of PBC/QA implementation and at yearly time periods through the project.

A. Initial Planning and Ongoing Decision Making

Cross-Site Overview

From document reviews and site visits, it was apparent that each site had its own unique structure for planning and making decisions related to PBC/QA implementation. In all sites, much of the initial high-level planning and decisions were made in meetings that included public agency leadership in conjunction with private agency Chief Executive Operators (CEOs) and executive staff. Despite the public agency (or private lead agency in FL) having fiscal control and responsibility, many key decisions appear to have been collaboratively made in partnership with private agencies. Perceptions of collaboration were relatively high at the beginning of the process in all sites.

In addition, the level of inclusiveness and participation in the planning and decision making process was relatively similar across sites. In all cases, PBC/QA planning included participants from private and public agencies. Each site also utilized their private/public partnerships to target efforts on particular areas of PBC/QA. In some cases, ad hoc workgroups and subcommittees were created to tackle particular issues (e.g., Florida and Missouri) while in others, an existing organizational decision-making structure was utilized (e.g., Illinois). Site specific PBC/QA planning is described below.

Florida

As previously described, Kids Central initially implemented performance based contracts during 2007 fiscal year (July 1, 2006 – June 30, 2007) prior to participating in the QIC. CMAs were offered incentives for achieving specified performance and outcome goals (largely related to CFSR measures) during this period. Under this contract, each CMA had the opportunity to earn up to \$60,000 in additional funds for meeting these targets. Overall, less than 50% of the available contractual incentives were earned by the CMAs. This poor performance led KCI to consider other ways of designing contracts and to look for other measures to incentivize in order to better meet system goals.

To design and implement their new PBC/QA model, Kids Central convened a series of meetings called the *CEO Roundtable* that were held one to two times a month from January 2007 to June 2007. Participants included:

- The CEOs of the Case Management Agencies (CMAs) in Circuit 5 that would work under the PBC
- Legal and administrative staff from the Florida Department of Children and Families in Circuit 5
- KCI administrative, contract and quality assurance staff

Administrators from KCI described several active steps they took to encourage collaborative decision making. First, KCI decided to use an outside facilitator to run these meetings who would be neutral and allow for a “level playing field” in the decision making process. The use of a neutral facilitator was intended to remove the perception that KCI or DCF controlled the discussion at the meetings and allowed for the three groups (CMAs, KCI, and DCF) to work collaboratively. The facilitator helped the group make several decisions about what were fair practices and outcomes to expect from CMAs and what were the best ways to measure the practices and outcomes specified in the PBC.

Second, KCI chose to develop meeting agendas during these planning meetings with all partners rather than set an agenda so that all parties could have a voice. This was done to allow all parties to discuss priorities and resolve issues as they emerged.

Initial discussions of these planning meetings focused on why the CMAs had not performed better on the prior contract’s incentivized outcomes. The group identified several barriers including lack of communication with (and training for) front line staff in what the measures were and how they might achieve them.

Time 2 Focus Group Finding

Front-line workers and supervisors in Florida perceived collaboration to be adequate at higher levels of administration; however, they did noted that the frontline workers and supervisors should be more included in the planning process.

Consequently, in addition to the top level meetings, KCI also convened a group of CMA supervisors in February 2007 to serve as a sounding board as to what were reasonable outcomes to expect from the CMAs and to provide feedback on how the new outcomes might be achieved and what practice changes were necessary. Convening this *Supervisor Group* was also an effort to enhance buy-in to the new contracts and to expedite implementation. Additionally, as contract outcomes were discussed, the groups across all meetings worked hard to collaboratively define and agree on the definition and measurement of the new outcomes included in the contracts. Reaching consensus and understanding about definitions was a major component of this collaborative process and took time to achieve.

Kids Central also sought input about the new PBC/ QA model from its *Advisory Board*. The group was made up of representation from local courts, community, legislature, the state child welfare agency, KCI's board of directors, and the Florida Coalition for Children. In contrast to the CEO Roundtable group which worked on the details of PBC/QA implementation, the Advisory Board offered more general guidance to the project. During the course of the project, the Advisory Board met twice, once on March 16, 2007 and a second time on May 8, 2007.

Although KCI, the CMAs, and DCF met regularly during the planning for the implementation of PBC/QA, the first few CEO meetings were perceived to be tense, as evidenced by a group-dynamic observational rating instrument completed at each meeting. A turning point appears to have happened during a meeting in March 2007 when risk sharing between KCI and CMAs was discussed. Shared risk was a point of contention during the first few meetings, however, according to evaluator notes, it became apparent that CMAs realized that they were being given a large say in the planning of PBC/QA through collaboratively developing CEO meeting agendas and through the neutral facilitator. After this meeting, evaluators reported higher levels of collaboration, cooperation and trust between the CMAs, KCI and DCF during the CEO meetings.

Time 1 Focus Group Findings

FL participants noted meeting more frequently as a result of PBC/QA and a new fiscal year.

On-going feedback and decision making occurred in monthly meetings between the CMAs directors/managers/supervisors and KCI staff. Led by the neutral facilitator, these groups worked on developing collaboratively driven solutions to issues encountered during the implementation of

PBCs. During these meetings, CMAs were given feedback on monthly performance and a great deal of time was spent discussing improving quality and discussing practice related to achieving the outcomes. While KCI retained the right to determine whether credit was given for specific outcome achievement, CMAs were able to discuss and resolve discrepancies with the KCI QA team.

Illinois

Leadership from the Illinois Department of Children and Family Services (DCFS) emphasized that they used several lessons they learned from their experience designing PBCs for foster care services in 1997 to design the new residential care PBCs. Site officials learned that the best way to ensure a shared vision of success (and a shared approach to achieving it) was to engage the private provider community and other stakeholders, including the courts, prior to contract development, in order to decipher program and implementation issues together (McEwen, 2006).

DCFS officials invited representatives from private provider agencies, community stakeholders (Office of the Public Guardian and child advocates), and university representatives to participate in the planning process for the implementation of PBC/QA. The new contracts were designed through a series of committees, subcommittees and work groups. In addition to these, the state has held State Wide Provider Forums and Data Summits to invite broader input from the private provider community on the PBCs and measuring outcomes.

The structure of the decision making process was based on existing committees and subcommittees developed during the state's previous efforts with PBCs in the 1990s. Specifically, the Child Welfare Advisory Committee (CWAC) had been established in 1995 by gubernatorial directive to advise DCFS on programmatic and budgetary matters related to the provision or purchase of child welfare services (Kearney and McEwen, 2007).

Within the CWAC, the Steering Committee for the QIC project consists of nine members from private provider agencies and nine members from the Department of Children and Family Services (DCFS). Steering Committee members are chairs of other committees, subcommittees and workgroups. The Steering Committee has provided a forum for chairs of subcommittees and workgroups to discuss their work and air concerns about the planning process and makes decisions and prioritizes the work of the subcommittees and workgroups.

Time 2 Focus Group Finding

Front-line workers and supervisors in Illinois perceived collaboration to be adequate at higher levels of administration; however, they did feel that the frontline workers and supervisors should be more included in the planning process.

Subcommittees and workgroups actively involved in planning for PBCs included the High End Subcommittee, Residential Monitoring Subcommittee, Data Test Workgroup, Older Adolescents Workgroup, ILO TLP Subcommittee, and Finance and Administration Subcommittee (FAS). Each group has taken on the task of guiding the development of protocols and processes under each topic area, all of which feed into the planning and continued implementation of PBCs.

Additionally, prior to and after DCFS decided to implement PBCs, private residential providers formed a separate Residential Group and listserv to discuss issues specific to their experience and to ensure that they had a voice at all levels advocating for them. This private Residential Group also was key in leading discussions related to measuring outcomes in residential contracts and working with DCFS staff to review existing clinical data on youth in placement.

Time 1 Focus Group Findings

IL participants noted meeting more frequently as a result of PBC/QA and a new fiscal year.

During the first year of the residential provider contracts, workgroups held more than 75 meetings to design the contracts. They performed the following tasks:

- Analyzed the service delivery in residential programs
- Reviewed available data and research pertaining to these programs
- Identified evidence-informed practices
- Determined gaps in existing data, and future needs for data collection
- Engaged national and local experts to provide technical assistance
- Discussed performance indicators and the data used to measure them
- Reached consensus on the proposed performance indicators
- Developed fiscal incentives
- Developed a preliminary risk adjustment model (Kearney & McEwen, 2007).

On-going decision making for the QIC project and for the implementation of PBCs continues through the above structure. Additionally, individual agencies in the private provider network are kept informed of all decisions and developments via a state-wide listserv which serves as a communication vehicle for the public/private partnership. Given the state-wide reach of this project and PBCs, Illinois learned to effectively develop and utilize the above collaborative structure in order to ensure that all parties are represented, heard, and contribute to the development of protocols and processes designed to improve outcomes for children and youth in residential and transitioning care.

Time 1 Focus Group Findings

After implementation of PBC/ QA, focus group participants in IL noted an increased engagement with stakeholders to support youth in care, including stakeholders in psychiatric hospitals, probation and parole, education, and foster care.

Missouri

Because Missouri implemented PBCs for its out-of-home care population prior to its involvement with the QIC, the following summarizes both the planning for its original 2005 contracts as well as the ongoing oversight structure it used to refine the second round of contracts implemented in 2008.

Beginning in 2002, Missouri spent three years researching and planning for the roll-out of its PBCs. Throughout 2002 and 2003, the Division completed a literature review and studied the experience of several states specifically: Illinois, Kansas, Florida, Los Angeles County, California, New York City, Iowa, Nebraska and Michigan. Site documents indicate that the site quickly learned a series of lessons about some necessary elements of putting this system in place:

- Commitment of high-level leadership
- A shared vision for success by private/public partners
- Adequate management and staffing structure
- Strong connections with community and consumer involvement in program design, implementation and evaluation
- Adequate contract funding
- Impetus for change should be driven by the desire to improve service quality service rather than financial savings
- Additional funding should be sought from outside the child welfare system—most notably, Medicaid and mental health funds
- Necessity of a solid information system that produces cost, service and outcome data and strong monitoring capabilities

Time 1 Focus Group Findings

Missouri focus group participants discussed an insufficient outreach to the judicial branch and other state/county departments outside child welfare. An attempt was made to solicit broader input through a series of pre-bid conferences prior to the 2nd contract's implementation.

In 2003, the Children's Division (CD) then sought input from current and potential bidders. The invitation list for the discussion meetings consisted of current contracted case management agencies and Intensive In-Home Services and Family Reunification Service contracting agencies. In addition, each region sent invitations to community members such as child advocates, court personnel, and legislators.

Discussion at the initial regional meetings focused on both the local conditions of that time (e.g. the state's performance on its first round of Child and Family Services Reviews) and the system goals of improved performance. State officials also outlined their initial

ideas about the new contract design in order to obtain feedback on general issues of what the contracts should involve, how they should be structured, and what level of funding was required for these types of services.

Time 1 Focus Group Findings

The frequency of meetings was reported to remain the same, and in some cases, decreased.

Attendance at the meetings was strong. Site documents indicate that in Kansas City, 22 potential contractors and eight CD personnel attended; in Springfield, 18 potential contractors, five CD personnel and two court personnel attended; and in St. Louis, 46 potential contractors and four CD personnel attended.

At each regional meeting, a high level administrator from the Children's Division summarized the state's goals for its new PBCs and described the decisions that the state had made, such as piloting the initiative in the three geographical areas, expectations for continuity in services array, and that the performance measures would relate to safety, permanency and stability. Other plans for the new contracts were discussed including how the contracts would be structured and what might be included in the treatment and placement costs for children. The Children's Division sought feedback from existing contractors about the current foster care case management process and ideas about improving the contracts. In addition, input was sought on how to incorporate family centered practices, such as keeping children tied to their communities and families, how to help children reach permanency more quickly, and how to implement contracts that support a multi-disciplinary approach.

A joint decision was reached to form three sub-committees of private agency representatives and Division staff that would make recommendations about outcomes, benchmarks and their assessment; organizational management/provider qualifications; and enrollment and disenrollment of cases. The state then convened follow-up statewide meetings to present the recommendations generated by the three subcommittees. This was important as the recommendations would help develop portions of the Request for Proposals (RFPs). Information was also distributed, in writing, to allow stakeholders an opportunity to provide input on these portions of the RFP.

Missouri is the only QIC site to conduct an actuary study to assess the true costs of care. In order to ensure that the contracts were sufficiently funded, the state contracted with Mercer Government Human Services Consulting to develop an actuarially sound case rate range for case management services. These included case management and

Time 2 Focus Group Finding

Front-line workers and supervisors in Missouri generally agreed that a stronger partnership was needed between state and contracted agencies in order to foster a more collaborative atmosphere. They also felt that a more collaborative environment would be more effective in achieving goals than some current punitive methods that appeared to persist on the frontline.

administrative costs, special expenditures for children, resource funding for the recruitment of foster and adoptive parents, foster care maintenance, and residential treatment costs. Separate analyses were done for different regional sites. These rate ranges were used in awarding contracts in 2005 and 2008.

As described above, under the QIC, the state has focused on improving the long-term maintenance supports and quality assurance processes of its PBCs. Since implementation, joint oversight and

problem solving has expanded in Missouri. The first joint oversight meetings involved the CEOs of the provider agencies and leadership of the Children's Division. In the first year (2005), these meetings were monthly to address any transitional issues related to the contract. Meeting minutes indicate that common discussion themes included: implementation and performance issues, cost matters, and quality assurance procedures. CEO meetings now take place on a quarterly basis.

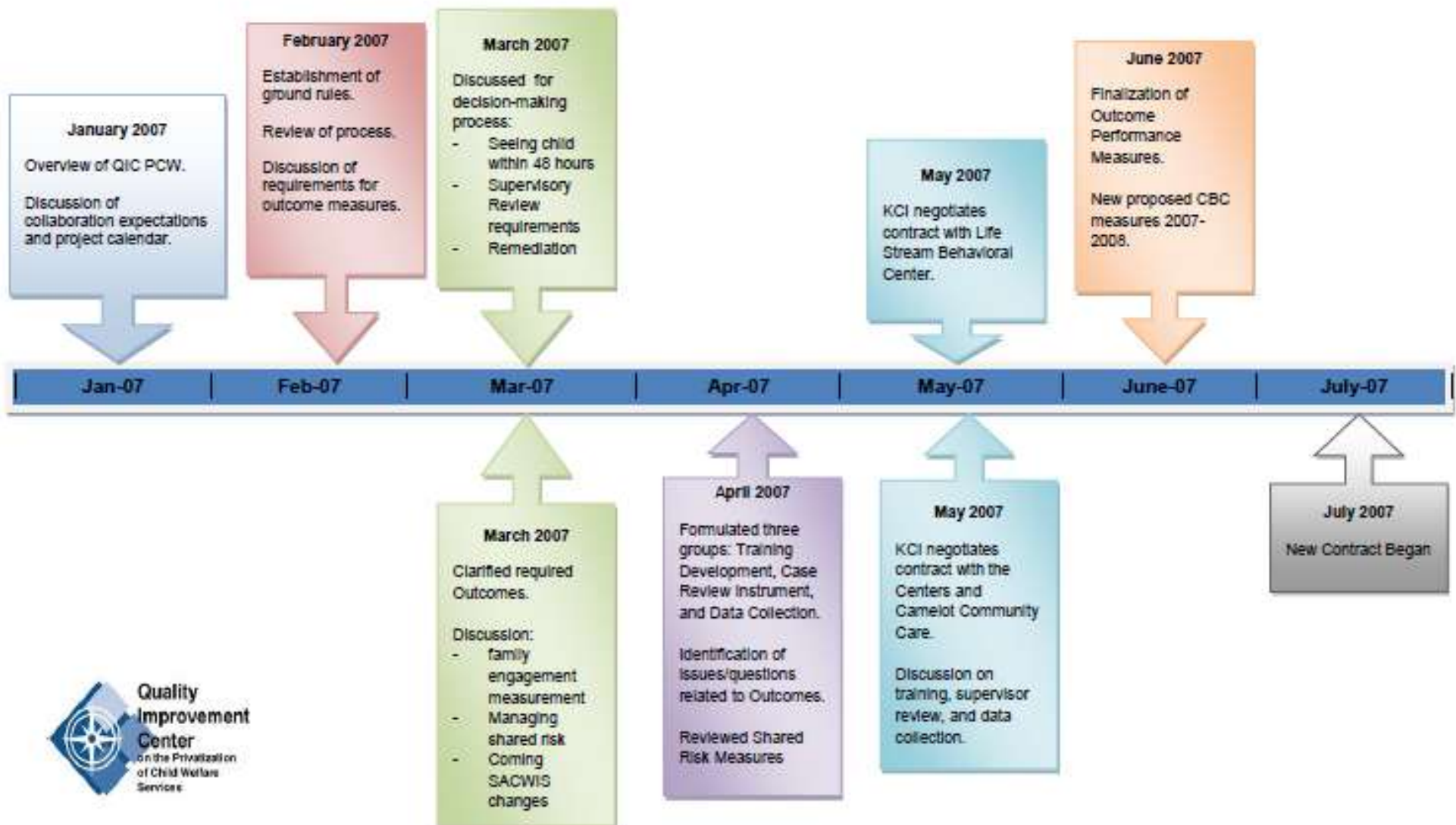
Like other sites, the trend is for the number of oversight meetings at the highest levels (e.g. CEOs) to be reduced over time and replaced by more meetings with supervisors and front-line workers that focus on practice and quality assurance issues. To accomplish this, the state established two other ongoing collaborative oversight meetings that support project implementation and quality assurance efforts. There are now quarterly meetings for program managers (in addition to the CEO meetings) and monthly meetings with direct service staff at the regional level to address specific challenges and concerns at the local level. Additional information about these meetings is provided below under the discussion about quality assurance.

B. Timeline of major milestones

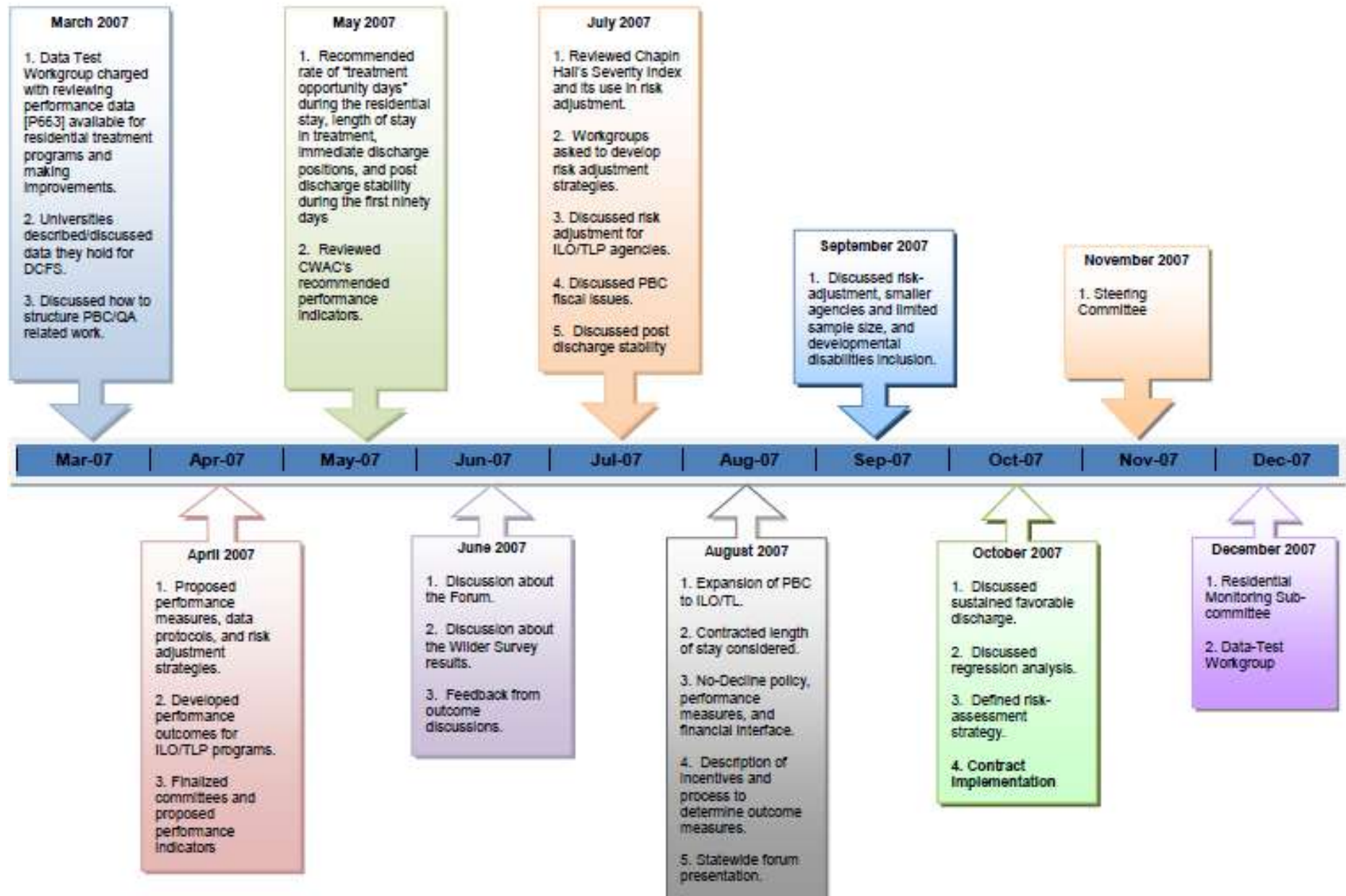
The following timelines were created to mark important events in the planning and implementation of PBC/QA in each site. Based on document review and site visit notes, these timelines provide a depiction on key meetings, decisions, and developmental processes specific to the planning process of creating or enhancing PBC/QA systems as they occurred in each site.

In the case of Florida and Illinois, the planning timeline encompasses the time in which they were first awarded the QIC demonstration grant (January 2007) to the point at which PBC was initiated in each site (~end of 2007). For Missouri, their planning process for PBC began several years prior to the QIC award and represents those initial planning activities leading up to the first year of QIC (2007). This reflects that Florida and Illinois were just starting PBCs in case management and residential services in their sites while Missouri had a PBC in place and expanded the support services around maintaining those contracts.

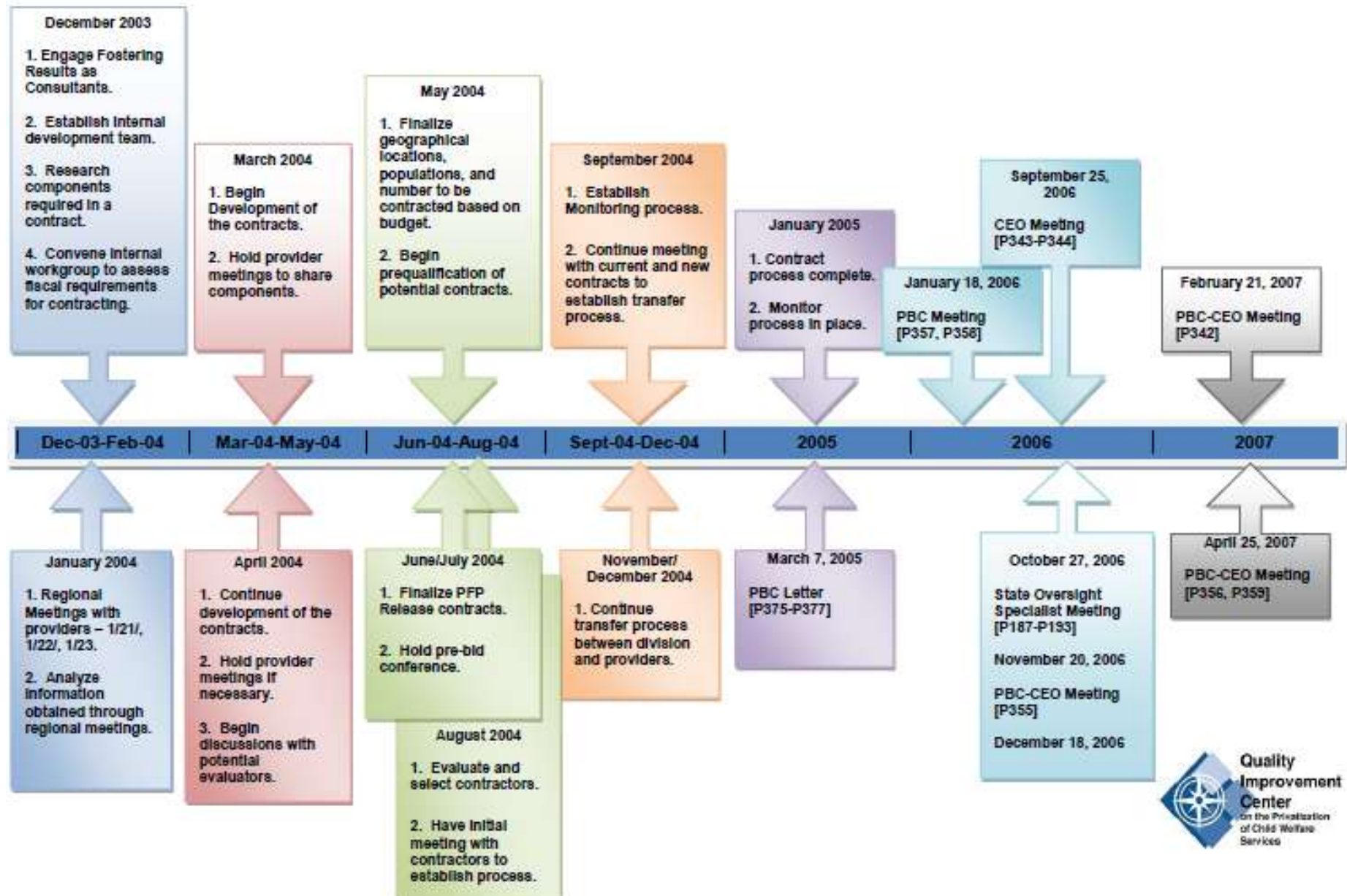
Florida Planning Process Timeline



Illinois Planning Process Timeline



Missouri Planning Process Timeline



C. Collaborative environment

The collaborative environment during the planning process and implementation phase of this project was hypothesized to have an impact on the initial buy-in and continued cooperation towards the shared work between public and private agencies utilizing PBC/QA. It was also considered to potentially impact staff perceptions of their involvement in and support of PBC/QA goals. To examine this link, the evaluation team worked with each site to measure collaboration perceptions of those most directly involved in the planning and implementation process via a common instrument: Wilder Collaboration Survey.

Additionally, focus groups and key informant interviews conducted over the course of this evaluation help provide supplemental perceptions of the collaborative environment across the public/private partnership. Those focus groups and interviews include the perspectives of both front-line staff as well as administrators and agency directors. Thus, multiple levels of analysis were conducted to better understand the role collaboration may have played in how PBC was developed and maintained in each site.

Wilder Collaboration Survey

The original Wilder Collaboration Survey (Mattessich, Murray-Close, and Monsey; 2004) was developed to include 40 items comprising 6 reliable domains: 1) collaborative structure, purpose, common mission and communication; 2) human and financial resources; 3) existence of a collaborative “attitude” evidenced by history of collaboration in a community, trust, and respect among collaborative members; 4) environmental conditions in which the collaboration operates, such as the respect and hope of others in the community, timing and political/social climate; 5) characteristics of the collaborative members; and 6) communication issues.

Bryan, Krusich, Collins-Camargo, & Allen (2006) found five domains accounting for 72% of the variance in a sample of 308 participants. There was general agreement between the domains identified by the survey developers and those found in this sample, though items in the communication factor instead loaded with the collaborative factor

In addition to the original 40 items, the project team created 3 project-specific items designed to measure the extent to which the right collaboration environment was in place to improve outcomes for children. Given the focus of the intervention and the agencies involved, these additional items help further clarify perceptions of collaboration around this specific intervention.

Given the small sample sizes in this project, a confirmatory factor analysis for this project was not completed. Instead, the evaluation team chose to use the original 6 domains and the newly created items as an additional domain. Reliability analyses were

conducted on the entire Baseline and Time 1 sample to confirm the items in those domains were reliable.

As expected, all but one domains including the newly created one, achieved high reliability with Cronbach's alphas ranging from $\alpha = .72$ to $\alpha = .91$. One domain (Resources) had a lower reliability of $\alpha = .64$, but was deemed acceptable to include with the caveat that its lower reliability should be taken into account when interpreting the results on this domain.

The following table presents the items for each domain used in this analysis and the reliability of those domains. Each item was scaled on a 5-point Likert scale (1 = Strongly Disagree; 3= Neutral; 5 = Strongly Agree).

Items on the Wilder Collaboration Survey		
Collaborative Environment $\alpha = .76$	Member Characteristics $\alpha = .72$	Collaborative Communication $\alpha = .88$
<ul style="list-style-type: none"> Public and private agencies in our state have a history of working together. Trying to solve problems through collaboration has been common in this community (collaboration between public and private child welfare agencies). It has been done a lot before. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish. Others (in this community) who are not part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work The political and social climate seems to be "right" for starting a collaborative project like this one. The time is right for this collaborative project. 	<ul style="list-style-type: none"> People involved in this collaboration always trust one another. I have a lot of respect for the other people involved in this collaboration work. The people involved in this represent a cross section of those who have a stake in what we are trying to accomplish. All of the organizations that we need to be members of this group have become members of this group. My organization will benefit from being involved in this collaboration. People involved in our collaboration are willing to compromise on important aspects of our project. 	<ul style="list-style-type: none"> People in this collaboration communicate openly with one another. I am informed as often as I should be about what goes on in the collaboration. The people who lead this collaborative group communicate well with the members. Communication among the people in this collaborative group happens both at formal meetings and in informal ways. I personally have informal conversations about the project with others who are involved in this collaborative group.
Collaborative Purpose $\alpha = .89$	Resources Available $\alpha = .64$	Child Welfare PBC/QA Goals $\alpha = .86$
<ul style="list-style-type: none"> I have a clear understanding of what our collaboration is supposed to accomplish. 	<ul style="list-style-type: none"> Our collaborative group has adequate funds to do what it wants to accomplish. 	<ul style="list-style-type: none"> The right level of agency staff is participating in this project such that decisions

<ul style="list-style-type: none"> • People in our collaborative group know and understand our goals • People in our collaborative group have established reasonable goals. • The people in this collaborative group are dedicated to the idea that we can make this project work. • My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others. • What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself. • No other organization in the community is trying to do exactly what we are trying to do. 	<ul style="list-style-type: none"> • Our collaborative group has adequate “people power” to do what it wants to accomplish. • The people in leadership positions for this collaboration have good skills for working with other people and organizations. 	<p>can be made</p> <ul style="list-style-type: none"> • I expect this project to successfully create an effective plan for improving services to children • I expect this project to ultimately be a success at improving outcomes for the children we serve
<p align="center">Collaborative Process $\alpha = .91$</p>		
<ul style="list-style-type: none"> • The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts. • Everyone who is a member of our collaborative group wants this project to succeed • The level of commitment among the collaborative participants is high. • When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues on what the decision should be. • Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part. • There is a lot of flexibility when decisions are made; people are open to discussing different options. • People in our collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working. • People in this collaborative group have a clear sense of their roles and responsibilities. • There is a clear process for making decision among partners in this collaboration. • . This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate or changes in leadership. • This group has the ability to survive even if it had to make major changes in its plans or add some new members to reach its goals. • This collaborative group has tried to take the right amount of work at the right pace. • We are currently able to keep up with the work necessary to coordinate all the people, organizations and activities related to this collaborative project 		

Methodology

In each site, local evaluators identified key personnel in both the public and private agencies who were and remain critically involved in the planning and implementation of PBC/QA in each site. These key informants were asked to fill out the Wilder survey at Baseline (Fall 2007/Spring 08), at Time 1 (Fall 2008/Spring 2009), and at a final Time 2 (Fall 2009/Spring 2010).

Local evaluators attempted to survey the same individuals at each time point with some variability occurring due to natural personnel changes and additions. Thus, the team was able to measure perceptions of collaboration at the group level during the early planning of the PBC/QA intervention, at the mid-point in implementation, and after the intervention had matured.

Across sites, respondents completed either a paper and pencil survey or an online version of it. Local evaluators obtained basic demographic information for site-specific analyses. The cross-site evaluation team received the data from each site and standardized the formatting and variable name information. The team added variables for site and time period to the data set to allow for cross-site analyses.

The sample sizes for each site are as follows:

	Baseline (Fall 2007/Spring 2008)	Time 1 (Fall 2008/Spring 2009)	Time 2 (Fall 2009/Spring 2010)
Florida	27	30	42
Illinois	131	172	93
Missouri	19	22	10

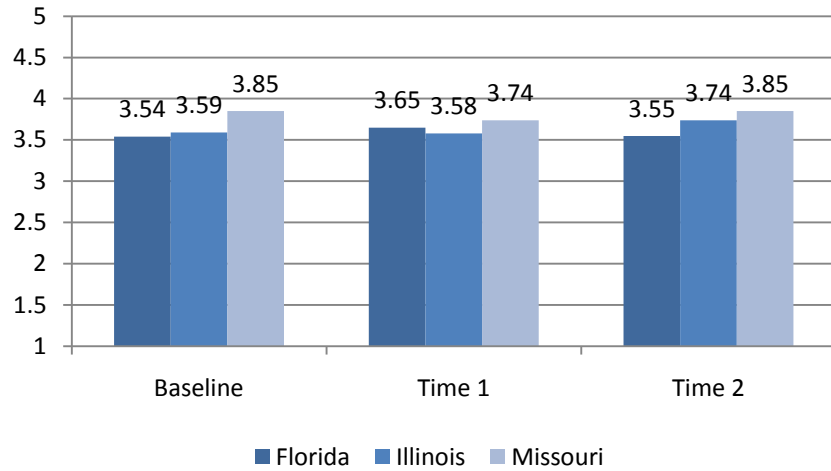
Analyses and Results

This report will focus primarily on difference within each site over time. Given that the three sites have a very different process and structure, direct comparisons on collaboration between the three sites is not necessarily the most appropriate approach for this survey. Rather, the cross-site evaluation team will focus the analyses on within-site analyses over time which are better suited to describing changes in perceived collaboration within a given group or site over time.

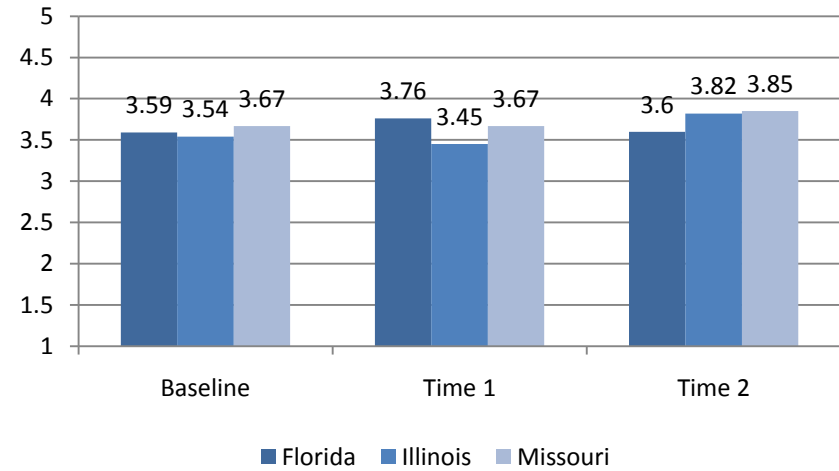
A multivariate analysis of variance (MANOVA) was performed to test for between-group differences. This analysis included all subscale domains and Time as a between-subjects factor to test whether perceived collaboration changed over time. Results showed that the overall main effect for Time was not significant ($F(14,1022) = .724, p < .75$).

The following graphs display the means for each site on each collaborative domain at each time point - Baseline, Time 1, and Time 2. Detailed analyses of those means between time periods for each site are presented following the graphs. For reference purposes, responses were on a 1-5 Likert scale with higher numbers indicating greater agreement with a given item/subscale. Thus, higher numbers indicate greater levels of perceived collaboration.

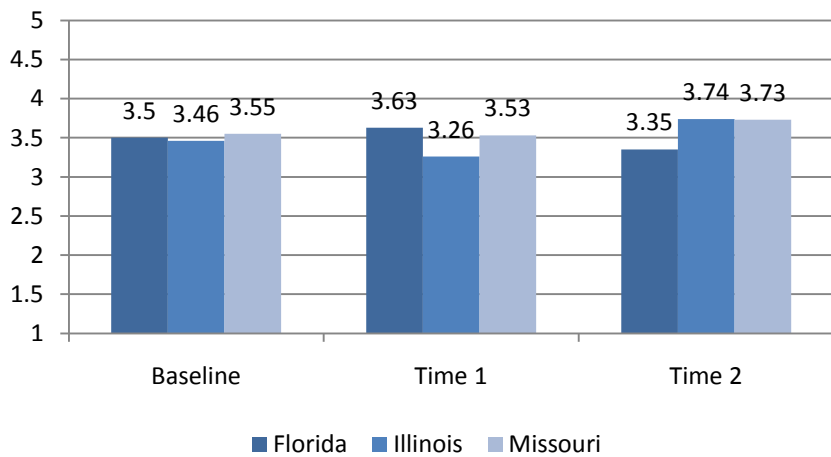
Collaborative Environment



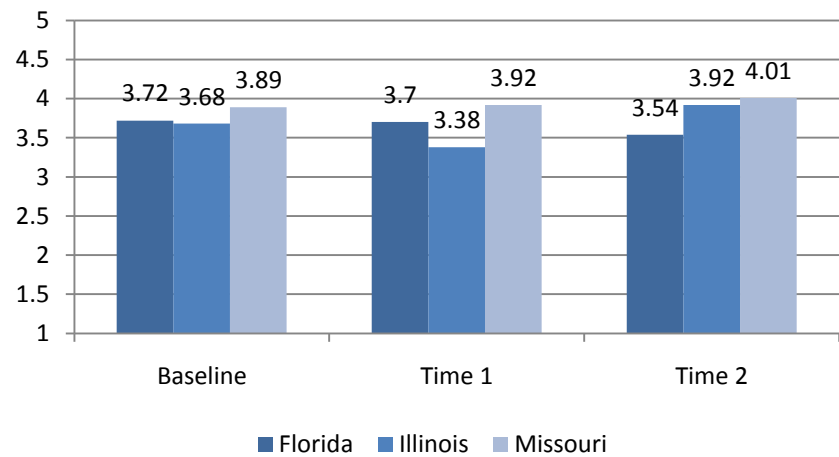
Member Characteristics



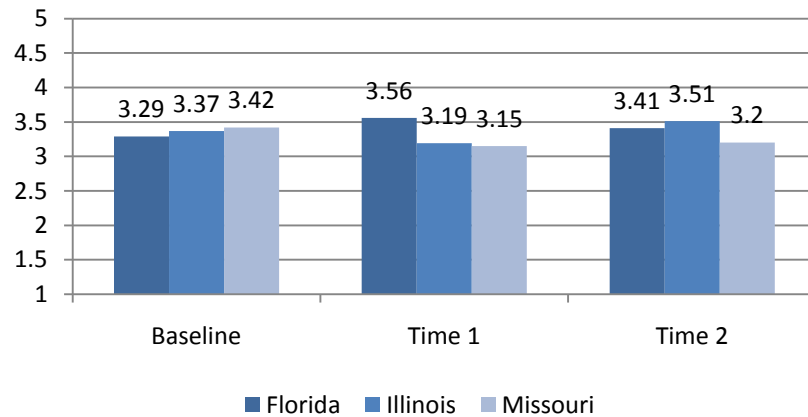
Collaborative Process



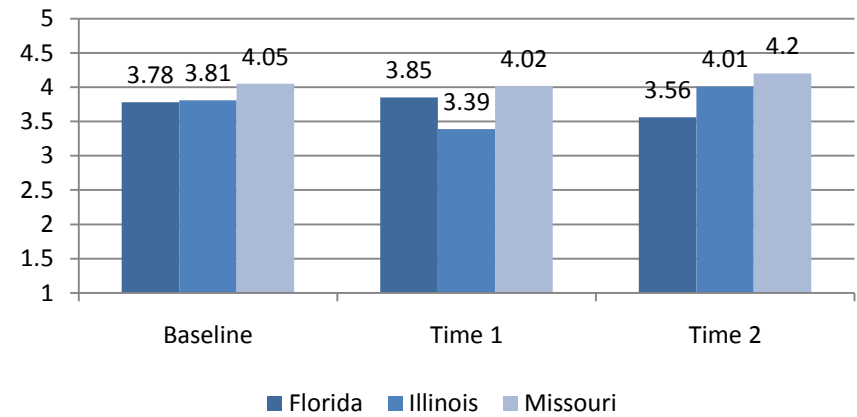
Collaborative Purpose



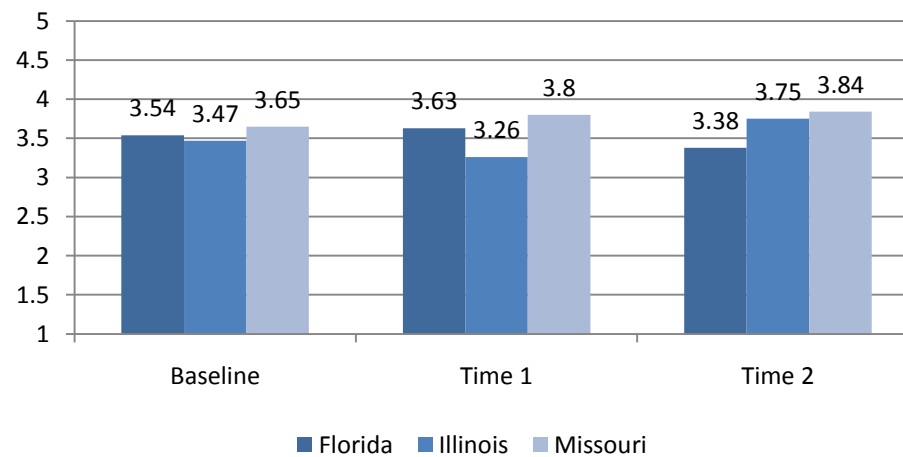
Resources Available



PBC/QA Goals



Collaborative Communication



Additional multivariate analyses were performed for each site separately to test whether domain means differed significantly within sites throughout the duration of the study. Significant differences were noted in the state of Illinois for the following domains: Member Characteristics ($F(2,394) = 12.0, p < .000$), Collaborative Process ($F(2,394) = 17.1, p < .000$), Collaborative Communication ($F(2,391) = 12.1, p < .000$), Collaborative Purpose ($F(2,392) = 18.3, p < .000$), Resources Available ($F(2,386) = 6.1, p < .003$), and PCB/QA Goals ($F(2,386) = 20.0, p < .000$). Additional post hoc analyses conducted on these domains revealed where significant differences across the three time points of Baseline, Time 1, and Time 2 occurred as marked by the subscripts in the following table.

Table 6 shows the mean on each domain for each site across time points. Higher numbers indicate greater perceived collaboration.

Cross-Site Perceptions of Collaboration					
Wilder Survey Domains	Time	Florida	Illinois	Missouri	Mean
Collaborative Environment	Baseline	3.54	3.59	3.86	3.61
	Time 1	3.65	3.58	3.74	3.61
	Time 2	3.55	3.74	3.85	3.69
	Overall	3.58	3.62	3.81	3.63
Member Characteristics	Baseline	3.59	3.54 _a	3.67	3.56
	Time 1	3.76	3.45 _a	3.67	3.51
	Time 2	3.60	3.82 _b	3.85	3.76
	Overall	3.64	3.57	3.71	3.59
Collaborative Process/Structure	Baseline	3.50	3.46 _a	3.55	3.48
	Time 1	3.63	3.26 _b	3.53	3.34
	Time 2	3.35	3.74 _{bc}	3.73	3.63
	Overall	3.48	3.44	3.57	3.46
	Baseline	3.54	3.47 _a	3.65	3.50

Collaborative Communication	Time 1	3.63	3.26 _b	3.80	3.36
	Time 2	3.38	3.75 _{bc}	3.84	3.66
	Overall	3.50	3.45	3.75	3.48
Collaborative Purpose	Baseline	3.72	3.68 _a	3.89	3.71
	Time 1	3.70	3.38 _b	3.92	3.47
	Time 2	3.54	3.92 _{bc}	4.01	3.82
	Overall	3.64	3.61	3.92	3.64
Resources	Baseline	3.29	3.37 _a	3.42	3.36
	Time 1	3.56	3.19 _b	3.15	3.23
	Time 2	3.41	3.51 _c	3.20	3.46
	Overall	3.42	3.32	3.26	3.33
Child Welfare PBC/QA Goals	Baseline	3.78	3.81 _a	4.05	3.83
	Time 1	3.85	3.39 _b	4.02	3.51
	Time 2	3.56	4.01 _c	4.20	3.90
	Overall	3.71	3.67	4.07	3.72

Quick Summary: Collaboration

- Overall, perceptions of collaboration were mostly centered in the mid-point range of the scale; most respondents indicated their ratings between neutral (3) and agree (4).
- The highest range of scores occurred for the domain of PBC/QA Goals while the lowest occurred for the Resources domain.
- Illinois was the only site to demonstrate significant change in these collaboration measures over time. As noted in the table, perceptions of collaboration were lowest at Time 1 compared to Baseline and Time 2. Contextual factors occurring during Time 1 include difficult budget negotiations between the State legislature, the Department, and private providers.

Time 1 Focus Group Collaboration Findings across Sites

Focus group participants across all three sites reported an increase in collaboration across all levels of care since the start of PBC/QA. Providers perceived themselves as part of a service delivery system instead of stand-alone entities. An increase in communication between the public sector and private providers was noted, as well.

Focus group participants in all three sites reported being cognizant of the shift in demographics of the youth in child welfare, noting a greater proportion of severe youth and aging youth with a short amount of time before emancipation. These cases are often more complex than cases typically encountered prior to the implementation of PBC/QA. As such, there was a recognition that increased collaboration was needed to ensure that these cases received quality care.

Time 2 Focus Group Collaboration Findings across Sites

Through the discussions at Time 2 Focus Groups, frontline workers and supervisors provided a ground-level perspective of the collaborative environment three years into the implementation of Performance Based Contracting. Four main areas emerged in these conversations: Competition, Goal Clarity, Planning Process, and Shared Responsibility.

Competition: Participants across the three sites reported that competition in the PBC setting interferes with collaboration and continuity among both private and public agencies. Sample quotes included: *“Contracts began to drive a wedge between the agencies. Workers stopped sharing ideas because everyone was looking at their numbers in relation to those of others.”*; *“Despite improvement, some underlying tension makes it difficult to collaborate. The tension appears to be due to miscommunication, perception of an uneven playing field, and the double role that the public agency plays in both directly serving clients and ‘monitoring’ the contracted agencies.”*; *“Smaller agencies are more impacted by PBC as they struggle to meet expectations and provide clients with all the services due to their lower staffing levels and fewer resources. Smaller agencies may be providing quality care, but cannot compete under PBC.”*

Goal Clarity: Frontline workers and supervisors often recommended that the PBC goals, measures, and activities be more clearly communicated down to the frontline level. The lack of clarity about PBC appeared to contribute to competition and hindered collaboration in some areas.

Planning Process: Focus Group participants in all three sites did feel strongly that the frontline workers and supervisors should be more involved in the PBC planning process in order to provide a “real-time” perspective. Generally, their involvement was invited

at the implementation stage and some participants (mostly supervisors) only had a role in making decisions regarding implementation at their agency. However, many participants felt that their input was reactive to the changes already made by higher administrators.

Shared Responsibility: Front-line workers and supervisors in all sites generally didn't feel that their input extended beyond their own agency. They were not sure if their input was ever received by higher authorities. However, these workers viewed themselves as the ones who would have to endure the "fall out" of the decisions made in the years to come; so, it would be in their best interest to have a role in making those decisions.

Final Site Visit Collaboration Findings across Sites

Across all sites, there was agreement across both sectors that the planning process was inclusive. It was also largely agreed that although for the most part the right people were at the table, representatives of frontline staff should have been included. In Illinois and Missouri, it was noted that the judiciary should have been involved. Others groups that were mentioned which could have been involved from the beginning included fiscal staff, community agencies, quality assurance staff and foster parents. Participants noted that for varying reasons, the timing of the initiative was favorable and this furthered the process. A tremendous amount of planning meetings was held. Responses varied regarding whether the timeline for planning was adequate.

An array of challenges was noted regarding communication, between and within sectors. A lack of a communication plan or consistent structure for this purpose was noted in two sites. In all states the lack of administrative processes and infrastructure such as agendas, minutes and consistent participation by leadership challenged the collaborative process. A few themes arose in two out of three sites: some existing issues not discussed in meetings, lingering trust issues, difficulty in maintaining momentum, and, incidents that did not involve the collaborative decision-making that had become expected. Individual states experienced additional challenges.

In all states, the need to build purposeful collaborative structures to facilitate the process was emphasized. In Illinois, the steering committee arose from their pre-existing Child Welfare Advisory Committee, and subcommittees thereof, which are co-chaired by public and private staff, as well as their provider association and a group of residential providers. Data and provider summits were also held to bring in providers statewide, and an implementation team within the public agency was established to promote internal communication among units. Missouri utilized its established CEO meeting structure, but also created a regular program managers meeting that could focus on practice improvement rather than administrative issues. A new process for collaboration among quality assurance staff was created to promote integration of use of data and practice change. In Florida, the community board and provider CEO group

was utilized but a neutral facilitator was added for planning and the supervisor roundtables that were created. A theme that crossed sites was the importance of leadership participation from both sectors so that decision-making was enabled.

In all sites, a major theme was that the collaborative process had resulted in an improved child welfare system and outcomes for children. Relationships and understanding of the roles and strengths across sectors had improved.

Summary

This section described the initial planning process and on-going discussions related to PBC/QA in each site. It highlighted the efforts in each site to establish a collaborative dialogue about the design and implementation of PBC/QA between both private and public partners. Given the complex relationship between public and private partnerships within a performance-based contracting system, each site identified the collaborative planning process as an important factor in the success or failure of their efforts. In most sites, this collaborative relationship was evident during site visits as all partners were included at the table.

The collaborative nature of the private-public partnerships in each site generally mirrors the results found on the Wilder Collaboration Survey in which there was general agreement that the group had a collaborative communication structure, process, purpose, goal, environment, and partners. While some variations exist within and across sites over time and by domain, the results generally demonstrate that the public private partnerships were collaborative in their initial planning process and maintained that over time.

The collaborative nature of the partnerships was not always reflected on the frontline level as evidenced by the conversations during the Time 2 Focus Groups. This could be an area where more targeted efforts are made to ensure that collaboration extends from the higher decision-making levels down to the frontline.

VI. Research Question 2: What are the necessary components of performance-based contracts and quality assurance systems that promote the greatest improvements in outcomes for children and families?

In general, identifying the necessary components of a PBC/QA system requires understanding the complexities and idiosyncrasies within a given state or locale. Key stakeholders in each site emphasized that there is no easy cookie-cutter template for developing a PBC or QA system that will apply to all states or agencies or that will ensure success. Rather, all agreed that the intervention was more about the collaborative public-private process than about the distinct components. Also, given the differences that existed across sites in this evaluation and how each site chose to support their PBC/QA efforts, identifying components that are critical was difficult. Sites have also implemented additional system-wide or organizational supports that are specific to each site and were important to promoting performance or improving quality services.

However, the following section outlines how each site implemented their PBCs and designed their QA system around these contracts. Several key themes emerged in developing PBC/QA across the sites which may be necessary considerations:

- The importance of selecting the appropriate contract outcomes and aligning those outcomes with shared goals across public-private partnerships
- The importance of setting appropriate benchmarks for performance in contracts and collaboratively monitoring performance
- The importance of sharing risk in a contractual relationship between public and private agencies
- The importance of having and using reliable data to assess performance and improve quality (QA/QI)
- The importance of fostering an organizational culture in which front-line and supervisory staff use data to inform their daily practice and achieve outcomes for children and families

Overview

Given the above discussion, findings on Research Question 2 are divided into three parts. This section begins with a more comprehensive description of the PBCs being implemented by the three sites. Logic models providing a depiction of each site’s activities and outputs leading to outcomes in their chosen performance measures are also included in this section.

While related, quality assurance/quality improvement activities went well beyond the analysis of contract performance and were aimed more generally at strengthening contract oversight and improving casework and services. The types of QA/QI activities being implemented across the sites were also documented via site visits, site semi-annual reports and the cross-site Quality Improvement Survey. The following sections will provide a more detailed description of the quality assurance systems in place at each site.

Finally, findings from the Staff Training and Supervision Survey are included to demonstrate the breadth and depth of PBC/QA-related changes in organizational culture from the perspective of front-line and supervisors. Early discussions by the project team, the development of evidence informed practice culture and change in staff attitudes toward evidence informed practice may be a driver of successful implementation of the PBC/QA system, a desired outcome, and a potentially necessary component of the PBC/QA system itself.

A. Performance-Based Contracts

Each site’s initial intent for their PBC/QA system is summarized below as well as ongoing changes that were observed to the system over the course of this evaluation. This information was obtained from document review and key informant discussions with each site, as well as from cross-site evaluation notes during site visits. The contract specifications are presented in this section and summarized by an accompanying table. For each contract, the study team catalogued the target population, the target services and practices, mechanisms for incentive/disincentives, and the financial risk structure.

Florida

The PBC in Florida’s Circuit 5 is between Kids Central, a private CBC lead agency and four case management agencies (CMAs). The CMAs are responsible for all day-to-day case management of foster care cases. The Circuit selected four performance measures for its contracts. Three of these measures are “process” measures over which workers have direct control. Kids Central wanted to incentivize measures that CMAs could easily influence as a way to increase “buy-in” for the PBC. The process measures were expected to impact the one

Time 1 Focus Group Findings

Participants reported that service delivery was being approached on the front end to divert families and children from entering care.

outcome measure that was selected to assess performance – improved timely permanence.

Compared to the other two sites, KCI's PBC model presents the least risk to the CMAs as they receive a base payment for their services, on top of which they receive incentives based on their performance on the measures. It was left to the discretion of the CMA as to how they would use the incentive money. In some cases, CMAs gave bonuses to individual staff members of a unit which met their targets.

Penalties were originally designed to occur after a period of poor performance and entailed CMAs receiving and eventually paying for technical assistance from KCI to enhance performance. This constituted what the site referred to as 'shared risk'.

During the course of this evaluation, no CMA was required to purchase TA despite performance levels. As documented by the local evaluation and KCI personnel, the decision not to impose penalties was made because CMAs showed continuing progress toward desired targets. In addition, the site felt that external variables, such as the implementation of the new SACWIS system, Florida Safe Families Network (FSFN), negatively impacted the ability of CMAs to reasonably meet certain goals, such as data entry within 2 business days. Thus, the penalty portion of this PBC model was not fully implemented.

Contractual Performance Measures

Descriptions of each of the original five measures included in the PBCs awarded to CMAs are drawn from information contained in the site's semi-annual reports.

Additional face-to-face supervisory meetings within 4 days of case receipt and again at 30-45 days (2 separate measures)

The definition of this measure is: "All new out of home cases transferred for services from the state's protective investigations unit will receive a supervisory screening with the worker between two and four working days from the transfer, and again between 30-45 days and quarterly thereafter".

This incentive has been divided into two parts. CMAs would earn individual incentive payments when target goals for conducting supervisory reviews within the initial four days after a case is received and again when the 30-45 day time frames are met. Incentives are paid when case supervision occurs in 100% of cases.

The intent of this measure was to improve casework and related outcomes by incentivizing quality direction and management of front-line workers through face-to-face supervisory meetings.

Earlier and more accurate data entry into state's administrative system within 2 day

The definition of this measure is: "All case information will be entered into the State's SACWIS system accurately and within 2 working days. The CMA shall input and update all required case management information into the SACWIS data information system. Furthermore, the CMA shall correct all errors indicated on the AFCARS Error Report minimally on a monthly basis and also by request from Kids Central".

CMAs obtain incentive payments when case information is entered in a timely manner 90% of the time. The intent of this measure was to improve data entry, by entering data in a timely manner, appropriate and accurate case-data analysis can be completed and used to inform management decisions. In addition, timely data entry into SACWIS is a mandated lead agency performance measure. Incentivizing the measure will increase Kids Central's overall performance within the statewide assessment of lead agency performance.

Increased caseworker contact with biological parents

This indicator has been refined over time from simply requiring case managers to have contact with biological parents of children in out-of-home care to now requiring workers to document that they both met with parents and discussed specific issues in the case plan.

The expected level of performance for this measure has evolved over time. It was tracked on an ongoing basis utilizing an agreed upon set of questions: (i.e.: describe your involvement with your case planning process; what is the hardest thing for you to achieve in the case plan? etc.). CMAs obtain incentive payments when contact with birth parents is made in a percentage of cases meeting the target goal. The target goal was established to continually increase required contact with birth parents over the contract period.

The intent of this measure was to expedite case progress and enhance case outcomes. Furthermore, contact with birth parents is another measured statewide performance expectation for CBCs.

Improved rates of maintained permanency for children

The definition of this original measure was: "Case management agency would achieve timely reunification or legal guardianship/kinship care and then maintain the permanent placement for 6 months".¹

¹ A third outcome, that youth have independent living services, was dropped during the first year as this was not a state-approved permanency option.

The means in which this measure was incentivized evolved over time. As noted, CMAs were originally asked to review their case loads and establish a baseline number of cases meeting established permanency goals in the next 6 months. The assessments were to establish payment levels for reaching various outcomes. This proved difficult for CMAs to do and thus, the methodology for receiving payment was modified to a self-report (by the CMAs regarding youth that have achieved and maintained permanency for six months.) CMAs were to receive a payment of \$1,000 for each child that maintains permanency in a legal guardianship/kinship care placement and \$1,500 for each child who is able to maintain permanency when successfully reunited with parents for six months.

Incentivizing maintenance of permanency was expected to encourage improved case planning and services thereby reduce the likelihood a child will return to services.

As noted by the local evaluators, this measure posed several challenges in terms of determining the appropriate permanency for some cases, establishing a target for performance, accurately assessing achievement, and planning for the fiscal liability by KCI. Determination of permanency outcomes occurred later than anticipated and was based on a review of those cases retrospectively by KCI quality assurance team members. Tracking on-going performance was difficult given that permanency must be achieved and maintained for 6 months. Incentives were paid from Sept 2007- Dec 2008. Data for this measure is not included in this report as the site is unable to provide essential elements for calculating performance (e.g., total eligible cases for each permanency type by CMA on a monthly or annual basis; total number of cases achieving permanency by CMA on a monthly or annual basis). Currently, a proxy for performance on this measure may be obtained by reviewing the incentive payouts for each CMA. Please see Florida Local Evaluation for this information.

Setting Targets for Performance

Unlike in the other sites, KCI chose to establish a monthly target for each performance measure and based incentive payments on the achievement of those targets. These contract targets were set during discussions with CMAs and KCI and reflect KCI's expectation for performance. For three of the four measures (i.e., data entry, supervision at 4 days and at 30-40 days), a high baseline of performance was set (e.g., 90-100% of cases). The site explained that because the monthly load of new cases for each CMA was sufficiently low, that CMAs were expected to meet the required target.

For one measure (i.e., contact with bio parents), the site set a graduated target for each CMA to reach to increase performance over time. Initially, the site reported that CMAs were expected to increase the number of cases for which contact with bio parents was achieved by 25%. It is unclear whether this was a total % increase over the course of a year or on a monthly basis. Approximately 10 months into the first year of the contract, this target was changed such that each month, CMAs were required to increase by 1%

their contact with biological parents. In other words, in July of 2008, CMAs were expected to contact 46% of the biological parents in their caseload while in August of 2008, they would be expected to contact 47% of bio parents in their caseload and so on. Under that target setting model, a year would yield an increase of 12%. Implications for performance and setting benchmarks are discussed in greater detail in Section VII.

For the permanency measure, incentives were to be paid when each case achieved a desired permanency level and maintained it for 6 months. There was no set expectations by KCI for the % of cases that might move to permanency in a given month or year. As noted by the site, CMAs were originally asked to review their case loads and assess how many youth will achieve various permanency goals to over the first six months of their current contract period (July 2007 – June 2008). The assessments were to be used to create a baseline expectation for each CMA and to establish payment levels for reaching various outcomes.

As will be discussed, the outcome measure of permanency proved difficult to measure by the site and essentially was de-emphasized within the PBC/QA structure. While still an important measure by which KCI assessed performance and outcomes for children and families, it was not included in this evaluation as the site was unable to obtain and provide reliable data to measure performance.

Using Data to Assess Performance

Performance on all measures was tracked by KCI either through the state SACWIS system (FSFN) or by internal sample reviews of cases. Given the change in the statewide data system during the course of this project and some of the difficulties it faced during implementation, KCI worked to develop an additional internal system to ensure that CMAs were accurately assessed and quality occurred. In this way, KCI merged their Quality Assurance and Quality Improvement (QA/QI) activities within their PBC model to align service review and performance.

Time 1 Focus Group Findings

Participants reported that monitoring was perceived to be done in a subjective manner. The sampling process was not perceived as accurate or sufficient to identify compliance with the objectives.

Exit interviews were added as another data collection method after implementation of PBC/QA.

For the data entry and contact with biological parent measures, the Quality Assurance team drew samples of cases each month in each CMA based upon a formula that assures 90% confidence with a 10% margin of error and includes an appropriate oversample. This approach was based upon an established quality assurance standard developed and used within the Statewide QA process.

For assessing supervisory review within established timeframes, KCI developed a Supervisory Review Tool (see *Additional Organizational and Systemic Programs to Support PBC/QA, Florida* for description) which allowed for the caseworker and supervisor to capture discussions about cases in a quality-driven manner. KCI reviews 100% of all supervisory review tools each month to assess if the supervision meeting meets the intent of the contractual incentive measure. Credit is given when documentation indicated that the review occurred “face-to-face” and key case-related factors were discussed.

Monitoring performance largely rests with KCI as they have had to develop internal systems to work around some of the data system issues in the development and refinement of their state wide FSFN database. Private agencies may also maintain their own internal methods of tracking performance, though it is unclear if this is consistently done. As it currently exists, private agencies must rely on reports generated from KCI rather than monitoring their own performance via FSFN.

Shared Risk

As previously noted, KCI attempted to develop a shared risk model in these PBCs. The intent was that, in addition to incentives for performance, there would also be penalties for poor performance. The new contracts stated that if performance on the incentivized measures was below expectations, CMAs would be afforded one quarter (3 months) to attempt to address the problems and improve performance. During this period, Kids Central would provide requested technical assistance, advice, or support to sustain the

Time 1 Focus Group Findings

Providers perceived themselves as more cognizant of how practice was tied to outcomes.

efforts of the CMA. After one quarter of below-par performance, CMAs would have to pay for technical assistance from KCI at a rate equal to the daily staff rate of \$250 that Kids Central pays to the CMAs. If the CMA continued to underperform, their contract could be terminated.

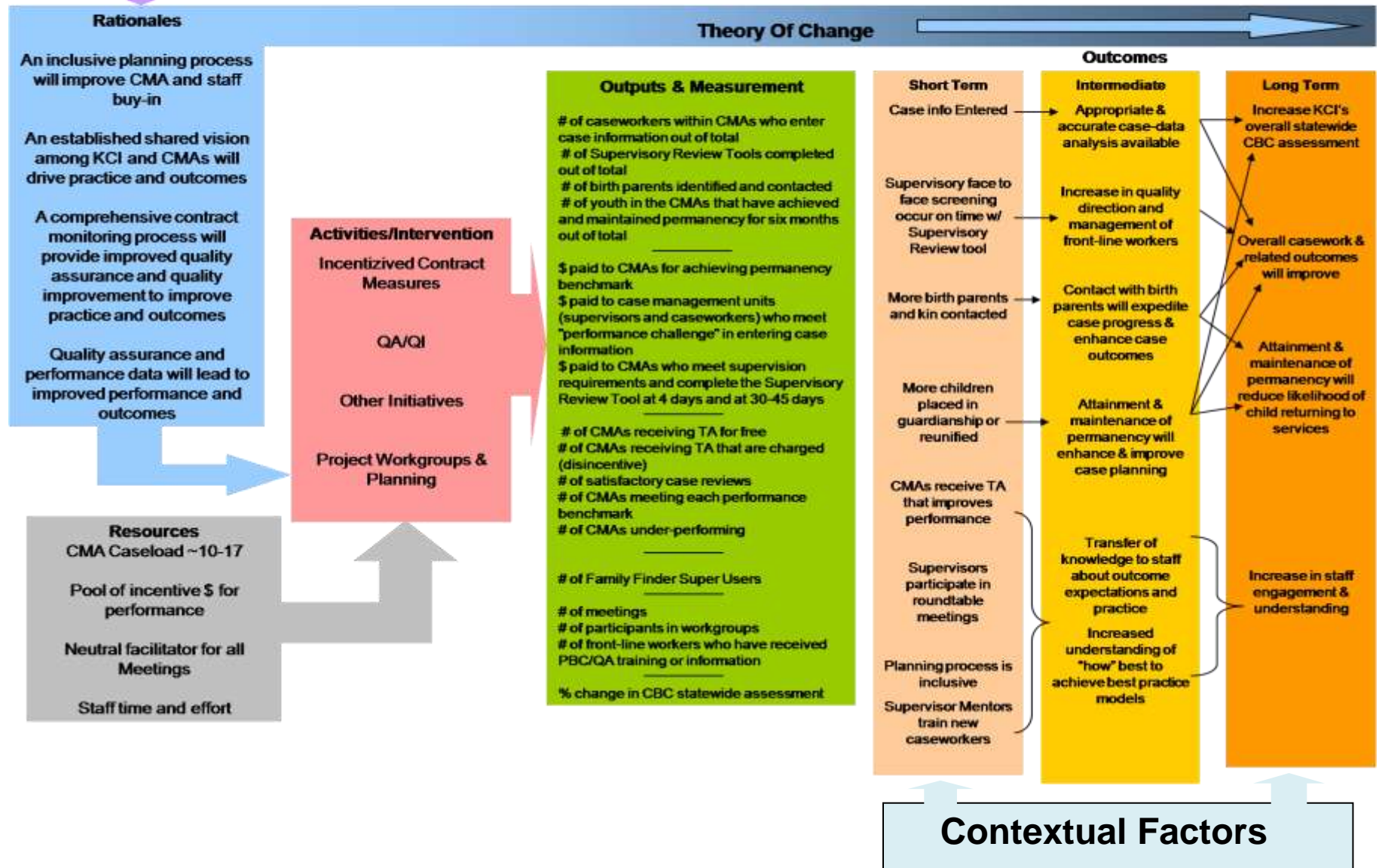
While written into the contracts, KCI has never fully implemented the penalties because the CMAs continued to demonstrate performance improvements even though they did not reach the target performance measures. KCI stated that they felt that it would harm the collaboration if they imposed penalties while performance continued to improve. Thus, while the original intent was a shared risk model, in actuality, the CMAs were not fiscally held responsible for poor performance during the project evaluation period.

Time 2 Focus Group Findings

Case managers in Florida were less likely to understand the measures associated with PBC and may need additional training on this.

Florida Logic Model

Problem Statement:
 Kids Central intends to demonstrate that a comprehensive planning process leading to the development of performance-based contracts and inclusion of performance measures in Kids Central's quality assurance process leads to improved outcomes



Illinois

Under the QIC, Illinois had planned to implement PBCs for all of its residential, independent living and transitional living programs (ILO/TLP) by 2008. These services for generally older youth were being provided by approximately 120 private providers throughout the state. However, site documentation and key informant interviews indicate that the Project Steering Committee recognized the unique challenges each population faces, and the lack of consist data that was being collected on ILO/TLP cases by provider agencies. Due to these challenges, the committee decided to move forward with the new residential care contracts first. In September, 2008, IL's QIC launched its new contracts for its residential providers. The new ILO/TLP PBC contracts were later launched in July of 2009.

Time 1 Focus Group Findings

The 2008 contracts were modified to include "general terms" about PBC/QA but did not have specific performance benchmarks. Contracts for 2009 were more detailed with individual benchmarks for each agency.

The overarching goals of the current expansion of PBC to residential care are to increase placement stability, sustain treatment gains obtained during residential placement post-discharge, and incentivize shorter lengths of stay in residential care while improving client stability and functioning. It was assumed that this would allow for the expanded availability of residential care beds for other children in need of these placements and thereby increase the likelihood that all children in need of residential placements would benefit from them.

Rather than issuing a competitive Request for Proposal (RFP) for agencies to participate in the demonstration project, Illinois added contract addenda containing the new performance measures. Providers agreed to cooperate in all data collection, evaluation, and training efforts. In addition, the state held its providers harmless for the first

Time 2 Focus Group Findings

Familiarity with PBC varied among the front-line workers and supervisors. Many workers were confused as to which activities were related to PBC and which were related to the Medicaid Conversion implemented at the same time.

contract year – not imposing financial rewards and penalties as a result of SFY 2008 performance. This allowed the Project Steering Committee and CWAC workgroups to closely scrutinize the data resulting from the demonstration year and make informed policy decisions pertaining to implementation. After the first year when providers were held harmless, the new contracts were fully implemented in July, 2009.

Contractual Performance Measures

Unlike Florida, the new PBC/QA contracts for residential care do not establish performance measures for process measures (services or casework practices) and instead focus on two outcome measures:

Treatment Opportunity Days (TODR)

For this measure, DCFS created an outcome to capture the extent to which a residential agency was able to provide the on-site treatment for youth that they were compensated for by the department. The goal was to reduce out of agency placements in detention or DOC, psychiatrically hospitalization, and runaways. To calculate this measure, the number of days that youth were present at the agency is divided by the total number of bed days in the residential stay. This calculation result in a percentage of time youths are in treatment. The performance targets for this measure vary by agency contract as a function of the risk adjusted target.

Time 1 Focus Group Findings

No changes in service delivery were noted during the first year of implementation. However, efforts were underway to increase time engaged with youth while in care, including vocational activities, recreation with staff, music, and art therapy.

For youth who are chronically mentally ill, this type of placement would be a neutral one, from traditional residential for this population to another long-term placement type. The emphasis for this measure was to maintain a stable placement for the youth and avoid multiple placements between programs, subsequent steps up into restrictive placements, hospitalizations, or runs.

Sustained Favorable Discharge

For this measure, DCFS created an outcome to capture a successful transition of a youth from a more restrictive setting to a less restrictive placement. Specifically they developed the measure to reward agencies for stepping down a child in placement to a less severe residential classification or a less restrictive non-temporary placement type.

Time 1 Focus Group Findings

Focus group participants reported an increase in creation of aftercare positions and assigning transition activities to existing or newly hired staff.

To calculate this outcome, the total number of youth who were transitioned into the new setting and were stable in that placement for 90, 180, and 270 days was divided by the number of youth served during the evaluation period. Current performance goals were established by increasing the baseline predicted Sustained Favorable Discharge Rate by a set percentage (e.g. 10 percentage points or 50% in the example below). Predicted rates are determined by applying a risk adjustment model to each agency's case mix and factoring in child characteristics that are predictive of sustained favorable discharges.

Setting Targets for Performance

In order to develop targets for performance, DCFS worked with university partners to develop a sophisticated strategy of using the vast wealth of existing data to develop models for predicting future outcome performance. Because residential providers in Illinois target distinct populations, the state developed a Residential Risk Adjustment Strategy. This adjustment determined performance targets on outcomes by taking into account caseload characteristics, past agency performance, and other measurable variables. Three step process: 1) Identify empirical factors that may impact performance outcomes AND for which data is available; 2) Perform regression analysis of factors applied to population sample (youth in residential treatment, FY04-06); and 3) Apply weighted factors to baseline population (youth in residential treatment, FY06 and FY07). Thus, tailored for each agency, the risk adjusted target for Treatment Opportunity Days and Sustained Favorable Discharge provided a way for agencies and DCFS to monitor performance fairly. More detailed information on the Risk Adjustment Strategy is found in the Illinois local evaluation report.

Using Data to Assess Performance

Illinois has created, with its university partners, a database called the Residential Treatment Outcomes System (RTOS) which stores a host of information used for both quality assurance purposes and for performance tracking. All data is current and allows DCFS and residential providers to track their performance on contract outcome measures. This system is also capable of presenting child/youth level detail thereby enabling each agency to reconcile their individual performance data with that used by the Department to calculate Treatment Opportunity Days Rate and Sustained Favorable Discharge Rate.

At the end of the contract year, performance data is reconciled with each individual agency to ensure accuracy. For Treatment Opportunity Days, agencies are assessed to determine whether they have met their contract targets for the year. If they have not, letters are sent by DCFS detailing the short-coming and outlining the repayment process. Agencies then work with DCFS to develop and implement an Action Plan intended to improve their ability to meet PBC benchmarks set for their agency.

For Sustained Favorable Discharge, the database will be used similarly, though instead of repayment based on missing performance targets, agencies will receive fiscal incentives for cases which meet the time period for sustaining a placement.

Time 1 Focus Group Findings

There are concerns about youth placed into programs shortly before emancipation and the financial risk that this presents to the provider agencies.

Illinois private agencies have access to the same database that DCFS maintains for tracking performance on outcomes. This provides a transparent system for all parties to examine the data and reconcile any discrepancies.

Shared Risk

Provider agencies can earn incentive pay through Sustained Favorable Discharge, or, through a “positive” or “neutral” discharge to a placement that is stable post-discharge for 90, 180, or 270 days. Agencies are given fiscal cash rewards for sustaining the desired placement – this requires both the discharging agency and the new placement agency to work together to prepare and maintain a youth for this transition.

The shared risk component is a function of the no-decline policy established to ensure that provider agencies accept all appropriately referred cases and the commitment to maintaining youth in treatment at the agency. Agencies who do not maintain youth in treatment (vs. placements in detention, psychiatric hospitals, or on run) are required to re-pay a percentage of the case per diem based on the discrepancy between their target Treatment Opportunity Days and the actual length of time youth are in the care of the agency.

Time 1 Focus Group Findings

Participants reported that providers were more aware of fiscal penalties and are monitoring the fiscal impact of their programs more closely than prior to implementation of PBC/QA. Providers perceived themselves as more cognizant of how practice was tied to outcomes.

The Risk Adjustment Strategy is meant to level the playing field among private provider agencies. If a provider agency has a history of receiving many children at risk of running away, their target Treatment Opportunity Days Rate is adjusted to take into account the

Time 1 Focus Group Findings

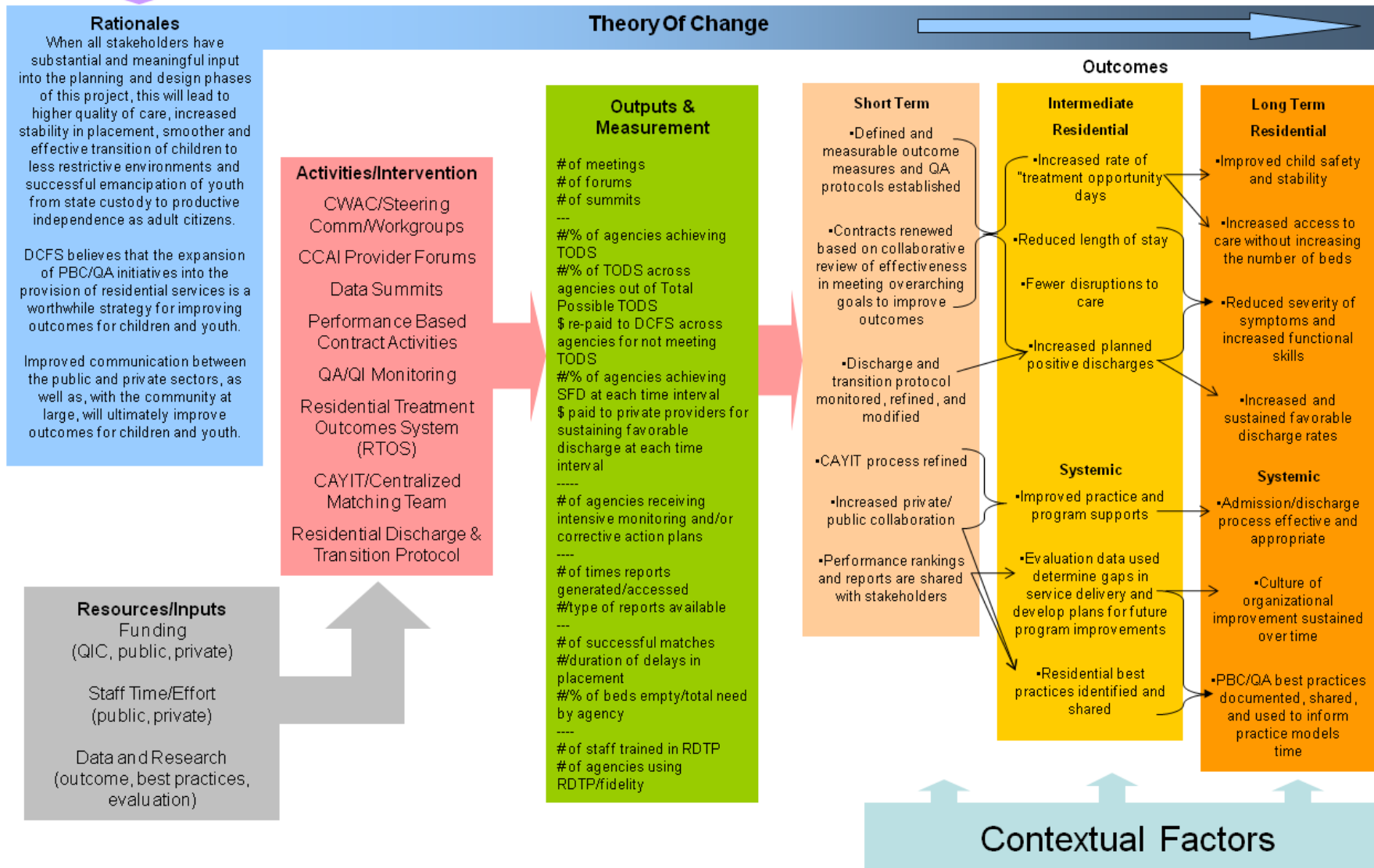
PBC/QA has highlighted the need to more appropriately match children and youth to the provider agency which would best fit their treatment goals. A change in the matching process required agencies to provide agency profiles and program plans. However, there is still concern that a disconnect between the needs of DCFS and what bed providers can offer exists.

increased risk of children running away. Much of the balance between risk and reward hinges on correctly matching a child with the appropriate level of care and type of residential facility. Thus, Illinois has developed a Centralized Matching Team who carefully reviews clinical information about the youth against the service array of all residential facilities to reduce the risk of misplacements which affect the contract performance outcomes. More information regarding these components of the PBC is provided in the QA/QI description section below.

Illinois Logic Model

Problem Statement:

CFSR reviewers found that the state of Illinois performed poorly on the CFSR in the area of Permanency Outcome 1 and that there was a lack of consistency with efforts to ensure placement stability, establish permanency goals in a timely manner, and ensure that older children in long-term foster care receive appropriate services to assist them in transitioning out of care into independent living.



Missouri

In 2005, Missouri implemented performance based contracts for its foster care and adoption case management providers in three regions of the state. The performance based contracts require providers to move a certain percentage of their caseloads to permanency each year. New referrals are given each month to replace those which are expected to move to permanency. However, the base caseload is not rebuilt until the end of the contract year. For instance, if a case load is set at 100, and the permanency rate is set at 25%, then 25 new cases are assigned throughout a contract year through a random rotation process. If a child leaves custody but does not remain in a permanent setting, the consortium accepts a replacement case and does not receive a permanency credit for the child who left custody. In short, the financial incentive for the providers is to move as many children to permanency as quickly as possible because if a provider moves more children than expected to permanent situations over the contract year, the children are not replaced until the end of the contract year through a rebuild process.

While the contracts contain multiple performance measures, only child permanency is directly incentivized. Rather than contracting with individual providers, Missouri contracts with seven provider consortiums to encourage agencies to pool resources and partner within their respective systems to provide a broader continuum of services to child welfare involved families.

The state paid new contractors a one-time payment for start-up purposes to ensure that they were fully staffed and prepared to take on cases when the contracts went into effect. The contract start date was June 1, 2005; however, contractors were not assigned cases until September 1, 2005. Those contractors who were serving children under a pre-existing contract would be re-assigned to the new contract as of September 1, 2005.

When the PBC began, in order to give all providers a level playing field (i.e. all providers worked with equally difficult cases), the Division entered into contract with the University of Missouri to “equalize caseloads.” Children (and sibling groups) were distributed based on gender, ethnicity, age, and time in out-of-home placement. Once this base caseload for each provider was established, the Division has continued to randomly assign cases to providers on an ongoing basis to preserve an equitable caseload mix.

The contracts were re-bid in June 2008 and now serve six regions of the state. While the same seven consortia provide all services, PBCs are now in effect in 12 additional counties in the central, south central and southwestern portions of the state.

Based on discussions with CEOs representatives of the consortia in July 2009, Children’s Division decided to drop one of the primary measures – *Stability* – because the measurement of this indicator contained an artifact of the system design. Specifically, in

building the initial caseload, all consortia were given a clean slate to measure the stability of the placement of new children in their care. However, the Children's Division and the federal requirements measure stability over the life of the case versus an annual stability rate which was used in measuring consortia performance. Thus, the way stability was measured did not accurately or fairly represent performance and it was agreed by both public and private agencies to drop official measurement of this indicator, though the Division will be tracking permanency rates overall.

The current contracts expire on 09/30/11. As of 04/30/09 approximately 38% of the state's foster care population was being served through contracted case management providers using these performance based contracts.

Contractual Performance Measures

As described above, Missouri chose to include standard child-welfare outcomes for which the state must report federally. Rather than focus on process outcomes like Florida or population-specific outcomes like Illinois, Missouri incorporated federal child outcomes in their contracts. The following section describes the four primary outcomes included in the contracts.

Time 2 Focus Group Findings

Private agency front-line workers and supervisors were more likely to know about PBC and its associated measures. Workers from the Children's Division were consistently less aware of PBC in general.

Reduced re-entry into foster care

This outcome is calculated as the total number of children who re-entered care within 365 days of their exit to permanency divided by the total number of children who exited to permanency. The target set for consortiums in the three regions is that 91.4% or more children must not re-enter custody or supervision within twelve (12) months of previous exit.

Increased stability

This outcome is calculated as the total number of unduplicated children with specific legal status codes that are active during the reporting period divided by the number of children who have two or less placements. Based on historical data, all parties agreed to increase stability 2% from this number to establish the target of 82% or more out-of-home children experiencing two or less placement settings.

It should be noted that calculating stability within the reporting period of the contract does not take into account the entire history of the child in placement which is what the state is federally required to report. This issue poses a significant problem in the measurement of each subsequent year's performance due to this discrepancy. This issue was recognized by contractors and the Children's Division during the second round

of three year contracts and it was decided that this outcome would be dropped from the performance-based contract in 2010.

Increased safety

This outcome is calculated as the total number of children from substantiated child abuse and neglect reports whose perpetrator is an 'alternate caregiver' divided by the total number of unduplicated active children served during the reporting period. Based on the existing federal standard at the time of initial contract negotiations (2005), all regional consortiums had a set target of 99.24% or more out-of-home children without a substantiated alternate caregiver perpetrated child abuse/neglect reports

Increased permanency

Of the four outcomes selected for inclusion in the contract, the permanency outcome formed the basis of fiscal incentivized performance. As previously described, the financial incentive for the contractors is to move a child to a permanent situation as quick as possible because children that reach a permanent situation are not replaced until the end of the contract year through a rebuild process. Thus, decreased caseload due to increased permanency will lead to greater fiscal benefits to consortiums.

This outcome is calculated as the total number of duplicated children with specific legal statuses achieving permanency divided by the total duplicated active children served during the reporting period. Permanency is defined as reunification, adoption, and guardianship. Targets were set using regional historical data plus the contractors' commitment to increase performance by 2% of that historical mark. Thus, targets for permanency varied by region with 32% set for St. Louis, 30% for Kansas City, and 24% for Springfield.

Other outcomes included in contract

Two other outcomes were initially included in the contracts, though they proved difficult to measure and were not emphasized by the Division. These were: a) Decrease residential utilization days whereby contractors were to reduce the average utilization days for residential treatment placements by 2 % based on the average utilization days originated from historical data for each region; and b) Development of resource (or foster care) homes in which the contractor originally stated the number of resource homes they would develop. For this report, these outcomes are not analyzed.

Shared Risk

As previously described, the cost and payment structure of the contract has built in a shared risk component for private providers. Specifically, all contractors are paid for a

specified caseload per month regardless of the number of children actually receiving services. Caseload is a major factor in the fiscal risk structure; the set caseload is used to calculate the total number of random referrals consortiums receive in a contract year. If consortiums do not move children to permanency at the target % rate, new random cases continue to be referred and agencies must serve those cases in addition to those existing cases. Thus, the fiscal incentive is to move children to permanency before the end of contract rebuild of cases.

Time 1 Focus Group Findings

Focus group participants agreed that a collaborative approach to spreading risk is used within the PBC/QA.

Incentives/disincentives were generally discounted by focus group participants as a driving force in practice innovation.

Setting Targets for Performance

In Missouri, there was a series of collaborative negotiation meetings to determine the targets for performance on each of the outcomes. From these meetings, the public and private agencies reviewed any historical data on past performance on the outcomes by region and also reviewed federal standards for each outcome. Via this collaborative discussion, the two sides agreed to utilize the federal standards for two of the outcomes (Re-entry and Safety) and to use historical regional performance data to set targets for the other two outcomes (Permanency and Stability). In early discussions, private contractors suggested that they would like to improve their historical performance by 2% on permanency and on stability, thereby improving outcomes for children overall.

Because there were contextual differences occurring in the three regions (e.g., Kansas City region was under a consent decree, differential population characteristics), it was decided that the targets for permanency would differ by region to better reflect the historical and contextual realities of the state. Therefore, three different permanency targets were set based on historical performance data plus the added 2% increase to improve future performance. For the other three outcomes, the same target was set for all regions. Thus, Missouri used a model of setting targets based on historical data combined with federal standards.

Time 1 Focus Group Findings

Participants in Missouri confirmed that two forms of contract adjustments took place – formal amendments and census modification based on practice experience.

In the second round of contracts, new benchmarks were discussed for safety and permanency based on previous contractual performance. Representatives from the consortiums and Children’s Division staff reviewed performance data and regional caseloads to develop new benchmarks for those indicators. As of this report, those new benchmarks have not been set.

Using Data to Assess Performance

Much like Florida, Missouri utilizes the state-wide SACWIS system to track and monitor performance both for private contractors and for the Children’s Division caseload. This system is not open to private providers, however, and as a result, most consortiums have developed their own data systems to enter and track their caseloads. Given the requirements of performance-based contracting, Children’s Division had to pull private contractor cases from their SACWIS system to reconcile performance on all outcomes with private consortium internal records. These final reconciled reports were then provided to all consortium representatives to use internally for QA and individual agency case management. Thus, in essence, a dual system of tracking performance was in place for private and public agencies

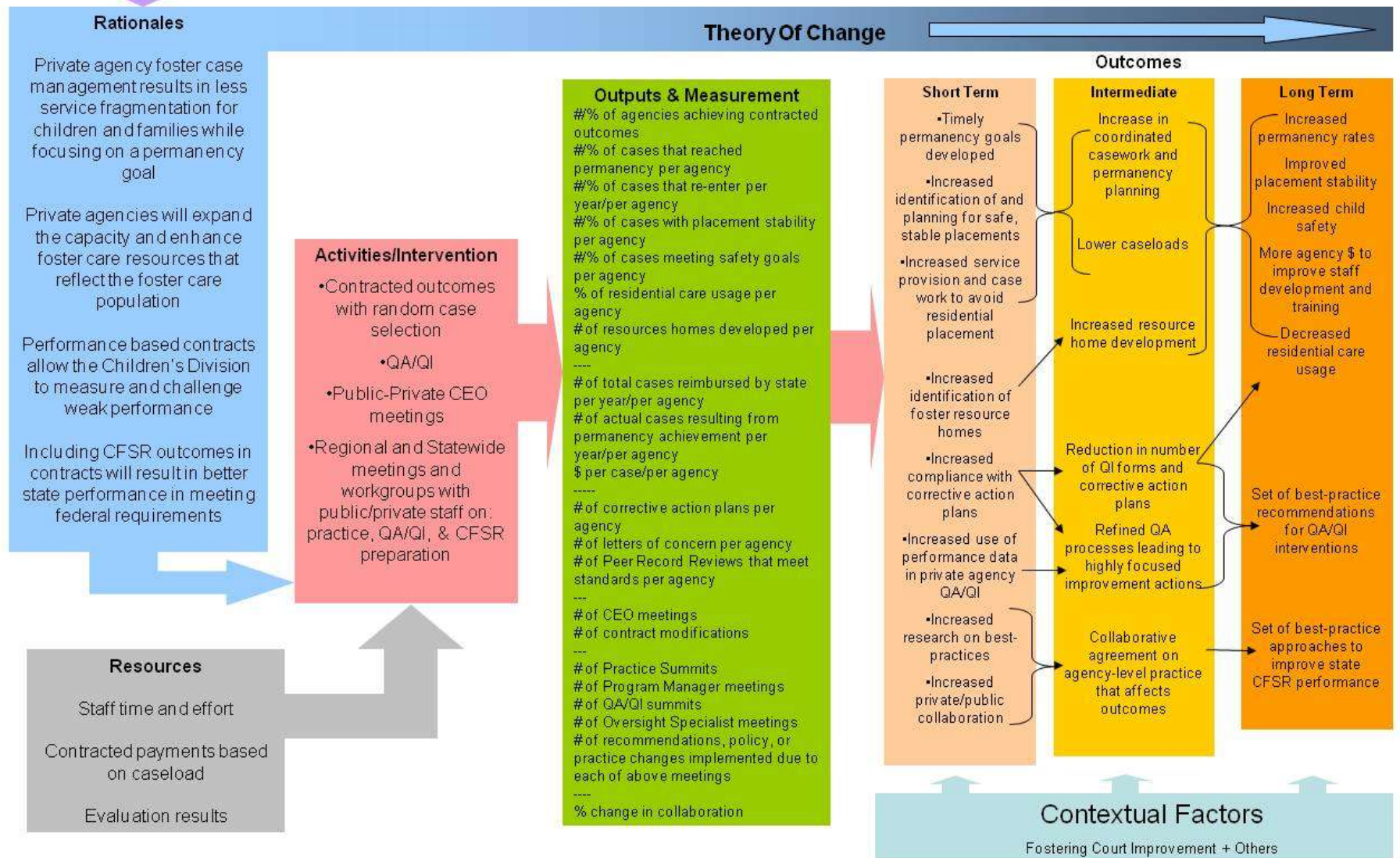
Time 1 Focus Group Findings

Assessments were reported to be performed in a timelier manner since the implementation of PBC/QA; however, this may be due to lower caseloads and increased sophistication of staff.

In the fall of 2009, Missouri’s SACWIS system was audited by the federal government and found to be non-compliant as a result of the disparity in private contractor data system reporting and legal access issues. As of this report, Missouri is working to resolve this issue, though it is unclear if that will result in an open system in which private providers are able to track their own performance on outcomes.

Missouri Logic Model

Problem Statement:
With an emphasis on achieving the permanency goals of children and families, the public child welfare sector was required to meet state-mandated accreditation standards and caseloads reduction through partnering with private agencies to provide foster care case management.



B. Cross-Site Comparison of PBC Components

The following table presents a state-by-state comparison of the three performance based contracts in use. It is based upon document review and key informant discussions.

Performance Based Contract Specifics					
<i>Site</i>	<i>Target Population</i>	<i>Geographic Coverage</i>	<i>Contractor</i>	<i>Date Contract Initiated</i>	<i>Date Payments Linked to Performance</i>
Florida	All foster care cases	Florida's Judicial Circuit 5 (formerly District 13) which includes Lake, Sumter, Marion, Citrus, and Hernando counties	Private, Lead Agency	July 2007	July 2007
Illinois	Children and youth in residential programs	Statewide	State Child Welfare Agency	September 2007 (for children in residential care only)	July 2008 (for children in residential care only)
Missouri	All children in out-of-home care	Three child welfare regions: St. Louis, Kansas City and Springfield	State Child Welfare Agency	1 st 3-year contract: June 2005 – June 2008 2 nd 3-year contract: June 2008 – June 2011	June 2005
Performance Based Contract Specifics					
<i>Site</i>	<i>PBC Design</i>	<i>Performance Measures</i>	<i>Rewards and Risks</i>		
Florida	Case Management Agencies (CMAs) are rewarded and penalized based on their	1. Earlier and more accurate data entry into state's administrative system. 2. Additional face-to-face	Rewards: CMAs receive incentive payments when: <ol style="list-style-type: none"> 1) case information is entered in a timely manner 90% of the time 2) supervisory reviews are held within the initial four days after a case is received and again 30-45 days later, 100% of time. 3) contact with birth parents is made in an agency-specified percentage of cases which is 		

	performance on casework activities and aggregate caseload outcomes	<p>supervisory meetings at 4 and 30-45 days.</p> <p>3. Increased contacts with biological parents.</p> <p>4. Improved rates of maintained permanency for children.</p>	<p>expected to increase over the contract period.</p> <p>4) individually established agency goals for rates of reunification and legal guardianship/kinship care are met.</p> <p>Penalties:</p> <p>Stage 1: CMA misses performance standard for one quarter – three months and the lead agency provides TA free-of-charge in conjunction with the development of a corrective action plan. CMAs will have a quarter to correct any problems and performance issues.</p> <p>Stage 2: CMA continues to miss performance standard for another quarter – 3 months and TA continues but CMA is charged for the TA at the rate of \$250 per day for 1 FTE if multiple days/FTEs this charge is multiplied.</p> <p>Stage 3: Termination of contract.</p>
Illinois	Residential providers are rewarded or penalized based on their performance on aggregate caseload outcomes using the following two measures:	<p>1. Sustained Favorable Discharge Rate (SFDR): “positive” or “neutral” discharge to a placement that is stable post-discharge for 90, 180, or 270 days.</p> <p>2. Rate of Treatment Opportunity Days (RTOD): The percentage of days in treatment out of the total number of days placed at the agency during the review period.</p>	<p>Reward:</p> <p>For each additional Sustained Favorable Discharge, an agency will receive the difference between the residential per diem and the step-down per diem for every day that the child remains stable in the discharge placement, up to 270 days. Predicted rates are determined by applying a risk adjustment model to each agency’s case mix and factoring in child characteristics that are predictive of sustained favorable discharges.</p> <p>Penalty:</p> <p>Private providers can lose money if they do not achieve a high enough RTOD. RTOD is the percentage of days in treatment out of the total number of days placed at the agency during the review period. This rate is derived by dividing the number of days that youth were present at the agency (i.e. not on runaway, placed in detention or DOC, or psychiatrically hospitalized) divided by the total number of bed days in the residential stay.</p>
Missouri	Missouri has 6 performance measures but only one is directly linked to payment. Each year, each provider	<p>1. Reduced reentry into foster care</p> <p>2. Increased stability</p> <p>3. Increased permanency</p>	<p>Reward:</p> <p>Each agency contracting with the State will be paid a set monthly fee for a pre-determined number of cases. Agencies will be expected to place a certain number of cases in a permanent setting each year and the State will randomly assign new cases to each provider in order to maintain a full caseload based on annual caseload expectations. Under this payment structure, agencies achieving higher than targeted permanency rates (closing a greater number of cases than are being</p>

	consortium has a set caseload (e.g. 100 children) and permanency rate (e.g. 30%). New children are rotated into the agency based on the agreed upon caseload and permanency rate.	4. Increased safety 5. Decrease residential utilization days 6. Development of resource (or foster care) homes	replaced through re-assignment), will be rewarded financially because the total revenue established by the contract will not be reduced for lower “actual” caseloads. Penalty: Penalties result from referral holds if the consortium does not meet performance standards, or if a complaint or issue by a client or by the Division is not resolved by the private agency in a manner deemed acceptable by the Division Director. Referral holds can result in a reduction of funding.
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Florida Summary

Performance-based contracting is carried out by private, lead agency not state. They chose to incentivized three process measures involving case practice they believe will lead to better performance on client level outcomes. Florida developed Supervisory Review tool to operationalize one of the performance measures and promote quality assurance. Additionally, they incorporated quality assurance efforts (e.g., quality and timely supervisory review and data entry) into its incentivized measures.

Illinois Summary

This is the only statewide PBC project and one of only two states nationally that is using performance based contracts for its residential services and only state to develop PBCs for its ILO/TLP programs. Illinois has designed the most complex outcome measures and has adjusted the financial penalty structure to take into account the distinct populations each agency serves (accounting for level of difficulty). The public-private committee structure in Illinois helped pave the way for collaboration to choose contract outcomes and work together to improve the residential system.

Missouri Summary

Performance based contracts started in 2005. Under the QIC, Missouri refined its quality assurance/quality improvement system and studying the evolution and success of a more “mature” PBC contracting process. It is the only QIC site to conduct an actuary study to assess the costs of care when designing contracts in 2005 and 2008. Missouri has 6 performance measures in its contracts but only 1 is directly incentivized. Like IL, MO has worked to “level the playing field” for providers before initiating financial rewards and penalties. Children (and sibling groups) were re-distributed based

on gender, ethnicity, age, and time in state care. Once this base caseload for each provider was established, the Division has continued to randomly assign cases to providers on an ongoing basis to preserve an equitable caseload mix first put in place by equalization.

Time 1 Focus Group PBC-QA Findings across Sites

As this round of focus group involved higher level child welfare officials and staff, participants in all three sites voiced concerns about the economy downturn during the course of the implementation and their ability to sustain incentives.

Time 2 Focus Group PBC-QA Findings across Sites

These focus group participants, which comprised of front-line workers and supervisors, were generally familiar with and understood the measures being tracked. However, not all workers knew that these measures were part of PBC. Overall, those in the focus groups agreed that the PBC increased focus on measures that are conducive to improved performance. However, not everyone was in agreement that the appropriate benchmark was set for each of these measures.

Front-line worker and supervisors in all three sites reported that a number of considerations should be made for circumstances hindering or preventing optimal performance when evaluating the performance of their agencies. These issues include: Staff Time; Casework; Case Assignment; Performance Credit.

Staff Time: The number of requirements placed on the staff and their time was a concern as focus group participants felt unable to balance program requirements and good practice. All groups reported a priority shift to administrative requirements and data entry versus therapeutic time with the children and their families.

Casework: The individual differences among children were also a concern when considering an agency's performance. Some focus group participants felt that the overall severity of cases had increased without appropriate mechanisms in place to support the agencies providing treatment. Furthermore, once involvement with a case/client ends they often have no control over circumstances; however, in many cases, they were still being held responsible for the long-term outcomes of the case.

Case Assignment: Other participants felt that some assignments of children to their agency were inappropriate as their agency did not have the strengths or services needed to serve children with particular needs.

Performance Credit: Another issue raising concern among front-line workers and supervisors was the uncertainty of how credit was given for performance in each

measure. They were not always clear on the role of incentives and/or penalties. Some workers thought they would be penalized for certain performance levels, when in reality, they would not. Front-line workers were sometimes unaware that their agency received incentives; others were aware, but did not know how the agency used the incentives received for their performance.

Final Key Informant Interview PBC/QA Findings across Sites

Participants largely agreed in all sites that progress had been made toward practice change within the child welfare system as a result of the projects. Due to project emphasis, this looked different across sites. In Florida some agencies had demonstrated practice improvement and use of supervisor review in this regard. Missouri participants noted that the program managers, practice summits and QA meetings focused on collaborative sharing of best practice across agencies based on their review of outcome data. In Illinois some providers were recognized for re-thinking their treatment process to focus on evidence-based methods. Practice protocols were created to address challenges such as centralized matching of youth to facilities and a transition protocol for stepping youth down into the community, as the achievement of outcomes required it.

A few comments were made regarding negative impact or missed opportunities were mentioned by individuals. For example, focus on this initiative may have diverted attention from other important reform, or that not enough emphasis in the local evaluation was used to answer important questions the state had regarding their system. However, no themes were identified across states.

C. Sites' Quality Assurance and Quality Improvement (QA/QI)

In order to capture the necessary components of each site's QA/QI system, document review and key informant discussions were used to fully describe each system. This section presents a description of each site's QA process.

Florida

There are two levels of quality assurance and quality improvement efforts that take place in the Florida PBC initiative. One level pertains to the state mandated QA/QI system which is a series of QA activities that Kids Central must follow to remain compliant with the state. The second level is Kids Central's own QA/QI system related to PBC/QA, which was implemented to help improve the practice of front-line staff.

Florida QA/QI Activities

DCF holds each CBC lead agency accountable for a series of performance measures that largely replicate the federal measures in the Child and Family Services Reviews. Using a “dashboard” approach, the performance of each lead agency is publicly available on the state’s website and performance on these measures helps drive contract renewal decisions. In addition, the state has begun to conduct quality improvement efforts by reviewing randomly selected case files. Overall, changes to the state’s QA/QI system are supposed to make the review process less focused on compliance and more focused on improving practice through learning and mentoring. Listed below are descriptions of components of the state QA/QI system after PBC was implemented.

Case Reviews

Quarterly, the DCF Central Office sends a list of cases based on certain criteria to Community Based Care QA staff. Based on the list of cases, Kids Central randomly selects twenty-five cases from all CMAs to conduct a review. Prior to a review, the QA staff must research FSFN (Florida’s SACWIS system) for child welfare history – child protective investigations and case management histories of the child and family whose case is being reviewed. A summary of prior reports and investigative histories is provided in a separate folder so the reviewer is assured that all of the information on the family is available.

Once all of the selected cases have been reviewed, CBC QA staff must internally analyze the data collected overall and identify trends, effective practices, and areas of concern, synthesizing the information to demonstrate CBC practices and performance. The resulting report of findings must be provided to CBC executive staff, Regional QA Managers and Contract Managers within 30 days upon completion of the review component.

Side-by-Side Reviews

A portion of the twenty-five cases are reviewed jointly, side-by-side by CBC QA staff, DCF Regional QA staff, and, typically, a representative from each CMA (CMAs do not always participate with these reviews). A tool, “Quality of Practice Standards for Case Management”, is used for this review. The tool has sixty-six items which are answered with a “yes” or a “no.” A “yes” means the standard has been met and a “no” means the standard has not been met. These side by side reviews are seen as a way to help improve both casework and client outcomes.

In-Depth Reviews

The DCF Regional QA also conducts in-depth reviews of a couple of the jointly reviewed cases using a method that is modeled after the CFSR model. DCF conducts in-depth interviews with case managers, parents, children (when appropriate), providers, and other stakeholders.

CBC Lead Agency QA/QI Activities

The second level of quality assurance is maintained by Kids Central. Within Circuit 5, leading officials described extensive initial and ongoing negotiations about what would be measured to assess performance and how the measurement would be done. The site's local quality assurance system was both integrated and aligned with its performance based contracts. The site incentivized timely and accurate data entry as well as timely and more in-depth caseworker/supervisor contact to review cases. In addition, the penalties or risk associated with this contract directly relate to performance on any of the four performance measures. Although never fully implemented, the idea was that CMA's would be required to participate and pay for technical assistance when their performance was low.

The Circuit selected performance measures that were considered "drivers" of strong performance. Rather than incentivizing only client outcomes, they selected three "process" measures that they felt would lead to the client outcomes they sought. For instance, more timely and in-depth supervisory contact was expected to support and encourage better casework and more positive outcomes for children and families. Similarly, increased contact with biological parents is expected to expedite case progress and enhance case outcomes.

Kids Central conducts several quality assurance activities in order to assess CMA performance on the contract measures and other state mandated performance indicators. The following chart summarizes how each of the contract measures is assessed.

Florida QA/QI Assessment	
Measure	Data Collection and Assessment
<i>Face-to-Face Supervision within 4 Days of Case Receipt and at 30 to 45 Days</i>	A Supervisory Review Form is completed each time a supervisory meeting occurs. The Kids Central quality assurance team reviews 100% of the forms completed for out-of-home care cases to assess compliance. Credit is given when documentation indicated that the review occurred "face-to-face" and key case-related factors were discussed.
<i>Case Information Entered within 2 Days</i>	This measure is assessed through a review of case data entered across a sample of out-of-home care cases for each CMA. The sample is selected based upon a formula that assures 90% confidence with a 10% margin of error and includes an appropriate oversample. This approach is based upon an established quality assurance standard developed and used

	within the Statewide QA process. The QA time reviews selected data entry elements to ensure they are appropriately entered within the required timeframe.
<i>Contact with Biological Parents</i>	This measure is assessed through an assessment of birth parent contacts made across a sample of cases for each CMA where the case goal is reunification. The sample is selected based upon a formula that assures 90% confidence with a 10% margin of error and includes an appropriate oversample. Leeway (credit for attempted contacts with one or both birth parents) is afforded when documented contacts are attempted but not responded to by the birth parent or when contact with the birth parent is not logistically reasonable or possible.
<i>Permanency</i>	Data pertaining to youth reaching and maintaining either reunification or legal guardianship/kinship care is self-reported by CMAs. This information is reviewed and validated by Kids Central's QA department prior to payment being made.

Monitoring the PBC largely rests with Kids Central. Performance on all measures is tracked by Kids Central either through FSN or by internal sample reviews of cases. Given the changes in FSN during the course of this project and some of the difficulties it faced during implementation, Kids Central worked to develop an additional internal system to ensure that CMAs were accurately assessed and quality occurred. In this way,

Time 1 Focus Group Findings

Participants reported broader and more frequent dissemination of outcomes to supervisory and front-line staff.

QA data was reported to be used in enhancing supervision of front-line staff and determining internal training processes. Additionally, training was reported to have been provided for front-line staff on PBC/QA.

Kids Central merged their QA/QI activities within their PBC model to align service review and performance. Kids Central distributes charts and graphs depicting each agency's performance on the measures along with comparisons to other CMA's at monthly meetings of CMA directors and supervisors. Additionally, Kids Central Quality Assurance team members provided specific feedback to CMAs for why a case was or was not credited based on the criteria set forth in the contract and discussions with the larger group. Reconciliation was possible if errors were detected by the CMA and Kids Central team.

CMA's can develop and maintain internal methods of tracking performance, though it is unclear if this is consistently done. CMA's primarily rely on reports generated from Kids Central. Contract performance information is shared with CMA directors during quarterly meetings and with supervisors in monthly meetings that focus on practice issues. These problem solving meetings continue to use the neutral facilitator to encourage participation and collaborative decision making. Information regarding performance is also discussed during town hall meetings and

newsletters distributed by Kids Central. Technical Assistance is provided at the supervisory roundtable meetings.

At monthly meetings of CMA directors and supervisors, KCI would distribute charts and graphs depicting each agency's performance on the measures. CMAs were able to also view the performance of other CMAs. Additionally, KCI Quality Assurance team members provided specific feedback to CMAs for why a case was or was not credited based on the criteria set forth in the contract and discussions with the larger group. Reconciliation was possible if errors were detected by the CMA and KCI team. Agency performance could then be shared with front-line staff within individual agencies to improve team performance. How and if staff used this information in their daily practice was discussed during focus groups and was also captured by the cross-site survey of evidence informed practice and the use of data by staff (see *Staffing under PBC/QA: Perceptions of Evidence-Informed Practice, Supervision and Training in Front-line and Supervisors*).

Time 2 Focus Groups Finding

Focus group participants revealed that sharing of QA information varied among agencies. However, front-line workers in Florida reported getting regular reports on their performance. Additional support and supervision varied among the agencies.

There have also been changes made to the Quality Improvement Team. These changes are not a result of PBC but do impact the overall QA/QI system. The Team meets once a month for two hours. The meetings are attended by Kids Central QA staff, CMA QA specialists, and the Utilization Management Director. The team develops QA projects and initiatives.

Kids Central implemented several protocols to assist with monitoring the performance measures. The Supervisory Review Tool is a fundamental aspect of Kids Central QA/QI system. The Tool is used to guide supervisory meetings between supervisors and front-line workers to assess the quality of practice by the front-line worker and to create learning/mentoring opportunities. The tool was designed to ensure that the supervision meeting was "of quality" (face-to-face) and so that measures on the tool give credit for "best practice" rather than "compliance." Both Kids Central and the CMAs wanted to ensure that face-to-face supervision truly impacted practice and was not just assessed through a "check-box" indicating whether the supervision meeting occurred or did not occur. The tool is used only with cases for children in out of home care. All of the Supervisory Review Tools are reviewed monthly by Kids Central QA staff. The Supervisory Review Tool was developed by KCI and was included as an optional part of the state's QA/QI system.

Illinois

The movement to PBC did not drastically change the QA/QI functions in Illinois but it did focus these efforts into managing toward the PBC specific outcomes: 1) Sustained

Favorable Discharges and 2) Rate of Treatment Opportunity Days. The changes to the QA/QI system that are most related to the implementation of PBC include the following: 1) the addition of the two performance outcomes in the Residential and Treatment Outcome System data base; 2) the creation of the Centralized Matching Team; and 3) the use of the data that is collected from the providers. There have been other changes to QA/QI that are not directly related to PBC but do assist in achieving PBC outcomes including organization changes to the monitoring division, creation and implementation of the discharge transition protocol, and the implementation of Rule 384. The different components of the QA/QI system are described below.

The essence of PBC is that agencies are given set benchmarks/outcomes that they must manage toward to demonstrate performance. Agencies are provided both financial incentives for surpassing their benchmarks and financial penalties for not meeting their benchmarks. The process and activities the individual agencies use to achieve success is monitored much less. QA/QI is focused on monitoring and tracking the data related to outcomes. PBC emphasized two outcomes (treatment opportunity days and sustainable discharges) which are tracked and entered into the Residential and Treatment Outcomes System (RTOS).

Centralized Matching Unit

In response to DCFS' request that no agency decline a child for placement in exchange for purchasing a specified number of beds, the department developed the Centralized Matching Team (CMT) in Spring 2008 to better match youth to providers. The no decline policy is central to the PBC initiative. The CMT reviews clinical information about the child or youth and reviews the type of services a residential agency has stated they are able to provide in their program plan. The CMT then matches children with the appropriate agency for placement. Private agencies update their service provision profiles and program plans to clearly delineate the types of child and youth they are willing and capable to serve. This matching and review process allows DCFS to monitor the services agencies provide given the population that is being served to identify where quality improvements may be made in the matching process or the residential service array.

Residential and Treatment Outcome System (RTOS)

The Residential and Treatment Outcome System (RTOS) data base system was in effect prior to PBC; however, the use and intent of RTOS was impacted by PBC. The two key performance outcome measures were added into RTOS after PBC. Treatment opportunity days is the denominator that is used for calculating numerous measures. RTOS includes information from the DCFS monitors visits and forms in addition to the outcomes data. The reports that are generated from this system help providers understand where they stand in terms of performance on the outcomes. DCFS wanted RTOS to be able to provide a means of giving information back to the providers in the

form of reports. The reports are available on-line and include aggregate and detailed information of how well the provider is performing on the outcomes. Although the system is able to capture a lot of data, it is not being fully utilized by providers.

Related Changes to QA/QI

Residential Monitors

The residential monitors were in existence prior to PBC. Over the years there have been changes made to the organization of the monitoring unit; however, the monitors have continued to provide a mix of technical assistance and oversight. The Monitoring Division is now a branch of DCFS that oversees Monitoring and QA/QI for residential and

Time 1 Focus Group Findings

The items monitored have not changed; however, the way they are monitored has been modified:

Monitoring protocols have been changed to include required documentation of compliance with contractual performance (for example, a bank statement and a signed lease in the youth's name may be needed to close the case of a youth being emancipated).

ILO/TLP. Residential Monitors are a major component of Illinois' Residential QA/QI system. This unit monitors the quality of care and the appropriateness of the level of care with the responsibility of identifying weaknesses in the overall system of care.

Each monitor has a specific caseload of agencies that they visit about once a week. Monitors are asked to complete File Reviews (a review of existing documentation on children in residential care), Milieu Observation Reports (a review of the physical and social setting of the

agency), and Staff Reports. This information is entered in the Residential and Treatment Outcome System for QA/QI review. Agencies are expected to report discharges to the Residential Monitoring Unit on a monthly basis for reconciliation purposes on the outcome measure of Treatment Opportunity Days. This provides another level of quality assurance that the services an agency states they are able to provide is being provided and that all children are safe and accounted for in treatment.

Discharge and Transition Protocol

This protocol was implemented around the same time as PBC. Although not directly related to PBC, the protocol provides residential providers with concrete steps that related to discharge planning which will help them to move children more quickly through their program and have more successful discharges. The intent of the protocol is to assist providers to effectively plan for discharges and to ensure that follow up is done with clients once they leave the facility. The success of this protocol does impact the sustainable discharge outcome.

Similar to the discharge and transition protocol, there were a couple of other initiatives that were originally piloted to assist agencies in managing toward their outcomes. The runaway project was put in place to try and help provider assess a child's risk of running and to develop a plan that would help prevent chronic running. Likewise, the PRN pilot matched residential providers with a psychiatric hospital in hopes of building collaboration between the two entities so that children would be hospitalized fewer times. Both of these initiatives were put in place to assist agencies in meeting their outcomes; however, neither of them was fully implemented across the system.

Rule 384 Reviews

This initiative was started prior to PBC. These reviews allowed DCFS to assess a residential provider's policy on discipline through file reviews and interviews with clients. Originally these reviews were going to be conducted periodically on all providers; however, due to staffing constraints with the monitors, these reviews are primarily conducted when a concern is noted.

Residential Agency QA/QI Systems

In addition to the QA/QI provided by DCFS, all residential providers have QA staff. The activities of these staff vary by agency; however, they are all involved with monitoring data related to the two performance measures in some manner. The expectation is that each provider is monitoring and tracking their outcomes separately from the Department. Providers that under perform related to Treatment Opportunity Days are financially penalized. Providers that outperform their target for sustained favorable discharge rates receive an incentive. Residential providers receive information about their performance on a regular basis and have the opportunity to reconcile the numbers based upon their own calculations. The involvement of the internal QA staff at each agency varies widely

Time 2 Focus Group Findings

Focus group participants reported that some agencies shared data down to the front-line; however, other agencies kept information from the front-line in order to keep the focus on milieu activities. Some workers felt that this worked well; however, others felt that this inhibited a complete understanding of the priorities of the agency. Hence, they misunderstood the reasons for the implementation of certain practices.

Time 1 Focus Group Findings

Participants reported broader and more frequent dissemination of outcomes to supervisory and front-line staff.

Outcome data was reported to be used in engaging in dialogue with fiscal staff and in preparing budgets.

Participants reported that trainings on PBC/QA were conducted with front-line staff; however, these trainings did not cover specifics of PBC/QA.

from working closely with residential staff to focusing on file checks and monitoring performance.

Residential providers that are having difficulty meeting their outcomes can receive assistance from the Technical Assistance Group (TAG) at the University of Illinois at Chicago. Staff from TAG can provide TA to either individual programs or the system as a whole. This unit is designed to help providers tweak their programs and/or milieu

to better meet their outcomes. The Department does offer training that is open to residential providers; however, the majority of the training (both pre and post hire) are provided by the residential providers themselves.

Missouri

Since implementing performance based contracts in 2005, Missouri has greatly increased its quality assurance efforts for contracted providers. The state has established several ways to examine contractor performance and improve practice. Missouri now operates both an agency-wide QA system that pre-dated PBC contracts and a parallel QA system that just focuses on the PBC contract. The agency-wide QA system involves standardized data collection and analysis, procedures, and continuous quality improvement teams at the local, regional and state levels. These teams review QA data, problem solve, and create plans for improvement.

The parallel QA system for PBC was created in consideration of the contractors the state selected based on their internal quality assurance (QA) plans and capacities and their compliance with national accreditation QA standards. CD expected that all contractors would have a QA division that would assist in the on-going monitoring and tracking of performance. To further evaluate the services being provided by the contracted agencies, CD developed mirror units in Greene and Jackson that matched the contractors on certain criteria including: type of cases served; services provided; caseload size; supervisory ratios; staff development expectations; and random assignment of replacement cases. The QA/QI structure for contractors included the following elements:

Correction Action Plans

The Children's Division has built in mechanisms to require corrective action on individual performance issues, as well as, systemic ones. CD retains the right to approve or disapprove plans if they do not meet their level of expectations. In the case where the plans are disapproved, a letter comes from the Division Director and if need be, referrals are put on hold. The state requires providers to complete corrective action plans when they are significantly out of compliance with the outcome measures. State documents indicated that in January 2008, the state was monitoring corrective action plans by five of the seven consortiums that were not meeting specific targets.

Oversight Specialists

The state uses Oversight Specialists to provide technical assistance and monitor performance contracts. The Oversight Specialists provide policy updates, notify contractors about upcoming training, and track enrollment; serving as a bridge between the State and contracted agencies. They attend all permanency planning reviews and

recently have begun to monitor child visitations. They also oversee the collection and resolution of the critical incidents reports. Primary job duties of the Oversight Specialist includes: 1) provide technical assistance, 2) track enrollments, 3) track complaints for resolution, 4) attend Permanency Planning Reviews, and 5) provide contract monitoring through regular checks via the automated system. While contracted supervisors and QA specialists are expected to monitor worker and consortium performance, the Oversight Specialists also serve in a QA role monitoring worker visits, Permanency Planning Reviews, and case goals. The state has also reduced the caseloads of the state staff that oversee contract agencies, and has expanded the number of avenues used to discuss and improve provider performance. In 2009 the state expanded the number of contract oversight specialists – there are now 15 specialists that carry a caseload of 70 cases each.

Meetings Focused on QA/QI

Within six months of initiating PBC, the state began both local and regional continuous quality assurance meetings. In most cases, quality assurance matters are first addressed at the local level through monthly meetings. If issues are not resolved, the matter is brought to regional meetings to develop joint QA plans. If an issue is not resolved at the regional level, it is then taken to the quarterly CEO meetings involving public and private staff. The state has also begun to offer quality assurance summits to provide system-wide training on best practice. The State has a CQI team at the state, regional, and local levels that meet quarterly to review findings and discuss improvement

Performance Measures

To assess provider performance, the state examines several indicators:

- Consortium performance on the measures listed in the contracts.
- Quality Improvement Requests (formerly Critical Incident Reports) – these are constituent complaints or concerns raised internally by CD staff about a provider. The concern could range from inadequate documentation to parents not being invited to team decision making meetings. A tracking log is used by the Oversight Specialists to record when issues arise, when an agency is notified and the timing and substance of their response. If areas of concern are identified – the state issues a formal letter of concern to the contractor who must reply with a corrective action plan.
- Results from Peer Record Reviews – these are completed on a quarterly basis on both contracted and public agency cases. The intent is to review daily practice in such areas as case planning. Results are shared with both CD staff and contractors.
- Challenges and issues raised by the providers themselves during local oversight meetings.

Quality Improvement Forms

The Quality Improvement (QI) form is completed anytime there is an external complaint against a contractor or when there are contract compliance issues which were not resolved through other means. The response from the contractor which would include any action taken is reviewed by an oversight specialist. In addition, all QI's are tracked on a spreadsheet to identify trends in the type of complaint and staff members they may be complaining about. If areas of concern are identified this is addressed through a formal letter of concern followed by a corrective action plan which is monitored at the state level.

Out of Home Investigations

All Out of Home Investigations (OHI) are now reviewed by Marcia Dunnegan or Lisa London if they involve a contracted case management provider. The reports are reviewed to ensure safety issues are addressed. QI forms are prepared as concerns are identified. For example, when one child/alleged victim was interviewed he stated his contracted worker was not visiting. The QI form resulted in a case record review. The worker had visited bi-monthly for most months and visited the child monthly for two months.

Peer Record Review

Peer Record Reviews are completed on a quarterly basis and include both CD and contracted cases. These reviews are designed to sample 10% of the cases yearly. CD and contracted staff participate in the review. Peer Record Review provides a tool to review daily practice such as case planning activities etc. The results are shared with CD and contracted staff and utilized to improve practice. Annual Peer Record Review Results have been compiled for 2006, 2007 and 2008. 1st and 2nd quarter Peer Record Review results for 2009 have been shared with private agencies. Strengths and needs were highlighted for each consortium upon distribution. Another QA/QI activity cited in these discussions was the use of joint public/private practitioner teams to conduct Peer Record Reviews in all sites. Because of the potential subjectivity and numerous confounding variables there is considerable reluctance about sharing these data on a unit-by-unit basis.

Practice Development Review

Practice Development Reviews (PDR) include CD and contracted cases. Cases are chosen at random with a smaller sample size than the Peer Record Reviews as the PDR is an in depth review of the child welfare system, as a whole, which is conducted over a three day period. PDRs involve reviewing the case record and interviewing key stakeholders and participants involved with the case. Contracted and state agency staff serves as reviewers. Feedback is provided to the stakeholders via an exit conference to improve service delivery.

Advisory Board Meetings

The advisory board meeting was held during the initial part of the grant. CD Regional Directors and CEOs attended. The primary purpose of this advisory group was to determine the information which is still needed to explain the quantitative outcomes and how this information will be collected. This group was resolved due to budget constraints.

FACES Training

CD targeted key components in the automated system and provided additional training to contracted QA Specialists. Such training will continue as issues are identified. QA Specialists were provided information regarding the reports which are available through the automated system to monitor worker visits etc. A demonstration was provided on August 4th during the QA meeting.

Collaborative Efforts

In addition to the components listed above, CD has developed joint quality assurance/quality improvement initiatives at both a regional and state level.

Regional Level: Joint initiatives at the regional level include circuit CFSR Readiness Assessments, Program Improvement Plans to address deficiencies identified through the circuit self assessments, and Peer Record Reviews. Contracted staff, including their QA Specialists, are invited to attend the local CFSR/PIP meetings. The desired outcome is the development of joint QA/QI plans to address areas of concern and sharing of best practice.

State Level: Joint initiatives at the state level include federal reviews such as worker visits with children, Child and Family Service Review, and AFCARS/data integrity. The contracted QA specialists are now routinely engaged in data clean up efforts to achieve improved data integrity.

Contracted QA staff attended the public statewide QA meeting on August 4, 2009. Discussion included MoHealth Net training, data/FACES training, pending memorandums and CFSR update. The CD CQI "In Focus" Quarterly Newsletter is shared with contracted providers. This newsletter emphasizes the quality assurance/improvement activities which are happening throughout the state.

Internal QA/QI Activities

In addition to the QA provided by CD, quality assurance monitoring remains a function reserved to each of the agencies as an internal process and these private agency generated data are not available for inspection under the terms of the either the old or

the new contracts. The public agency has made their data available for review but the private agencies maintain their own distinct monitoring systems at both the individual agency and consortia levels per the mandates of both their accreditation standards and the contract provisions. All agencies, in accordance with accreditation standards, have a minimum of one professional position devoted to Quality Assurance. The Missouri contract is somewhat unique in that it does not measure processes but focuses instead on outcomes. Process components are, of course, referenced in contract standards and adherence to the Missouri Children's Division Child Welfare *Manual of Practices* is a core requirement.

Time 2 Focus Group Findings

Focus group participants reported that the sharing of QA data within agencies varied among the agencies. Private agencies were likely to use the data and the focus on permanency was conveyed even down to the clients/parents.

D. Cross-Site Quality Improvement Assessments

In addition to the descriptions of the performance based contracts and quality assurance systems in place in each site, the cross-site team has also collected data from the quality assurance directors in private agencies in each site. This survey data outlines a number of specific QA/QI activities related to PBC/QA.

As previously described, the cross-site team developed a multi-item survey. The survey covered a listing of 14 traditional quality assurance activities in child welfare agencies and asked multi-level questions to assess three main domains: 1) level of implementation of activity; 2) whether activity supports the goals of PBC/QA; and 3) whether activity is effective in improving practice and outcomes. Each question was scored on a 5-point Likert scale with an additional Not Applicable choice. The survey was designed for Quality Assurance directors in private agencies; however, the survey participants varied widely in their roles and responsibilities according to the needs or requirements of their respective agencies or consortiums.

Quality Improvement Activity Implementation

Using this survey instrument, the cross-site team was able to track changes in level of QA activity implementation over the three time points of Baseline, Time 1, and Time 2, as well as, within sites. The following table presents the basic mean level of implementation at each time point for each site. Higher numbers indicate greater level of implementation (on a scale of 1 to 5).

Statistical analyses were conducted to assess differences in the extent of implementation of QA activities. Once again, these analyses focus on variations within each site over time. Analysis of Variance tests were conducted to detect overall differences among the mean levels of implementation of all QA activities. A significant difference over time was found for Internal Staff Training in Quality Improvement

activity in both Illinois ($F(2,42)=3.9$, $p<.028$) and Missouri ($F(2,19)=3.7$, $p<.045$). Post Hoc analyses revealed the time points showing significant differences, which are noted with different subscripts in a row in the table below:

Extent of Implementation of QA/QI Activities			
	Illinois		
Activity	Baseline (N=19)	Time 1 (N=9)	Time 2 (N=15)
Peer Record Review	4.74	4.89	4.60
Unusual Incident Review	4.32	4.89	4.80
Priority Review	4.26	4.89	4.67
Consumer Input	4.16	4.67	4.13
Office Review	4.11	4.33	3.93
Supervisory Review	4.00	4.33	4.33
Outcomes Management	4.21	4.67	4.40
Using CFSR Data	3.53	4.11	3.80
Program Evaluation	3.95	4.22	4.07
Staff Training in QI	3.58_a	4.33_b	4.47_b
Quality Improvement Planning	4.21	4.67	4.33
Action Planning & Follow-Up	3.89	4.22	4.13
Research & Best Practice	3.26	3.44	3.13
Link QI to Contract/QA	3.47	4.22	4.20
	Florida		
	Baseline (N=6)	Time 1 (N=3)	Time 2 (N=6)
Peer Record Review	4.00	3.33	4.75
Unusual Incident Review	4.50	4.33	4.67
Priority Review	4.40	4.67	4.83

Consumer Input	4.40	4.33	4.33
Office Review	3.60	4.00	3.83
Supervisory Review	4.60	5.00	4.33
Outcomes Management	4.40	4.33	4.67
Using CFSR Data	3.60	4.67	4.20
Program Evaluation	3.60	4.33	4.60
Staff Training in QI	4.00	4.67	4.67
Quality Improvement Planning	4.20	4.67	4.67
Action Planning & Follow-Up	3.60	4.67	4.67
Research & Best Practice	3.40	4.67	4.00
Link QI to Contract/QA	3.40	4.67	4.33
	Missouri		
	Baseline (N=9)	Time 1 (N=9)	Time 2 (N=2)
Peer Record Review	4.00	4.44	4.50
Unusual Incident Review	4.11	4.56	4.00
Priority Review	4.78	4.67	5.00
Consumer Input	4.11	4.44	5.00
Office Review	4.67	4.33	5.00
Supervisory Review	3.89	3.78	4.00
Outcomes Management	4.89	4.67	5.00
Using CFSR Data	3.67	3.89	4.00
Program Evaluation	3.44	4.11	4.00
Staff Training in QI	4.56 _a	3.67 _b	4.50 _a
Quality Improvement Planning	3.89	4.33	4.50
Action Planning & Follow-Up	4.22	4.44	5.00

Research & Best Practice	2.56	3.33	4.50
Link QI to Contract/QA	3.78	4.33	4.50

Note: Scaling 1= pre-planning implementation stage; 2=planning implementation stage; 3 = beginning implementation; 4= partially implemented; 5 = fully implemented

Quick Summary: QA Implementation

- Generally, almost all QA activities showed increasing implementation over the course of the PBC/QA project, though the means were not always significant. This does suggest increased attention toward using data within the PBC system.
- In Illinois, staff training in quality improvement increased over time with a significant difference noted between Baseline and Time 2. Florida showed no significant changes in implementation activity level over time. Missouri showed a significant dip in staff training in quality improvement from Baseline to Time 1; the implementation level does rise for Time 2, however this is not a significant change.
- The small sample size of Quality Improvement Directors involved in these studies should be kept in mind when considering the implications of these findings.

Quality Improvement Activity Supporting PBC Goals

The cross-site team also assessed the Quality Assurance directors' perceptions of the extent the QA activities supported the PBC/QA's overall goals. This was measured across time and within each site, with the basic mean levels presented in the following table. Again, higher means indicate a greater extent of support. Analysis of Variance tests were conducted and **did not detect any change in the extent to which activities were perceived to support PBC goals within each site over the course of the intervention.**

Extent QA/QI Activities Support PBC Goals			
Activity	Illinois		
	Baseline (N=14)	Time 1 (N=7)	Time 2 (N=15)
Peer Record Review	4.50	4.29	4.07
Unusual Incident Review	4.07	4.71	4.27

Priority Review	4.21	4.86	4.27
Consumer Input	4.07	4.43	3.80
Office Review	4.00	4.14	3.33
Supervisory Review	3.71	4.43	3.87
Outcomes Management	4.50	4.57	4.60
Using CFSR Data	3.86	3.86	3.53
Program Evaluation	4.07	4.00	3.80
Staff Training in QI	3.71	3.86	3.87
Quality Improvement Planning	4.14	4.00	4.20
Action Planning & Follow-Up	3.93	4.00	3.80
Research & Best Practice	3.42	3.57	3.80
Link QI to Contract/QA	3.71	4.29	4.13
	Florida		
	Baseline (N=5)	Time 1 (N=3)	Time 2 (N=5)
Peer Record Review	3.61	3.33	5.00
Unusual Incident Review	4.40	4.33	4.60
Priority Review	4.40	4.33	4.80
Consumer Input	4.40	4.00	4.60
Office Review	3.60	4.00	4.00
Supervisory Review	4.60	4.67	4.80
Outcomes Management	4.60	4.33	4.80
Using CFSR Data	3.80	4.67	4.80
Program Evaluation	3.00	4.00	4.40
Staff Training in QI	4.00	4.00	4.40
Quality Improvement Planning	4.20	4.67	4.80
Action Planning & Follow-Up	3.80	4.33	4.80
Research & Best Practice	3.80	4.67	4.40
Link QI to Contract/QA	3.60	4.33	4.60
	Missouri		
	Baseline (N=9)	Time 1 (N=6)	Time 2 (N=2)
Peer Record Review	3.44	3.83	4.00
Unusual Incident Review	3.78	4.17	4.00
Priority Review	3.67	4.50	4.00
Consumer Input	3.56	4.00	4.50
Office Review	3.33	3.50	4.00
Supervisory Review	3.89	3.80	4.00
Outcomes Management	4.44	4.67	5.00
Using CFSR Data	2.00	3.50	3.50
Program Evaluation	3.78	4.00	3.50

Staff Training in QI	3.67	3.50	3.50
Quality Improvement Planning	3.89	4.00	4.50
Action Planning & Follow-Up	3.44	4.00	4.00
Research & Best Practice	2.11	3.17	3.50
Link QI to Contract/QA	2.89	4.33	4.00

Note: Scaling 1 = Not at all supportive; 2 = Slightly supportive; 3 = Somewhat supportive; 4 = Moderately supportive; 5 = Very supportive

Quick Summary: QA Activities Supporting PBC Goals

- While QA directors perceived some activities to be more supportive of PBC Goals than others, there were no significant differences over time in any of the sites regarding the supportiveness of individual QA activities.
- Low sample size contributes to this non-effect, though data does help show relative differences among the activities within a site.

Staff Perceptions of Quality Improvement Activity Effectiveness

All respondents were asked to evaluate the extent to which they believed these QA activities are effective in improving practice and client outcomes. For each activity, respondents rated the effectiveness of it on a 5-point Likert scale. Higher numbers represent greater perceived effectiveness of the activity. The basic mean levels are presented in the table below. Analysis of Variance tests revealed **no difference in the perceived effectiveness of QA activities over the course of the implementation within each site by either QA directors or front-line staff.**

QA Directors: Perceived Effectiveness of QA Activities			
Activity	Illinois		
	Baseline (N=13)	Time 1 (N=7)	Time 2 (N=14)
Peer Record Review	4.15	3.86	3.71
Unusual Incident Review	4.00	4.14	4.07
Priority Review	4.08	4.29	4.14
Consumer Input	3.69	4.00	3.57
Office Review	3.77	3.71	2.93
Supervisory Review	3.58	3.86	3.71
Outcomes Management	4.00	3.71	4.21

Using CFSR Data	3.69	3.71	3.43
Program Evaluation	4.00	3.86	3.64
Staff Training in QI	3.46	3.43	3.86
Quality Improvement Planning	4.00	3.86	4.07
Action Planning & Follow-Up	3.67	3.71	3.86
Research & Best Practice	3.15	3.29	3.29
Link QI to Contract/QA	3.46	3.86	3.71
	Florida		
	Baseline (N=3)	Time 1 (N=2)	Time 2 (N=3)
Peer Record Review	3.67	4.00	4.33
Unusual Incident Review	4.00	3.50	4.00
Priority Review	4.00	4.00	4.00
Consumer Input	4.00	3.50	4.00
Office Review	3.00	3.50	3.67
Supervisory Review	4.00	3.50	4.33
Outcomes Management	4.00	3.50	4.00
Using CFSR Data	4.00	4.00	4.33
Program Evaluation	4.00	3.50	4.33
Staff Training in QI	4.00	3.50	4.33
Quality Improvement Planning	4.00	4.00	4.33
Action Planning & Follow-Up	3.67	4.00	4.00
Research & Best Practice	3.00	4.00	3.67
Link QI to Contract/QA	3.33	4.00	4.00
	Missouri		
	Baseline (N=4)	Time 1 (N=8)	Time 2 (N=2)
Peer Record Review	3.50	3.50	3.50
Unusual Incident Review	4.25	3.75	4.00
Priority Review	4.00	3.88	4.50
Consumer Input	3.25	3.38	4.00
Office Review	3.75	2.88	3.50
Supervisory Review	3.75	3.57	4.00
Outcomes Management	4.50	4.00	4.50
Using CFSR Data	2.50	3.50	3.50
Program Evaluation	3.50	3.50	3.50
Staff Training in QI	4.00	3.13	4.00
Quality Improvement Planning	3.50	3.75	4.50
Action Planning & Follow-Up	3.25	3.62	4.50
Research & Best Practice	2.75	2.62	4.00
Link QI to Contract/QA	3.25	3.63	3.50

Note: Scaling 1 = Not at all effective; 2 = Slightly effective; 3 = Somewhat effective; 4 = Moderately effective; 5 = Very effective

Frontline Workers & Supervisors: Perceived Effectiveness of QA Activities			
Illinois			
Activity	Baseline (N=270)	Time 1 (N=177)	Time 2 (N=197)
Peer Record Review	3.58	3.38	3.40
Unusual Incident Review	4.00	3.83	3.99
Priority Review	4.09	4.01	3.98
Consumer Input	3.49	3.36	3.36
Office Review	3.60	3.48	3.46
Supervisory Review	3.91	3.72	3.75
Outcomes Management	3.62	3.53	3.54
Using CFSR Data	3.39	3.28	3.32
Program Evaluation	3.70	3.63	3.54
Staff Training in QI	3.84	3.55	3.65
Florida			
	Baseline (N=56)	Time 1 (N=39)	Time 2 (N=21)
Peer Record Review	2.86	3.31	3.52
Unusual Incident Review	3.36	3.36	3.75
Priority Review	3.64	4.00	4.06
Consumer Input	3.44	3.33	3.80
Office Review	3.02	3.31	3.30
Supervisory Review	3.98	3.92	4.10
Outcomes Management	3.63	3.59	3.76
Using CFSR Data	3.17	3.47	3.53
Program Evaluation	3.38	3.47	3.60
Staff Training in QI	3.57	3.90	3.76
Missouri			
	Baseline (N=21)	Time 1 (N=122)	Time 2 (N=118)
Peer Record Review	3.10	3.13	3.03

Unusual Incident Review	3.10	2.96	2.99
Priority Review	3.62	3.33	3.46
Consumer Input	3.43	3.34	3.26
Office Review	2.76	3.08	3.08
Supervisory Review	3.71	3.65	3.72
Outcomes Management	3.67	3.54	3.47
Using CFSR Data	3.10	3.26	3.19
Program Evaluation	3.33	3.47	3.30
Staff Training in QI	3.60	3.61	3.42

Note: Scaling 1 = Not at all effective; 2 = Slightly effective; 3 = Somewhat effective; 4 = Moderately effective; 5 = Very effective

Quick Summary: Quality Assurance Effectiveness

- *Priority Review* and *Supervisory Review* were ranked the most consistently high by all respondents in all sites as effective in improving practice and outcomes.
- *Office Reviews* ranked the most consistently low in all sites as less effective in improving practice and outcomes.
- In each site, discrepancies existed between perceptions of the Quality Assurance Directors and front-line staff, with significance differences found between the two groups in viewing some activities as effective in improving practice and outcomes.

QA Activity Effectiveness Rankings

In addition to asking Quality Assurance directors about specific QA activities in the *Quality Improvement Survey*, the cross-site team embedded a series of questions in the *Staff Training and Supervision Survey* to assess perceptions of front-line and supervisors. The focus was on ten QA activities that the Quality Assurance directors also responded to in the QA/QI survey. This helped triangulate data on perceptions of quality improvement within each site by broadening the staff population to determine whether there are shared perceptions.

The following tables present the combined responses from all three time points in rank order of perceived effectiveness. Separate tables for each site are created so that comparisons between the responses of the Quality Assurance directors can be compared to the responses of the front-line and supervisory staff. Analysis of Variance tests were administered to assess for significant differences in the perception of effectiveness between the frontline workers/supervisors on the front line and the QA Directors developing and facilitating the QA activities.

Florida Results: Frontline workers and supervisors (n = 110) in Florida were significantly less likely to rate the use of CFSR Data ($p < .041$) and Peer Record Review ($p < .046$) as effective quality assurance activities as compared to the QA Directors (n = 8).

Perceived QA Effectiveness Rankings			
Florida			
Quality Assurance Directors		Front-Line Workers & Supervisors	
Rank Order	Mean	Rank Order	Mean
CFSR Data	4.13	Supervisory Review	3.97
Priority Review	4.00	Priority Review	3.80
Staff Training in QI	4.00	Staff Training in QI	3.71
Supervisory Review	4.00	Outcomes Management	3.65
Program Evaluation	4.00	Consumer Input	3.49
Peer Record Review	4.00	Program Evaluation	3.46
Consumer Input	3.88	Unusual Incident Review	3.42
Unusual Incident Review	3.88	CFSR Data	3.34
Outcomes Management	3.88	Office Review	3.19
Office Review	3.38	Peer Record Review	3.13

Illinois Results: Frontline workers and supervisors in Illinois (n = 643) were significantly less likely to rank outcomes management ($p < .010$) and peer record reviews ($p < .046$) as effective QA activities when compared to the QA Directors (n = 37).

Perceived QA Effectiveness Rankings			
Illinois			
Quality Assurance Directors		Front-Line Workers & Supervisors	
Rank Order	Mean	Rank Order	Mean
Priority Review	4.14	Priority Review	4.04
Unusual Incident Review	4.05	Unusual Incident Review	3.95
Outcomes Management	4.03	Supervisory Review	3.82
Peer Record Review	3.92	Staff Training in QI	3.71
Program Evaluation	3.81	Program Evaluation	3.63
Consumer Input	3.76	Outcomes Management	3.58
Supervisory Review	3.67	Office Review	3.52
Staff Training in QI	3.65	Peer Record Review	3.47
CFSR Data	3.65	Consumer Input	3.42
Office Review	3.43	CFSR Data	3.34

Missouri Results: A significant difference was also found in the rankings of Outcomes Management ($p < .018$), Priority Review ($p < .017$), and Unusual Incident Review ($p < .000$) when comparing the means of frontline workers/supervisors ($n = 256$) and QA Directors ($n = 20$).

Perceived QA Effectiveness Rankings			
Missouri			
Quality Assurance Directors		Front-Line Workers & Supervisors	
Rank Order	Mean	Rank Order	Mean
Outcomes Management	4.05	Supervisory Review	3.68
Priority Review	4.00	Outcomes Management	3.53
Unusual Incident Review	3.95	Staff Training in QI	3.52

Supervisory Review	3.79	Priority Review	3.42
Program Evaluation	3.75	Program Evaluation	3.39
Staff Training in QI	3.65	Consumer Input	3.32
Consumer Input	3.50	CFSR Data	3.22
Office Review	3.50	Peer Record Review	3.08
Peer Record Review	3.45	Office Review	2.06
CFSR Data	3.15	Unusual Incident Review	2.99

All Site Quick Summary: Quality Assurance Effectiveness

- *Priority Review* and *Supervisory Review* were ranked the most consistently high by all respondents in all sites as effective in improving practice and outcomes.
- *Office Reviews* ranked the most consistently low in all sites as less effective in improving practice and outcomes.
- In each site, discrepancies existed between perceptions of the Quality Assurance Directors and front-line staff, with significance differences found between the two groups in viewing some activities as effective in improving practice and outcomes.

Time 1 Focus QA/QI Group Findings across Sites

Local evaluators also assessed their sites through a series of focus groups. Conversations during these groups provided the following insights regarding the use of data and quality assurance activities which were common across the three sites.

Overall, participants from the three sites reported that PBC measures were included as part of the regular QA reviews. And the resulting data was used in engaging front-line and clinical staff. An increase in quality improvement feedback, along with broader and more frequent dissemination of QA/QI information, was noted across the three sites, as well. This information was

more likely to be used by program managers and front-line staff to inform practice changes after implementation of PBC/QA.

QA data was also reported across the sites to be used as an impetus for more in-depth analysis of staff patterns. SACWIS was reported to be an obstacle to data collection, as well as, to the availability and accuracy of data in all three sites. Overall, an increased use and understanding of data was reported. This increased accountability and transparency, allowing agencies to hold one another accountable for service delivery.

Final Key Informant Interview QA/QI Findings

Data Systems: A crucial component discussed extensively was the quality of the data system in each site, both in terms of ability to measure outcome indicators as well as in continuous quality improvement. Sites experienced challenges in their current data systems, whether in reliability of the data in Florida and Missouri, or in use of historical data to forecast benchmarks. In Illinois, a primary challenge was the integration of data housed in multiple universities. The need to carefully consider the selection of contract targets for outcome indicators was a theme that emerged, including whether to use the contracts to promote incremental change or threshold achievement. In all states, a necessary component of the process was a system for reconciliation of data and indicator measurement between sectors. In all sites an enhanced use of data-driven decision-making was noted, connecting practice to child outcomes.

Incentives/Penalties: Site visits did not reveal consensus on the comparative benefits of the use of incentives versus disincentives in the contracts. Some participants expressed that it is the healthy competition that drives performance. Others felt strongly that either penalties may promote performance or incentives do. A couple of themes did emerge, however. Many participants agreed that some form of fiscal consequence—which is of course the crux of true performance based contracting—focuses attention on outcome achievement and virtually all believed improvement would be demonstrated over time. Second, concessions may need to be made in order to enable providers to commit given the risk, such as guaranteeing a set number of beds while requiring a no decline policy. Clarity regarding to outcome definition how they would be measured is crucial. Attention was needed related to transitional processes such as case transfer decisions. The system needs to use data regularly to revisit benchmarks, examine the relationships between the contract indicators and other desired practice and client outcomes, and identify unintended consequences such as certain types of providers or children who may be disproportionately impacted. Finally, thought needed to be given to how earned incentives could be used, and whether or not providers should be required to re-invest in some way.

QA/QI Processes: Themes related to key components of the quality assurance system were also illuminated through interviews. In all three sites, emphasis shifted from

compliance and oversight to technical assistance and developing a continuous quality improvement approach over the three year process. The value of data sharing across providers to promote practice improvement was mentioned. Illinois and Missouri participants talked about developing processes for quality improvement for low performers. Florida and Missouri utilized peer case review processes. It was noted that providers have varying capacity for quality assurance processes despite accreditation, and attention may need to be paid to moving the system forward in this regard.

The combined performance based contract, and the use in a more integrated quality assurance and improvement process was believed to have resulted in enhanced evidence-informed practice and data-driven decision-making.

E. Additional Organizational and Systemic Programs to Support PBC/QA

As the projects progressed, it became apparent that in addition to implementing performance-based contracts and quality assurance systems, each site had also developed or enhanced other programs that in effect helped support their intervention. In other words, each site experienced organizational or systemic changes in conjunction with their intervention that were often designed to enhance performance and support improved practice and outcomes. How each site chose to implement additional supports varied in scope. This is one important reason why it is difficult to attribute changes in outcomes as a function of the PBC/QA intervention alone. It is, however, important to describe the entire system surround PBC/QA, particularly those components which directly or indirectly support improved practice and outcomes. Of particular emphasis in each site were the changes in the way QA/QI was conducted and its link to PBC.

QA/QI Linked to PBC

It is evident that each site's approach to QA/QI was driven by local context and needs, and the types of PBC outcomes chosen. In addition to ensuring that the PBC outcomes were met, QA/QI was also aimed at providing necessary supports to meet these measures. These are summarized here.

Florida's PBC measures were primarily practice-oriented, and as a result, the QA/QI activities undertaken by the lead agency and the CMAs were more practice-oriented in nature than the other two sites and were the most directly related to the PBC measures. Compliance with face-to-face supervision is assessed through the Supervisory Review Form, all of which are reviewed by the lead agency's QA team. Case information entered within two days and contact with biological parents are both assessed through case review. In particular, the Supervisory Review Tool became a fundamental aspect of QA/QI and also came to serve as a valued practice guide. The tool is used to guide

meetings between supervisors and front-line workers to assess the quality of caseworker practice and to create opportunities for learning and mentoring.

Because Illinois' and Missouri's PBC measures were more outcome-oriented, the QA/QI activities undertaken by the state agency were more systemic in nature, and were less-related to the achievement of specific practice changes. One exception in Illinois is the Discharge and Transition Protocol, providing residential providers with concrete steps related to discharge planning that will help them move children more quickly through their programs and enable more successful discharges. Missouri reviews focused on practice include the Peer Record Review and the Practice Development Review. The Peer Record Review is completed on a quarterly basis, reviewing case planning activities etc. The Practice Development Reviews are comprised of a smaller sample and involve reviewing the case record and key stakeholders and participants in order to assess the child welfare system as a whole as it relates to practice.

Apart from these exceptions, both Illinois and Missouri used well-established, centralized QA/QI offices. Illinois relied on the Residential Monitoring Unit, in existence prior to PBC. Each monitor has a specific caseload of agencies that they visit once per week. Monitors undertake comprehensive reviews including file reviews of existing documentation of the children in care, Milieu Observation Reports of the physical and social setting of the agency, and Staff Reports. Agencies report discharges to the unit on a monthly basis in order to measure outcome achievement and provide an opportunity for reconciliation. Missouri uses Oversight Specialists to serve as a bridge between the state and contracted agencies. They keep providers informed of policy updates, notify contractors about upcoming training, track enrollment, and monitor contract compliance. The child welfare agency has built in mechanisms to require corrective action on individual performance issues as well as systemic ones. The state requires providers to complete corrective action plan when they are significantly out of compliance with the outcome measures.

All sites emphasized data feedback to agencies operating under PBC as a way to take corrective action and target needed TA and support. In Florida, this function takes place within monthly meetings of CMA directors and supervisors, in which charts and graphs depicting each agency's performance on the measures in relation to other CMAs. At the case level, Kids Central Quality Assurance teams provided specific feedback to CMAs on why a case was or was not credited based on the criteria set forth in the contract. If warranted, reconciliation was undertaken through this process. Among sites, during Florida focus group in particular, participants revealed that QA information was shared, and that front-line staff received regular individualized reports on their performance.

In Illinois, this function is supported through the Residential and Treatment Outcome System (RTOS) data base system. The Monday Report continues to update all member agencies of the project's status and methods for providing feedback to the Project Steering Committee. The Residential Data Test Workgroup's electronic "base camp"

continues to be used to post minutes, reports, relevant research and meeting notices. The Technical Assistance Group (TAG), housed at the University of Illinois at Chicago, provides assistance to providers having difficulty meeting their outcomes.

Sites varied in the establishment of structures to formulate QA/QI activities and refine them over time. At a systemic level, in Florida, project workgroups meet regularly at different levels to discuss specific implementation, management issues and assess performance based contracts and individual incentive measures. The Supervisor Roundtables were also noted as key. These were facilitated by a neutral facilitator in order to create level playing field between the public child welfare agency, the lead agency, and CMAs.

Illinois relied on the Child Welfare Agency Committee (CWAC), to help formulate and guide its QA/QI. Subcommittees and workgroups of public and private agency staff review and develop proposed metrics, process and outcome measures, and data collection and quality assurance protocols for inclusion in PBC. The structure is designed to facilitate internal communication between the Department's various program offices and resolve issues pertaining to contract implementation. Statewide provider forums were organized to provide stakeholders with the opportunity to engage in the planning process, provide critical feedback on the proposed metrics, measures, data collection protocols, program implementation, and share best practices.

Through quality assurance meetings, Missouri initiated both local and regional continuous quality improvement within six months of initiating PBC. Issues are first addressed at the local level through monthly meetings. However, if matters are not resolved at this level, they are brought to the regional meetings. From here, unresolved issues can be brought to the quarterly CEO meetings involving both public and private agency staff.

For all sites, the achievement of PBC outcomes drew on a variety of key supports. Examples in Florida include client support groups for parents with a goal of reunification, and support groups for fathers and teens and the Family Finder units, funded through a separate initiative helped find family resources. Examples in Illinois include the Centralized Matching Unit developed by the Department to better-support the "no reject" policy put in place for referrals. The unit reviews clinical information for each child and reviews the services offered by each provider in order to find the best placement.

Finally, examples in Missouri included practice summits that brought together public child welfare and private provider agency staff to share innovative strategies and dialogue on effective practices. The joint QA/QI Summit was a facilitated meeting that gave an overview of the QA/QI process. Agencies shared tools for internal record review, consumer surveys, and supervisory reviews etc. Program Managers Meetings coordinated joint QA/QI training to align practices and improve performance. Other

workgroups formed between public and private agencies developed policy recommendations and tracking tools.

F. Organizational Culture: Perceptions of Evidence-Informed Practice, Supervision and Training in Front-line and Supervisors

In addition to the contract components and the QA/QI processes in each site, the cross-site evaluation examined another potential necessary component for improving outcomes under PBC/QA. Specifically, the organizational culture and how front-line staff carries out the agency's work to achieve outcomes may be as important as the structure of the PBC/QA system itself.

For the cross-site evaluation, the study team wanted to understand the effects of implementing PBC/QA on front-line staff. Equally vital, the team also theorized that as the intervention took hold and matured, front-line staff would play an important part in changing practice to support PBC/QA goals within each site. As discussed previously, the types of outcomes each site chose varied in their proximity to front-line practice; however, improved outcomes for children and family remained at the center of all contracts. Because of the variability across sites, it is difficult to assess individual practice-level changes made by staff that inherently has an effect on performance and outcomes. Thus, the team developed a cross-site survey to better understand the relationship between the nature of PBC/QA, its goals, and outcomes with that of front-line practice.

The next sections describe the survey itself, the methodology used to administer the surveys in each site, respondent characteristics, and finally, results on sets of thematic questions

Survey Background and Psychometric Testing

As outlined in the introductory sections of this report, the study team comprised of cross-site evaluators and project staff developed a 30-item survey that focused on the use of data, outcomes, and evidence informed practice by front-line and supervisor staff. Individual survey items and sub-questions were derived from three main sources and current work in the field of child welfare (Research in Practice, 2006; Organizational Excellence Group, 2001; & Institute for Behavioral Research, 2002). The survey itself contained a mixture of items that were scaled on 5-point Likert ratings, categorical responses, and a several open-ended questions.

Given the thematic grouping of the items and the fact that it was developed to capture several different conceptual topics, psychometric testing was limited to performing factor analysis on two sets of items: four items that captured teamwork and ten items

on an embedded survey on the intent to remain employed. Reliabilities for these subscales are included in the appropriate sections below.

Methodology

For cross-site data collection, the team worked with local site evaluators to distribute the survey at three points in time to ensure standard time intervals across sites – Baseline, Time 1, and Time 2 which are approximately 1 year apart. This allowed for the team to capture staff perceptions at the beginning of the PBC/QA intervention in each site and to track changes in perceptions over time as components of the intervention were relayed to staff.

For each site, the local evaluators and project team identified front-line case managers and supervisors who were involved in performing services under PBC/QA. Hard copies of the surveys were either mailed to individual staff members or the survey was emailed to staff members in the form of a SurveyMonkey™ link. The site evaluators then entered the data in a pre-designed SPSS data file or sent the Excel spreadsheet to the cross-site team. Each site's data was formatted with standard variable names and included grouping information to code the site, the administration time, and if appropriate, treatment or control status (for Florida site only).

In addition to the individual items, the survey also contained demographic variables to identify key information such as staff type, agency type, and other important characteristics. The cross-site team analyzed only private agency staff data and included only responses from front-line caseworkers and supervisors. Major categorizations for this data included site and time period.

The cross-site team conducted site-specific Analysis of Variance and Chi-Square analyses to determine significant changes in elements of interest within each site over time. Most of these analyses differentiate differences by position (frontline worker versus supervisor) and time points.

Survey Content and Data Display

A great deal of information is captured in this survey. In many cases, individual items on the survey are analyzed separately and presented in a table or graph form. To help categorize the general focus and content of the items, the sections are broken down into 7 broad areas of information:: 1) Staff Knowledge of PBC Goals and Client Outcomes; 2) Using Evidence to Inform Practice – Performance and Supervision; 3) Front-line Practice and Supervision; 4) Supervisory Practice; 5) Teamwork to Improve Client Outcomes; 6) Training of Staff; and 7) Staff Retention.

The forthcoming sections contain data on survey items broken down by site and position type. Each graph displays the appropriate survey question at the top and

scaling information is contained along the x-axis. In some cases, data for “Yes-No” categorical questions are shown as percentages while others display means for Likert-type scales. Tables contain similar information in the appropriate format.

Each graph also displays error bars which are used to represent standard error amounts for each data point. For the purposes of this report, error bars are provided to allow readers to estimate a few details about the data. First, the spread of the data will determine the length of the error bar, as will a smaller sample size. So, a longer error bar is likely to mean a small sample size or that the data may have varied widely. Second, the error bars can be used to generalize where the mean may fall. Two bar graphs with overlapping error bars are generally going to have more similar means and probably do not differ significantly. Where two error bars do not overlap, it is possible that a significant difference exists between those means. However, to ensure a clear understanding of our findings, the graphs representing significant findings are also described further in the text.

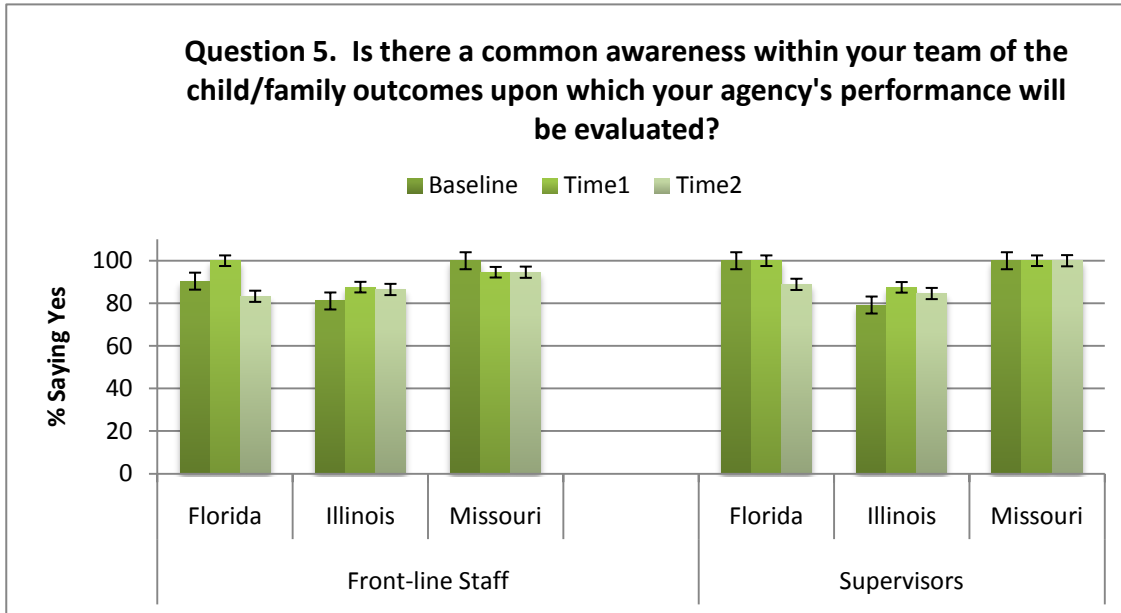
Survey Respondents

Descriptive demographic information was obtained from all respondents who completed surveys in each site. Collapsed across administration time points, the following table presents sample sizes, employment information, and education level of front-line case managers and supervisors by site.

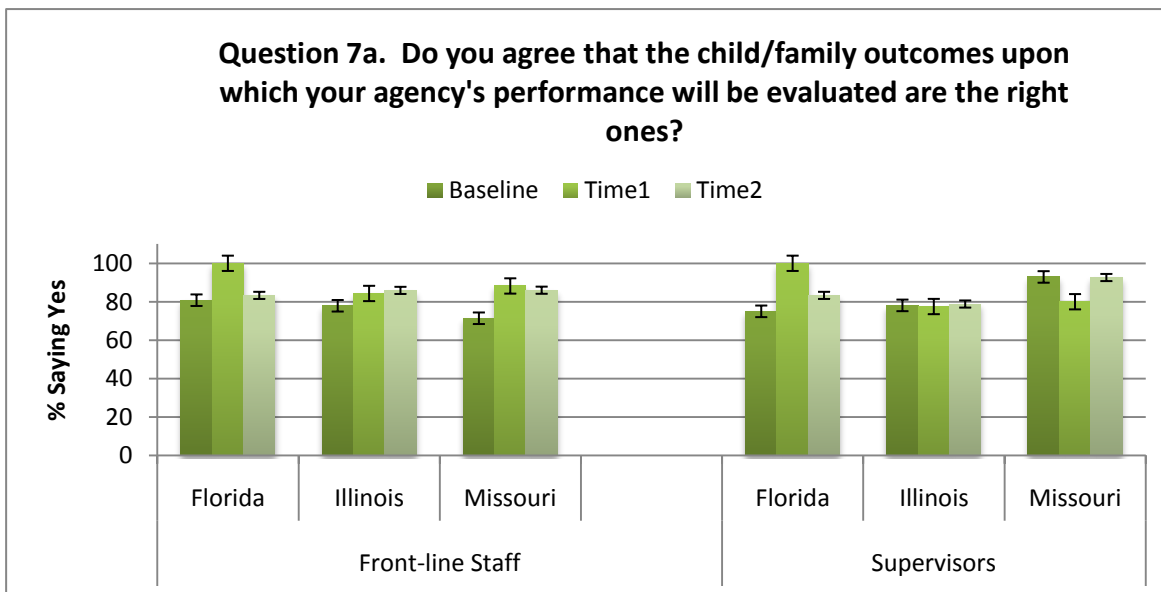
Survey Respondent Demographics										
			Sample Size	Employed in Current Position (Mean Years)	Employed in Child Welfare Field (Mean Years)	Education Level				
						HS	Assoc	Bach	MA	DR
Florida	Treatment	Frontline	97	2.63	7.34	1.0%		84.5%	14.4%	
		Supervisor	41	2.90	9.59		2.4%	87.8%	9.8%	
	Control	Frontline	30	2.70	6.97	0.4%	6.7%	63.6%	26.9%	0.4%
		Supervisor	4	0.75	12.75		2.6%	63.2%	33.3%	
Illinois	Front-line		618	4.00	7.00	32.4%	12.8%	45.4%	8.4%	
	Supervisor		187	5.03	10.95	7.5%	9.1%	52.4%	29.4%	1.1%
Missouri	Private Providers	Frontline	193	1.95	6.50		3.6%	50.3%	43.0%	
		Supervisor	71	2.61	9.46			19.7%	80.3%	
	Public Agency	Frontline	253	3.36	6.09	3.3%		80.0%	13.3%	3.3%
		Supervisor	114	4.83	11.00			100%		
Note: Combined Baseline, Time 1, and Time 2 Samples										

Staff Knowledge of PBC Goals and Client Outcomes

Given the importance of performance-based outcomes on daily practice, this section describes the extent to which agency staff members understand and are aware of the performance measures contained in the contracts. There were no significant differences over time in the awareness of evaluated outcomes.



Staff members were then asked the extent to which they believed that the performance outcomes selected were appropriate. A significant difference in the percent saying “yes” was noted in Florida front-line staff from Baseline to Time 1 ($p < .005$).



Regarding the child/family performance outcomes, the third question was “*How are these outcomes articulated to you?*” Significant changes in the response rates within sites over time are denoted by subscripts in the table below.

Question 6. Percentage of Staff Who Have Received Outcome Information By Method										
How Outcomes Are Articulated	Position	Florida			Illinois			Missouri		
		Baseline	Time1	Time2	Baseline	Time1	Time2	Baseline	Time1	Time 2
Written documentation	Front-line	76.9%	90.9%	75%	64.7%	71.3%	67.2%	85.7%	68.8%	78.5%
	Supervisors	75%	90.9%	88.9%	72.9%	75%	69.2%	71.4%	83.3%	88.9%
Communication by agency leadership	Front-line	65.4% _a	84.8% _b	66.7% _b	44.2%	47.2%	48.4%	100%	65.6%	75.3%
	Supervisors	83.3%	100%	88.9%	66.7%	62.5%	63.5%	71.4% _a	96.7% _b	88.9%
Formal training	Front-line	71.2%	84.8%	66.7%	55%	50.6%	51.6%	57.1%	53.8%	60.2%
	Supervisors	58.3% _a	63.6% _a	72.2% _b	44.8%	45%	44.2%	78.6%	60%	55.6%
Discussions with Supervisor	Front-line	76.9%	87.9%	75%	64.3%	65.7%	60.9%	100%	77.4%	77.4%
	Supervisors	75%	81.8%	72.2%	64.6%	60%	71.2%	100%	80%	92.6%
Discussions in staff meetings	Front-line	75% _a	93.9% _b	75%	84.7%	86.5%	87%	100%	81.7%	91.4%
	Supervisors	83.3%	100%	83.3%	84.4%	85%	80.8%	85.7%	96.7%	100%

Usage of written documentation and discussions with supervisors did not change over the course of the intervention, according to the front-line workers and supervisors in all the sites.

In Florida, we see the most fluctuation in the use of other information dissemination methods over the course of the intervention. Front-line workers in Florida showed significant changes in the levels of communication by agency leadership from Baseline to Time 1 ($p < .041$) and to Time 2 ($p < .046$). The number reporting discussions in staff meetings also increased significantly from Baseline to Time 1 ($p < .022$). The proportion of supervisors in Florida reporting the use of formal training also increased significantly both from Baseline to Time 2 ($p < .015$) and from Time 1 to Time 2 ($p < .031$). It is important to note that some of the changes

in numbers for Time 2 in Florida appear to be large; however, those changes did not display significance due to large drops in the sample size for Time 2 in Florida.

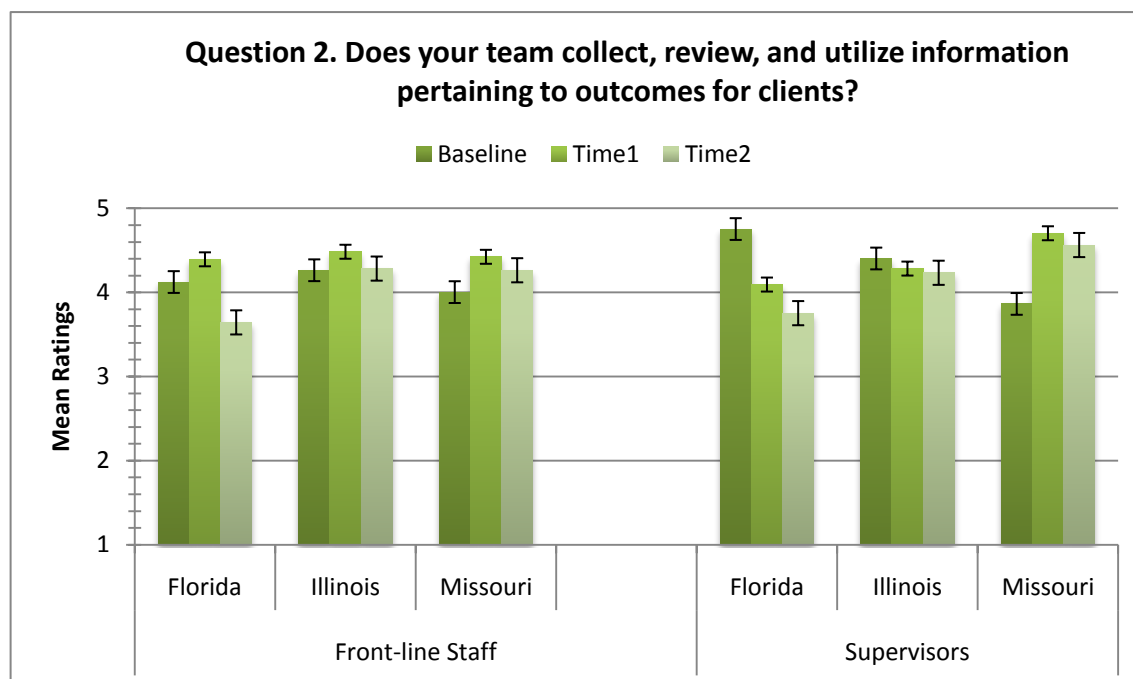
Supervisors in Missouri reported a greater use of communication by agency leadership from Baseline to Time 1 which was significant, as well ($p < .029$).

Quick Summary: Staff Knowledge of PBC Goals & Client Outcomes

- Staff members were generally knowledgeable of the outcomes used in their agency's evaluation and there was little change over time for this measure. From 80 to 100% of participants reported awareness of these outcomes.
- Overall, it appears that front-line workers and supervisors agreed that the selected performance measures were appropriate for evaluation purposes.
- Sites used a variety of ways to communicate these performance measures to staff and in some cases, these methods increased over time for Illinois and Florida.

Using Evidence to Inform Practice: Performance and Supervision

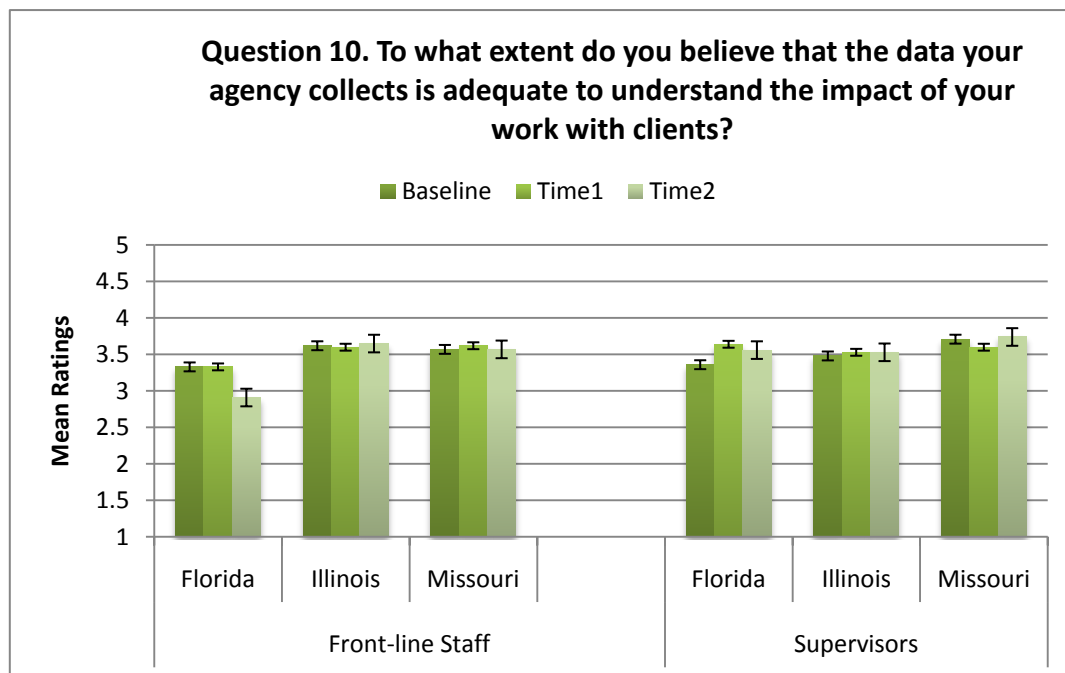
The next set of items was designed to better understand the extent to which agency staff used data and discussions about performance within their daily practice. Again, each item question is shown at the top of each graph.



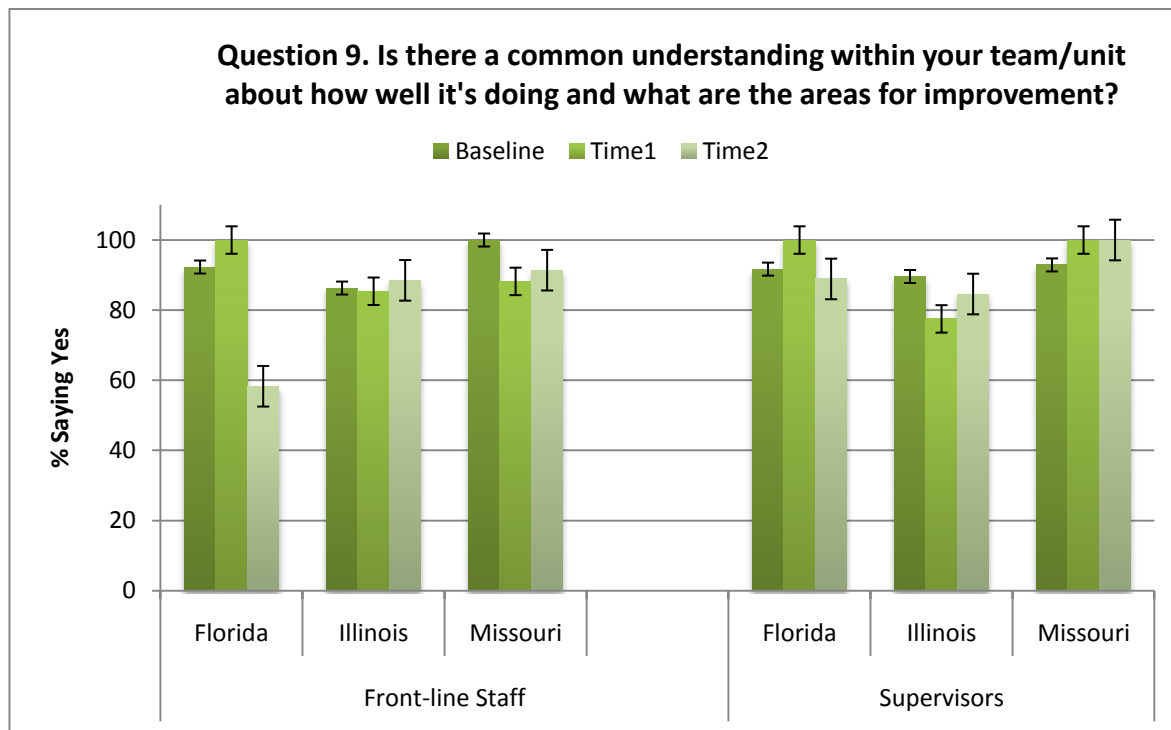
For question 2, responses ranged from 1 (Never) to 5 (Always). Among frontline workers, a significant and positive change in responses was observed in Illinois from Baseline to Time 1 ($p < .020$). However, a significant, negative change in responses occurred from Time 1 to Time 2 ($p < .046$) in Illinois. In Florida, the drop in response ratings among the frontline workers approached significance ($p < .065$); however, it is likely that a decrease in the sample size from Time 1 to Time 2 may have impacted that analysis.

Among supervisors, a significant, negative change in responses was observed in Florida from Baseline to Time 1 ($p < .008$) and again from Time 1 to Time 2 ($p < .001$). Significant, positive change was observed in the responses from Missouri supervisors from Baseline to Time 1 ($p < .000$) and overall from Baseline to Time 2 ($p < .002$).

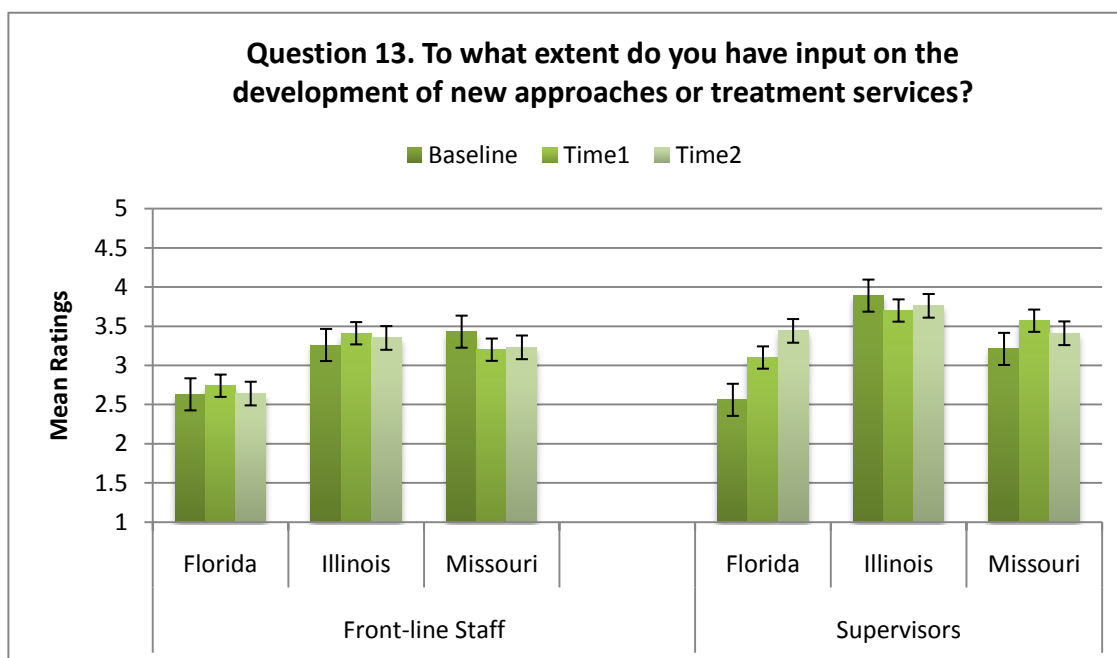
For question 10, responses ranged from 1 (Not at all) to 5 (Very much). Analysis showed no significant changes over time in any site.



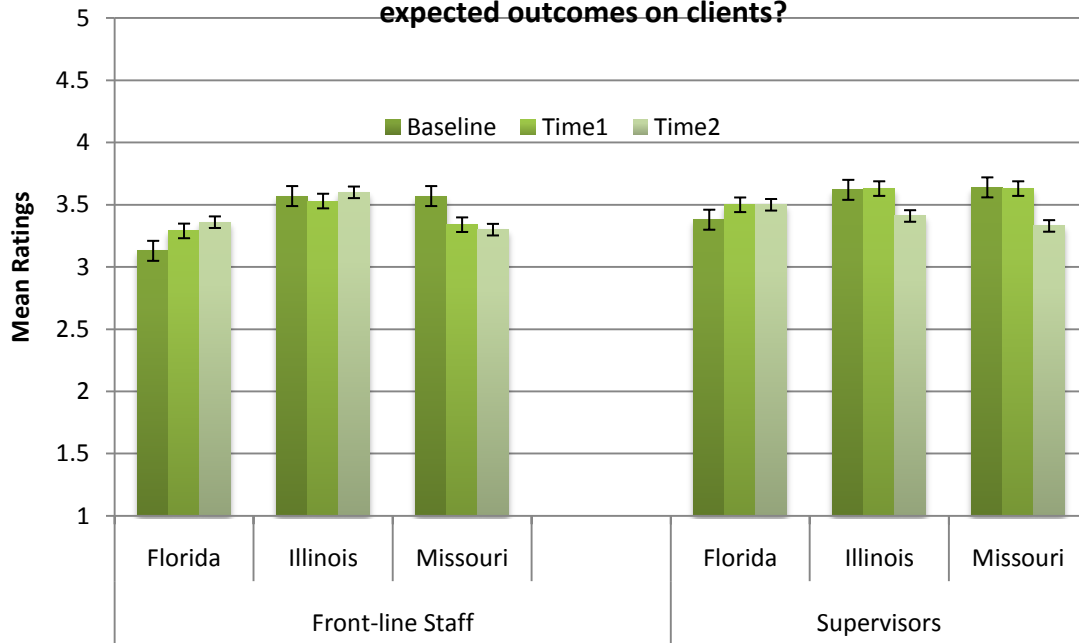
However, the responses for Question 9 did change significantly in the negative direction for Florida frontline workers and Illinois supervisors. In Florida, the responses at Time 2 were significantly lower than Baseline ($p < .003$) and Time 1 ($p < .002$). In Illinois, the responses among supervisors changed significantly from Baseline to Time 1 ($p < .007$). As shown in the following graph, responses ranged from 1 (Not at all) to 5 (Very much).



For the next two questions which asked about new and innovative services or approaches, there were no significant changes over time for Questions 13 and 14 in any site. Responses ranged from 1 (Not at all) to 5 (Very much) and were mostly centered around the midpoint of the scale.



Question 14. When new treatment service or approaches to work with children/youth/families are implemented, does your agency assess whether these new services and approaches are having expected outcomes on clients?



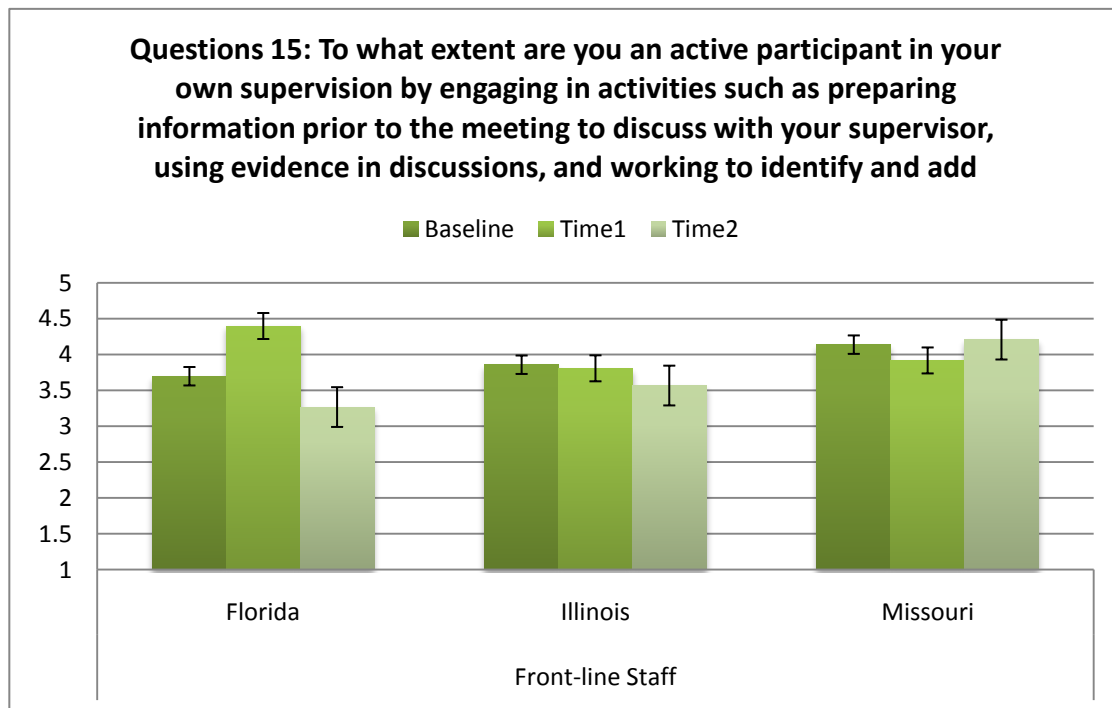
Quick Summary: Use of Evidence and Performance Data

- Participants indicated that their teams were generally likely to gather data pertaining to client outcomes. However, they also reported that the data agencies collected was only somewhat likely to reflect the work they do with clients.
- Overall, both frontline workers and supervisors appear aware of their team's performance with about 88% reporting an understanding of how well their team/unit is doing.
- Most respondents reported that new services and practice were only moderately assessed to determine if they were effective for improving outcomes.
- For the most part, both front-line workers and supervisors reported low to moderate levels of input into new approaches and treatment services for their agencies.
- Significant changes in responses varied among the groups analyzed and were not consistent across sites or agency position.

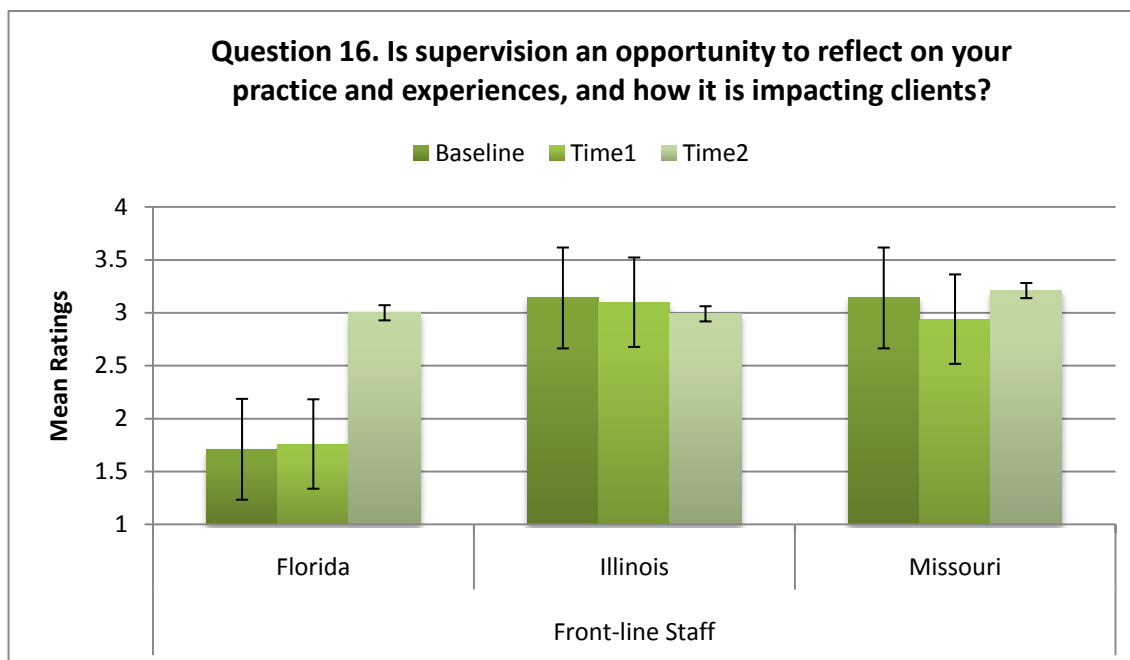
Front-line practice and supervision

The next series of questions focused on the responses of front-line case managers with regard to their own supervision.

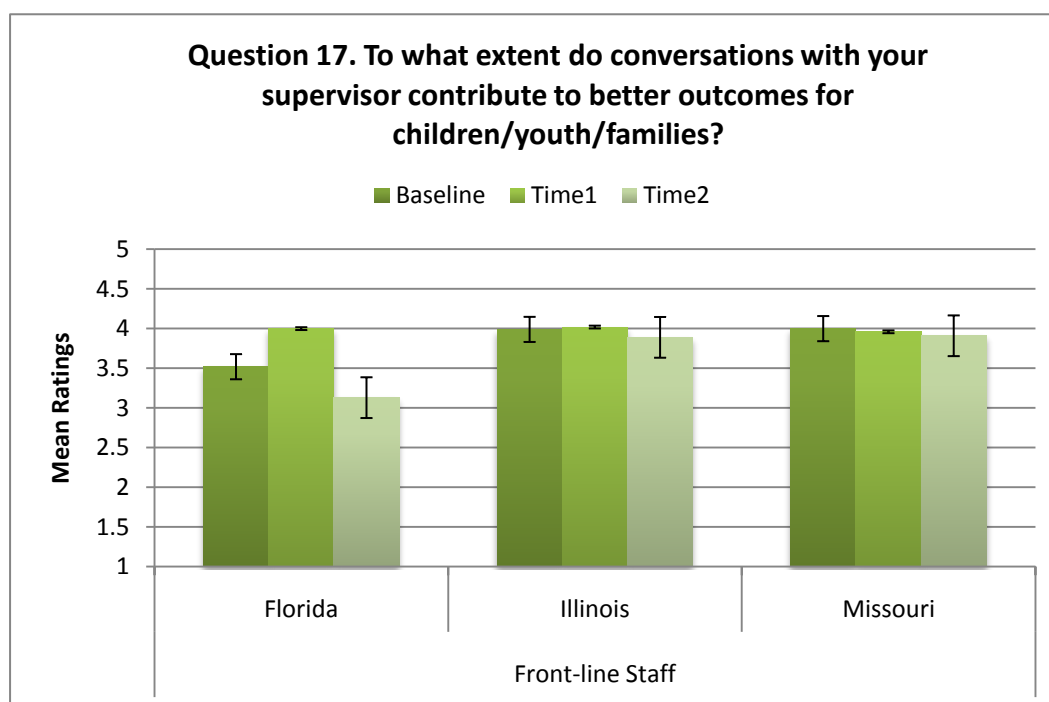
Question 15 responses ranged from 1 (Not at all) to 5 (Very active). While Missouri's responses remained steady, both Florida and Illinois showed significant changes in their responses. A positive significant change was seen in Florida from Baseline to Time 1 ($p < .002$); however, this change was negative from Time 1 to Time 2 ($p < .000$).



Responses for Question 16 ranged from 1 (Never) to 4 (Always). No significant changes in responses were seen in Illinois or Missouri. However, in Florida, perceptions at Time 2 increased significantly from Baseline ($p < .000$) and Time 1 ($p < .000$).

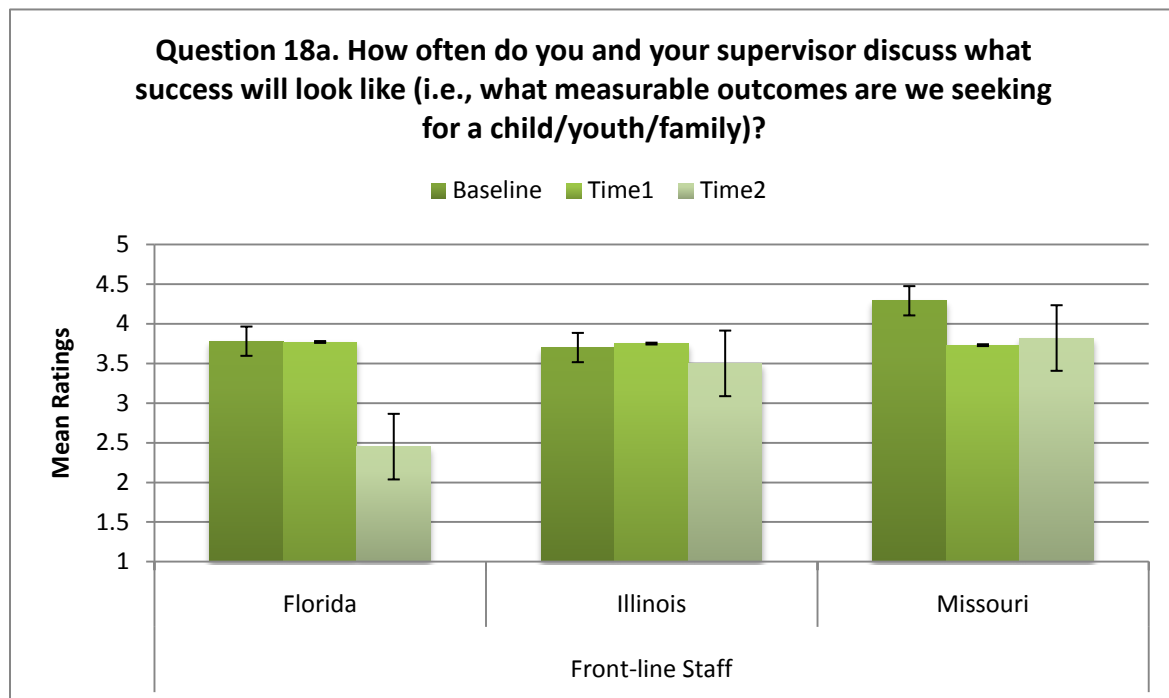


Question 17 responses ranged from 1 (Not at all) to 5 (Very much). Only one instance of significant change was observed in Florida from Time 1 to Time 2 ($p < .032$). Front-line staff perceived that conversations with supervisors were less likely to contribute to outcomes at Time 2.



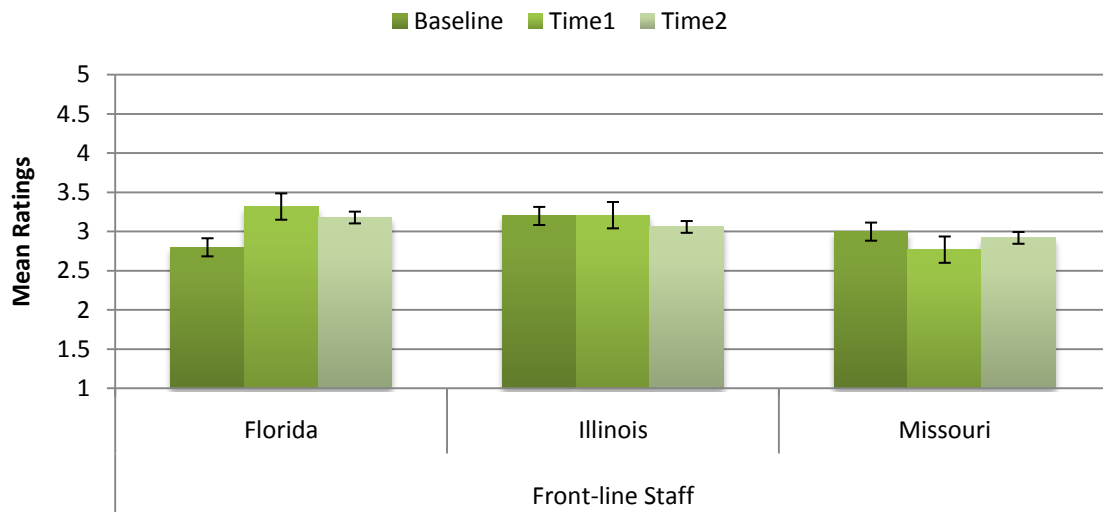
The next series of questions focused on the content of discussions between front-line workers and their supervisors. These questions were only directed toward the front-line workers. Responses ranged from 1 (Never) to 5 (Very often).

For Question 18a, a significant change in responses was found for Florida and Illinois. As is apparent in the graph, Time 2 responses in Florida showed a negative change from Baseline ($p < .000$) and Time 1 ($p < .000$). However, not so evident in the graph was the negative change in Time 2 responses in Illinois from Baseline ($p < .028$) and Time 1 ($p < .014$) as well.

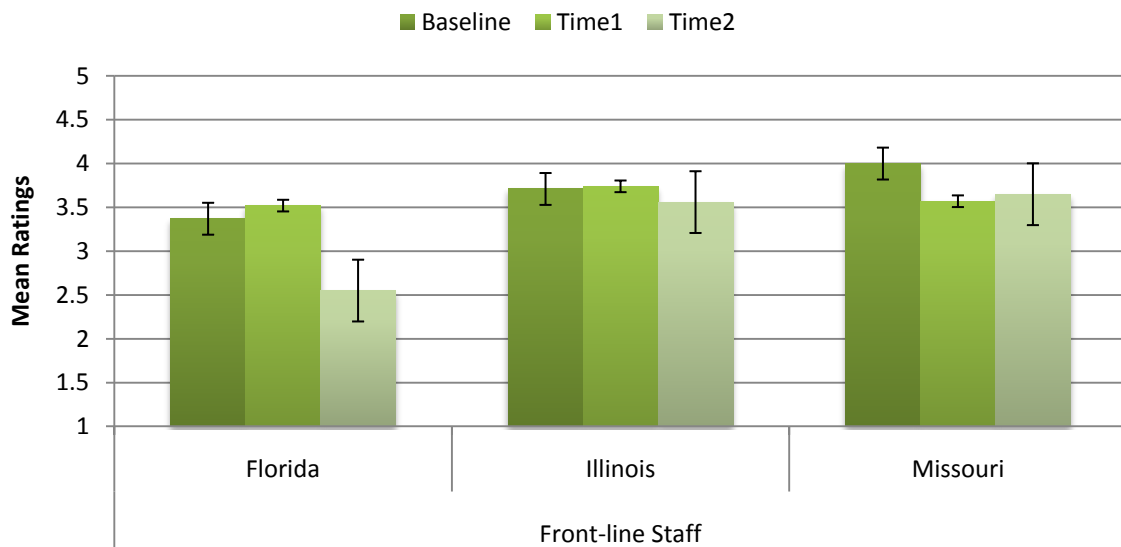


No significant changes were detected in the responses for Question 18b. However, a significant, negative change was detected in Florida in the responses for Question 18c. Both Baseline ($p < .023$) and Time 1 ($p < .011$) responses different significantly from Time 2 responses. No significant changes in responses were observed for any of the sites in Questions 18d and 18e.

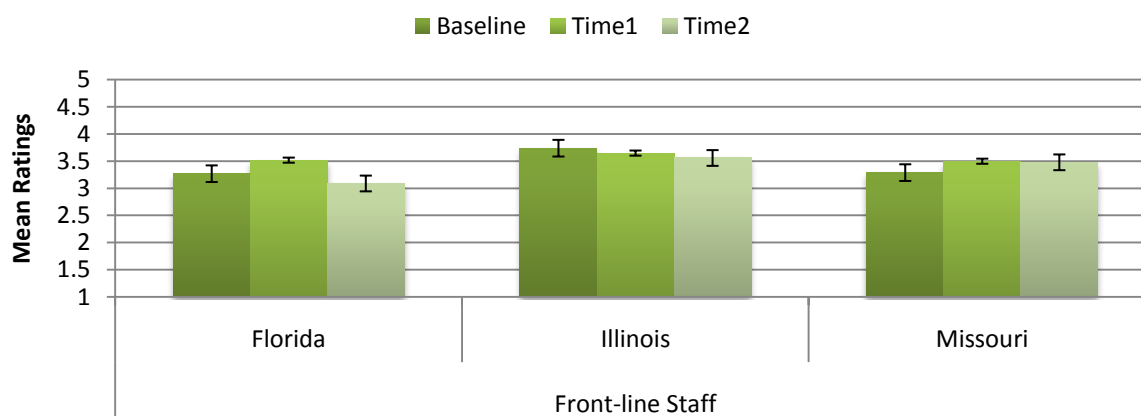
Question 18b. How often do you and your supervisor discuss what research tells us is most likely to work for someone in this situation?



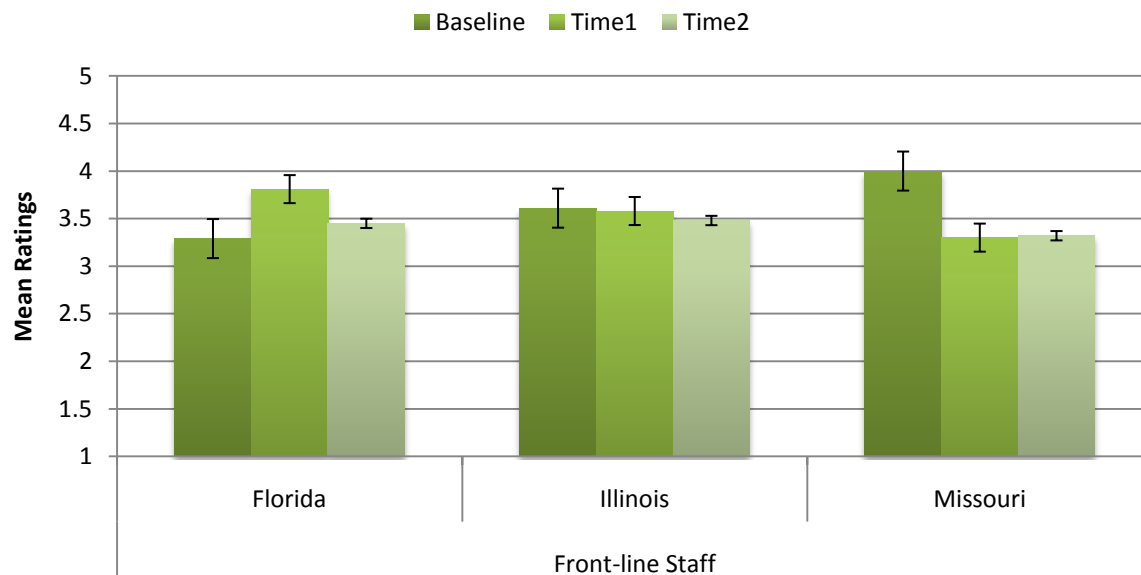
Question 18c. How often do you and your supervisor discuss which of the alternative courses of action is likely to be more effective, and how you will know?



Question 18d. How often do you and your supervisor discuss what evidence we have about what clients want or find helpful in these situations?



Question 18e. How often do you and your supervisor discuss what your team's performance data tells you that may help you improve your practice with clients?



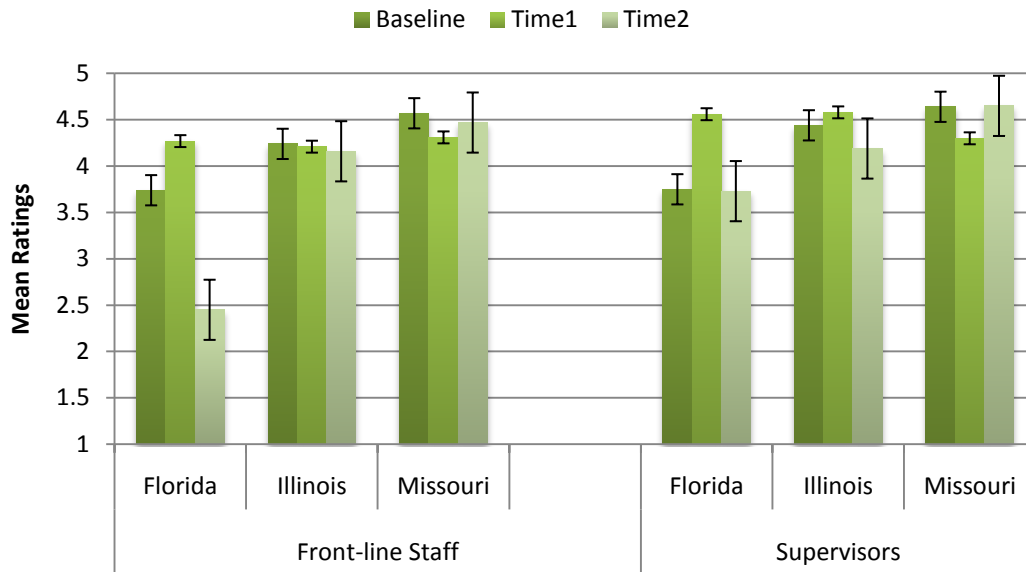
Quick Summary: Perceptions by Front-Line Staff About Supervision

- Overall, front-line workers reported moderate levels of active involvement and discussion during supervision.
- Front-line workers reported that supervision time was usually used to reflect on practice and experiences; however, this trend was not observed in Florida until the 3rd observation period (Time 2).
- Generally, front-line workers viewed their conversations with their supervisors as a component of achieving improved outcomes for their clients.
- Generally, front-line workers showed moderate involvement in supervisory activities for all areas assessed.
- Florida demonstrated the greatest variability in these measures over time, which was significant at times.

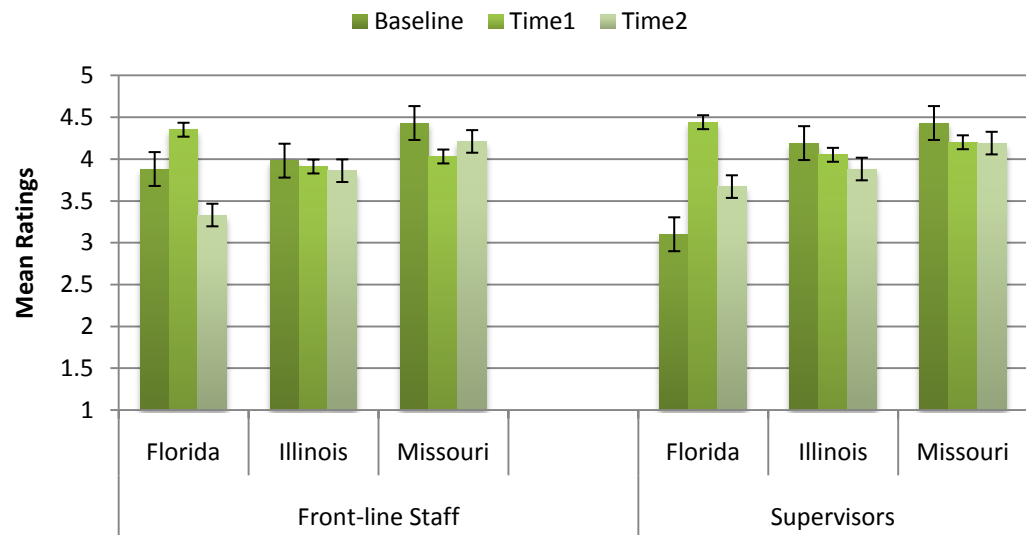
For questions 19, both front-line staff and supervisors were asked to consider how they interacted with their immediate supervisors. Florida front-line workers showed a significant decrease in their ratings in comfort discussing new approaches with supervisors from Baseline to Time 2 ($p < .001$), as well as, from Time 1 to Time 2 ($p < .000$). There were no significant differences in supervisor perceptions.

Florida was the only site to show significant change for Question 20 as well. Front-line workers' ratings declined significantly from Time 1 to Time 2 ($p < .003$). Supervisors' ratings increased significantly from Baseline to Time 1 ($p < .001$); however, the ratings declined back to Baseline levels at Time 2 ($p < .044$).

Question 19. How comfortable do you feel discussing new approaches for case planning with your supervisor?



Question 20. How comfortable do you feel discussing case planning with your supervisor when you disagree with the best course of action with children/youth/families?



Supervisory practice

To complement perceptions of front-line workers' perceptions of supervision, supervisors were asked to respond to a series of questions asking to what extent they used a variety of methods and approaches to guide their front-line workers' practice.

Question 21. Percent of Supervisors Who Employ Each Method									
Questions	Florida			Illinois			Missouri		
	Base line	Time 1	Time 2	Base line	Time 1	Time 2	Base line	Time 1	Time 2
Do you use data evidence or reports to guide your worker's practice?	100%	81.8%	83.3 %	69.8%	65%	63.5%	0% _a	90% _b	88.9% _b
Do you use research findings to guide your worker's practice?	66.7%	72.7%	61.1%	54.2%	47.5%	57.7%	0%	63.3%	55.6%
Do you role play or model client scenarios to guide your worker's practice?	50%	45.5%	44.4%	86.5%	85%	76.9%	0%	70%	66.7%
Does your supervision session include a clear set of expectations and objectives to guide your worker's practice?	100%	81.8%	77.8%	89.6%	92.5%	84.6%	0% _a	90%	100% _b
Do you feel comfortable challenging current practice with research-based ideas?	66.7%	63.6%	66.7%	82.3%	80%	80.8%	0% _a	83.3%	92.6% _b

The supervisors in Florida and Illinois reported no changes in the use of these methods and approaches as they supervised front-line workers across the course of the implementation of PBC. Only in Missouri is a significant change observed over time in the use of some of the methods; however, it is important to note that the Baseline sample size was of 1 or 2 supervisors. The significant jumps in the use of certain methods from Baseline is likely due to the fact that more supervisors participated in the surveys at Time 1 and Time 2, providing a more accurate portrayal of the practices of supervisors in Missouri.

A significant increase in use of evidence or reports among Missouri supervisors was seen from Baseline to Time 1 ($p < .020$) and to Time 2 ($p < .016$). Supervisors also reported an increase in using a clear set of expectations and objectives from Baseline to Time 2 ($p < .036$). Finally, Missouri supervisors significantly increased their report of feeling comfortable challenging current practice from Baseline to Time 2 ($p < .047$).

Quick Summary: Supervisor Practice

- Overall, supervisors used all of the practices equally. An average of 78% reported using each of these activities to guide worker's practice.
- No clear patterns emerged in the use of each method over time with supervisors indicating both increased and decreased use depending on the approach.

Team Work to Improve Client Outcomes

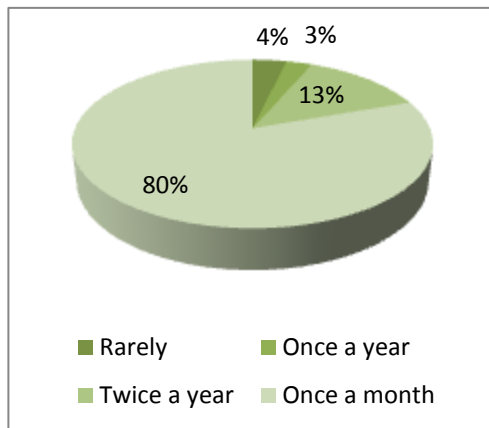
Several items were included to capture the extent to which staff believed that their work teams are a part of the goal setting and decisions making process while working within a PBC/QA context. These questions also speak to the collaborative environment at the front-line and supervisor level.

Team Function and Practice

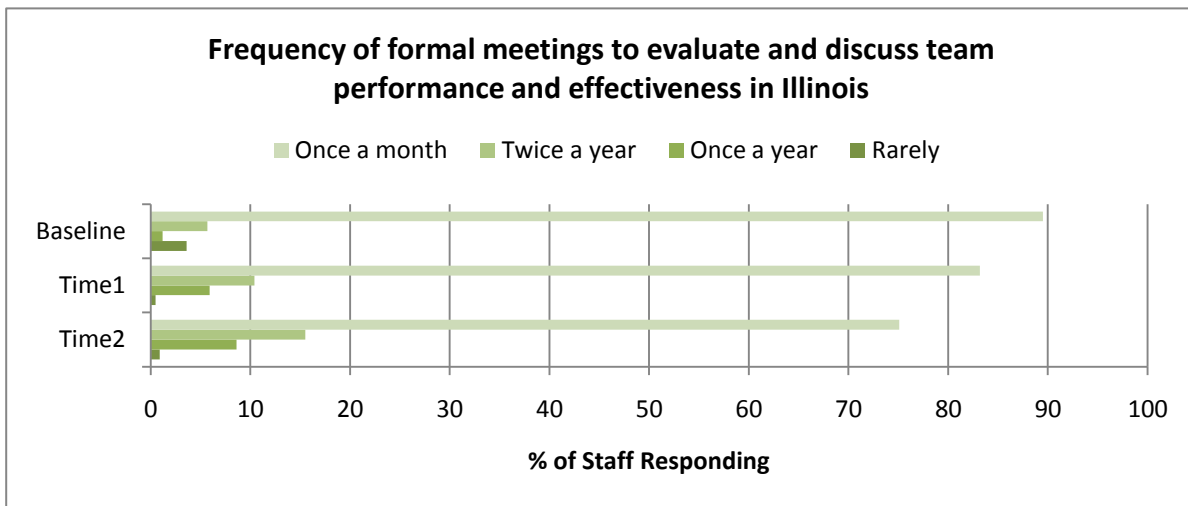
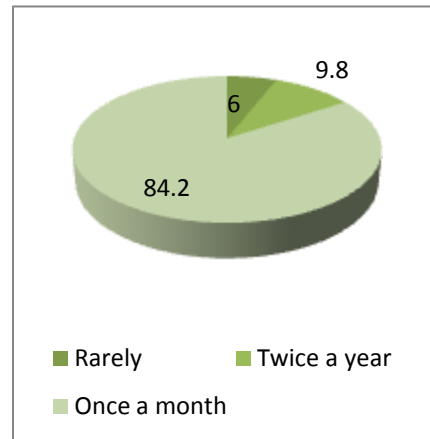
All staff members were asked to respond to two related questions. The first was: "How often does the team formally come together to evaluate its effectiveness and to reflect on overall team performance and team well-being?" Overall, the timing of meetings remained steady for both Missouri and Florida throughout the course of the intervention and are reflected in the following Pie Charts. However, the timing of meetings in Illinois differed significantly from Baseline to Time 2 ($p < .002$) as reports of once-a-month meetings decreased and bi-annual meetings increased. This data is shown on a separate graph to display the information.

Question 8a: Frequency of formal meetings to evaluate and discuss team performance

Missouri



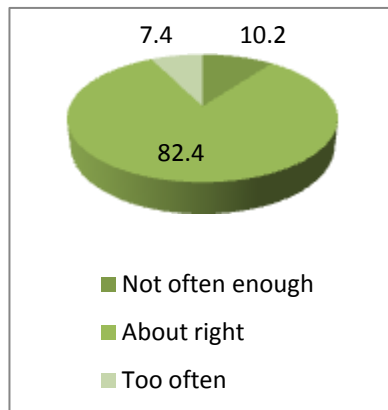
Florida



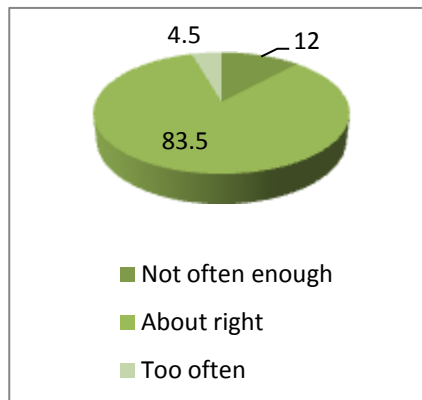
The follow-up question asked the extent to which staff believed that the frequency of this level of interaction was sufficient. There were no significant differences in the responses over the course of the intervention. So, the average responses for the three sites are provided below.

Question 8b: Is the frequency of meetings sufficient?

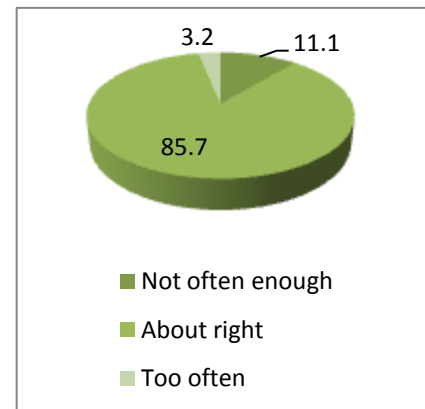
Missouri



Florida



Illinois



Quick Summary: Team Function and Practice

- The **majority of front-line workers and supervisors reported that team meetings occurred once a month**, with the next largest group reporting team meetings twice a year.
- The majority of staff believed the frequency in meetings was “about right” with a little more believing this amount was “Not often enough” rather than “too often”.

The next series of questions asked staff members to reflect on the **content of team discussions in terms of their daily practice with clients**. Response means are provided in the table below. Responses ranged from 1 (Never) to 5 (Very often); so, a higher mean indicates a greater use of that method. Significant changes in responses are denoted by the subscripts.

Question 11. How Often Does Your Team Discuss the Following in Terms of What It Might Mean for Your Work with Clients?

Topics discussed	Staff	Florida			Illinois			Missouri		
		Baseline	Time1	Time2	Baseline	Time1	Time2	Baseline	Time1	Time2
Quality assurance reports	Front-line	3.72	3.68	4.00	3.32	3.32	3.23	4.00	3.43	3.55
	Supervisors	3.58	3.70	3.53	3.46	3.38	3.09	3.57	3.53	3.85
Reports on the team's meeting practice standards	Front-line	4.06 _a	4.23 _a	3.55 _b	3.79	3.71	3.67	4.43	3.76	3.96
	Supervisors	4.17	4.40	3.88	3.74	3.45	3.65	3.79	3.70	4.07
Reports on the team's performance in meeting client outcomes	Front-line	3.74	4.09	3.54	3.83	3.85	3.73	4.29	3.67	3.90
	Supervisors	3.75	4.00	3.68	3.69	3.83	3.58	3.79	3.90	4.00
Peer Case Reviews	Front-line	2.94	3.03	3.55	3.42	3.53	3.39	3.71	3.42 _a	3.77 _b
	Supervisors	3.17	3.20	3.19	3.46	3.46	3.15	3.64	3.60	3.74
Local performance information/tables giving data for all teams	Front-line	3.55	3.87	3.55	2.95	2.98	2.83	3.29	3.27	3.27
	Supervisors	3.67	4.10	3.75	2.99	3.03	2.89	3.00 _a	3.00 _a	3.67 _b
State performance information/tables giving data for all teams	Front-line	3.18	3.32	2.91	2.72	2.81	2.55	3.00	3.14	3.05
	Supervisors	2.83 _a	3.90 _b	3.44	2.74	2.70	2.68	2.92	3.13	3.29
Research on what improves outcomes for children and/or families	Front-line	3.00	3.45	3.10	3.14	3.20	3.08	2.71	3.09	3.18
	Supervisors	2.92	3.30	3.31	2.97	2.88	2.72	3.29	3.37	3.11
How we should work with children and/or families in order to achieve identified outcomes	Front-line	3.44	3.90	3.73	3.78	3.87	3.67	3.71	3.57	3.87
	Supervisors	3.83	4.00	3.94	3.72	3.93	3.65	4.14	3.90	3.85

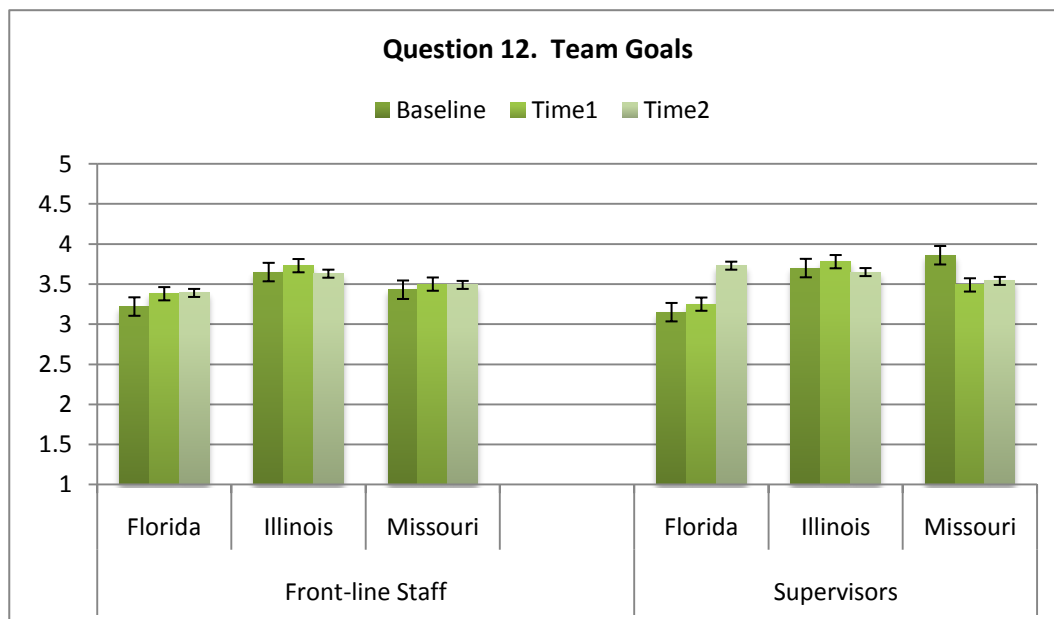
Among the three sites, there was not significant change in the discussion of quality assurance reports, reports on the team's performance in meeting client outcomes, research on what improves outcomes for children and/or families, and how we should work with children and/or families in order to achieve identified outcomes.

Illinois also showed no significant changes in the content of discussions over the course of the intervention. However, significant changes were observed for Florida and Missouri. Florida front-line workers reported less use of reports on the team's performance meeting practice standards from Baseline to Time 1 ($p < .048$) and to Time 2 ($p < .014$). Florida supervisors significantly increased their report of using state performance information from Baseline to Time 1 ($p < .004$). Missouri front-line workers increase their report of using peer case reviews from Time 1 to Time 2 ($p < .015$). And, Missouri supervisors reported a significant increase in using local performance information from Baseline to Time 2 ($p < .019$) and from Time 1 to Time 2 ($p < .004$).

Team Goals

A subscale of Team Goals was created to capture how involved staff teams were in working together on PBC/QA goals. On a 5-point Likert scale, respondents indicated level of agreement with each item (1=strongly disagree; 5=strongly agree).

Demonstrating high reliability (Cronbach α range across sites = .82 to .89), four items were included in this subscale: *"As a member of the team, we have an opportunity to participate in the goal setting process"; "As a member of the team, decision making and control are given to employees doing the actual work."*, *"As a member of the team, we seem to be working toward the same goals."*; and *"As a member of the team, work groups are actively involved in making work processes more effective."*



Analysis of variance analyses revealed no significant change in the elements related to team goals throughout the duration of the project within the sites.

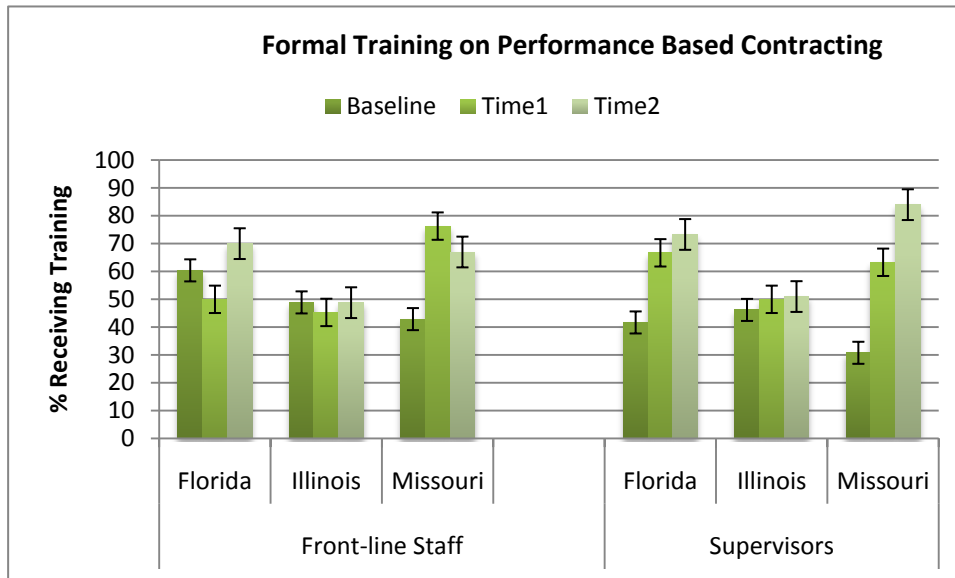
Quick Summary: Team Work Towards Goals

- Overall, staff members moderately agreed about the level of involvement their teams had in the overall process of establishing and meeting larger performance goals.
- There was little variability in these responses over time.

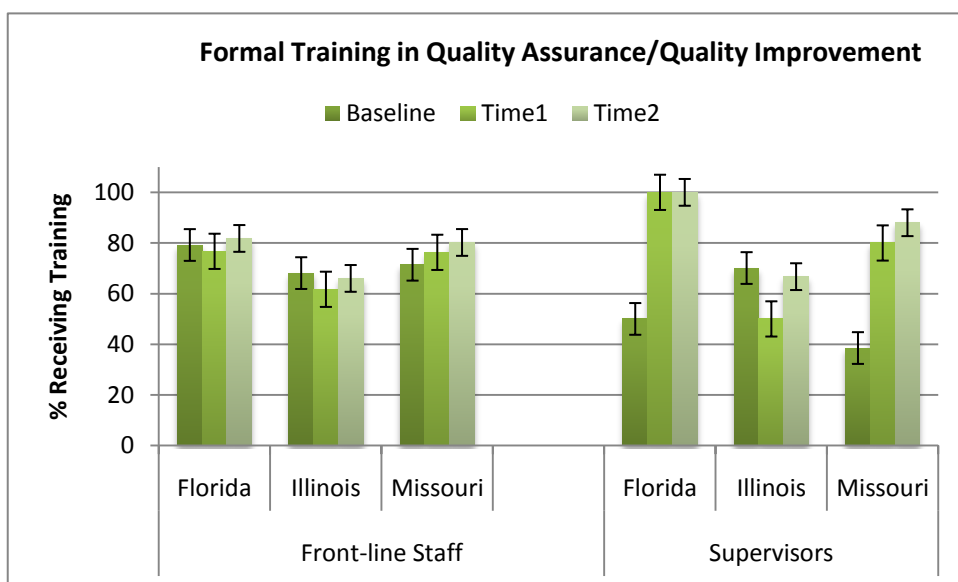
Training for Front-Line and Supervisors

The project team and sites believed that some elements of staff training and supervision may be necessary components of a successful PBC/QA system. To that end, several questions within the *Staff Training and Supervision Survey* are particularly relevant. As noted previously, staff perceptions of PBC outcomes and goals may indicate how well the collaborative planning process and environment facilitates and encourages front-line and supervisor buy-in. Similarly, this evaluation also seeks to identify whether staff training related to PBC/QA is necessary to support the performance goals and client outcomes and how that training evolves over time.

The following charts shows the percentage of front line and supervisors who indicated they had received formal training on the use of performance-based contracts and the quality assurance/continuous quality improvement activities of their agencies. There was no significant change in the proportion of workers receiving training with the exception of Missouri supervisors which approached significance from Baseline to Time 1 with a p-value of 0.051 and was significantly different from Baseline to Time 2 ($p < .002$).



The percentage of supervisors receiving training in Quality Assurance/Quality Improvement activities shifted dramatically over the duration of the PBC while the percentage of front-line workers remained consistent. The proportion receiving training increased significantly from Baseline to Time 1 in both Florida ($p < .017$) and Missouri ($p < .014$). As this number remained the same or increased for Time 2, the difference from Baseline to Time 2 was significant as well for Florida ($p < .004$) and Missouri ($p < .003$). A significant decrease in the proportion receiving training was seen in Illinois from Baseline to Time 1 ($p < .026$).



Quick Summary: Staff PBC/QA Training

- Collapsed across all sites, a greater proportion of staff members had received training in Quality Assurance practices (67%) than in Performance Based Contracts (53%).
- Levels of formal training in Quality Assurance/Quality Improvement among supervisors showed the most change over time across all three sites.

Satisfaction with and Usefulness of PBC/QA Training

Staff members who received PBC and QA training were asked follow-up questions regarding their satisfaction with the trainings and the extent to which they used lessons from those trainings in daily practice. Responses ranged from 1 (Not at all) to 5 (Very much). Response means are provided in the tables below with significant differences in the findings denoted by subscripts.

Question 23. Mean Ratings of Training on Performance Based Contracting										
Questions	Staff	Florida			Illinois			Missouri		
		B	T1	T2	B	T1	T2	B	T1	T2
How satisfied were you with the training provided?	Front-line	3.42	3.76	5.00	3.78	3.57	3.71	4.33	3.41	3.21
	Supervisors	4.00	3.80	4.10	3.44	3.45	3.40	3.50	3.47	3.40
Have you used any of the ideas or materials from the training?	Front-line	3.47	3.38	5.00	3.85	3.59	3.61	4.00	3.22	3.11
	Supervisors	4.00	3.80	4.30	3.34	3.45	3.08	3.25	3.68	3.21
If so, how useful were they?	Front-line	3.47	3.50	5.00	3.80	3.66	3.51	3.67	3.30	3.16
	Supervisors	3.75	4.00	4.00	3.23	3.50	3.25	3.25	3.68	3.21
Have you recommended or discussed them with your team mates?	Front-line	3.28	3.63	4.00	3.73	3.58	3.36	4.00	3.00	2.93
	Supervisors	3.75	3.60	3.90	3.45	3.85	3.32	2.75	3.53	3.21

Have you discussed them with your supervisor?	Front-line	3.33	3.38	4.00	3.65	3.59	3.28	3.33	2.99	2.93
	Supervisors	3.33	3.75	4.10	3.28	3.95	3.52	3.25	3.84	3.21
Do you expect to use these materials in the future?	Front-line	3.68	3.54	5.00	3.87	3.72	3.55	3.67	3.32	3.04
	Supervisors	3.66	4.00	4.20	3.53	3.68	3.40	2.75	3.58	3.32

No significant differences in the ratings of PBC trainings were observed over time within each of the sites involved. And, regarding the ratings of the Quality Assurance trainings, only the Illinois front-line workers showed a significant decrease from Baseline to Time 1 ($p < .033$) and to Time 2 ($p < .042$) in discussing training ideas or materials with supervisors.

Question 25. Mean Ratings of Training on Quality Assurance										
Questions	Staff	Florida			Illinois			Missouri		
		B	T1	T2	B	T1	T2	B	T1	T2
How satisfied were you with the training provided?	Front-line	3.42	3.67	3.20	3.83	3.61	3.69	3.60	3.32	3.22
	Supervisors	3.00	3.71	3.92	3.42	3.39	3.15	3.80	3.43	3.43
Have you used any of the ideas or materials from the training?	Front-line	3.42	3.44	3.00	3.68	3.55	3.42	3.25	3.19	3.05
	Supervisors	3.00	3.86	3.67	3.38	3.44	3.12	3.40	3.32	3.24
If so, how useful were they?	Front-line	3.46	3.44	3.00	3.72	3.61	3.52	3.25	3.17	3.16
	Supervisors	3.00	3.86	3.92	3.48	3.28	3.08	3.20	3.32	3.33
Have you recommended or discussed them with your team mates?	Front-line	3.17	2.88	2.60	3.56	3.29	3.44	3.75	3.00	2.85
	Supervisors	3.33	4.00	3.58	3.32	3.61	3.19	3.20	3.32	3.38
Have you discussed them	Front-line	3.13	3.06	2.40	3.54 _a	3.18 _b	3.21 _b	3.75	3.03	2.97

with your supervisor?	Supervisors	3.20	4.00	3.42	3.32	3.67	3.15	2.80	3.29	3.29
Do you expect to use these materials in the future?	Front-line	3.33	3.44	2.80	3.72	3.58	3.49	3.75	3.19	3.12
	Supervisors	3.17	3.86	3.83	3.63	3.56	3.37	3.80	3.41	3.33

Quick Summary: Staff PBC/QA Training

- Responses concerning the usefulness and expected benefit of the training showed no clear pattern of results with the majority of respondents reporting moderately on all items.
- Similarly, the results were equivocal on whether there was improvement over time; in some cases, respondents reported an increase in the usefulness and satisfaction with the training, while in other cases, there was a decrease over time.
- Overall, differences in ratings over time were not overwhelmingly significant.

Barriers to Using PBC/QA Training

In order to better understand information about the training staff members received in PBC/QA, several items were developed to identify the barriers to using this training in everyday practice. Two items asked respondents to select the factors that prevented them from using the PBC/QA training they had received.

The following tables rank order the number of barriers selected within each site by front-line workers and supervisors. The proportion of staff selecting those barriers is provided, as well. Those surveyed did not rank every barrier, they simply selected the barriers they acknowledge in their practice. Furthermore, not everyone receiving training acknowledged that any of these barriers poses a problem for them. Hence, conducting comparison analyses over time was difficult due to very low sample sizes. Overall, there were no remarkable changes in the barriers recognized in the use of training in every day practice.

Question 24. Top Three Barriers to Using PBC Training		
Front-Line Staff		
Florida	Illinois	Missouri
Rank Order	Rank Order	Rank Order
I already use similar strategies from other sources (20.6%)	I already use similar strategies from other sources (13.8%)	Lack of time (21.8%)
Lack of time (5.2%)	Lack of time (12.8%)	I already use similar strategies from other sources (14%)
My agency does not have the resources to use them (4.1%)	I do not feel properly trained to use them (7.5%)	I do not feel properly trained to use them (5.2%)
Supervisors		
Florida	Illinois	Missouri
Rank Order	Rank Order	Rank Order
Lack of time (22%)	Lack of time (17.9%)	Lack of time (18.3%)
I already use similar strategies from other sources (22%)	I already use similar strategies from other sources (13.9%)	I already use similar strategies from other sources (11.3%)
My agency does not have the resources to use them (2.4%)	I do not feel properly trained to use them (12.7%)	My agency does not have the resources to use them (7%)
I do not feel properly trained to use them (2.4%)		
Question 26. Top Three Barriers to Using QA Training		
Front-Line Staff		
Florida	Illinois	Missouri
Rank Order	Rank Order	Rank Order
I already use similar strategies from other sources (16.5%)	I already use similar strategies from other sources (11.5%)	Lack of time (14%)
Lack of time (6.2%)	Lack of time (10.9%)	I already use similar strategies from other sources (10.9%)
My agency does not have the resources to use them (3.1%)	I do not feel properly trained to use them (5.6%)	Strategies/materials are difficult to use (3.1%)
Strategies/materials are difficult to use (3.1%)		Strategies/materials do not comply with agency's

		philosophy (3.1%)
Supervisors		
Florida	Illinois	Missouri
Rank Order	Rank Order	Rank Order
Lack of time (22%)	Lack of time (14.7%)	Lack of time (12.7%)
I already use similar strategies from other sources (12.2%)	I already use similar strategies from other sources (11.2%)	I already use similar strategies from other sources (9.9%)
I do not feel properly trained to use them (4.9%)	I do not feel properly trained to use them (8.8%)	I do not feel properly trained to use them (5.6%)

Quick Summary: Perceived Barriers to Using PBC/QA Training

- Overall, the majority of staff members reported that a lack of time and the use of similar strategies as the main reasons for not using training in PBC/QA.
- This information can be used in each site to review their training procedures and content to further develop and refine their approaches to introducing staff members to the concepts and practices related to PBC/QA.

General Service Training

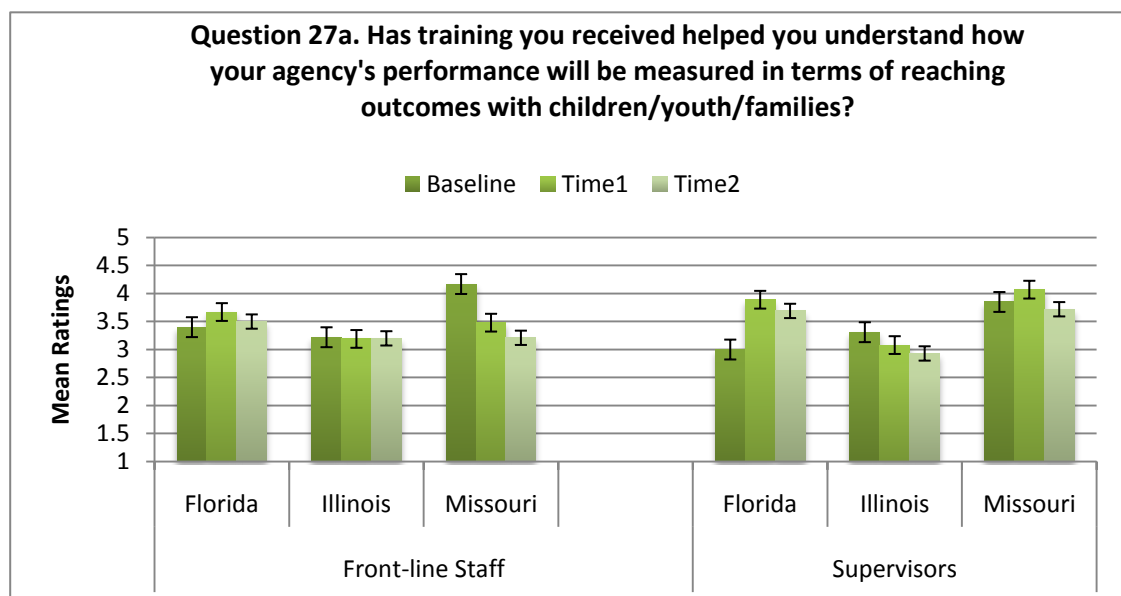
Front-line workers and supervisors were also asked if they received formal training in a number of other areas relevant to their practice. The following table shows the proportions of participants reporting that they have received training in each area. Significant changes in the proportion of workers receiving training across the three time points are marked by the subscripts.

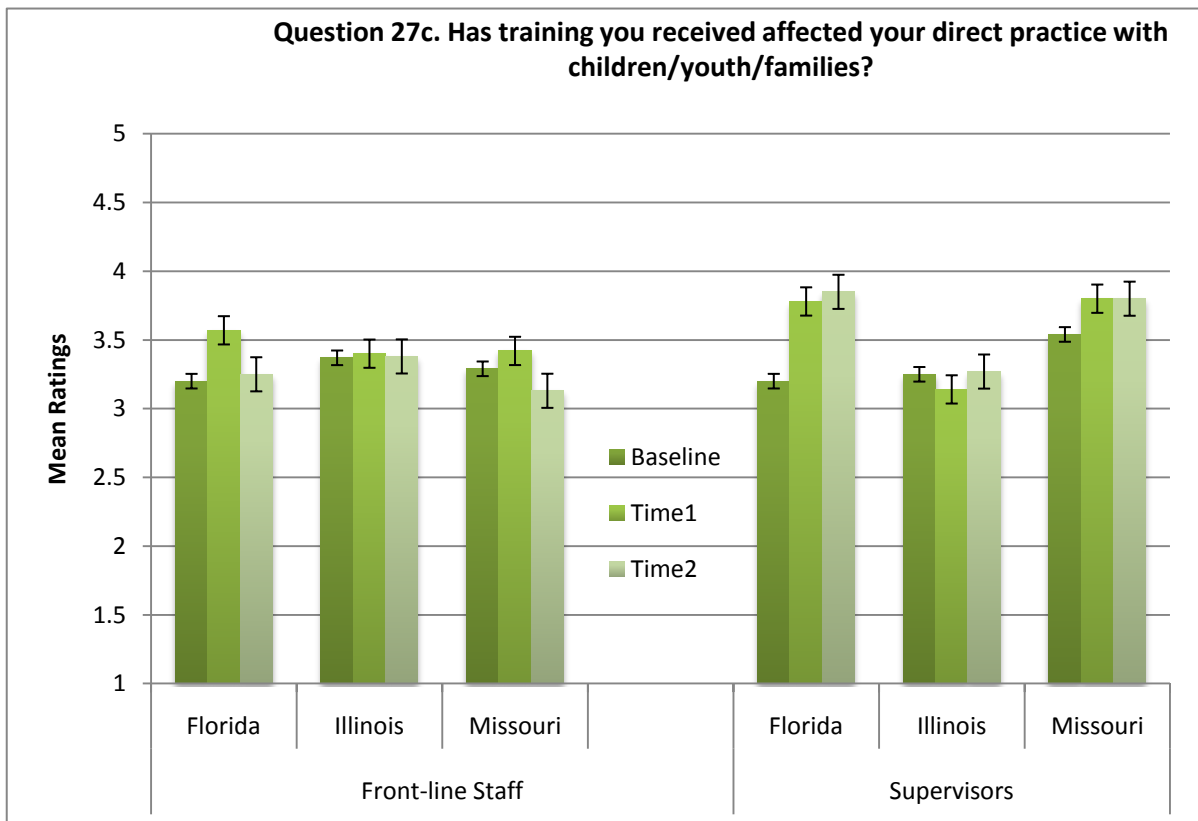
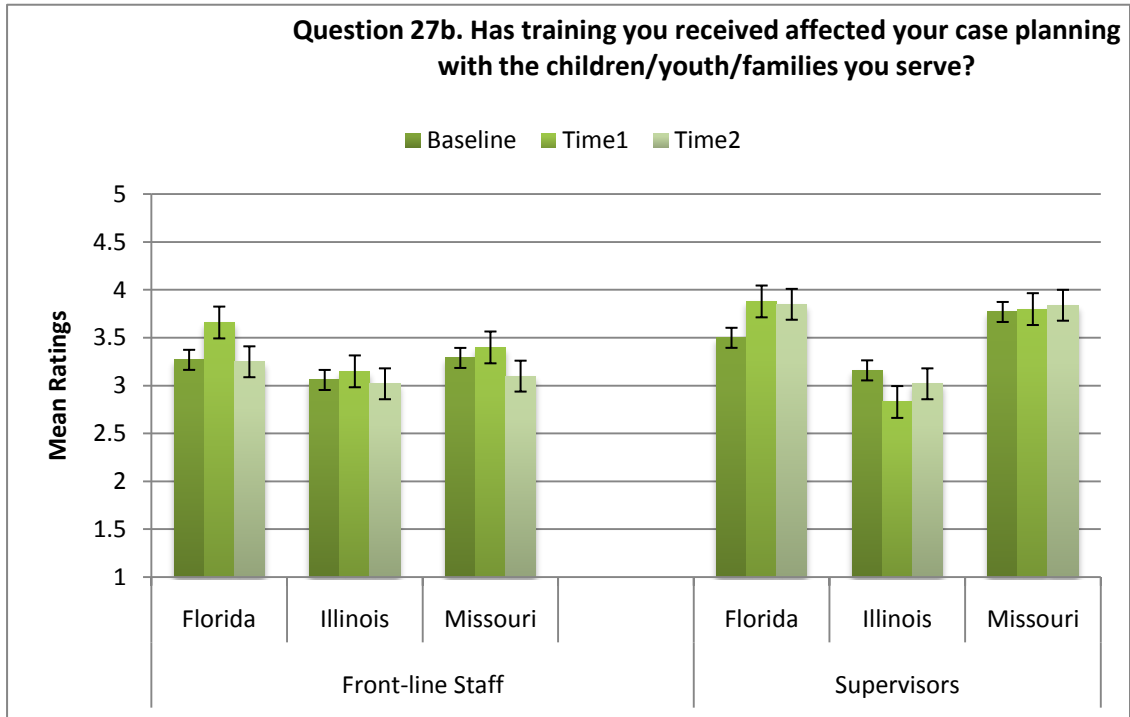
Question 22. Have you received formal training in these areas?										
Training Topic	Staff	Florida			Illinois			Missouri		
		B	T1	T2	B	T1	T2	B	T1	T2
Gathering evidence to	Front-line	70.8	76.7	63.6	59.2	61	62.7	42.9	67.4	69

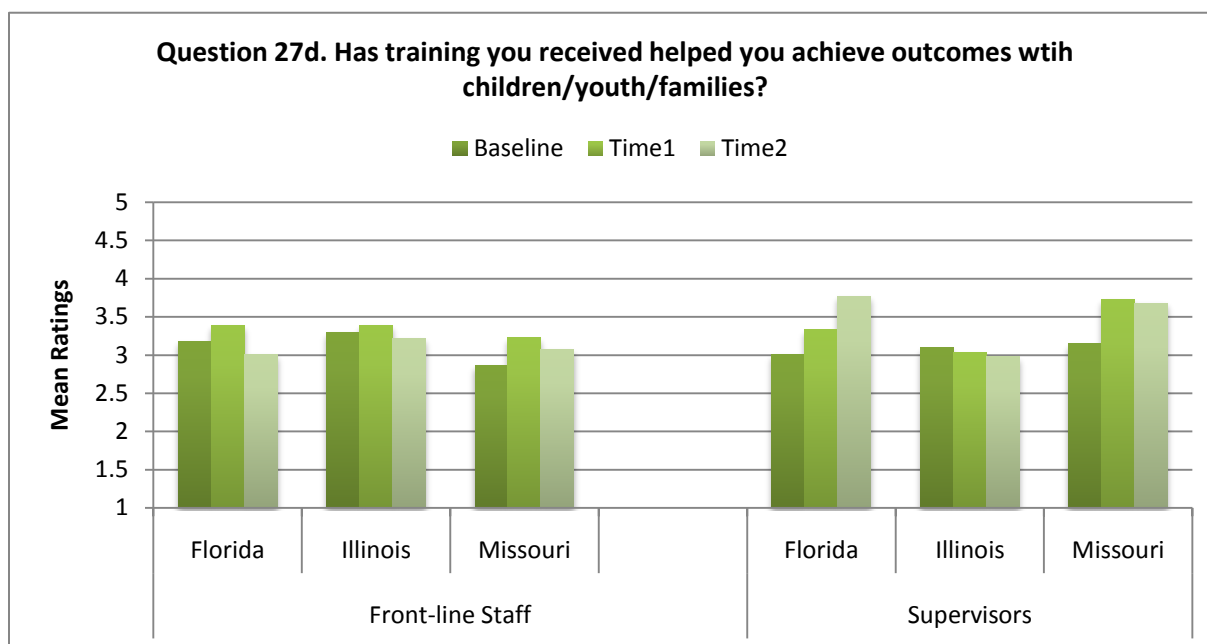
inform your practice and decisions	Super	66.7	66.7	92.9	61.6	48.6	61.4	53.8	60	80.8
Conducting literature searches	Front-line	26.9	30.3	8.3	21.3	28.7	22.9	14.3	16.1 _a	25.8 _b
	Super	8.3	18.2	11.1	16.7	15	21.2	14.3	23.3	22.2
Knowing where to find information about effective interventions	Front-line	59.6	73.3 _a	36.4 _b	60.5	62	63.6	0 _a	45.1 _b	56.3 _b
	Super	33.3 _a	77.8	85.7 _b	56.8	40.5	54.5	46.2	50	52
Using the internet to access reliable, high quality information to inform your work	Front-line	61.7	70	36.4	36 _a	45.3 _b	45.7 _b	53.8	50	80
	Super	33.3 _a	77.8	85.7 _b	48.1	43.2	50	28.6	60.4 _a	65 _b
Knowing the most useful websites in the field	Front-line	42.9 _s	56.5 _b	54.0	52.1	76.7	45.5	28.0	32.3	32.1
	Super	53.8	50.0	61.5	41.7	77.8	78.6	33.7	34.2	35.6
Checking the soundness of research findings	Front-line	0 _s	18.3 _s	20.7 _b	27.1	36.7	0	22.3	24.4	27.3
	Super	7.7	26.7	15.4	8.3	33.3	42.9	14.0	13.2	23.9
Applying/interpreting research findings in another context	Front-line	0 _a	20.4 _a	30.2 _b	34.0 _a	33.3	0 _b	25.5	33.3	34.6
	Super	15.4	30.0	26.9	33.3	44.4	50.0	20.9	21.1	28.9
Understanding national	Front-line	57.1	44.1	39.1	58.3 _a	50.0	54.4 _b	28.5	31.6	37.3

and local performance indicators	Super	38.5 _a	63.3	57.7 _b	33.3	66.7	78.6	22.4	28.9	26.1
Conducting your own research or program evaluations	Front-line	14.3	21.5	28.2	29.2 _a	23.3 _b	27.3	23.5	35.3	29.8
	Super	0	24.1	26.9	33.3	11.1	42.9	32.1 _a	23.7	23.9 _b
Knowing relevant findings and practice applications from research in the field	Front-line	28.6	38.7	42.4	45.8	53.3	36.4	36.8	36.1	38.8
	Super	46.2 _a	37.9	50.0 _b	25.0	55.6	71.4	31.8	23.7	28.9

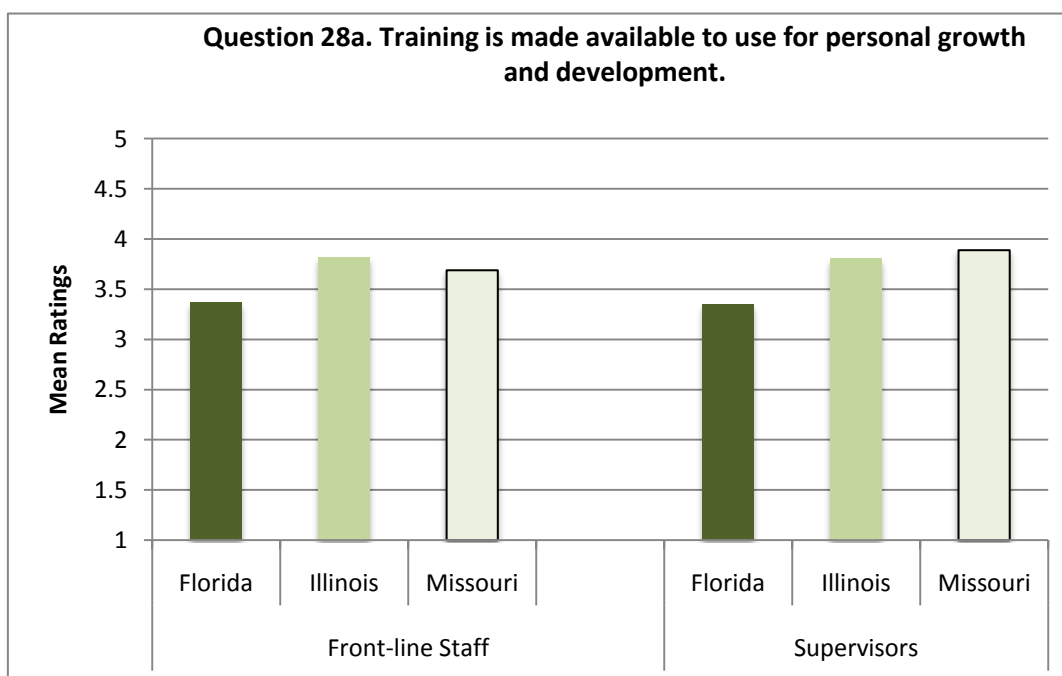
The front-line workers and supervisors were also assessed on their perceptions of the helpfulness and impact of general training on their practice delivery and outcomes. The following graphs depict their ratings on the trainings as it impacted different areas of their work. The participants' responses ranged from "Not at all" to "Very much". The only significant change in responses was seen in Missouri front-line workers for Question 27a. Their mean ratings declined significantly to Time 2 from Baseline ($p < .013$) and from Time 1 ($p < .047$). No significance changes over time were seen in the responses for Questions 27b-d.



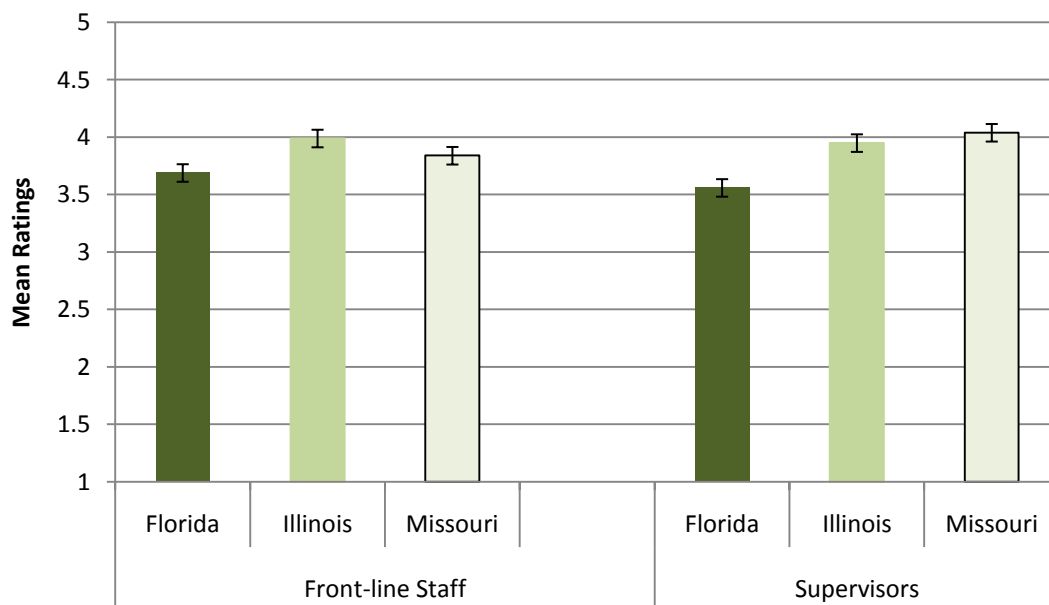




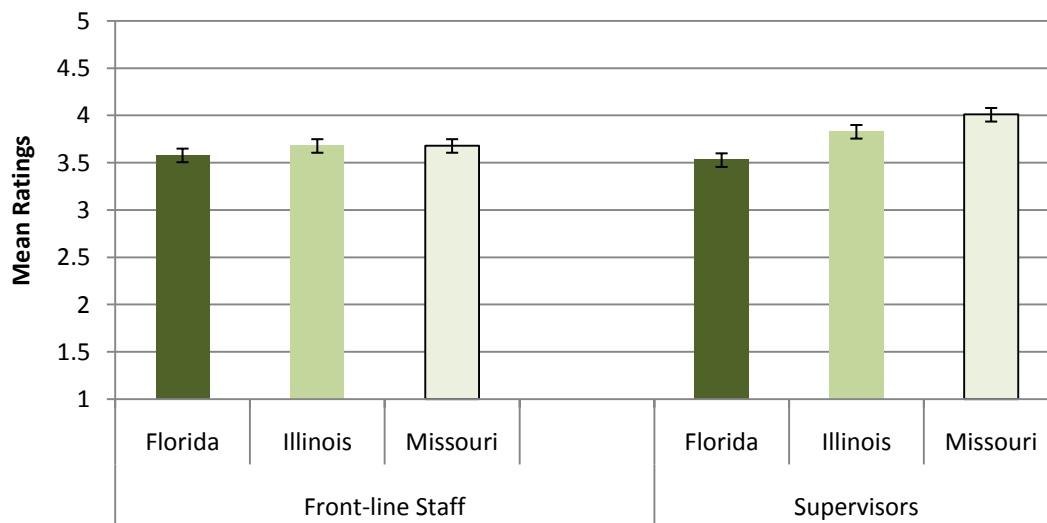
The overall ability of this service training was also assessed among front-line workers and supervisors. As there was no change in responses in any of the sites across time, the mean response in each site across all time points is provided in the following graphs. Responses ranged from 1 (Strongly Disagree) to 5 (Strongly Agree).



Question 28b. Training is made available to us so that we can do our jobs better.



Question 28c. We have access to information about job opportunities, conferences, workshops, and training.



Staff Retention

In developing the *Staff Training and Supervision Survey*, the team and sites believed that a critical component of PBC/QA was the effect of staff-turnover. This may affect the success of PBC/QA in achieving contract performance goals and client outcomes.

To that end, the cross-site team included a sub-scale within the survey to measure the staff intent to remain employed (Ellett & Ellett, 2003). This 10-item measure was scored on a 5-point Likert type scale (1=strongly disagree; 5= strongly agree) with higher numbers indicating a greater intent to remain employed. Examples of the types of items found in this survey include: *“I intend to remain in child welfare/residential services as a long-term professional career”*; *I am actively seeking other employment outside the field of child welfare/residential services”*; *I am committed to working in child welfare / residential services even though it can be quite stressful at time”*; and so forth.

Given the small sample size, a factor analysis was not conducted and the entire scale was used as one conceptual measure. Reliability for this survey was high across all respondents (Cronbach’s alpha = .81) and thus, an overall mean for the entire scale was calculated. The following table presents those means.

Personal Perspectives Regarding Employment in Child Welfare									
Staff	Florida			Illinois			Missouri		
	Baseline	Time1	Time2	Baseline	Time1	Time2	Baseline	Time1	Time2
Front-line	3.35	3.39	3.25	3.48	3.57	3.53	3.73 _a	3.17 _a	2.97 _b
Super	3.57	3.82	3.60	3.53	3.62	3.64	3.51 _{ab}	3.65 _a	3.20 _b

Analysis of variance tests revealed no changes in this measure in Florida or Illinois. However, significant effects were observed for Missouri in both the front-line workers and supervisors. Means decreased significantly for front-line workers over the course of the entire implementation of PBC from Baseline to Time 2 ($p < .009$). A significant, negative change in means was also evident from Time 1 to Time 2 ($p < .040$). Supervisors showed a negative change in their responses from Time 1 to Time 2 as well ($p < .002$).

Quick Summary: Staff Intent to Remain Employed at Baseline
<ul style="list-style-type: none"> Overall, all staff members reported moderate levels of agreement that they intended to remain employed in child welfare/residential services. Missouri’s front-line workers and supervisors responded that they were less likely to want to remain in their job over the course of the project.

VII. Research Question 3: When operating under a performance-based contract, are the child, family and system outcomes produced by private contractors better than those produced under the previous contracting system?

As previously outlined in the analysis plan, measuring the impact of a system-level initiative requires a methodological approach that takes into account the variability within and across sites. Each site is measuring the impact of PBCs on outcomes in their local evaluations and the analyses in those reports show a more detailed discussion of site-specific impact. For the cross-site evaluation, the team has developed two main methods of measuring performance under PBC: *Performance over Time* and *Achieving Contractual Targets on Outcomes*. Each begins to address the question of whether outcomes have improved under the interventions initiated in each site. Results presented here are based on a cross-site analysis that combines data within each site for an overall picture of findings on all outcomes over time.

In order to conduct cross-site analyses, several important considerations must be made to ensure that a rigorous evaluation of impact is made and limitations are acknowledged.

Standardizing Measurement

One key imperative for evaluating performance in this cross-site evaluation is the need to identify the appropriate type of performance and then standardize measurement across sites. In other words, the methods selected for how to measure performance must be independent of what is being measured. Given that what is being measured in each site varies and there is no consistent outcome across sites, it is critical that the cross-site evaluation analyze performance using a standardized measurement methodology to capture overall changes in performance regardless of what performance indicator is being used in each site. This allows the cross-site evaluation to determine if outcomes improve over time under the PBC intervention. That is, the analyses the team will conduct will be able to show whether performance under PBC improved over time which is a meaningful finding to measure the overall impact of the intervention.

Levels of Analysis

It is also important to attempt to utilize the same unit of agency measurement in these analyses. In other words, whenever possible and the data is available, the team will analyze outcomes at the individual private agency level. Unfortunately, only two sites are able

to provide agency-level outcome data (Florida, Illinois); the other site (Missouri) is able to provide consortia-level outcome data.

In Missouri, a number of individual private agencies comprise a single consortium of providers and there are seven consortiums operating under PBC. Thus, it must be acknowledged that the level of analysis will not be similar across sites. However, this difference is not expected to negatively affect the interpretation of overall performance under PBC. That is, the methods selected for analyzing this data are sufficiently robust to detect change over time in performance regardless of the level of analysis. If anything, the unit of analysis (consortium) in Missouri is a combination of individual level agency units; the variance of those units can dilute overall consortium performance. In other words, any changes detected in consortia performance suggests that the intervention is sufficiently strong to produce effects at this higher-level of analysis.

Each site has selected two to four contract outcomes for measuring performance. Depending upon the analysis, outcome data will be combined and aggregated over indicators. In other words, for some analyses, data from all of the indicators a site has selected for their contract performance measures will be combined together to present an overall picture of agency performance in a site. For site-specific analyses

The time period for which data on indicators is collected influences the level of analyses. Each site has selected different PBC models which collect, monitor, and track performance at different points in time. Depending upon the model selected, contract incentives are awarded on a monthly, annual, or other point in time basis. Thus, some sites tabulate outcomes on an annual basis (IL, MO) while others track outcomes on a monthly basis (FL). For site specific analyses, the cross-site team will use the time unit selected by the individual sites, while for the cross-site summary, all performance data will be translated into an annualized unit of time.

Because this cross-site evaluation focused on changes in the system during the course of the QIC funding, complete data from all sites was available for only two years – 2008 (Project Year 1) and 2009 (Project Year 2). Although it is difficult to demonstrate sustained performance with only two data points, data obtained provide a glimpse at the possible trend in performance over time. Additional post-QIC data would be beneficial in better assessing whether the PBC/QA and system improvements initiated under the QIC would be sustained over time.

Comparison Groups

As discussed in the analysis plan, not every site has an appropriate comparison group design that will allow for testing whether private agency outcomes are better under PBC compared to public or private agency outcomes not under the PBC intervention. These analyses focus only on private contractor or provider performance; no public agency

data is included in the cross-site analysis because all three sites were not comparing public vs private agency performance. Missouri was the only site in which public agency performance was available. Thus, caution should be used when interpreting the results beyond what the data and design are able to provide.

Child-level Outcomes

Traditional child welfare outcomes of permanency, safety, and well-being are differentially emphasized in the sites involved in this project. For Missouri and Florida where the PBCs focus is on foster care case management, these outcomes are both incentivized (MO) and the intended long-term outcomes (FL). However, in Illinois, the focus of PBC is on residential care of older youth and the traditional child welfare outcomes are less relevant than in the other sites due to the population and associated goals of care. Thus, examining child outcomes at the cross-site level of analysis will not be done. Rather, child outcomes will be examined at the site-specific level.

Thus, caution is warranted when interpreting the data as it will be impossible to conclude that PBC causes better outcomes for children. Given the complex interaction of contextual variables and the lack of a true randomized design, the results will at minimum be able to describe the relationship or association between PBC services and outcomes for children. It would be erroneous to attribute any differences in child outcomes *solely* to PBC in any of the sites. This limitation must be acknowledged while interpreting the results.

B. Performance Over Time

For this set of analyses, the cross-site team analyzed overall raw change in performance over time. Specifically, the first set of analysis tested whether performance on the measures included in performance-based contracts increased or decreased over time. The other analysis examined the size of the change in performance over time to help show how incentivized outcomes under PBC may have influenced performance positively or negatively. For the cross-site analysis, all data will be combined to chart overall private agency performance from the beginning of the intervention and throughout the project. This set of analyses answers the following questions:

- Are agencies improving their performance on outcomes over time?
- Does performance plateau over time; when do agencies reach optimal performance?

Methodology

The cross-site team gathered agency or consortium-level performance data on the contract performance measures. In all cases, the sites were able to provide monthly or

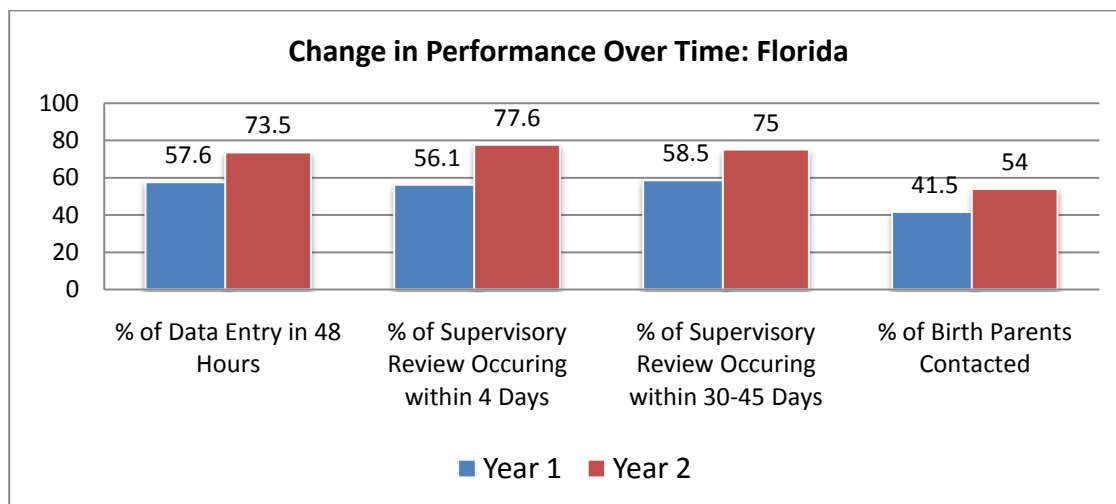
annual performance data on each of their contract outcomes. Analyses were conducted at both the site-specific and cross-site level. There are two types of pure performance analyses that will be taken and each approach presents the data in a different way to round out the picture of performance on PBC contract measures across sites.

Performance Trends Over Time

This approach plots outcome data over time to show the relative increase or decrease in agency performance over time. The cross-site team will combine data from all sites and show the trend line for all outcomes on an annual basis for each year of the project. This trend line will present the aggregate performance data and demonstrate whether performance under PBC across sites showed an overall increase, decrease, or neutral level of improvement over the course of this project.

Florida

As can be seen in the following graph, the private CMAs improved their performance on all outcomes from Project Year 1 to Project Year 2. Aggregated across all CMAs, the data indicates that the percentage of workers who entered data in 48 hours increased, the percentage of supervisory reviews occurring within 4 days and again at 30-45 days increased, and that the percentage of biological parents who were contacted increased. Thus, the trend over time shows that performance outcomes included in CMA contracts improved in Florida.

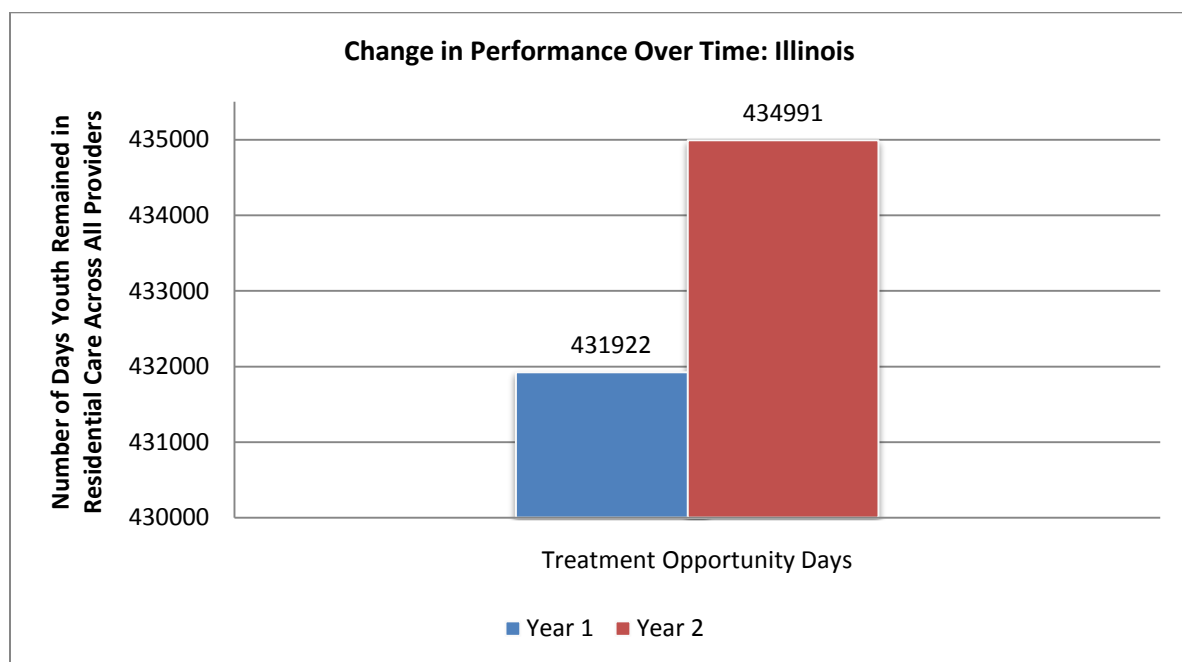


Illinois

Illinois had two different outcomes in their contracts, each on a different scale. As noted in previous sections, Treatment Opportunity Days is an aggregate number of days across

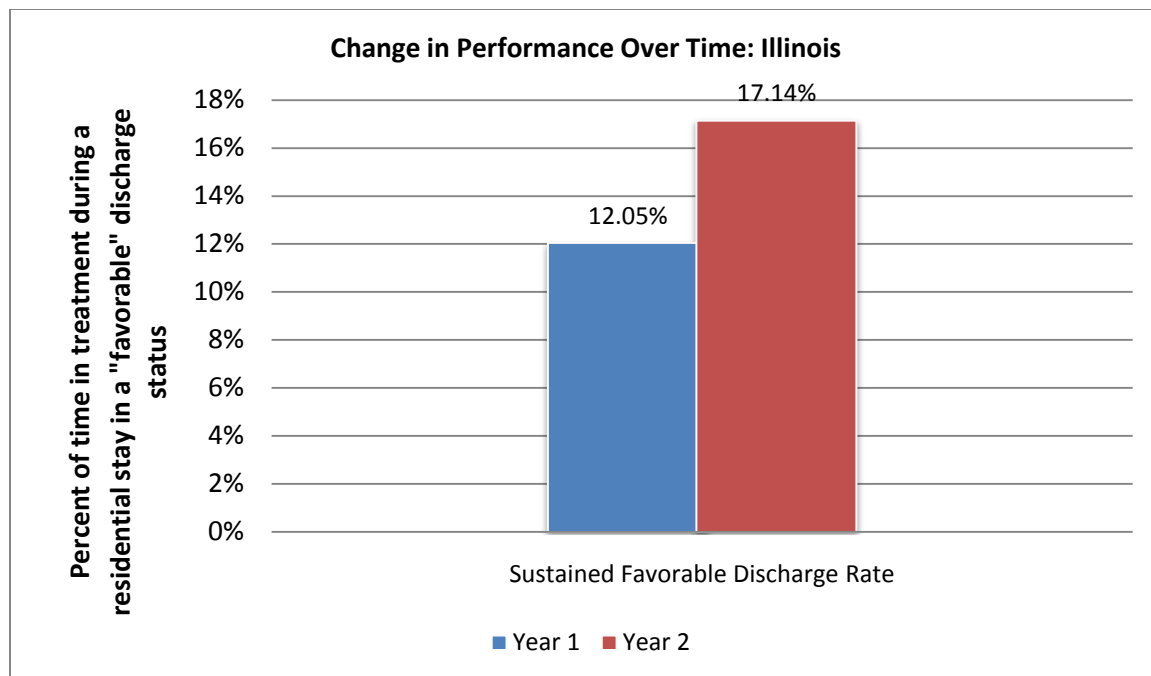
all providers that youth in care remained in care. Data is kept at the individual agency level by the Department for performance monitoring and was an outcome in which agencies were penalized for not achieving their contract target. Twenty four agencies (out of 41) were penalized for a total of \$712,033 with median penalty of \$23,915.

However, for this analysis, the overall effect on the state system of care can be seen in the below aggregate number. From the first year PBC was in place to its second year, the raw number of days youth were kept in care increased by over 3000 total days across the system. This change resulted in fewer dollars spent on hospitalization or incarceration and resulted in more days for residential agencies to provide the appropriate level of care in their facility.



The next graph shows data on the Sustained Favorable Discharge outcome in aggregate form. This represents the percentage of residential stays ('spells') in which the youth remained in favorable discharge status or step-down facility. This outcome was incentivized in the contract and \$3,155,904 was awarded to private agencies in fiscal incentives with average award of \$45,227.

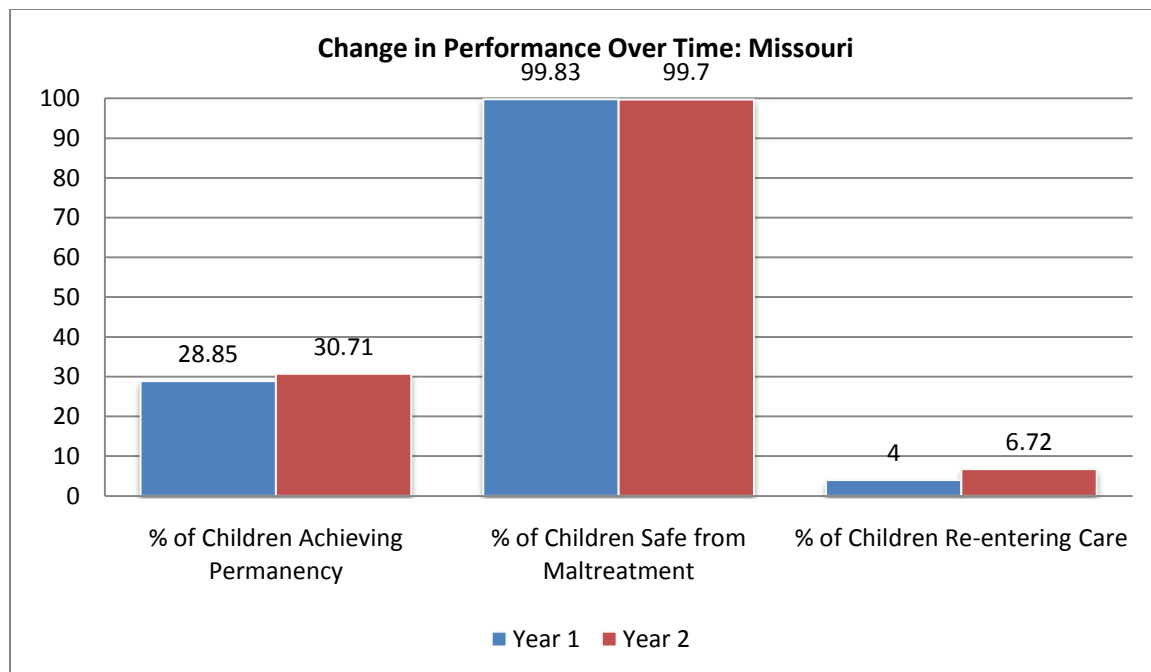
At the system level, the overall percentage of spells in which youth remained in favorable discharge (step-down) for 180 days post-discharge across all providers increased by over 5% of the total population in care.



Missouri

For this analysis, three of the four outcomes in the original contract were included. Because the public agency decided to drop the stability outcome from consideration between Year 1 and Year 2, the remaining three outcomes were analyzed. Fiscally, only one outcome (permanency) was incentivized in the contract, though both the public and private agencies used data on the other two outcomes to monitor overall performance and identify areas in which the public-private partnership could focus quality improvement efforts across the system.

Data presented here are aggregated across the three regions of the state in which PBC was implemented and across the 7 consortia within those regions. Data from public mirror sites was not included in the cross-site analysis (see Missouri QIC report for more information). As can be seen on the incentivized permanency outcome, private contractors increased the percentage of children who achieved a positive permanency status from Year 1 to Year 2 of the QIC project. Thus, the overall permanency rate increased by a total of 1.86% in all private contractors under PBC. To illustrate the magnitude of this change, if 100 children achieved permanency in Year 1, almost 20 more would have achieved permanency in Year 2 under this project or if 1000 achieved permanency in Year 1, approximately 200 more would be in a permanent placement in Year 2.



Safety and re-entry show small changes from Year 1 to Year 2 as shown above. Given that the analysis was at a consortia-level (7 total), one or two cases of maltreatment within a single agency is sufficient to affect the aggregate percentage. Similarly, the small re-entry rate overall can be influenced by a few single cases. However, this data was used by the public and private agencies to concentrate on identifying ways of improving safety within a single agency or using resources to help support placements and reduce re-entries.

Standardized Change Scores

To assess the impact of PBC on outcomes over time, the evaluation team examined the raw data from each site to assess the absolute change in performance from Year 1 to Year 2. Baseline data pre-PBC was not available in all sites to truly assess whether outcomes were better under PBC than under previous system. This approach allowed the team to determine the overall size of increases or decreases in performance over time.

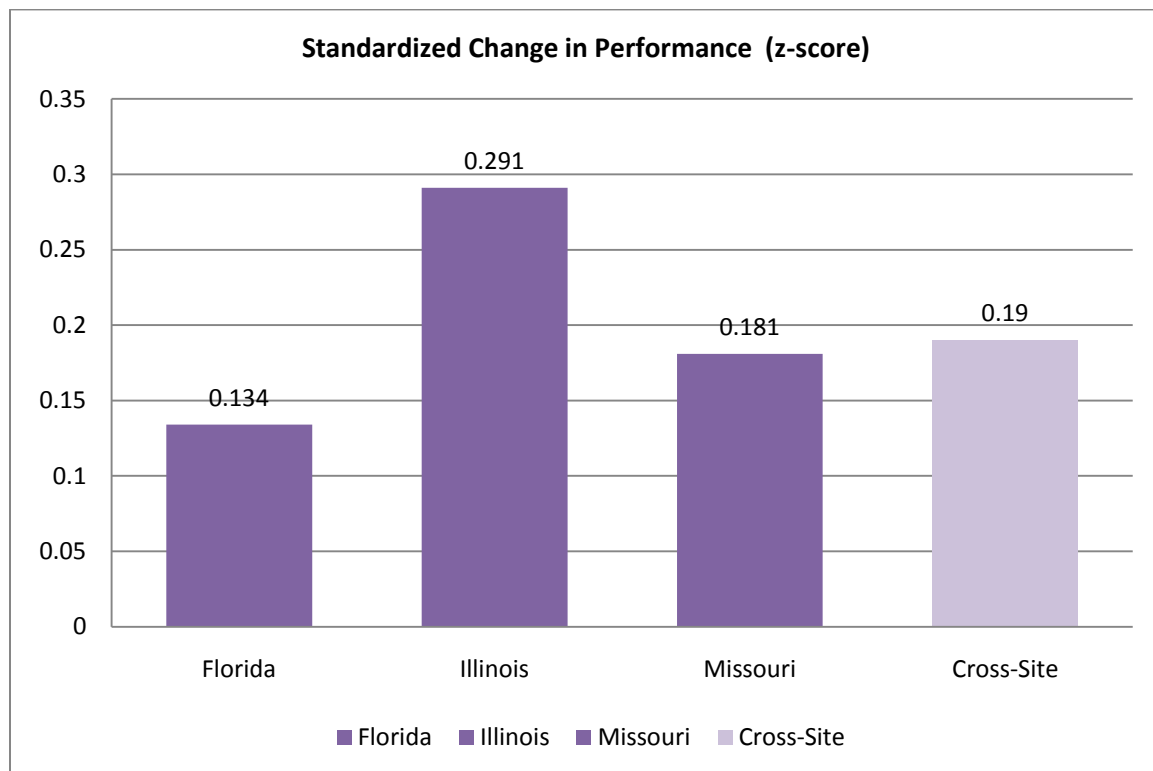
The team calculated a change score in agency performance for the appropriate site time period unit (monthly or annual). For example, a change score would be calculated as the difference in a given performance percentage on an outcome between Year 1 and Year 2. In Missouri, for example, the change score in permanency was 1.85%. The change score for Treatment Opportunity Days in Illinois is 3069 days.

Because each outcome is scaled on a different metric across sites (i.e., some outcomes are measured in percentages on an annual basis; some are measured in total days; some

are measured in percentages on a monthly basis), it was necessary to standardize the change scores across all sites into a common metric in order to analyze the relative size change over time. To do this, the team calculated a change score for each outcome aggregated across providers/consortia. For Florida, four separate change scores were calculated for their four outcomes. For Missouri, three separate change scores were calculated for their three outcomes. And for Illinois, two separate change scores were calculated for their two outcomes.

These 9 change scores were then converted to z-scores, which is a standardized measurement metric. Z-scores are calculated based on population mean and standard deviation and this distribution has a mean of 0 and SD of 1. Positive scores are interpreted as being above the mean, negative are below. For performance interpretation, positive values above 0 would indicate an increased performance on all outcomes from Year 1 to Year 2. Negative values below 0 would indicate that performance decreased on all outcomes over time.

One-sample t-tests were conducted to determine if standardized z-score differed significantly from 0 with a 95% confidence interval. This determines whether the change in performance significantly increases or decreases relative to the mean across all outcomes within a site. Figure 1 shows the standardized change score for each site across all outcomes within that site and a standardized change score for all sites and their outcomes combined.



Results showed that across all sites, the standardized change was positive and above the mean of 0. This reflects the raw data on performance over time previously presented for each site by outcome. Regardless of the outcome or how it was measured, performance increased over time relative to 0 (mean/no change) in all sites. One-sample t-tests conducted within each site indicated that this change was significantly different from 0 only within the Illinois site ($t=30.45$, $p<.021$).

However, the relative change in performance on all outcomes in all sites was significant ($t=3.197$, $p<.013$). What this indicates is that over the course of the two years during which the QIC project was on-going, performance on contracted outcomes across all sites improved significantly from the mean. As agencies were able to make systematic changes to their organization and measure the impact of putting PBCs in place, their relative performance on the outcomes specified in their contracts showed a positive and significant increase overall. These results are promising in that the direction of agency or system change is positive and leading to improved outcomes at the organizational and child/family level. Additional post-QIC data would help monitor whether this improvement is sustained beyond the QIC project.

C. Achieving Contractual Targets on Outcomes

For this set of analyses, the team analyzed the ability of private agencies to meet their contractual performance expectations on outcomes. Specifically, the team measured the extent to which agencies within a site met the performance targets set in their PBCs from year to year. This analysis shows how effective agencies are at achieving the performance standards on outcomes and how effective those targets are in promoting performance. This set of analyses answers the following questions:

- Are agencies able to meet the performance targets set on all outcomes?
- Are agencies able to sustain performance over time by consistently meeting their targets on outcomes?

Setting Contract Targets

One key aspect of designing a PBC is how to set the level of performance on each outcome in the contract. Each site has designed a PBC intervention model and set the targets for expected performance differently. This has very different implications for interpreting performance on outcome within each site and across sites. The method that the cross-site team has taken to measure whether agencies meet their target is independent of the methodology that sites have chosen to determine how they will set their contract targets. However, it is helpful for understanding the PBC intervention in each site as well as outlining potential methods that may be used to set contract targets. Each methodology plays a role in how agencies are evaluated under PBC and thus, is a critical component of the intervention.

The sites in this project have utilized four different methods for setting contract targets as shown in the following table

Methodologies for Setting Contract Performance Targets		
Method	Description	Site
Past Performance	For this method, sites use existing data on past performance for each contractual outcome to set future performance targets. In some cases, agencies are simply asked to perform at the same level on outcomes as they had in the past (MO) while in others, a predictive model is developed that takes into account a host of variables to predict future performance (IL). Use of this model is predicated on the existence of a robust dataset of past performance.	MO, IL
Expected Performance Standard	For this method, sites with no past performance data must set a standard of expected performance for a given outcome based on collaborative negotiation and best estimates. Use of this method can pose difficulties if the expected target is too high or too low. May be an initial first step until performance data is collected and target can be refined.	FL
Graduated Performance	For this method, sites with no past performance data collaboratively develop an initial low target for performance and then gradually increase the expected level of performance over time to assess and encourage improvement.	FL

Methodology

For this analysis, the team calculated the number of agencies within a site that were able to meet the established performance target for an outcome out of the total possible opportunities available within the site for agencies to meet the target. The denominator is the total number of possible opportunities for targets to be met on a set of outcomes within a given site; the numerator is the total number of targets that are met by an agency or agencies within a given site.

This percentage is referred to as the target achievement percentage (TAP) and it reflects the ability for agencies within a site to meet their performance levels on the outcomes included in PBCs. A complete description of the calculation for each site on this measure is provided below in the results section.

Because this data is preliminary, the full picture of CMA performance in terms of achieving contract targets will be developed in subsequent reports. Additionally, the explanations for why agencies may or may not achieve each outcome target are multi-faceted and it is premature at this time to offer definitive answers. Target achievement may be a function of performance as well as how the target level itself was set. However, this data allows the sites to examine performance under the contract specifications and determine whether adjustments need to be made. Ideally, targets should be set after careful consideration of many factors and assessed based on a set of performance data to determine if they are realistic.

Measures

Each site collected monthly or annual data on the performance of private agency contractors or consortia in achieving the outcomes specified in their performance-based contracts. In Florida, the four outcomes chosen were practice-level in nature and included: 1) the % of frontline workers who entered case data within 2 days of case opening by front-line staff; 2) the % of frontline workers who received a supervisory review within 4 days of case opening; 3) the % of workers who received the review again at 30-45 days; and 4) the % of quality contacts with biological parents. In Illinois, the two outcomes chosen focused on residential services for older youth and included: 1) the number of days youth remained in care (i.e., treatment opportunity days); and 2) the % of youth who remained in a less restricted placement setting for 90 days post discharge (i.e., sustained favorable discharge). In Missouri, the three outcomes chosen were based on federal child and family service review (CFSR) outcomes and included: 1) the % of children who remained safe while in foster care; 2) the % of children achieving reunification, adoption, or guardianship; and 3) the % of children who do not re-enter foster care after discharge.

Florida

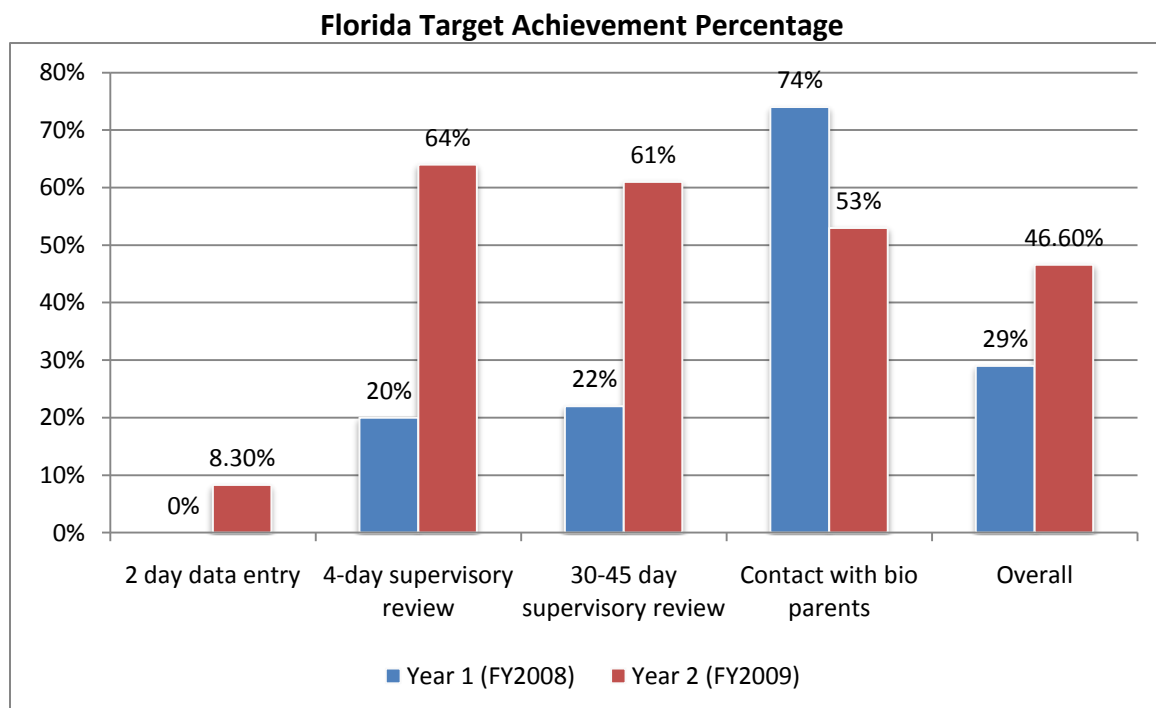
In Florida, there are 4 CMA agencies operating under 6 contracts for KCI. There are four contract outcomes measured in each contract on a monthly basis. To calculate the target achievement percentage for each outcome in each contract, the denominator is the total opportunities to meet a target for each outcome ($6 \times 12 = 72$). Thus, out of 6 CMA contracts, the total number of CMAs who met their monthly target for each outcome over the course of a year was calculated.

As a reminder, the monthly targets CMAs were required to reach is found below.

Florida Outcome Targets	
Contract Incentive Measure	Monthly Target

Data Entry Within 2 Days of Case Receipt	90% of all new cases
Supervisory Review within 4 Days of Case Receipt	100% of all new cases
Additional Supervisory Review within 30-45 Days of Case Receipt	100% of all re-reviewed cases
Contact with Biological Parents	<ul style="list-style-type: none"> • Incremental % increase starting from a 22.66% baseline on 10/07 • 1% increase over time starting from 46% on 8/08

The numerator for each outcome was determined by reviewing the performance on each outcome for each agency contract and counting the number of times an agency was able to meet the established outcome within the timeframe. The following graph shows the percentage of agencies across contracts that were able to meet the monthly contract target for each outcome. What these percentages show is cumulative extent to which all CMAs were able to meet their monthly contractual outcome targets for each timeframe. For example, in Year 1, across all CMAs, monthly use of the supervisory review tool within the 4 day contract target timeframe occurred 20% of the time. The graph shows the results for the other outcomes.



Quick Summary: Florida

- Across outcomes, Florida agencies increased their benchmark achievement by 17.5% from Year 1 to Year 2.
- Data entry within 2-days proved most difficult for CMAs to achieve while supervisory reviews showed the greatest increase in target achievement over time.
- Contact with biological parents showed a decline in CMA target achievement over time.

Illinois

In Illinois, there are 45 private residential agencies performing services for DCFS under 77 contracts in both years. Targets were calculated by DCFS on an annual basis, rather than monthly. After the reconciliation process was completed, Year 1 had 75 contracts for which data was available. In Year 2, all 77 contracts had data.

It should be noted that in Year 1 (FY2008) of the Illinois project under this evaluation, there was no established benchmark. Rather, all previous years (2006-2008) served as data points in the risk adjusted model used to establish the FY2009 benchmarks. Thus, Year 1 data reported here is the extent to which agencies 2008 performance achieves the 2009 benchmark. As such, it is not comparable to the actual contract performance of 2009 for which agencies were penalized for not meeting the 2009 benchmark, it is included here as a point of reference.

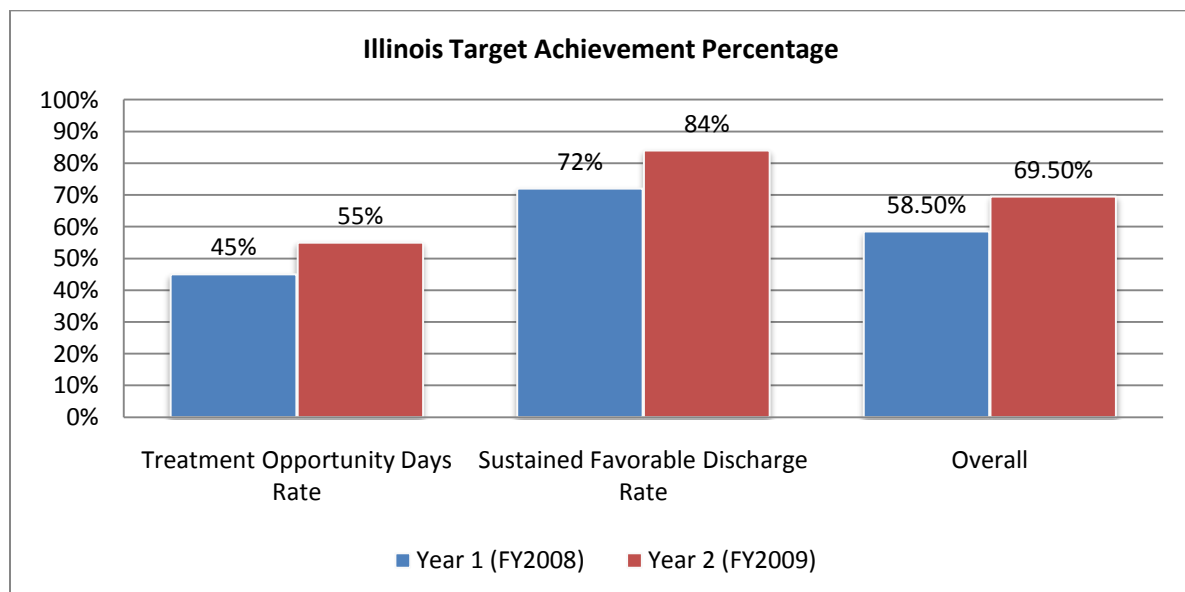
Illinois Outcome Target	
Contract Incentive Measure	Annual Target
<i>Treatment Opportunity Days</i> - the percentage of days in treatment out of the total number of days placed at the agency during the review period	Current performance goals are established by predicting an agency's expected Treatment Opportunity Days rate based on a risk adjustment model applied to each agency's case mix that factors in child characteristics predictive of runaways, detention/DOC placements or psychiatric hospitalization. It varies by agency and

	ranges across all contracts from 88.94 to 98.00
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In Illinois, DCFS has established targets for each agency's contracts for Treatment Opportunity Days using the risk adjusted model previously described. There are no such targets set for the other contract outcome of Sustained Favorable Discharge. The structure of the contract in Illinois is to purchase all beds at an agency and expect that the caseload remains in treatment at that agency for a given percentage of time. This is the contractual target and agencies that do not reach that target must repay a pro-rated amount of the original contract purchase based on deviations from the target. Thus, for this outcome, it is appropriate to measure target achievement.

For the other contract outcome, Sustained Favorable Discharge, no explicit targets are set for agencies as this is an incentive above and beyond their original contract. In other words, DCFS does not contractually require agencies to sustain a certain % of children favorably discharged. Rather, it provides incentives to agencies for youth who are maintained in their favorable discharge for 180 days which is calculated based on days or spells in the step-down discharge. It is included here for comparison purposes only.

The graph below shows the target achievement percentage for Treatment Opportunity Days for Year 1 and Year 2. As reminder, this number represents the number of agency contracts that met the FY2009 benchmark in 2008 and 2009 divided by the total number of possible contracts in each year (75 in 2008; 77 in 2009). For Sustained Favorable Discharge, the data shows the percentage of stays ('spells') in which youth were maintained 180 days post-discharge across all agencies.



Quick Summary: Illinois

- Across all Illinois contracts, half of the agencies' performance in 2008 would have met the future 2009 benchmark; after agencies were held fiscally responsible for meeting their contractual benchmarks in FY2009, less than half of those agencies met their targets.
- Overall, slightly less than half of the agencies would be required to repay a portion of their initial contract payment for not meeting their expected rate of treatment for children in their care.

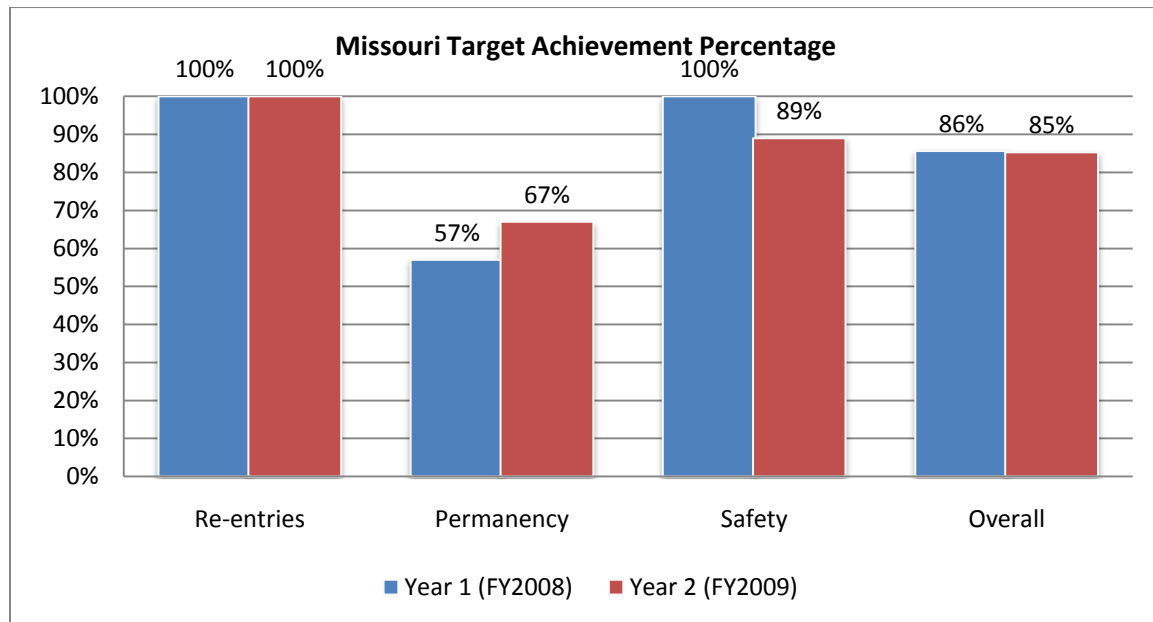
Missouri

For Missouri, there are a total of 6 private agency consortiums and 3 contract performance outcomes measured annually in Year 1. In Year 2, 7 consortiums were involved. Therefore, for each of the three outcomes, there are 6 total opportunities to meet the annual target in Year 1 and 7 opportunities in Year 2. For each outcome, a target achievement percentage was calculated as the number of consortiums who met their annual contract target divided by the total opportunities to meet that target. Targets for each outcome were set either the same across all regions as in the case of re-entries, and safety, or differed by region in the case of permanency. As a reminder, Missouri dropped stability as a formal "PBC" outcome during the QIC project and thus, it is not considered in this analysis. The contract targets for Missouri are shown below:

Missouri Outcome Targets			
Contract Incentive Measure	Annual Target		
Re-entry	91.4%		
Permanency	St Louis 32%	Springfield 24%	Kansas City 30%
Safety	99.43%		

As a noted limitation, there was not agency-specific data on each outcome to make the level of analysis comparable to Florida and Illinois. In other words, in Missouri, a single consortium is comprised of multiple agencies. Consortium representatives choose not to disclose individual agency performance and thus, all individual agency performance is combined to produce a consortium-level outcome. The public agency tracks and negotiates performance at the consortium-level and does not compile agency-specific outcomes. They have left that internal monitoring to the consortia. It should therefore

be noted that in Missouri, the level of analysis is not similar. However, this should have little effect on the overall interpretation of the data. The following graph presents the target achievement percentages for Year 1 and Year 2 in Missouri on each of their three contract outcomes and overall.



Quick Summary: Missouri

- Across outcomes, consortiums were most likely to meet their re-entry target rates, followed by safety, and then permanency.
- For the incentivized measure of permanency, consortiums showed an increase over time in moving children to permanency and meeting their contract targets on this outcome. In Year 4, close to 70% of the consortiums were meeting their permanency targets.

D. Cross Site Summary

Using similar methodology for calculating target achievement percentages within site, the cross-site team examined how well private agencies were able to meet their contract outcome targets overall. However, this analysis calculates target achievement across outcomes. To do this, the team took into account the number of outcomes

measured in each site and its impact on total opportunities, the timeframe those outcomes were measured (monthly/annually), and the specific targets set for each outcome. This will provide an overall picture of the change in performance over time in meeting contractual targets across sites during the course of the QIC project.

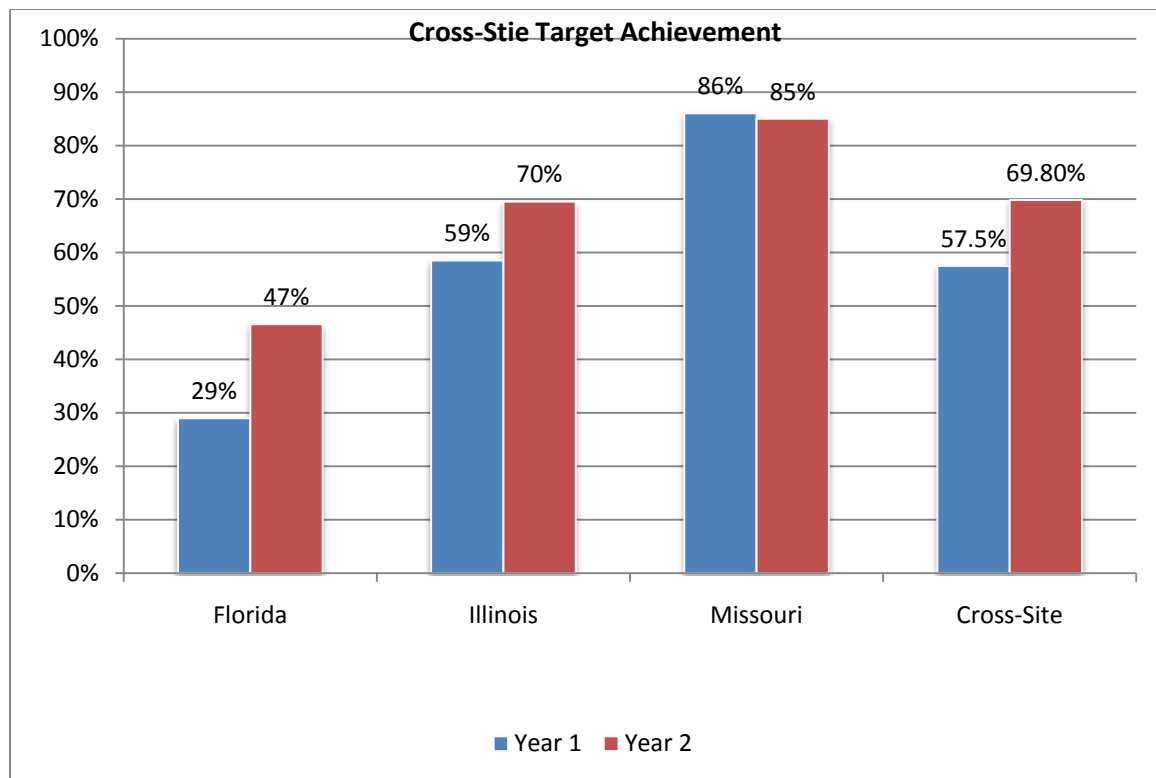
As previously noted, Illinois has a single outcome (Treatment Opportunity Days) assessed annually with a specific target or benchmark attached to it. Because no such target was set for Sustained favorable discharge, it was not included in this particular analysis since it was not truly a measure of the extent to which agencies met a specified contract target like the other sites. Therefore, its total opportunities remain the same as in the site-specific calculation.

In Florida and Missouri, there are multiple outcomes and multiple agency contracts. This difference changes the numbers used in the percentage calculations by increasing the sites' overall total number of opportunities.

For Florida, there are 6 contracts (among 4 agencies) for each outcome measured monthly in Year 1. This equals 72 total target achievement opportunities (6 contracts X 12 months). In the 7 months of Year 2, those same 6 contracts were in place and resulted in 42 total achievement opportunities (6 contracts X 7 months). The total number of agency contracts for which targets were met was tallied and divided by the total target achievement opportunities value.

For Missouri, two of the most recent years' worth of data was considered Year 1 (FY2007-2008) and Year 2 (FY2008-2009). In addition, because the site excluded stability as an official performance measure after FY2008, it was dropped from these analyses. Thus, in Missouri, there are 7 private consortiums with 3 outcomes equal 21 total target achievement opportunities per year. The total number of consortiums who were able to meet their targets across all three outcomes was divided by the total target achievement opportunities value.

The graph below shows the aggregated target achievement percentages across all outcomes within a site and across sites.



As with the performance analysis, a change score was calculated within sites and across sites to measure percentage of agencies achieving their contracted targets from Year 1 to Year 2. However, unlike the performance measures, target achievement is calculated on the same metric for all sites and therefore, there was no need to standardize these change scores into z-scores. One-sample t-tests were conducted on the change score within each site to determine if it was significantly different than 0 with 95% confidence. Results showed that while target achievement increased from Year 1 to Year 2 for Florida and Illinois, this difference was not significant for any individual site or for the cross-site.

Quick Summary: Cross-Site Target Achievement	
<ul style="list-style-type: none"> Averaged across all sites, target achievement increased from 55.5% to 69.8% from Project Year 1 to Project Year 2 Preliminary result suggest that agency performance in meeting their contract targets increases over time or remains stable under PBC/QA across sites. Other factors may affect target achievement and must be taken into 	

consideration while interpreting this data.

Factors Affecting Target Achievement

While these results are preliminary and further analyses are required, there are several factors that may affect the ability to meet contract targets. As previously mentioned, achieving contract targets can be a function of agency performance, but also other factors. For example, variation in type of outcomes in a contract can affect ability of individuals/agencies to meet targets. Differences may occur based on whether those outcomes are linked to direct practice or worker control, whether they are linked to incentives, or whether there are other organizational supports within the system to help achieve these outcomes.

Another factor influencing the ability of agencies to meet targets and/or sustain performance may be the way in which contract target levels are set. Setting a target too high with no previous data to support that level of performance may be an issue. Similarly, setting a target too low such that all agencies are able to meet it may artificially inflate performance. A balance must be identified and maintained in target levels between too high and too low.

Finally, the variation in individual agency target achievement drives overall system performance. In other words, the distribution of high and low performing agencies within a site may skew the results in one direction or another. Systems with fewer agencies are most susceptible to skewed performance because of restricted variability and greater weight on individual agency performance.

Summary

Overall, results on performance on outcomes under PBC show a positive trend for the two years under which data was collected for the QIC. On almost all outcomes in all sites, agencies showed an improvement in performance and demonstrated that they consistently improved their ability to meet their contract targets from Year 1 to Year 2.

Across all sites, relative change in performance from Year 1 to Year 2 was positive and significant. Similarly, across all sites, relative change in meeting the outcome targets set in their contracts was positive from Year 1 to Year 2, though this change was not significant. Taken together, the data suggests that sites in this study who implemented PBC for this project (Illinois, Florida) or those that made changes to their existing PBC system (Missouri) were able to demonstrate some significant and positive changes in outcomes at the organizational and child-level. Future data beyond these two years is needed to determine if this impact is sustained.

VIII. Research Question 4: Are there essential contextual variables that independently appear to promote contract and system performance?

The cross-site team documented contextual variables that may have had positive or negative effects on contract and system performance. Because these factors were self-determined and reported by the sites, it is difficult to determine the magnitude of their impact on outcomes. However, they are necessary to understanding the performance achieved; they provide the context for interpreting results presented here as well as factors that may have influenced how each site implemented and maintained PBC/QA systems in their state or region.

The information provided below came from the following sources: 1) Bi-annual QIC team site visit notes; 2) Key informant interviews; and 3) semi-annual reports from each site. If drawn from site reports, the explanation is retained in its original form to ensure accuracy of interpretation.

Florida

Resource and Fund Allocation and Availability: Two contextual factors allowed the state to invest in front-end and supportive services. These included the granting of title IV-E waiver allowing for federal foster care funding to be spent more flexibly and the implementation of the child welfare prepaid mental health plan implemented in early 2007. Under the title IV-E waiver, Florida primarily invested in front-end services, in an effort to stabilize children in their extended family and community. In this way, the number of children for which placement was needed would be lowered. For those children placed in care, the child welfare pre-paid mental health plan allowed increased and timely access to supportive community services, facilitating children reaching permanency within a timely manner. With these initiatives in place, caseworkers may have been better-able to concentrate on undertaking activities related to the PBC outcomes, thereby facilitating their successful achievement.

However, the positive impact of these initiatives may have been offset the state's economic slow-down in 2008 which was accompanied by an increase in the number of child welfare cases entering care. The site anticipated that prevention and other services would be affected by a reduction in funding. Budget cuts were thought to impact CMAs, services, administration, and independent living.

Family Finders Initiative: This initiative emphasized locating family resources for children in care and developing permanency plans that include these families. It was implemented by the state in February of 2008. Stakeholders felt this initiative helped

support the PBC outcome aimed at increasing the consistency and quality of in-person contact with biological parents.

State SACWIS System Changes: Changes in the state SACWIS database system in April – May of 2007 and delays in its implementation had a direct impact on the QA/QI system for PBC. Given the change in the statewide data system during the course of this project and some of the difficulties faced in implementation, KCI developed a “workaround.” Specifically an additional internal system ensured that CMAs accurately assessed key activities related to the measures. Stakeholders felt that the unintended consequences of this approach had a positive impact on the use of data in supervision, impacting the following outcomes.

Unable to use the SACWIS system, the Quality Assurance team drew samples of cases each month in each CMA for the data entry and contact with biological parent measures. For assessing supervisory review within established timeframes, KCI developed a Supervisory Review which allowed the caseworker and supervisor to capture discussions about cases in a quality-driven manner. KCI reviewed all supervisory review tools each month to assess if the supervision meeting met the intent of the contractual incentive measure. Credit was given when documentation indicated that the review occurred “face-to-face” and key case-related factors were discussed.

Unintended benefits associated with these changes emerged. Participants noted that the case reviews provided a level of depth to the QA process that would be lacking otherwise. Moreover, the sample is large enough that it frequently includes the same case so that change and progress over time can be reviewed and assessed.

On-site visits revealed that the team supervisor reviews were positive in that the CMAs realized that KCI was not using these as an opportunity to be overly-critical, but as a learning process for both KCI and the CMAs. They noted that vast differences in practice emerged, ranging from very good and thorough, to very cursory. The results helped clear up resistance and mistrust. As a result, positive, instructive steps could be taken. As a result, these QA/AI changes were thought to positively impact their associated PBC measures.

Other Contextual Factors Noted by the Site:

- **Changes in Leadership:** This site reported changes in state leadership in 2007 which were anticipated to impact PBC agencies. Those heavily involved in initial planning and implementation moved on to other duties.
- **Restructuring of service regions:** Districts were reconfigured into regions in 2007. The boundaries of service regions were changed for some but not all agencies, effecting continuity of PBC measurement over time.

- **Court Involvement:** The site reported in 2008 that through their decisions, judges are affecting how well child welfare workers are able to reach outcome goals. This is compounded by the fact that lawyers can also advocate for decisions that the case managers do not agree with, which then may impact outcome goals.

Illinois

Changes in Leadership: The Illinois Department of Children and Family Services changed leadership early in PBC implementation. DCFS Director McEwen was confirmed by the Illinois Legislature. His commitment to and support of PBC is well known. During on-site visits, stakeholders emphasized that his ongoing active involvement in PBC helped ensure the initiative's success. In addition to making changes to the initiative when needed, his leadership was essential for minimizing the harmful effects of budget cuts and the state's consent decree, explained below.

Resource and Fund Availability and Allocation: In 2008, Illinois began experiencing substantial budget reductions that impacted the entire DCFS system of care. This was compounded by difficulties introduced by the change in gubernatorial position that delayed the approval of Illinois' 2010 fiscal budget. The crisis encountered during the months of June and July, 2009 posed a substantial risk for complete project shut down. Although that did not occur, the repercussions of that period are still being felt, particularly in agencies that have contracts with other state agencies to provide substance abuse and mental health treatment services.

DCFS' sister agency, the Department of Human Resources, which provides substance abuse and mental health services in local communities, had already experienced significant cuts to its infrastructure during the FY 2009 budget cycle. These cuts were previously identified by providers as having the potential to effect residential agency performance if foster care case managers were not able to actively pursuing post-discharge placements in the community either due to their own increased case loads or the lack of supportive treatment services in less restrictive settings. With the FY 2010 budget crisis, these cuts were made deeper. Coupled with the loss of support services, the Transitional Living and Independent Living providers have expressed concern about meeting employment outcomes when fewer jobs are available for youth given the economic downturn, thereby potentially impacting the ability of residential care providers to meet the two PBC outcomes of sustained favorable discharge and reductions in treatment opportunity days.

The budget stalemate continued throughout the month of June, 2009 resulting in a failure of the state to pass and enact a budget for FY 2010. An emergency meeting of the Child Welfare Advisory Committee was held to prepare for the implementation of cuts and layoffs in both the public and private sectors. Director McEwen held an open

town hall meeting to discuss the potential impact of the cuts and to stress the importance of maintaining critical placement services for children.

Consent Decree: The Illinois child welfare system has been under the jurisdiction of United States District Court for the Northern District of Illinois for almost two decades pursuant to a consent decree entered into in the case of *B.H. v. McEwen*, No. 88-cv-05599. The plaintiffs in this class action law suit, all children in the custody of the Illinois Department of Children and Family Services, are represented by the American Civil Liberties Association (ACLU). The ACLU sought and received an emergency hearing before Federal District Court Judge John F. Grady on June 29, 2009.

Director McEwen was the sole witness during the hearing and detailed the nature of the cuts and their impact on the plaintiff class. Based on the evidence presented, the Court found “that Director McEwen is an extraordinarily credible and knowledgeable witness with an understanding of the multiple problems facing the system.” Judge Grady made a specific finding of potential harm to the plaintiff class if services were reduced or eliminated. He entered written Supplemental Order to Enforce Consent Decree on June 30, 2009 which held that Director McEwen and the Department follow a number of rules to ensure the provision of services to this population.

Medicaid Conversion

In 2008, the state of Illinois began working toward a potential change in Medicaid funding and billing procedures. The change required providers to account for every unit of billable service. Stakeholders noted that this diverted attention away from PBC implementation. However, the changes were also noted to result in increased funding for community services that directly support the PBC outcomes, although the varied ability of provider agencies to meet targets may have a more immediate negative consequence. Finally, Medicaid documentation allowed for better analysis of practice structure and their relation to outcome achievement.

On-site discussions with supervisors and caseworkers confirmed a dramatic increase in the amount of paperwork and documentation associated with this conversion, interfering with their ability to provide the necessary casework needed to provide care to children and thereby reach PBC outcomes. However, salutary effects of this change were also noted. Participants reported that this documentation allowed for better understanding the ways in which residential providers provided services. Therefore, not only could the relative performance of agencies be compared, but also the practice structures that lay behind their achievement. Lessons learned in this regard may have positively impacted the PBC outcomes.

In 2009, the Medicaid conversion was implemented, resulting in a large increase in documentation of billable activities. Many providers reported the conversion was very costly for their agencies in terms of fiscal outlay for software and staff training. DCFS’s increasing reliance on Medicaid as a funding stream was increasing the need for

providers to become Medicaid certified. This is seen to have a growing impact on the agencies' ability to focus on what is needed for successful participation in PBC.

In late 2009, the Medicaid expansion initiative of the Department continued to increase the availability of mental health services for clients while simultaneously maximizing the federal reimbursement received by the Department under the federal Medicaid program. Department contracts targeted for Medicaid expansion relevant to PBC include: counseling, performance-based foster care, specialized foster care, adoption and case management administrative costs. As noted in a 2010 DCFS Budget Briefing, the anticipated revenue increase from this work being implemented through a joint public and private sector effort is projected at \$17 million, positively impacting the achievement of PBC outcomes.

Striving for Excellence Project's Up-front Agency Funding: The Striving for Excellence project changed the fiscal model to do away with the former bed hold policy and guarantee each provider payment for 100% of their DCFS purchased bed capacity during a given fiscal year. Prior to the inception of PBC, providers were operating at approximately 92% bed capacity. This guaranteed rate amounted to a substantial increase in revenue, allowing residential providers to invest in the necessary infrastructure necessary to meet the PBC outcomes. The new model gave providers a stable revenue base which was not dependent upon client census, increasing their initial buy-in to the project which potentially placed them at greater risk if they were not able to maintain their treatment opportunity days at a sustainable amount.

CAYIT Matching Team: The site reported that the development and implementation of the CAYIT Matching Team to centralize and streamline the residential referral and admission process was a considerable contextual variable during early 2008 implementation activities. In 2009, the site reported that the use of the Centralized Matching Team to centralize, automate and streamline the residential referral and admission process has had a positive impact on decreasing the time from initial referral for residential services to admission. Providers report the transparency of the process used to refer clients, i.e. the use of the D-Net system and the "e-mail stream" has increased their trust in the integrity of the system.

Discharge and Transition Protocol: In 2008, the site noted the development and implementation of the discharge and transition protocol to clarify the roles and responsibilities of the residential agency and post-discharge placement. The intent of the protocol is to assist providers to effectively plan discharges and to ensure that follow-up is completed with clients once they leave the facility. Therefore, the success of this protocol was thought to positively impact the sustainable discharge PBC outcome.

In early 2009, refinement and implementation of the revised Discharge and Transition Protocol designed to clarify the roles and responsibilities of the residential agency and

the post-discharge placement was found to have fostered increased networking between residential providers and step-down placements. In late 2009, the site reported that some agencies have experienced a delay in placements due to the implementation of this protocol.

Other Contextual Factors Noted by the Site:

- **Federal CFSR Review:** This time-consuming process potentially diverts the focus of agencies away from implementing PBC/QA.
- **Fostering Connection Act:** In 2008, the U.S. Congress passed HR 6893 “Fostering Connections to Success and Increasing Adoptions Act of 2008”. This legislation extends kinship caregiver supports, provides federal assistance to foster youth over the age of 18, and allows title IV-E training funds to be used for private non-profit child welfare workers. Illinois has an existing Title IV-E waiver for kinship care which is expiring. The legislation has been deemed critical to the entire Illinois child welfare system because it will allow the current kinship care system operating under the waiver to remain intact, allow for federal reimbursement for some costs incurred serving youth over the age of 18; and allow for partial federal reimbursement for training costs for private agency staff performing child welfare services.

As of March of 2009, an implementation team within DCFS worked to examine the implications of this legislation. Although the Department has decided not to modify its IV-E state plan at this time to take advantage of the Guardianship Assistance Program (GAP) because of the loss of administrative costs currently covered by its existing kinship waiver, other aspects of the P.L. 110-351 will have a positive impact on this project and facilitate residential providers’ ability to meet the PBC outcomes by providing more permanency outcomes. The federal funds recouped for older wards will supplant the current state general revenue funds which support this program.

- **Licensing Foster Families:** In 2009, the site reported a continuing challenge to license home of relative (HMR) foster parents. The full impact of the Federal Deficit Reduction Act (DRA) signed in 2006 continues to be a primary area of revenue loss specifically by inhibiting the ability to claim administrative costs associated with children in unlicensed HMR. The Department and private sector providers are approaching this challenge with focused attention in the coming year to address barriers to licensure in order to increase the percentage of homes licensed.

Although this change potentially increased permanency outcomes for youth targeted under PBC, the Department continues to encounter some resistance from kinship care families who do not wish to be licensed (under the current

waiver, these families can receive assistance without licensure requirements). The Department has exerted pressure upon the private agencies which provide case management services to these families to process license applications. Although the number of homes eligible for licensure has steadily increased over the past six months, the current budgetary gap is substantial. This is particularly critical because of the expiration of the Department's kinship care waiver as of October 1, 2009. The Department has elected not to draw down funds to which it would be otherwise entitled under the P.L 110-351 Guardianship Assistance Program (GAP) at the present time because of the loss of administrative costs. They intend to seek GAP funds upon expiration of the waiver when it is anticipated a substantial number of HMR homes will be licensed and eligible for Title IV-E funding.

- **Family Focused Legislation:** The Illinois General Assembly passed legislation which allows a court to restore parental rights for older adolescents after a termination if it is safe to do and in the best interests of the child. The Director sees this as a critical support for older wards who wish to return to their biological families and for whom adoption by others is not a viable option. As with all reform efforts, there is resistance within both the public and private sectors responsible for implementing these more family focused innovations.
- **Nurse Practice Act:** This state legislation requires residential facilities to have a nurse or other medically certified provider in the unit to provide medications. This poses an additional staffing and financial burden on the agencies to have these nurses present, especially for over-night medication disbursements. Discussions within DCFS are currently being held to help ease this burden of this mandate on residential facilities.

Missouri

Resource and Fund Availability and Allocation: The site reported changes in funding and/or internal administrative support for incentivized PBCs in 2007. The annual budget process and PBC contract renegotiation may lead to new issues related to fairness, collaboration, completion, caseload pressures, and other contractual and service delivery changes.

The annual budget process and PBC contract renegotiation in February of 2009 led to changes in the following: number of contractors, number and/or type of cases each contractor accepts, and outcome level expectations. Due to the state economic situation, the site saw a shortfall in tax revenue and a change in judicial officers.

Rebuild Process: In 2007, stakeholders reported disruption in case continuity and casework as "rebuild" and "accreditation" cases were transferred from between

agencies. Initial rebuild activities were aimed at ensuring that each agency participating in PBC had a similar mix of cases in order to create a “level playing field.” Cases were also transferred from the public agency to private agencies in order to lower the public agency caseload as Missouri worked toward accreditation.

The rebuild process continued on a yearly basis. On a monthly basis, new referrals are assigned to each participating provider on a rotating basis to replace those expected to move to permanency. At the end of each year, caseloads are reconciled and cases are reassigned in an annual rebuild process. Stakeholders widely acknowledged that this disrupted case progress, negatively impacting the achievement of PBC outcomes of increased stability and permanency.

Court Involvement: The judicial leadership in different regions is perceived to have differing impacts among the regions involved in the PBC. In 2007, the site reported that judges in the Springfield region may hold kids in care longer than judges in metro regions. In St. Louis City and County, the judicial leadership is perceived as being unwilling to terminate parental rights without permanency plans in place (unwilling to create “legal orphans”). This approach to TPRs is believed to reduce timeliness of placement, particularly in adoptions. However, other changes in judicial policies across the state increase time to reunification in order to exercise caution in returning children to the home. These policies are supportive of kinship placements.

Other Contextual Factors Noted by the Site:

- **State SACWIS System:** The site is planning an expansion of the state SACWIS system for alternative care case management. The first conversion provided a history in which to base the second conversions potential impacts, therefore delays are expected in data input (from field) and data extraction (from research and evaluation).
- **Fostering Court Improvement:** The initiative to improve courts’ use of data with respect to dependency cases was implemented in 3 circuits: 22, 23, and 31. This was later expanded to 11 of the 45 circuits.
- **Family to Family Initiative:** The Family to Family Initiative was implemented in St. Louis (unclear whether it was implemented statewide) to drive appropriate placements. It pushed a focus on always stepping children down to less restrictive placements.
- **Consent Decree:** A Consent Decree in Jackson County (affecting Kansas City) impacts caseloads size and requires a great deal of oversight of local policies and requirements.

IX. Research Question 5: Once implemented, how do program features and contract monitoring systems evolve over time to ensure continued success?

During the three years of site implementation, the cross-site team tracked changes to contract features, QA/QI systems and activities, and additional features sites have designed to support the goals of PBC/QA. This section provides an analysis of system evolution over time within and across sites.

Data is primarily drawn from key informant interviews conducted during site visits and focus groups. The final on-site visits included semi-structured interviews and focus groups with 55 individuals, including 21 administrators and program management level staff from private agencies and 15 from public agencies. Remaining participants were evaluators, university collaborators and a representative of a provider association in one state. Focus groups with supervisors and case managers were also held with a total of 183 participants. A number of issues were explored with participants, including changes made throughout the project and the reasons for making these changes.

Within all three sites, staff noted that over the three-year period, emphasis shifted from compliance and direct oversight of practice and process, to technical assistance and developing a continuous quality improvement approach focused on outcome achievement. To help become effective TA resources focused on CQI, their focus changed to include an emphasis on effective practice. QA/QI and attendant TA also became more data driven and focused. All sites provided evidence that these changes are not easy. They struggled with measurement and data collection.

A final observation related to the evolution of QA/QI systems to CQI was the emergence of two-way communication and a greater understanding of the role of the public and private agencies involved. For instance, on-site visits supervisory reviews in Florida helped build communication between KCI and the CMAs. Participants noted that it was a learning process for both the lead agencies and the subcontract agencies providing services. As a result, positive, instructive steps could be taken. Better documentation of practice under Medicaid claiming allowed Illinois to better document and understand how private agencies provided services and relate these to relative outcome achievement. Missouri solicited frequent feedback from the private agency program managers on the public agency Oversight Specialists, and their functioning as a resource.

The following sections provide specific findings related to each site.

Florida

The PBC in Florida's Circuit 5 is between Kids Central, a private CBC lead agency and four case management agencies (CMAs). The CMAs are responsible for all day-to-day case management of foster care cases. The Circuit selected four performance measures for its contracts. Three of these measures are "process" measures over which workers have direct control. Kids Central wanted to incentivize measures that CMAs could easily influence as a way to increase "buy-in" for the PBC. The process measures were expected to impact the one outcome measure that was selected to assess performance – improved timely permanence.

- Additional face-to-face supervisory meetings within 4 days of case receipt and again at 30-45 days (2 separate measures)
- Earlier and more accurate data entry into state's administrative system within 2 days
- Increased caseworker contact with biological parents
- Improved rates of maintained permanency for children²

Changes to Performance Indicators and Measurement

Florida made changes to one of its performance indicators "increased caseworker contact with biological parents." Specifically, the indicator was refined from simply requiring case managers to have undefined contact with biological parents of children in out-of-home care to requiring that they physically met with **both** parents, **and** discussed specific issues in the case plan. The intent of these changes was to expedite case progress and enhance case outcomes. Information on both parents was collected systematically in order to inform case practice.

Changes to Incentives and Disincentives

KCI attempted to develop a shared risk model in their PBCs. The original intent was that in addition to incentives for performance, there would also be penalties for poor performance. The contracts stated that if performance on the incentivized measures was below expectations, CMAs would be afforded one quarter (3 months) to attempt to

² This measure posed several unanticipated challenges in terms of determining the appropriate permanency for some cases, establishing a target for performance, accurately assessing achievement, and planning for the fiscal liability by KCI. Determination of permanency outcomes occurred later than anticipated and was based on a review of those cases retrospectively by KCI quality assurance team members. Tracking on-going performance was difficult given that permanency must be achieved and maintained for 6 months. Incentives were paid from Sept 2007- Dec 2008. For this reason, data for this measure is not included in this report.

address the problems and improve performance. During this period, Kids Central would provide requested technical assistance, advice, or support to sustain the efforts of the CMA. After one quarter of below-par performance, CMAs would have to pay for technical assistance from KCI equal to the daily staff rate of \$250 that Kids Central pays to the CMAs. If the CMA continued to underperform, their contract could be terminated.

While written into the contracts, KCI has never fully implemented the penalties because the CMAs continued to demonstrate performance improvements even though they did not reach the target performance measures. KCI stated that they felt that it would harm collaboration if they imposed penalties while performance continued to improve. Thus, while the original intent was a shared risk model, in actuality, the CMAs were not fiscally held responsible for poor performance during the project evaluation period.

Other Supportive Changes

Technical Assistance on Desired Outcomes and QA Process: Florida participants noted that traditionally they had provided TA on how the QA process worked and its associated requirements. This occurred through clarifications, staffings, and trainings. Building on this foundation, during the course of the three years KCI's focus shifted, focusing on helping the CMAs develop an understanding of what the overall performance targets were, and how they could be better documented through a more interactive process. KCI strove not to criticize existing practice, but to engage in an ongoing dialogue with CMAs to see if they were undertaking needed activities directly related to performance targets, and emphasizing that these needed to be documented. The purpose was made clearer by working through various case scenarios.

As a result of these changes, KCI reported improvements in outcomes and documentation, but work remained. Participants noted that with this shift, the TA provided was generally well-received and that the dialogue was open and interactive, rather than closed and defensive. In meetings focused on implementing this shift, most CMAs included staff from all levels and KCI credited the CMAs efforts to facilitate broad attendance. This allowed the information to be gained at all levels, rather than filtering down through the supervisors and managers. It also allowed KCI to receive comments on the QA process from all levels within the CMAs.

Using Performance in Supervision: Another change made by Florida was sharing information on performance directly with the supervisors within each CMA. The goal was for performance to become an integral part of supervision. Separate focus groups with supervisors and case managers confirmed that this shift occurred in three of the four CMAs. Within these agencies, case managers reported getting regular internal updates on their individual performance on the measures and targets. Case managers from two agencies discussed receiving additional supervision and support targeted on meeting the measures.

Changes in QA Processes: Performance on all measures was tracked by KCI either through the state SACWIS system or through internal sample reviews of cases. Given the change in the statewide data system during the course of this project and some of the difficulties it faced during implementation, KCI developed a “work-around,” developing an additional internal system to ensure that CMAs were accurately assessed and quality assurance occurred. In this way, KCI merged their Quality Assurance and Quality Improvement (QA/QI) activities within their PBC model to align service review and performance.

For the data entry and contact with biological parent measures, the Quality Assurance team drew samples of cases each month in each CMA. For assessing supervisory review within established timeframes, KCI developed a Supervisory Review which allowed for the caseworker and supervisor to capture discussions about cases in a quality-driven manner. KCI reviewed all supervisory review tools each month to assess if the supervision meeting met the intent of the contractual incentive measure. Credit was given when documentation indicated that the review occurred “face-to-face” and key case-related factors were discussed.

Unintended benefits to these changes emerged. Participants noted that the case reviews provided a level of depth to the QA process that would be lacking otherwise. Moreover, the sample is large enough that it frequently includes the same case so that change and progress over time can be reviewed and assessed.

On-site visits revealed that the team supervisor reviews were positive in that the CMAs realized that KCI was not using these as an opportunity to be overly-critical, but as a learning process for both KCI and the CMAs. They noted that vast differences in practice emerged, ranging from very good and thorough, to very cursory. The results helped clear up resistance and mistrust. As a result, positive, instructive steps could be taken. A growing recognition was reported that supervisors were key agents of change.

Illinois

Illinois focused its project on youth in residential care. Unlike Florida, the new PBC/QA contracts for residential care do not establish performance measures for process measures (services or casework practices) and instead focus on two outcome measures:

- **Treatment Opportunity Days (TODR):** For this measure, DCFS created an outcome to capture the extent to which a residential agency was able to provide the on-site treatment for youth that they were compensated for by the department. The goal was to reduce out of agency placements in detention or DOC, psychiatrically hospitalization, and runaways.

- **Sustained Favorable Discharge:** For this measure, DCFS created an outcome to capture a successful transition of a youth from a more restrictive setting to a less restrictive placement.

Changes to Implementation Plans

Under this project, Illinois had planned to implement PBCs for all of its residential, independent living and transitional living programs (ILO/TLP) by 2008. A network of private providers throughout the state was providing these services, typically reserved for older youth. However, site documentation and key informant interviews indicated that the Project Steering Committee recognized the unique challenges each population faced, and the lack of consistent data that was being collected on these cases by provider agencies. Due to these challenges, the committee decided to move forward with the new residential care contracts first. In September, 2008, IL's QIC launched its new contracts for its residential providers. The new ILO/TLP PBC contracts were later launched in July of 2009.

Other Supportive Changes

Technical Assistance on Desired Outcomes and QA Process: Similar to Florida, Illinois transformed its residential monitoring process to focus more on TA and less on compliance. Changes took place at two levels – the residential monitoring unit level and to the functions of the individual monitors themselves.

Originally, the Residential Monitoring Unit function was focused on the monitoring organization-wide performance. But over time, its function changed. Site visit participants noted that the unit focused more on individual child monitoring, collecting data on them initially, reviewing files and holding staffings, and advocating to move children to transition whenever possible. A process for identifying candidate cases for more intensive staffings was developed. Participants agreed that they thought these changes were for the better. Efforts to change practice became more data-driven. Supportive of this philosophy, the monitors were viewed less as being compliance-driven, but rather in providing TA and advice on how to move children forward in the transition process. The monitors were encouraged to spend more time within the agency and their oversight became more clinically focused. Site visit participants reported that the monitors were widely accepted, and were viewed as helpful in their approach rather than punitive.

Data on Practice within QA/QI Processes and Supervision: In general, the site reported that QA/QI processes were steadily becoming more data driven across programs and initiatives. Changes within the PBC QA/QI process paralleled those in other processes such as those used for Medicaid claiming data. Participants reported that these changes allowed Illinois to better document and understand how private agencies provide services. Therefore, not only could the relative performance of agencies be

compared, but it also allowed the comparison of their practice structures that lay behind the outcomes achieved.

Quality Improvement plans for low performers: Over time, Illinois used its comprehensive QA/QI system to provide targeted TA. Specifically, the state identified approximately 12 providers that were the lowest performers on outcomes. Residential monitors identified practice and other issues within these agencies. DCFS then met with each of these providers and developed a quality improvement plan that included specifics that were linked to outcome achievement by other organizations (such as the use of clinical staffings). Contracts for some providers were not renewed.

Missouri

In 2005, Missouri implemented performance based contracts for its foster care and adoption case management providers in three regions of the state. The performance based contracts require providers to move a certain percentage of their caseloads to permanency each year. New referrals are referred to providers each month to replace those which are expected to move to permanency. The contracts were re-bid in June 2008 and now serve six regions of the state.

Rather than contracting with individual providers, Missouri contracts with seven provider consortiums to encourage agencies to pool resources and partner within their respective systems to provide a broader continuum of services to child welfare involved families. While the same seven consortia provide all services, PBCs are now in effect in 12 additional counties in the central, south central and southwestern portions of the state.

Missouri chose to include standard child-welfare outcomes for which the state must report federally. Rather than focus on process outcomes like Florida or population-specific outcomes like Illinois, Missouri incorporated federal child outcomes in their contracts:

- **Reduced re-entry into foster care:** This outcome is calculated as the total number of children who re-entered care within 365 days of their exit to permanency divided by the total number of children who exited to permanency.
- **Increased stability:** This outcome is calculated as the total number of unduplicated children with specific legal status codes that are active during the reporting period divided by the number of children who have two or less placements.
- **Increased safety:** This outcome is calculated as the total number of children from substantiated child abuse and neglect reports whose perpetrator is an 'alternate

caregiver' divided by the total number of unduplicated active children served during the reporting period.

- **Increased permanency:** This outcome is calculated as the total number of duplicated children with specific legal statuses achieving permanency divided by the total duplicated active children served during the reporting period. Permanency is defined as reunification, adoption, and guardianship.³

Changes to Performance Indicators and Measurement

Based on discussions with CEOs representatives of the consortia in July 2009, Children's Division decided to drop the stability measure because this indicator contained an artifact of the system design. Specifically, in building the initial caseload, all consortia were given a clean slate to measure the stability of the placement of new children in their care. However, the Children's Division and the federal requirements measure stability over the life of the case versus an annual stability rate that was used in measuring consortia performance. Thus, the way stability was measured did not accurately or fairly represent performance and it was agreed by both public and private agencies to drop official measurement of this indicator, though the Division will be tracking permanency rates overall.

Two other outcomes were initially included in the contracts, though they proved difficult to measure and were not emphasized by the Division. These were:

- Decrease residential utilization days whereby contractors were to reduce the average utilization days for residential treatment placements by 2 % based on the average utilization days originated from historical data for each region
- Development of resource (or foster care) homes in which the contractor originally stated the number of resource homes they would develop. For this report, these outcomes are not analyzed

In the second round of three-year contracts, new benchmarks were discussed for safety and permanency based on previous contractual performance. Representatives from the consortiums and Children's Division staff reviewed performance data and regional caseloads to develop new benchmarks for those indicators.

Other Changes

Tiered CQI Process Linked to QA/QI: Mid-way through PBC implementation, the state re-vamped its QA/QI process. Under the direction of new leadership, a coordinated, but

³ This is the only measure of the four that is directly incentivized.

tiered continuous quality improvement (CQI) process was initiated to facilitate communication on changes needed in light of QA/QI findings. At the state level, statewide meetings were held to share ideas on practice and resource utilization, as they related to outcome achievement.

Additionally, regional CQI meetings were initiated. The state provided only broad direction to the content and structure of these latter meetings. Participants noted that these meetings varied in their effectiveness given differences in terms of data sharing and openness. To address this potential roadblock, the child welfare agency began routinely sharing data with each of the individual private agencies. Private agency staff reportedly appreciated this. There was wide acknowledgement that with this increased focus, the standard of QA/QI improved across all consortia and providers, although differences remained.

Finally, at the agency level, periodic meetings between the private agency QA/QI designee and parallel public child welfare agency staff were emphasized. Supervisors who participated in focus groups described expanded efforts to track performance over the course of the contract. Each contract agency had a QA unit and the public child welfare agency had an Oversight Specialist assigned to each unit. Supervisors reported increased communication across the board during the project, with some having weekly interaction with this individual to review cases.

Transformation of Oversight Specialist Role to more QA and TA: Consistent with the other two sites, participants noted that QA/QI evolved from a focus on compliance to one of outcome oversight and TA. This came into sharp focus with the state's transformation of the duties and function of the Oversight Specialists. Training initiated during implementation focused on role playing with feedback to emphasize this focus. Ongoing feedback from the program managers within the private agencies on these individuals was sought and incorporated into ongoing transformation. As a result, child welfare agency staff reported they hear frequently from the program managers concerning the specialists. In turn, private agency staff report reliance on the specialists as a resource when faced with a problematic case or issues.

QA/QI and Practice Summits: Under this QIC, the state funded practice summits to provide consistent information on the process and outcomes being measured. Items discussed ranged from the practical (including public and private agencies combining and coordinating consumer surveys rather than sending out duplicate ones, and reviewing particularly low QA/QI scores to identify actions needed) to policy issues such as methods for identifying and engaging fathers.

Summary

Within all three sites, staff noted that over the three-year period, emphasis shifted from compliance and direct oversight of practice and process, to technical assistance and developing a continuous quality improvement approach focused on outcome achievement. In support of this, communication emerged as key:

- In Florida, CMAs included staff from all levels in the meetings with the lead agency, allowing the information to be communicated at all levels, rather than filtering down through those in attendance.
- In Illinois, monitors were encouraged to spend more time within the agency. They were viewed as a helpful resource.
- Missouri developed a tiered approach at the statewide, regional, and agency level. When potential roadblocks emerged at the regional level with respect to data sharing, the state assumed this role directly with the consortia and agencies involved. Practice summits also emphasized communication.

Participants in two of these sites focused on transforming the role of key individuals and units charged with oversight and QA/QI. To help become effective TA resources focused on CQI, their focus changed to include an emphasis on effective practice:

- In Illinois, the role and function of both the Residential Monitoring Unit and monitors was enhanced and changed. The work focused on TA and became more clinically focused.
- In Missouri, oversight specialists fulfilled a similar function.

QA/QI and attendant TA also became more data driven and focused:

- Florida shared information on information directly with supervisors, to facilitate performance becoming an integral part of supervision.
- Illinois developed a process for the Residential Monitoring Unit to identify individual candidate cases for more intensive staffings. At the provider level, residential monitors identified low performing provider agencies and developed quality improvement plans for them.

Sites provided evidence that these changes are not easy. They struggled with measurement and data collection:

- The lead agency in Florida chose not to implement planned penalties citing that improvements were forthcoming without them and that they might have a chilling effect on needed collaboration. The site was also unable to set appropriate targets for its permanency measure.

- As a “work-around” to problems with the site’s reliance on data originating from the state’s automated child welfare information system, the lead agency developed review tools and protocols that added greater depth to the QA/QI process.
- Illinois delayed full implementation of its PBCs given population challenges and the lack of consistent data.
- Missouri dropped its stability measure given measurement difficulties given differences with the state and federal government measured this outcome. Two other outcomes were initially included in the contracts but proved to difficult to measure (development of residential utilization days and development of resource homes for children).

X. Overall Cross-Site Evaluation Summary

Planning Process

The report highlighted the efforts in each site to establish a collaborative dialogue about the design and implementation of PBC/QA between both private and public partners. Given the complex relationship between public and private partnerships within a performance-based contracting system, each site identified the collaborative planning process as one of the most important factors in the success or failure of their efforts. In most sites, this collaborative relationship was evident during site visits as all partners were included at the table. The structure of the decision making process was different across sites, but it was evident that the sites took an inclusive approach when negotiating performance-based contracts and designing quality assurance systems.

The collaborative nature of the private-public partnerships in each site shows that there was general agreement that the group had a collaborative communication structure, process, purpose, goal, environment, and partners. While some variations exist within and across sites over time and by domain, the results generally demonstrate that the public private partnerships were collaborative in their initial planning process and maintained that over time.

The collaborative nature of the partnerships was not always reflected on the frontline level as some workers indicated in focus groups that they felt less included in the process. In all sites, many workers were unclear about some of the details of PBC and how decisions were made. However, sites showed an effort over time to use data to help assist staff in understanding best practices and how outcomes were measured. This could be an area where more targeted efforts are made to ensure that collaboration and communication extends from the higher decision-making levels down to the frontline.

Finally, undertaking this level of system change requires sufficient time to plan since it affects all levels of an organization or agency. Sufficient time is needed to ensure that all parties understand the outcomes being measured, how they are measured, and how these contracts affect each side fiscally. Additionally, time is needed upfront to make sure the right data is available to measure each outcome or to make the necessary changes to guarantee accurate and reliable data to inform the system as a whole.

Necessary Components of PBC/QA

While it is difficult to identify any one necessary component of a successful PBC/QA system, some key lessons learned from these three sites identify important factors that any site needs to consider when designing such a system:

- The importance of selecting the appropriate contract outcomes and aligning those outcomes with shared goals across public-private partnerships

- The importance of setting appropriate benchmarks for performance in contracts and collaboratively monitoring performance
- The importance of having and using reliable data to assess performance and improve quality (QA/QI)
- The importance of sharing risk in a contractual relationship between public and private agencies

There were several common elements across the sites that emerged and were identified as being key to the successful implementation of PBC/QA. How those elements played out in an individual site or the level of significance each one played cannot be known. Instead, general themes emerged across sites and are shown in the table below.

Common Elements for Success	
Political	Right Time and Support for Change
Leadership	Right Leaders Driving Change & Staying Involved
Collaboration	Inclusive Planning Process Between Public & Private
Planning	Sufficient Time to Plan
Communication	Formalized, Transparent Communication Structure
	Meaningful Feedback to All Levels
Practice	Support for Practice Change
Data	Having and Using Reliable Data
QA/QI	Restructuring QA/QI Process to Support PBC
Outcomes	Selecting Right Outcomes and Building a Contract Around Them

The following site-specific components were identified as helping facilitate outcomes and help improve organizational and system change:

Site-Specific Supports for Achieving Success			
	FLORIDA	ILLINOIS	MISSOURI
Collaboration Support	<ul style="list-style-type: none"> • Neutral Facilitator • Supervisory Roundtable 	<ul style="list-style-type: none"> • Provider Forums & Info Dissemination • Issue-Specific Workgroups 	<ul style="list-style-type: none"> • Program Manager Meetings • Issue-Specific Workgroups
Outcome Support	<ul style="list-style-type: none"> • Supervisory Review Tool • Family Finders 	<ul style="list-style-type: none"> • Discharge & Transition Protocol • Child Youth Investment Teams (CAYIT) & Centralized Matching 	
Practice Support			<ul style="list-style-type: none"> • Statewide Practice Summits
Decision Making Support		<ul style="list-style-type: none"> • Child Welfare Advisory Committee (CWAC) 	<ul style="list-style-type: none"> • CEO Meetings
Organizational/System Support		<ul style="list-style-type: none"> • University Research Partnerships 	
Data Support		<ul style="list-style-type: none"> • Residential Treatment Outcome System (RTOS) • Data Test Workgroup 	<ul style="list-style-type: none"> • Random Case Assignment
Quality Assurance Support	<ul style="list-style-type: none"> • Detailed Agency & Worker-Specific 	<ul style="list-style-type: none"> • Monitoring Shift to Quality vs Compliance 	<ul style="list-style-type: none"> • Joint Public/Private QA/QI Alignment

Improved Outcomes

Overall, data from this cross-site evaluation showed that on almost all outcomes in all sites, agencies showed an improvement in performance and demonstrated that they consistently improved their ability to meet their contract targets from Year 1 to Year 2. Regardless of the outcome or how it was measured, this improved performance was consistently positive. For example, more biological parents were contacted by case workers in Florida in the second year of PBC than in the first. In Missouri, more children were moved to permanency placements in the second year of PBC than in the first. In Illinois, youth remained in residential care more days and were hospitalized or incarcerated less in the second year of PBC than in the first.

As agencies were able to make systematic changes to their organization and measure the impact of putting PBCs in place, their relative performance on the outcomes specified in their contracts showed a positive and significant increase overall. These results are promising in that the direction of agency or system change is positive and leading to improved outcomes at the organizational and child/family level.

Taken together, the data suggests that sites in this study who implemented PBC for this project (Illinois, Florida) or those that made changes to their existing PBC system (Missouri) were able to demonstrate some significant and positive changes in outcomes at the organizational and child-level. Future data beyond these two years is needed to determine if this impact is sustained.

Contextual Factors

While each site had unique state or local factors, four common variables appeared across the sites and were perceived to have an important role in influencing the implementation of PBC/QA, the public-private partnership, and the outcomes under consideration.

Leadership: In all sites, stakeholders believed that the changes necessary to implement PBC and to the system as a whole were a function of key leadership at both the public and private level. System changes inherent in PBC require leaders who will drive those changes via a strong public-private collaborative partnership, leaders who will hold agencies accountable for performance, and leaders who will assume responsibility for the difficult decisions and compromise necessary for this work.

Leadership at all levels can help drive practice and bring necessary resources to help improve outcomes for children.

Resources, Budgets, and Political Climate: All sites discussed the challenges of PBC when resources are tight, budgets are cut, and the political climate makes change difficult. Fewer resources make it difficult for agencies to provide the range of services needed to ensure positive outcomes for the children they serve. Additionally, budget cuts impact the extent to which public agencies can incentivize contracts and support private partners. A robust cost analysis of PBC was not conducted for this evaluation, but such data is necessary for determining the effectiveness and efficiency of PBC within a foster care system. Given potential cuts to social services across the country, understanding the fiscal implications of PBC will be key for stakeholders in the legislature, the public child welfare agency, and the private provider community.

Data Systems: One key factor stakeholders identified as affecting the implementation of PBC and effectively managing outcomes across diverse agencies is the data system used to monitor performance. Given the complexity of the outcomes measured in sites and the kind of data required for PBC, an unreliable or incomplete data system can be a huge barrier to overcome. State-wide data management systems are often not designed to easily generate the data needed for monitoring PBC. Duplicate agency data systems and work-arounds are common. All sites agreed that PBC requires a transparent, robust, and accurate data system. Data systems may not influence outcomes themselves, but they do impact the ability of the public and private agencies to monitor performance outcomes and identify necessary changes to improve services.

Concurrent Initiatives: In all sites, PBC did not operate in a vacuum within the child welfare system and service delivery agencies. Many concurrent initiatives designed to improve services and practice at the system and agency level occurred in all sites. These programs included programs to address the front-end of the child welfare system. Other initiatives focused on changes to how practice and supervision occurred. As a result, it is impossible to attribute all outcomes achieved during the QIC project to PBC alone. Rather, complex systems such as those in place in the sites require complex explanations for the kinds of outcomes they produce.

Evolution Over Time

Within all three sites, staff noted that over the three-year period, emphasis shifted from compliance and direct oversight of practice and process, to technical assistance and developing a continuous quality improvement approach focused on outcome achievement. In support of this, communication emerged as key. The evolution of QA/QI systems to CQI in conjunction with PBC produced a greater understanding of the role of the public and private agencies involved.

Additionally, as sites implemented PBC and began monitoring outcomes, it became apparent that other adjustments were made during this project: 1) Outcomes selected were either refined, re-defined, or dropped all together from the contracts; 2) New quality assurance activities were designed and data was used to initiate joint private-public quality improvement changes; 3) Incentives and disincentives were re-negotiated, discontinued, or refined in response to fiscal factors or collaborative practices; and 4) Communication efforts began to more effectively target front-line case managers and supervisors.

All sites indicated that successfully implementing PBC in their individual sites was an on-going process rather than a static one-time change in the structure of the system and the way business was done. Much of the evolution over time in the sites was in response to data directly related to and generated by performance-based contracts. Additionally, all sites indicated that, while at times challenged and difficult, the public-private partnerships grew stronger due to the collaborative nature of the planning process and the on-going work together.

XI. Other Cross-Site Activities

A. White Paper

In July, 2009, the study team completed a report that described several current models of performance based contracts in child welfare services. The paper describes only those models that directly link payment to performance (rather than those that include performance measures in the contracts but use provider performance as a factor only to determine contract renewal).

Information for this paper was gathered through informal telephone discussions with child welfare administrators from 27 states (and in a small number of cases, county and/or private agencies)⁴ and through a review of the performance based contracts (PBCs) in use in these states. The discussions were held in May, June and July, 2009. The 27 states were identified from similar discussions with child welfare administrators from 47 states in 2008. At that time, each state's official was asked whether they used PBCs in their child welfare services, but few details about the structure of the contracts were collected. Twenty-seven of the 47 states discussed using some form of PBC at that time; many other states described an interest in, or concrete plans to implement them in the future.

For the most recent discussions of 2009, state officials were first asked whether the PBCs they used directly linked payment to performance. Those that reported that they used this approach in at least one service contract were then asked to describe the following about each:

- Service contracted (and target population(s))
- Geographic region served
- When the contract(s) were initiated (and whether this differed from when payments were linked to performance – i.e. were providers given a period of time when they were “held harmless” to adjust to the new measures)
- Performance measures listed in the contracts, and
- Nature and structure of the PBC model.

State officials were also asked to describe one or two major lessons learned about developing and/or operating these contracts.

The report summarized the findings across the 24 states that completed the discussions. More detailed information was also presented for the 12 states that are presently using

⁴ Florida provides an example of a state where a private, lead agency (not a public child welfare agency) uses performance based contracts with its case management agencies. For more details, see the state's contract description on page 8.

PBCs that link payment directly to performance, and that shared their contracts with QIC staff.

The purpose of the paper was to describe a range of PBCs in child welfare services that directly link payment to performance. It is designed to give state and county child welfare administrators examples of the kinds of services for which states have used PBCs and how these contracts are structured. This paper also provides contact information for state and county officials who administer these contracts, to enable future dialogue.

Findings

States are using PBCs to pay for a variety of child welfare services and activities. These contracts incentivize a range of service and client outcome measures and use a range of PBC models to reward strong performance.

Of the 25 states for which discussions were completed, 14 had some service contracts that directly linked payment to performance.

TABLE 1
States' Use of PBCs in 2009
(Based on those States Reporting Use of PBCs in 2008)⁵

	Operational Definition	States	N
PBCs link contractor payment to performance	States with at least one PBC that links payment to performance, most commonly in the way of service or client outcomes	AZ FL IA ID IL MI MN MO NC ND NE NM TN WY	14
PBCs inform contract renewal decisions	States using performance measures in contracts primarily to gauge contract renewal decisions	AK AR CA CO CT IN LA OH OR WA WI	11
Total			25

Within these 14 states, officials provided examples of 16 PBCs:

- 7 involve adoption (or foster/adoption resource family) recruitment, licensing and/or placement services (IA, ID, MN, 2 in NC, ND, NM)
- 4 involve foster care case management services (FL, IL, MO, TN)
- 2 involve in-home services (IA, NE)
- 2 involve residential care (IL, WY)
- 1 involves services for children in Independent Living and Transitional Living Programs (IL)

⁵ Interviews were not completed in two additional states identified in the 2008 survey – NY and PA.

The majority of the contracts described in the report were implemented in the past two to four years. Only four of the contracts took effect between 1995 and 1999 (IL, MN, two in NC).⁶ The remaining 12 contracts were initiated after 2005.

Structure of the Performance Based Contracts

Generally speaking, the 16 contracts described in this paper could be classified into one of three performance based contracting models:

Incentives and Penalties: Providers receive base contract payments; on top of which they are paid incentives (or are charged penalties) for their performance on select measures. Idaho offers an example of this model in its resource family recruitment contracts. While providers receive a flat monthly fee for ongoing recruitment activities, they also receive a small incentive payment for each family recruited. These contracts produce the least risk to the private providers as payments for performance are generally only a small part of their contract payment. Florida, Iowa, Idaho and Tennessee fall into this category.

Caseload Models: Agencies are required to accept a certain percentage of their caseload in new referrals, and move a certain percentage to permanency each year. Agencies are expected to manage their caseload balancing the cost of cases flowing in, by moving an equal or greater number of cases to permanency. Similarly, the cost of higher level care cases is balanced by stepping down an equal or greater number of cases to lower level placement setting. Agencies that fail to achieve the standards set under the contract risk serving more children than they are being paid for and having their new intakes placed on hold. While there is variation among them, Illinois' foster care contract and Missouri's contract fall into this category

Pure Pay-for-Performance Contracts: These contracts only pay providers when they have met a key milestone. These contracts produce the greatest risk to the private providers but, as will be discussed below and in the following pages, vary greatly in what is funded and on what schedule. There are three variations of this model:

- ***Contracts that only pay when clients have achieved a system goal.*** For instance, in North Carolina and North Dakota, providers are only paid when a child is placed in an adoptive home or when a child's adoption is finalized. In North Dakota, providers receive additional payments when adoptions are completed within 12 months of TPR; and/or when

⁶ Michigan's adoption contracts (that were being re-negotiated at the time of data collection for this paper) are another example of PBCs first implemented in the mid 1990's.

they place children who did not have a pre-identified placement. In Wyoming's residential care contracts, providers are paid decreasing amounts the longer the child remains in residential care.

- ***Contracts that pay for a mix of completed services and client outcomes.*** In Minnesota for example, all contract payments are linked to completing discrete services (e.g. training adoptive parents and completing home studies) and for placing children into adoptive homes. Minnesota also pays providers enhanced amounts for placing older children and sibling groups.
- ***Contracts that only pay when target services are delivered.*** New Mexico redesigned its contracts to pay providers higher rates for home studies completed more quickly. The state pays three different rates for completed home studies, based on time to completion.

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Appendix A

Time 2 Cross-Site Focus Group Questions

Private Agency Directors

1. First, to help us put your answers in context, we need to know everyone's role in the implementation of these contracts and how long you've been involved with them. First briefly tell us **your role in overseeing these contracts** and then tell us **how long** you've been doing this for these contracts.
2. We're now going to ask you about the planning for and oversight of these contracts. We understand that you have participated in contract oversight or decision making meetings to discuss and refine the contracts and/or data collection. Since the contracts were implemented, did the **purpose or focus of these meetings change**? If so, can you give examples?
3. Since these contracts were initially implemented, have there been any **changes in your role in the decision making process** and the amount of input you give in the decisions about these contracts? Explain.
4. Turning now to the contracts themselves, what do you believe are the **central goals of these contracts**?
5. **Did these contracts and QA bring about any changes to the way you did business? Did you change any front line practice? Caseloads? Did you implement any new program supports** [e.g. protocols, new case management systems, etc] to help you meet the performance targets and/or monitor your performance?
6. **For your agency, did the PBC and the expanded QA system have the intended effects on the performance measures? Why or why not?**
7. You mentioned some changes you made related to [practice/caseloads/supports], thinking about all of the changes that have taken place in the past couple of years, what one or two things had the greatest impact on the performance measures?
8. Were there other, **unintended consequences** of these contracts?
9. What other **contextual events** have impacted the performance measures?
10. Do you have any **recommendations** for other states and jurisdictions that might implement these types of contracts?

Private Agency Supervisors

1. First, to help us put your answers in context, we need to know everyone's role in the implementation of these contracts and how long you've been involved with them. Briefly tell us your role in working with these contracts (e.g. I am a supervisor in the foster care unit) and then tell us how long you've been doing this for these contracts.
2. We're now going to ask you about the planning for and oversight of these contracts. Did you ever participate in any planning or oversight meetings for these contracts?
 - a. (If no) Were you ever asked to provide input on the performance measures contained in these contracts or the kinds of data that should be collected?
 - i. (If so,) did you feel like your input in these meetings was incorporated into the decisions?
 - b. (If yes) Since the contracts were implemented, did the **purpose or focus of these meetings change**? If so, can you give examples?
 - c. Over time, have there been any **changes in your role in the decision making process** and the amount of input you give in the decisions about these contracts? Explain.
3. What do you think are the **overall goals** of these contracts?
4. As you know, the contracts have specific performance measures about []. Do you think that any case practice has changed (the way your workers work with families or the way they conduct casework) to help meet these measures? If so, what has changed?
 - a. Have there been changes made to staffing/caseloads?
5. Were any **program supports** put into place [e.g. training, protocols, new case management systems, etc] to help you meet the performance targets and/or monitor performance? If so, which were most helpful to improving performance?
6. How, if at all, have changes in your agency's QA system impacted the way you work with your staff?
7. **Has your team/unit's performance on these measures changed since the contracts were implemented Why or why not?**
8. Were there other, unintended consequences of these contracts?
9. What other **contextual events** have impacted the performance measures?
10. Do you have any **recommendations** for other states and jurisdictions that might implement these types of contracts?

Private Agency Caseworkers

1. First, to help us put your answers in context, we need to know everyone's role in the implementation of these contracts and how long you've been involved with them. First briefly tell us your role in working with these contracts (e.g. I am a caseworker for the out-of home care population) and then tell us how long you've been doing this for these contracts.
2. Turning now to the contracts implemented in ____, what do you think are the **overall goals** of these contracts?
3. Were you ever asked to provide input on the performance measures contained in these contracts or the kinds of data that should be collected?
 - a. (If so,) did you feel like your input in these meetings was incorporated into the decisions?
4. As you know, the performance measures in these contracts are related to: [list]. Do you think that any case practice has changed (the way you work with families or the way you conduct casework) to help meet these measures? If so, what has changed?
 - b. Have there been changes in the services you provide or staffing/caseloads?
5. Turning now to the **quality assurance system** in place to monitor these contracts, were you directed to change the way you reported on the services you provide to families or the way you report on the status or outcomes of your families? Can you provide examples?
6. Were any **program supports** put into place [e.g. training, protocols, new case management systems, etc] to help you meet the performance targets and/or monitor your performance? If so, which were most helpful?
7. **Is your team/unit performing any better on these measures? Why or why not?**
8. Were there other, unintended consequences of these measures?
9. What other **contextual events** have impacted the performance measures?
10. Do you have any **recommendations** for other states and jurisdictions that might implement these types of contracts?

SECTION 4

SUSTAINABILITY AND DISSEMINATION

Sustainability

Many aspects of the PBC/QA interventions are currently being built into the overall workings of the agencies involved, and therefore sustainability will be simplified and achievable. As budgets are extremely tight or even at a reduced level, it is difficult to fund some of the work of the project, especially evaluation of current practices. However, Illinois is continuing the funding of the local evaluation of the Residential and ILO/TLP PBC.

Missouri and Illinois are continuing their efforts in PBC/QA the most closely to their original model. Florida is continuing to use a PBC with the two new CMAs although the project's QA model is not being implemented. For example, Illinois will be looking at additional performance measures, specifically length of stay, and how it might be incorporated into the current PBC. The ILO/TLP PBC did get off the ground and they continue use knowledge learned throughout the project regarding communication, collaboration and planning. The Steering Committee is still in place and continues to guide the work of the Residential and ILO/TLP PBCs. In Missouri, some lessons learned have been applied in the expansion region in addition to the continued use of the CEO, Program Managers and QA/QI meetings. Missouri's continued use of cross-sector learning of best practices holds promise for system improvement. Florida is utilizing a PBC with its two new CMAs and is incorporating lessons learned in regards to the planning and implementation of the PBC with its new CMAs; however, it is not known how the current QA processes are being conducted.

Dissemination

QIC PCW shared the Children's Bureau's belief that in order for the field to learn from the knowledge developed from this Center and the projects, dissemination must be a primary focus from the beginning. It was important to strike the balance between getting information out in a timely way and not sharing information until there are conclusive findings. In the beginning, the QIC PCW collaborated with all three projects in the writing of peer-reviewed articles to presentations at national meetings and conferences. Individual project staff also presented on a state and local level as well as published articles specific to their project's work. In the final phase, the QIC staff, project staff and Advisory Board members are collaborating on a special issue publication for early 2012. The QIC Team coordinated the development of a committee consisting of National Advisory Board members and project staff to identify national dissemination opportunities in the last year of this grant.

Below are presentations and publications (published and non-published) that were conducted throughout the grant period by QIC Study Team and Project Staff. They are listed in the order in which they occurred.

Presentations & National Meetings

2006

- Hall, J. (2006). *National Quality Improvement Center on the Privatization of Child Welfare Services Needs Assessment*. CWLA Annual Conference Executive Leadership Institute, Washington, D.C.
- Collins-Camargo, C., Leavey, J., Metzenthin, J., Torres, E. (2006). *Preparing for Privatization—What Experience Has Taught Us: Case Studies from Two States*. CWLA Transforming Systems of Care Conference. Marlborough, MA.
- Collins-Camargo, C. & Hall, J. (2006). *National Quality Improvement Center on the Privatization of Child Welfare Services Needs Assessment* Council on Accreditation Meeting. New York, NY.
- Collins-Camargo, C. & Ensign, K. (2006). *Quality Improvement Center on the Privatization of Child Welfare Services: A Knowledge Development Initiative on Public/Private Partnerships*. National Conference on Child Welfare Privatization: Best Practices for Children and Families. Austin, TX.
- Collins-Camargo, C. (2006). *Regional Quality Improvement Centers Annual Meeting*. Children's Bureau. Washington, D.C.
- Brown, L., Collins-Camargo, C., Englander, B., Metzenthin, J. (2006). *Privatization: Adapting to Change in the 21st Century*. Child Welfare League of America Commissioner's Roundtable, Providence, RI.

2007

- Collins-Camargo, C., Ensign, K., & Hall, J. (2007). *Developing Knowledge Regarding the Usefulness of Privatization in Child Welfare Services*. 16th National Conference on Child Abuse and Neglect: Protecting Children, Promoting Healthy Families, and Preserving Communities. Portland, OR.
- Collins-Camargo, C., Kelly, M., & Krueger, L. (2007). *The Child Welfare Privatization Evidence Base: Where Do We Go From Here?* Council on Social Work Education Annual Program Meeting, San Francisco, CA.
- Collins-Camargo, C. & Hall, J. (2007). *American Federation of State, County and Municipal Employees (AFSCME) Meeting*. Washington, D.C.
- Collins-Camargo, C. & Hall, J. (2007). *Privatization of Child Welfare Services: What Do We Know and Where Do We Go from Here?* Prevent Child Abuse Kentucky: Kids Are Worth It! Conference, Lexington, KY.

2008

- Hall, J. (2008). *Public-Private Partnerships: Lessons Learned*. National Conference on Strengthening Families. St. Louis, MO.
- Collins-Camargo, C. (2008). *9th Annual Excellence in Supervision Conference: Strategies for a Brighter Future sponsored by the Kansas Department of Social and Rehabilitation Services Children and Family Services and the Child Welfare Resource Network, University of Kansas School of Social Welfare*. Lawrence, KS.
- Collins-Camargo, C. & Hall, J. (2008). *Annual Meeting of National State Organizations of Child Care Providers, Savannah, GA*.
- Collins-Camargo, C., Elder, J., Kearney, K. & Sundet, P. (2008). *Using Data to Drive Evidence-Informed Practice and Outcomes: Performance Based Contracting and Quality Assurance Systems*. 11th National Child Welfare Data and Technology Conference. Washington, D.C.
- Collins-Camargo, C. & Hall, J. (2008). *Emerging Themes and Finding Regarding Public/Private Partnership in Service Delivery*, Kentucky Department for Community Based Services, Frankfort, KY.
- Berglind, M. (2008). *Performance Based Contracting in Illinois*. Texas Child Care Administrators Annual Conference, Texas Alliance for Child and Family Services, Austin, TX.
- Berglind, M. & McEwen, E. (2008). *Public/Private Partnerships and the Illinois Child Welfare Advisory Committee*. Texas Child Care Administrators Annual Conference, Texas Alliance for Child and Family Services, Austin, TX.
- Bloom-Ellis, B. & Morris, A. (2008). *Moving the System Forward: Performance Based Contracting in Residential Treatment in Illinois*. American Association of Children's Residential Centers Annual Conference, San Diego, CA.

2009

- Jordan, N. (2009). *Development and Implementation of Risk-Adjusted, Performance-Based Contracting System for Children's Residential Treatment Programs*. Integrating Services, Integrating Research for Co-Occurring Conditions Conference, Sponsored by the University of South Florida, National Institute on Drug Abuse (NIDA), and the National Institute of Mental Health (NIMH), Bethesda, MD.
- Anderson, M. & Hall, J. (2009). *Wall Street to Main Street: An Economic Crisis in Child Welfare*. National Child Welfare League of America Conference, Washington, D.C.
- Bloom-Ellis, B, Jordan, N., Kearney, K. & Morris, A. (2009). *Leveling the Playing Field: Using Risk Adjustment to Enhance Performance Based Contracting in Residential Treatment*. National Conference on Child Abuse and Neglect, Atlanta, GA.
- Collins-Camargo, C., McEwen, E., Schuler, C., Sundet, P. (2009). *Using Data to Drive Evidence-Informed Practice and Outcomes: Performance Based Contracting and Quality Assurance Systems*. National Conference on Child Abuse and Neglect, Atlanta, GA.
- Billingsley, J., D'Aiuto, W., Elder, J., & Foster, S. (2009). *Performance Based Contracting & Quality Assurance - Implementation and Practice Implications from a Front-Line Perspective*. National Conference on Child Abuse and Neglect, Atlanta, GA.

- Hollie, M., Kearney, K. & McEwen, E. (2009). *Building a Protective Timeline for Strengthening Families with Effective Public-Private Partnerships*. National Conference on Child Abuse and Neglect, Atlanta, GA.
- Collins-Camargo, C. (2009). *Public/Private Partnership in Child Welfare*. National Network for Social Work Managers 20th Management Institute, Orlando, FL.
- Crowel, R. L., Blasé, K., Collins-Camargo, C., & Vincent, P. (2009). *Defining and Evaluation Organizational and System's Change*. National Child Welfare Evaluation Summit, Washington, D.C.
- Jordan, N. (2009). *The Development of the Risk Adjustment Model for Residential Treatment, National Institute of Mental Health*. 20th Conference on Mental Health Services Research: Increasing the Efficiency of Research and Mental Health Services Delivery, Washington, D.C.
- Collins-Camargo, C., DeStefano, D., Haslag, L., Garstka, T., Kearney, K., & Sundet, P. (2009). *Performance Based Contracting and Quality Assurance Systems as Drivers of Evidence-Informed Practice and Outcome Achievement: Public/Private Partnership and Innovation in Three States*. National Data and Technology Conference: Making IT Work for Children: Improving Data for Agencies, Tribes and Courts in Bethesda, MD.
- Bloom-Ellis, B., Kearney, K., & McEwen, E. (2009). *Striving for Excellence: Illinois QIC PCW Project*. National Summit on Public/Private Partnership: The Audacity of Partnership, St. Louis, MO.
- Collins-Camargo, C., Ensign, K., Garstka, T., & Hall, J. (2009). *National Summit on Public/Private Partnership: The Audacity of Partnership*, St. Louis, MO.
- Cooper, J., Elder, J., & Schuler, C. (2009). *Florida: Improving Outcomes for Children in Out-Of-Home Care through Performance-Based Contracting and Enhanced Quality Assurance Processes*. National Summit on Public/Private Partnership: The Audacity of Partnership, St. Louis, MO.
- Garstka, T. (2009). *Evaluating Performance: Findings from the National Cross-Site of the QIC PCW*. National Summit on Public/Private Partnership: The Audacity of Partnership, St. Louis, MO.
- Haslag, L. & Sundet, P. (2009). *The Road to Performance Based Case Management Contracts: The Missouri Experience*. National Summit on Public/Private Partnership: The Audacity of Partnership, St. Louis, MO.
- Lee, E. (2009). *Examples of Performance-Based Contracting in Child Welfare Services*, National Summit on Public/Private Partnership: The Audacity of Partnership, St. Louis, MO.
- Collins-Camargo, C., McEwen, E., Schuler, C., Sundet, P. (2009). *Using Data to Drive Evidence-Informed Practice and Outcomes: Performance Based Contracting and Quality Assurance Systems*. National Conference on Child Abuse and Neglect, Atlanta, GA.
- Billingsley, J., D'Aiuto, W., Elder, J., & Foster, S. (2009). *Performance Based Contracting & Quality Assurance - Implementation and Practice Implications from a Front-Line Perspective*. National Conference on Child Abuse and Neglect, Atlanta, GA.

- Hollie, M., Kearney, K. & McEwen, E. (2009). *Building a Protective Timeline for Strengthening Families with Effective Public-Private Partnerships*. National Conference on Child Abuse and Neglect, Atlanta, GA.

2010

- Collins-Camargo, C. (2010). *CEO Advisory Committee: A Strategic Conversation: The Future of Child Welfare* at the National Child Welfare League of America Conference, January 2010, Washington, D.C.
- Kearney, K. (2010). *Texas Child Welfare Reform Advisory Panel of the Striving for Excellence performance based contracting model for residential care*. San Antonio, TX. Sponsored by Casey Family Programs as a peer-to-peer initiative.
- Kearney, K. & Vimont, M. (2010) *Public/Private Partnerships: Improving Outcomes for Children and Families*. American Association of Children's Residential Centers: Celebrating Our Roots, Nurturing Our Future. Boston, MA.
- Collins-Camargo, C., Haslag, L., Kearney, K., & Schuler, C. (2010). *Performance Based Contracting and Quality Assurance Systems: Findings from a Three-State Study Regarding Improvement in Organizational, Practice and Child Outcomes*. 13th Annual National Child Welfare Data and Technology Conference. Washington, D.C.
- Elder, J. & DeStefano, D. (2010). *Performance-Based Contracting: Key Components for Developing a Foundation and Framework for Successful Implementation*. 13th Annual National Child Welfare Data and Technology Conference. Washington, D.C.
- Kearney, K. & Bloom-Ellis, B. (2010). *Putting It All Together: Using Data and Performance Based Contracting to Drive System Improvement in Residential, Independent & Transitional Living Programs in Illinois*. 13th Annual National Child Welfare Data and Technology Conference. Washington, D.C.
- Hall, J., Garstka, T., DeStefano, D. & Kearney, K. (2010). *Innovations in Performance-Based Contracting and Quality Assurance Systems*. National Alliance for Children and Families Conference. Milwaukee, WI.
- Collins-Camargo, C. (2010). *A Study of Child Welfare Performance Based Contracting and Quality Assurance Systems*. Council on Social Work Education Annual Program Meeting, Portland, OR.
- Collins-Camargo, C., Garstka, T., Hall, J. (2010). *National Organization for State Associations for Child Caring Agencies (NOSAC) Bi-annual Meeting*. Key West, FL
- DeCerchio, K., Collins-Camargo, C., & Sullivan, R. (2010) *Fostering Public/Private Partnerships/Strengthening Families*. Children's Bureau Discretionary Grantees Meeting, Family Connections Cluster. Washington, DC.
- Collins-Camargo, C., & Hall, J. (2010). *Public/Private Partnerships in Child Welfare—What Have We Learned?* National Webinar sponsored by the National Resource Center on Child Protective Services and the National Citizen Review Panel's National Advisory Board.

- McBeath, B., Collins-Camargo, C., & Ensign, K. (2010). *Managerial Agency in the Context of Privatization and Performance Contracting in Child Welfare*. Society on Social Work and Research Annual Meeting, January 2011, Tampa, FL.

Publications

The following documents (non-published) were created by the QIC PCW Study Team:

- QIC PCW Brochure
- Florida Project Fact Sheet
- Illinois Project Fact Sheet
- Missouri Project Fact Sheet
- Knowledge Gaps Analysis Findings (2006)
- Literature Review on Child Welfare Privatization (2006)
- Literature Review on Performance Based Contracting and QA Systems (2006)
- Updated Annotated Bibliography (2009)
- Key Informant Report (2006)
- Key Informant Report (2008)
- Examples of Performance Based Contracting in Child Welfare (2009)
- Assistant Secretary for Planning and Evaluation (ASPE) Topical Papers
 - Assessing Site Readiness: Considerations About Transitioning to a Privatized Child Welfare System (2007)
 - Program and Fiscal Design Elements in Privatized Child Welfare Programs (2007)
 - Evolving Roles in Public and Private Agencies in Privatized Child Welfare Systems (2008)
 - Evaluating Privatized Child Welfare Systems: A Guide for Program Managers (2008)
 - Preparing Effective Contracts in Privatized Child Welfare Systems (2008)
 - Ensuring Quality in Contracted Child Welfare Services (2008)
- Summit Proceedings Reports (2007 - 2010)
- Findings from Final Site Visits (2010)
- Executive Summary of Final Findings (2011)

The following publications were created by QIC PCW Study Team, Project Staff and partners and either have been or are being published in peer-reviewed journals:

Collins-Camargo, C. (In Press). Special Editor's Introduction. *Journal of Public Child Welfare*.

Garstka, T., Collins-Camargo, C., Hall, J., Neal, M., & Ensign, K. (In Press). Implementing Performance Based Contracts and Quality Assurance Systems in Child Welfare Services: Preliminary Results from a National Cross-Site Evaluation. *Journal of Public Child Welfare*.

- Elder, J.K., DeStefano, D., Blazeviski, J., & Schuler, C. (In Press). Key Considerations for Developing a Foundation and Framework for Successful Implementation of Performance-Based Contracting: A Case Study of a Child Welfare Lead Agency in Florida. *Journal of Public Child Welfare*.
- Haslag, L., Matt, R. L., & Neal, M. (In Press). Missouri's Developing Public/Private Partnership for Child Welfare: Using Performance-Based Contracting to Achieve System-wide Results. *Journal of Public Child Welfare*.
- Kearney, K. A., Bloom-Ellis, B., & Thompson, R. (In Press). Breaking Down the Silos: Lessons Learned from the Expansion of Performance Based Contracting to Residential Treatment Services in Illinois. *Journal of Public Child Welfare*.
- Collins, J., Edwards, M., Light, A., Miller, N., Makievsky, P., Snell, L., & Collins-Camargo, C. (In press) The Future of Public/Private Partnership in Child Welfare: A Multidimensional Exploration of the Perspectives of the Public and Private Sectors, the Judiciary, Frontline Staff, and the Community. *Journal of Public Child Welfare*.
- Collins-Camargo, C., Shackelford, K. & Kelly, M. (In Press). Collaborative Research in Child Welfare: A Rationale for Rigorous Participatory Evaluation Designs to Promote Sustained Systems Change. *Child Welfare*.
- Collins-Camargo, C., McBeath, B. & Ensign, K. (In Press). Privatization and Performance-Based Contracting in Child Welfare: Recent Trends and Implications for Social Service Administrators. *Administration in Social Work*.
- Collins-Camargo, C. & Ensign, K. (2010). Driving Case Outcomes in Child Welfare: Are Performance-Based Contracts the Answer? *Policy and Practice Magazine*. Published by the APHSA.
- Hall, J. & Collins-Camargo, C. (2010). How Creating a Shared Vision Can Improve More than Outcomes. *Policy and Practice Magazine*. Published by the APHSA.
- Kearney, K.A., McEwen, E., Bloom-Ellis, B., & Jordan, N. (2010). Performance-based contracting in residential care and treatment: Driving policy and practice change through public-private partnership in Illinois. *Child Welfare*, 89(2), 39-55.
- Collins-Camargo, C. (2007). Public/private partnership in the delivery of child welfare services: Is privatization a trend and is it working? *State News*, published by the National Council of State Governments, 50(1): 23-25.

- Collins-Camargo, C. (2007). Special editor's introductory note: Privatization and performance based contracting in child welfare. *Professional Development: The International Journal of Continuing Social Work Education*, 10(3), 5-6.
- Collins-Camargo, C., Ensign, K., & Flaherty, C. (2008). The National Quality Improvement Center on the Privatization of Child Welfare Services: A program description. *Research on Social Work Practice*, 18(1), 72-81.
- Collins-Camargo, C., Hall, J., Flaherty, C., Ensign, K., Garstka, T., Yoder, B., & Metz, A. (2007). Knowledge development and transfer on public/ private partnerships in child welfare service provision: Using multi-site research to expand the evidence base. *Professional Development: The International Journal of Continuing Social Work Education*, 10(3), 14-31.
- DeStefano, D., Elder, J., Cooper, J., & Schuler, C. (2007). Performance-based contracting: The impact of inclusive contract planning, incentive measures and continuous quality improvement on child welfare practice and outcomes within a Florida community based care network. *Professional Development: The International Journal of Continuing Social Work Education*, 10(3), 58-66.
- Flaherty, C., Collins-Camargo, C., & Lee, E. (2007). Privatization of child welfare services: Lessons learned by experienced states regarding site readiness assessment and planning. *Children and Youth Services Review*, 30(7), 809-820.
- Flaherty, C., Collins-Camargo, C., & Lee, E. (2008). Privatization of child welfare services: Lessons learned by experienced states regarding contract payment systems, contract management and ongoing oversight of privatized systems. *Professional Development: The International Journal of Continuing Social Work Education*, 11(1), 6-18.
- Kearney, K.A., & McEwen, E. (2007). Striving for excellence: Extending child welfare performance based contracting to residential, independent and transitional living programs in Illinois. *Professional Development: The International Journal of Continuing Social Work Education*, 10(3), 32-48.
- Watt, J.W., Porter, R., Renner, L.M., & Parker, L.M. (2007). Maintaining positive public-private partnerships in child welfare: The Missouri project on performance-based contracting for out-of-home care. *Professional Development: The International Journal of Continuing Social Work Education*, 10(3), 49-57.
- Wright, V., & Radcliff, L. (2007). The Privatization of Child Welfare Services: Issues and Efforts at the Federal Level. *Professional Development: The International Journal of Continuing Social Work Education*, 10(3), 7-13.

SECTION 5

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The following conclusions are organized around the QIC PCW's five research questions that guided the work of the local and cross-site evaluation:

1. Does an inclusive and comprehensive planning process produce broad-scale buy-in to clearly defined performance-based contract goals and ongoing quality assurance?
2. What are the necessary components of performance-based contracts and quality assurance systems that promote the greatest improvements in outcomes for children and families?
3. When operating under a performance-based contract, are the child, family and system outcomes produced by private contractors better than those produced under the previous contracting system?
4. Are there essential contextual variables that independently appear to promote contract and system performance?
5. Once implemented, how do program features and contract monitoring systems evolve over time to ensure continued success?

Conclusions Related to the Planning Process

Given the complex relationship between public and private partnerships within a performance-based contracting system, the *collaborative planning process was identified as one of the most important factors in the success or failure of their efforts*. Although the structure of the decision making process was different across sites, it was evident that the sites took an inclusive approach when negotiating performance-based contracts and designing quality assurance and quality improvement systems.

The collaborative nature of the private-public partnerships in each site shows that there was general agreement that the group had a collaborative communication structure, process, purpose, goal, environment, and partners. While some variations existed, the results generally demonstrate that the public private partnerships were collaborative in their initial planning process and maintained that over time.

The collaborative nature of the partnerships was not always reflected on the frontline level as some workers indicated in focus groups that they felt less included in the process. In all sites, many workers were unclear about some of the details of PBC and how decisions were made. However, sites showed an effort over time to use data to help assist staff in understanding best practices and how outcomes were measured. This could an area where

more targeted efforts are made to ensure that collaboration and communication extends from the higher decision-making levels down to the frontline.

Finally, undertaking this level of system change requires sufficient time to plan since it affects all levels of an organization or agency. Data collected as a part of the QIC PCW's first year knowledge gaps assessment revealed that many states had not taken—or were not permitted to take—sufficient time to plan, and frequently did not reach out beyond the public agency for its planning efforts. Many times legislatures or other policy-makers mandate an unreasonably short time period to roll out required privatization or contracting initiatives. The data collected by the QIC suggests that this is a major error and may be closely tied to the significant challenges and poor outcomes suffered in some jurisdictions. Sufficient time is needed to ensure that all parties understand the outcomes being measured, how they are measured, and how these contracts affect each side fiscally. Additionally, time is needed upfront to make sure the right data is available to measure each outcome or to make the necessary changes to guarantee accurate and reliable data to inform the system as a whole.

Conclusions Related to the Necessary Components of Performance Based Contracting and Quality Assurance Systems

While it is difficult to identify any one necessary component of a successful PBC/QA system, some key lessons learned from these three sites identify important factors that any site needs to consider when designing such a system:

- The importance of selecting the appropriate contract performance measures and aligning those outcomes with shared goals across public-private partnerships
- The importance of setting appropriate benchmarks for performance in contracts and collaboratively monitoring performance
- The importance of having and using reliable data to assess performance and improve quality (QA/QI)
- The importance of sharing risk in a contractual relationship between public and private agencies

In regards to the above components, it should be emphasized that the “right” performance measures/indicators and benchmarks this is not an established list which can be adopted from one state to another. The QIC is often asked by states to provide such a list, in “cookbook fashion.” The right combination for any state is unique and is based on their current system's performance, the nature of the data they have available, their goals related to Child and Family Service Review findings and plans, and the services being shifted to the private sector. The process of the public and private sectors, and the appropriate external partners, of determining the right measures and benchmarks is as important as the selection itself as it leads to system-wide buy-in and clarity on how performance will be measured and improvement promoted. As important as the establishment of the contract itself is the quality improvement processes that need to be put in place to enable the sectors to collaboratively track progress, assess relevant incentives and disincentives, and share promising practices that seem to be associated with the

achievement of positive outcomes across sectors and agencies. A certain amount of interagency competition can be healthy, however the public sector should not allow this, and proprietary business practices within individual agencies to get in the way of overall system improvement. The very flexibility and creativity that contracting with private agencies offers the more bureaucratic public child welfare system should be harnessed to enable the kind of outcomes for children and families that are desired system-wide.

There were several common elements across the sites that emerged and were identified as being critical to the successful implementation of PBC/QA. How those elements played out in an individual site or the level of significance each one played cannot be known. Instead, general themes emerged across sites and are shown in the table below.

Common Elements for Success	
Political	Right Time and Support for Change
Leadership	Right Leaders Driving Change & Staying Involved
Collaboration	Inclusive Planning Process Between Public & Private
Planning	Sufficient Time to Plan
Communication	Formalized, Transparent Communication Structure
	Meaningful Feedback to All Levels
Practice	Support for Practice Change
Data	Having and Using Reliable Data
QA/QI	Restructuring QA/QI Process to Support PBC
Outcomes	Selecting Right Outcomes and Building a Contract Around Them

The following site-specific components were identified as helping facilitate outcomes and help improve organizational and system change:

Site-Specific Supports for Achieving Success			
	FLORIDA	ILLINOIS	MISSOURI
Collaboration Support	<ul style="list-style-type: none"> • Neutral Facilitator • Supervisory Roundtable 	<ul style="list-style-type: none"> • Provider Forums & Info Dissemination • Issue-Specific Workgroups 	<ul style="list-style-type: none"> • Program Manager Meetings • Issue-Specific Workgroups
Outcome Support	<ul style="list-style-type: none"> • Supervisory Review Tool • Family Finders 	<ul style="list-style-type: none"> • Discharge & Transition Protocol • Child Youth Investment Teams (CAYIT) & Centralized Matching 	
Practice Support			<ul style="list-style-type: none"> • Statewide Practice Summits
Decision Making Support		<ul style="list-style-type: none"> • Child Welfare Advisory Committee (CWAC) 	<ul style="list-style-type: none"> • CEO Meetings
Organizational/System Support		<ul style="list-style-type: none"> • University Research Partnerships 	
Data Support		<ul style="list-style-type: none"> • Residential Treatment Outcome System (RTOS) • Data Test Workgroup 	<ul style="list-style-type: none"> • Random Case Assignment
Quality Assurance Support	<ul style="list-style-type: none"> • Detailed Agency & Worker-Specific QA Reports 	<ul style="list-style-type: none"> • Monitoring Shift to Quality vs. Compliance 	<ul style="list-style-type: none"> • Joint Public/Private QA/QI Alignment

Conclusions Related to Outcome Improvement

While it was not possible in this evaluation to systematically test whether outcomes achieved under the PBC model were better than those under the previous system, it was possible to analyze whether outcomes in the demonstration sites improved over time while under the PBC model. This speaks to the issue of whether sites were able to improve and sustain agency performance given the contract structure and other organizational supports in place.

Overall, data from this cross-site evaluation showed that on almost all outcomes in all sites, agencies showed an improvement in performance and demonstrated that they consistently improved their ability to meet their contract targets from QIC Project Year 1 to QIC Project Year 2. Regardless of the outcome or how it was measured, this improved performance was consistently positive. For example, more biological parents were contacted by case workers in Florida in the second year of PBC than in the first. In Missouri, more children were moved to permanency placements in the second year of PBC than in the first. In Illinois, youth remained in residential care more days and were hospitalized or incarcerated less in the second year of PBC than in the first.

As agencies were able to make systematic changes to their organization and measure the impact of putting PBCs in place, their relative performance on the outcomes specified in their contracts showed a positive and considerable increase overall. These results are promising in that the direction of agency or system change is positive and leading to improved outcomes at the organizational and child/family level.

Taken together, the data suggests that sites in this study who implemented PBC for this project (Illinois, Florida) or those that made changes to their existing PBC system (Missouri) were able to demonstrate some positive changes in outcomes at the organizational and child-level. Future data beyond these two years is needed to determine if this impact is sustained.

Conclusions Related to Contextual Factors that Promote Contract and System Performance

While each site had unique state or local factors, four common variables appeared across the sites and were perceived to have an important role in influencing the implementation of PBC/QA, the public-private partnership, and the outcomes under consideration.

Leadership: In all sites, stakeholders believed that the changes necessary implement PBC and to the system as a whole were a function of key, committed and authentic leadership at both the public and private level. System changes inherent in PBC require leaders who will drive those changes via a strong public-private collaborative partnership, leaders who will hold agencies accountable for performance, and leaders who will assume responsibility for the

difficult decisions and compromise necessary for this work. Leadership at all levels can help drive practice and bring necessary resources to help improve outcomes for children.

Resources, Budgets, and Political Climate: All sites discussed the challenges of PBC when resources are tight, budgets are cut, and the political climate makes change difficult. Fewer resources make it difficult for agencies to provide the range of services needed to ensure positive outcomes for the children they serve. Additionally, budget cuts impact the extent to which public agencies can incentivize contracts and support private partners. Similarly they impact the extent to which private agencies can sustain penalties and keep the doors open. A robust cost analysis of PBC was not conducted for this evaluation, and would not have been valid given the economic situation that impaired states through the latter half of the intervention period. Such data is necessary for determining the effectiveness and efficiency of PBC within an out-of-home care system. Given potential cuts to social services across the country, understanding the fiscal implications of PBC will be critical for stakeholders in the legislature, the public child welfare agency, and the private provider community.

Data Systems: One key factor stakeholders identified as affecting the implementation of PBC and effectively managing performance across diverse agencies is the data system used to monitor performance. Given the complexity of the performance indicators measured in sites and the kind of data required for PBC, an unreliable or incomplete data system can be a huge barrier to overcome. State-wide data management systems are often not designed to easily generate the data needed for monitoring PBC. Duplicate agency data systems and workarounds are common. Challenges associated with the state's data system were a major impediment in two of three demonstration sites. All sites agreed that PBC requires a transparent, robust, and accurate data system. Data systems may not influence outcomes themselves, but they do impact the ability of the public and private agencies to monitor performance and identify necessary practice changes to improve services.

Concurrent Initiatives: In all sites, PBC did not operate in a vacuum within the child welfare system and service delivery agencies. Many concurrent initiatives designed to improve services and practice at the system and agency level occurred in all sites. These programs included programs to address the front-end of the child welfare system. Other initiatives focused on changes to how practice and supervision occurred. As a result, it is impossible to attribute all outcomes achieved during the QIC project to PBC alone. Rather, complex systems such as those in place in the sites require complex explanations for the kinds of outcomes they produce.

Conclusions Related to the Evolution of the PBC Over Time and Continued Success

Within all three sites, staff noted that over the three-year period, emphasis shifted from compliance and direct oversight of practice and process, to technical assistance and developing a continuous quality improvement (CQI) approach focused on outcome achievement. In

support of this, communication emerged as a critical component. The evolution of QA/QI systems to CQI in conjunction with PBC produced a greater understanding of the role of the public and private agencies involved.

Additionally, as sites implemented PBC and began monitoring performance, it became apparent that other adjustments were made during this project: 1) Performance measures selected were either refined, re-defined, or dropped all together from the contracts; 2) New quality assurance activities were designed and data was used to initiate joint private-public quality improvement changes; 3) Incentives and disincentives were re-negotiated, discontinued, or refined in response to fiscal factors or collaborative practices; and 4) Communication efforts began to more effectively target front-line case managers and supervisors.

Another factor that is ever-present over time is the evolution of the public/private partnership itself. The three sites all demonstrated that this is not a relationship that is established once and for all, allowing the system to move forward. Ups and downs in the relationship are inevitable. Even in Illinois with a partnership that spans decades, the public/private relationship was strained to its limits at particular times in the intervention. Leadership changes which are common in child welfare only exacerbates this challenge. It is imperative that the partnership establish formalized communication and collaborative structures—perhaps through formal legislation or interagency agreement—that can withstand changing administrations and serve as a foundation for working through the partnership challenges that will be experienced.

All sites indicated that successfully implementing PBC in their individual sites was an on-going process rather than a static one-time change in the structure of the system and the way business was done. Much of the evolution over time in the sites was in response to data directly related to and generated by performance-based contracts. Additionally, all sites indicated that, while at times challenged and difficult, the public-private partnerships grew stronger due to the collaborative nature of the planning process and the on-going work together.

Recommendations

Recommendations for policy-makers and program-developers

The following recommendations have been made by the QIC and grantees for public and private agency child welfare administrators and leadership as they go about planning and implementing a performance based contract and quality assurance/improvement system:

- ***Institutionalize a collaborative planning process*** through which leaders from both public and private sectors can engage with one another and seek shared solutions to child welfare policy and practice problems. When this type of venue is created, it can stand the test of time and change (i.e. public administration).

- The ***partnership needs to be built upon ongoing, open communication***. Provide forums for regular communication regarding progress and issues. Public agency leaders have to set the tone for the partnership.
- ***Clearly define*** the intent of the contract performance measures. It is important that not only should the creators of the performance measures understand what is being measured, how benchmarks were selected and how incentives or disincentives will be earned, but this must be understood by all who are responsible for performance improvement.
- ***Utilize a continuous quality improvement loop*** to continually identify the practice issues that arise when meeting contract performance measures. If the frontline is responsible for achieving outcomes, then the frontline should be engaged in the measurement of their performance and have input regarding the strategies for practice improvement. Front line staff can more often identify the facilitators and barriers to performance achievement.
- ***Identify existing data measures*** that can support PBC outcomes or, in the absence of existing measures, identify ways to implement PBC measures that can be assessed within budgetary constraints. Develop performance measures with the ***input of QA/QI staff***.
- ***Establish and maintain a clear strategic plan*** to ensure continuous direction and progress.
- ***Establish reasonable, achievable goals*** pertaining to outcome expectations and slowly increase target expectations as performance improves. If benchmarks are set too high, system improvement will be impeded.

Recommendations concerning QIC activities

It should be noted that despite the favorable findings of the QIC model generated by the national evaluation of the original, regional QICs, implementation of Quality Improvement Centers on a national level presents some unique opportunities and challenges. In addition, there are likely implementation tools and strategies developed by the current QICs that would be of use to newly funded QICs. It is recommended that the Children's Bureau develop strategies for sharing of such tools and lessons learned for both regional and national QIC implementation.

Although the Children's Bureau has begun to make strides in determining the role of Quality Improvement Centers within their broader Training and Technical Assistance Network,

and to facilitate enhanced collaboration with the National Resource Centers and other entities within it, much progress is still left to be made. It is critically important for this role to be established and clearly articulated. QICs present a very different yet valuable resource within the Network.

Based on the experience to date, we would make the following recommendations regarding future QICs:

- ***Allocate sufficient funding for subgrantees in order to provide for a quality independent evaluation of each project.*** Evaluator activities often exceeded the allotted FTE due to the requirements of the cross-site evaluation and local evaluation. The amount of technical assistance that the QIC must provide to grantees does not decrease substantially over time, and the role of particularly national QICs in overall knowledge development beyond the demonstration projects and facilitation of a national dialogue has become apparent. Therefore, sufficient funding at the QIC level is critical.
- ***Extend funding from a five-year cycle to a seven-year cycle,*** or possibly institute a re-application process if the knowledge being developed is proven to be timely and needed by the field. Models for such ongoing lines of research on topics of interest to the field are available elsewhere in the federal system. It is important to be able to demonstrate clear trends and findings and a three-year project implementation period does not allow enough time to demonstrate these kinds of findings.
- ***The Children's Bureau should require integration of the QICs and the T/TA Network.*** Each QIC should be partnered with an existing National Resource Center(s) (NRC) from the beginning so that knowledge learned during the grant period can be easily transferred and housed within that NRC, and consultants for the work can be identified and utilized through the T/TA Network to enable states to apply the knowledge gained through the QIC. The need for technical assistance by states has increased as the QIC PCW grant period is coming to a close, which demonstrates the critical need that states have in improving their systems through public/private partnership.
- ***The value of the National Advisory Board cannot be understated.*** This should be a required aspect of the QIC model. Selection of advisory board members should include representation from national, state and local agencies, public and private, as well as subject matter experts and researchers. The QIC PCW's Board proved to be a valuable asset in making key decisions, such as selecting the topical focus for the projects' work and developing and taking part in the dissemination plan. A great number of Board members provided the QIC and its project staff quality technical

assistance and were instrumental in opening doors for knowledge development and dissemination in collaboration with important national and state level organizations.

- ***A formal communication plan for the QIC and the projects should be required.*** Regular communication via email, monthly conference calls with individual projects, quarterly all project conference calls, and bi-annual in-person meetings helped to create camaraderie and set the tone for strategy and solution-building among the projects.
- ***It is worth the effort to negotiate the common methodology of the cross-site evaluation*** with the evaluators for each project. Although this can be a difficult process, it establishes a relationship between the researchers and an understanding that they are part of a larger initiative. The collaborative development—rather than centralized imposition—of common methodology cannot be emphasized enough. This is one of the benefits that the QIC model enables as opposed to other models of multisite research. This does not mean that rigor should be compromised. Requirements for compliance with the negotiated cross-site research design should be included in contracts with grantees, however, as well as sharing of all data collected and products develop through the demonstration project with the QIC for ultimate national dissemination as appropriate.
- ***QICs should make sure demonstration projects are similar enough to allow comparability and some common measurement.*** Part of this process involves helping projects to be explicit about how their intervention differs from others, and what aspects they all have in common. The QIC PCW experienced challenges in this regard despite significant efforts to explore aspects of this with applicants prior to funding decisions being made.
- ***Assure that local project evaluators are truly independent and external to the primary subgrantee.*** This should be explicated in the request for proposals and applicants should be required to address this in their narratives. If evaluators have other contracts or ongoing responsibilities with an agency, the pure and independent nature of the evaluation is compromised.
- ***Knowledge, as it is learned, needs to be disseminated to the field on a timely but cautious basis.*** Throughout the five-year grant period, the field moved forward quickly in looking at the evidence related to the topics of public/private partnership, performance based contracting and quality assurance systems. Knowledge learned through the participation of public and private agency leaders at the annual Summits provided an important opportunity for this QICs knowledge to be shared in a timely way without prematurely endorsing research findings. Other interim dissemination methods may be similarly useful.

- ***The QIC model implemented on a national level provides significant opportunity for engaging a national dialogue around topics of interest to the field***, as well as knowledge development initiatives beyond the demonstration projects. This opportunity should be taken advantage of, as the topical nature of the QICs enables specialization on a level not possible in the NRCs but of real value to the field.

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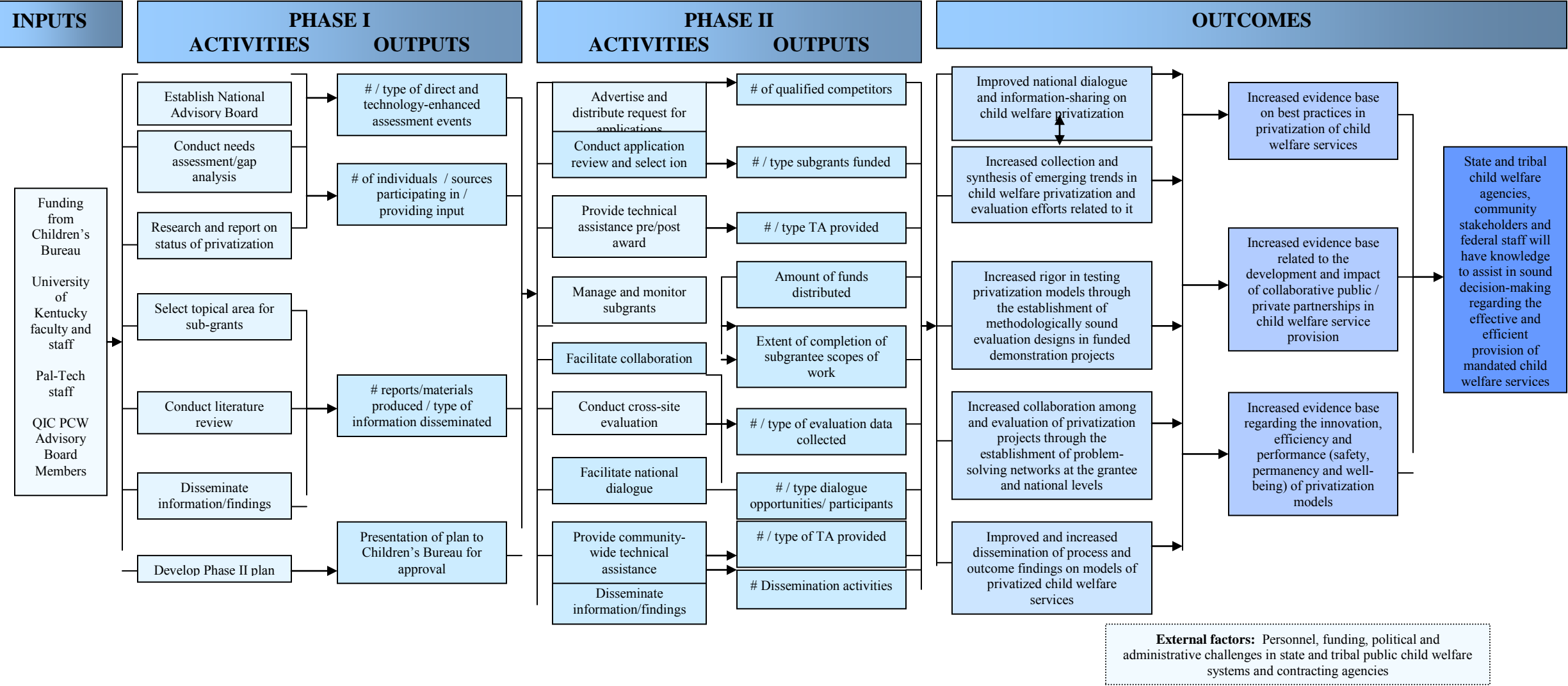
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APPENDICES

QUALITY IMPROVEMENT CENTER ON THE PRIVATIZATION OF CHILD WELFARE SERVICES LOGIC MODEL

SITUATION: Public child welfare agencies are required to demonstrate accountability and effectiveness in new ways. The results of the Child and Family Services Reviews, in conjunction with increasingly difficult caseloads and tight state budgets, have pressed states to assess alternative ways to meet service mandates. Some states are considering various forms of privatization of services or functions. There is a need to build a knowledge base of best practices in privatization efforts, and determine the effectiveness and efficiency of such approaches, and reaching consensus on appropriate reform models.

ASSUMPTIONS: Both public and private agencies need to be able to demonstrate their effectiveness in promoting the safety, permanency and well-being of children and their families. There is an underlying assumption that privatization leads to increased accountability and competition in the provision of child welfare services, but this is untested. Privatization efforts require clarification of roles and responsibilities between the state agency and private contractor, coupled with a collaborative partnership. Using a participatory approach, rigorous evaluation strategies are necessary to compare efficiency as well as progress toward organizational and client outcomes.





QIC PCW BEST PRACTICES

SHARED VISION

Through a shared vision of improved outcomes for the children and families of our Circuit, both the lead agency and the case management agencies can work together to implement positive change in the planning, contracting and evaluation of service provision.

PLANNING AND CONTRACT NEGOTIATION

Development of the shared vision is accomplished by creating contractual performance-based measures through an inclusive planning and consensus-building process.

CONTRACT MONITORING

Through fiscal incentives and disincentives and thorough contract monitoring, adherence to established performance-based measures can be encouraged.

QUALITY ASSURANCE

Evaluation of the project measures the impact of the collaborative contractual planning process, the influence of incentives on the ability of contracting organizations to meet these measures and the effectiveness of modifications to the quality assurance processes that monitor these contracts.

QUALITY IMPROVEMENT CENTER PRIVATIZATION OF CHILD WELFARE SYSTEMS (QIC-PCW) FLORIDA DEMONSTRATION PROJECT

The Florida Department of Children and Families (DCF), in collaboration with Kids Central, Inc. has established and implemented a demonstration project to identify the impact of several promising privatization practices on child welfare related outcomes.

Kids Central is the Community Based Care (CBC) Lead Agency responsible for organizing the network of care in Florida Judicial Circuit 5, which includes Citrus, Hernando, Lake, Marion and Sumter Counties. As the Lead Agency in Judicial Circuit 5, Kids Central is responsible for creating a system of care through contracts and informal agreements with community-based organizations, called Case Management Agencies (CMAs). The performance-based contracts and quality assurance processes between Kids Central and CMAs are the focus of this demonstration project.

The practices focused on in this project include:

- Articulation of a shared vision driving practice and outcomes
- Implementation of an inclusive planning and contract negotiation process involving private and public providers, administrative and practice staff
- Implementation of a comprehensive contract monitoring process, and
- Development of a quality assurance framework that ensures that the new outcome measures are appropriately evaluated and incorporate feedback-reporting procedures.

The target population for this project are children placed in out-of-home care. This includes all children residing in foster homes, residential treatment facilities, emergency shelters and group homes.

QUALITY IMPROVEMENT CENTER ON PRIVATIZATION OF CHILD WELFARE SERVICES FLORIDA DEMONSTRATION PROJECT

HISTORY OF PRIVATIZATION IN FLORIDA

In Florida, the term "privatization" refers to strategies that involve the provision of publicly funded services and activities by non-governmental entities. In 1996, the Florida Legislature mandated the outsourcing of child welfare services through the use of a Lead Agency design. Under this type of arrangement, the public agency contracts with one or more agencies within a designated region to provide or purchase services for the target population from the time of referral until the obligation ends, often at case closure. The intent of the original legislation was to strengthen the support and commitment of local communities to the reunification and care of children and their families, and increase the quality, efficiency and accountability of services.

Between 1999 and 2005, DCF systematically and effectively transitioned the management and day-to-day operations of the Child Welfare system to 22 Lead Agencies; including Kids Central, the experimental group in this demonstration project, and Partnership for Strong Families, the control group in this demonstration project.

Child abuse reports of neglect and abandonment (Hotline Reports) and CPS investigations remain in the public sector and are managed by DCF or by the local Sheriff's Department.

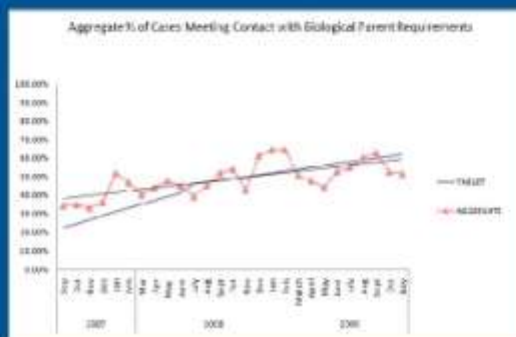
As the Lead Agencies in each of their respective districts, Kids Central and the Partnership for Strong Families are responsible for developing, coordinating and implementing a system of care through contracts and formal agreements with community-based organizations. In both the experimental and control groups, case management services are provided through multiple contract agencies referred to as Case Management Agencies (CMAs).

IMPROVED OUTCOMES FOR CHILDREN IN OUT-OF-HOME CARE

Through our rigorous evaluation process, we have identified three primary indicators of success of this program, including:

- **Face-to-Face Supervision**—These supervisions should occur within 4 days of receipt of the case and then again between 30-45 days after receipt of the case.
- **Entry of Case Information**—Case information should be entered into the SACWIS system within two days of receipt of case.
- **Contact with Biological Parents**—Federal law mandates that every effort be made to have contact with biological parents regarding the disposition of any case.

Below, we have provided information regarding the progress that has been made thus far on these indicators and the current status of each.



- A "Supervisory Review Tool" has been designed to guide and focus supervisory sessions with front-line staff
- Kids Central QA has assessed the quality and outcomes of face-to-face supervision
- The Tool has been modified by DCF and made available State-wide

- Extensive discussion centered on the intent of the measure and how it is to be measured.
- Continued difficulty in meeting target
- Strategies to promote compliance with measure proved successful on a short-term basis

- Compliance with required contact with biological parents was extremely low across the entire State
- Consensus regarding giving "credit" for attempted contacts or alternative methods of contact was reached
- Project partners have discussed engagement with parents extensively

STRIVING FOR EXCELLENCE:
Expanding Performance Based Contracting to Residential,
Independent Living and Transitional Living Programs in Illinois



Project Overview

Illinois led the nation in the implementation of performance based contracting and quality assurance (PBC/QA) initiatives for foster care case management. This initiative extends performance based contracting to over 60 residential, independent and transitional living programs serving approximately 2,500 children and youth in the Illinois child welfare system, many of whom have increasingly severe and complex treatment needs. The *Striving for Excellence* project is a partnership between the Illinois Department of Children and Family Services (public child welfare agency), the Child Care Association of Illinois (private child welfare agency association) and the Children and Family Research Center of the University of Illinois (project evaluator).

The overarching goals of the *Striving for Excellence* project are to:

- Improve outcomes for children and youth;
- Build on success in foster care and kinship care case management;
- Enhance the existing public-private partnership in delivery of child welfare services;
- Address Child and Family Services Review (CFSR) deficiencies in Permanency and Well-Being; and
- Inform the field through rigorous evaluation and documentation of the project

A core principle of the Illinois theory of change model is allowing all stakeholders to have meaningful input into the planning, design and implementation phases of this project. Using the existing Child Welfare Advisory Committee (CWAC) structure, over 400 collaborative working sessions have been held since project inception in February, 2007. These workgroups, comprised of both public and private agency representatives developed the project's performance indicators, risk adjustment strategy and fiscal structure. A Project Steering Committee meets monthly to provide oversight and policy guidance. Experts in the fields of statistics, social work, psychology and psychiatry from Northwestern University, Chapin Hall Center for Children at the University of Chicago, Northern Illinois State University, and the University of Illinois work collaboratively to provide technical assistance to the various workgroups on project implementation.

Residential Care

The Project Steering Committee and CWAC Workgroups set the following goals for residential treatment:

- To improve the safety and stability of children during residential treatment;
- To effectively and efficiently reduce symptoms and improve the functional skills of children through residential treatment; and
- To improve outcomes for children at and following discharge from residential treatment.

Two performance indicators were derived from these goals and incorporated into residential contracts: Treatment Opportunity Days Rate and Sustained Favorable Discharge Rate. Agencies are given performance benchmarks for each performance indicator which are adjusted for risk using a risk adjustment model including historic child specific characteristics (e.g. history of running away), demographic characteristics, and residential placement characteristics (e.g. geographic location). Since Illinois adopted a "no decline" policy to discourage agencies from taking only those children most likely to succeed, a risk adjustment model which takes into consideration an agency's case mix was critical for providers.

“Treatment Opportunity Days Rate” is a percentage of the total number of days in a fiscal year that residents are not on the run, psychiatrically hospitalized or incarcerated. Agencies are guaranteed payment for 100% of DCFS client beds, but if their performance is below the agency’s performance benchmark, the agency will be penalized at the rate of 25% of the per diem cost for each bed day represented by the difference between their performance benchmark and actual performance.

Treatment Opportunity Days Rate	
FY 2008	FY 2009
71 Contracts (40 Agencies)	69 Contracts (39 Agencies)
32 Contracts Met or Exceeded Benchmarks	38 Contracts Met or Exceeded Benchmarks
45%	55%
Net Gain of 2,587 Bed Days	

In Fiscal Year 2009, 24 residential agencies were penalized for failing to meeting performance benchmarks for a total of \$712,033 assessed. Penalties ranged from \$1,602 to over \$108,000 with a median amount at the agency level of \$23,915. Penalties are deducted from the current year’s rate paid to that provider. A formal reconciliation process was developed to ensure the accuracy of the data and resolve conflicts.

Agencies can earn bonuses if they exceed their established “Sustained Favorable Discharge Rate” performance benchmark. This performance indicator is based upon the percentage of all treatment spells from which youth that were favorably discharged were able to sustain their discharge placement for 180 days. Each agency is given a benchmark, adjusted for risk, which sets expectations for the number of youth to be discharged and remain stable post-discharge for a minimum of six months. Favorable discharges are defined as step-downs to less restrictive settings or placements in chronic mental health settings. Unfavorable discharges are step-ups to more restrictive settings, lateral moves between agencies, running away, psychiatric hospitalization or detention. Bonuses are calculated based upon the difference between the statewide weighted average of residential per diems and the statewide weighted average per diems for less restrictive settings. Bonuses in excess of \$3 million were awarded to 21 providers for exceeding their Sustained Favorable Discharge benchmark at the end of Fiscal Year 2009, with an average award of \$44,449.

Independent and Transitional Living Programs

The *Striving for Excellence* project established two performance measures for Independent Living (ILO) and Transitional Living (TLP) Programs effective in state fiscal year 2010. Two performance measures were established for agencies working with older adolescents: Transitional Living Placement Stability Rate (TLPSR) and Discharge Potential Rate with Indicators of Self-Sufficiency (DPR/ISS). Unlike residential treatment, the data upon which a risk adjustment strategy can be based is not yet robust enough for use in creating agency specific risk adjusted performance benchmarks. Plans are underway to incorporate a risk adjustment model as data collection improves.

Systemic Changes to Support Performance Based Contracting

The *Striving for Excellence* project recognizes that performance based contracting does not successfully occur in a vacuum, but requires coordinating efforts and strong communication between the public and private sectors represented by the project’s theory of change diagram set forth below:



Systemic changes which have occurred as a result of this project include:

- Standardization of provider rates and performance expectations;
- Centralization and automation of the admissions process through a new Centralized Matching Team to ensure appropriate and timely placement of youth in residential care;
- Monthly performance reports available through the Residential Treatment Outcomes System (RTOS) to keep providers apprised of their performance and allow for reconciliation of data issues;
- Use of a Discharge and Transition Protocol designed to facilitate step-downs to less restrictive settings and clarify roles and responsibilities of the various provider agencies;
- Development of pilot programs to address specific issues impacting treatment opportunity days rate such as the Runaway Assessment and Treatment Process pilot and the Residential-Hospital Networks pilot; and
- Shared strategies to engage youth in treatment developed through informal provider networking and best practices forums.

For more information on the *Striving for Excellence* project contact:

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Prevention

**Maintenance Needs in Performance-Based Contracting Success:
The Missouri Project on Privatization of
Out-of-Home Care for Children**

Partnership



Protection

Project Overview

Missouri's study will examine the processes necessary for maintaining public and private partnerships in performance-based contracting of out-of-home services in child welfare beyond the initial contract implementation process. Using a mixed method design, the project expects to determine public/private contracting and contract monitoring processes that provide a best-practice model for ongoing use of performance-based contracting in the delivery of out-of-home care case management services. Both qualitative and quantitative data will be used in the development of this best practices model.

Description of Sites

The performance based foster and adoption case management contracts were initially awarded to seven consortiums effective 06/01/05. Case assignment did not begin until 09/01/05. The contracts were awarded in three regions; St. Louis, Kansas City, and Springfield. Initially cases were only assigned from Greene County, in the Springfield Region, to one provider. When the region was expanded to include the 38th and 39th Circuits, during the 2nd year, case assignment began to a second contractor. Three provider consortiums serve St. Louis City; St. Louis County, St. Charles, and Jefferson Counties in the St. Louis Region. Two provider consortiums serve Jackson, Andrew, Buchanan and Clay Counties in the Kansas City Region. Two provider consortiums serve Greene, Christian, Taney, Lawrence, Barry and Stone Counties in the Springfield Region. Three additional contracts were awarded on 09/01/08 to serve 12 counties in the central, south central and southwestern portions of the state. Each region is served by one consortium. Prior to the potential contractors submitting competitive bids, several non-negotiable items were established. Those items included a minimum number of working units, a supervisor to worker ratio, a continuum of services, and a maximum fee for a child's care and case management services (set by an actuary study). These non-negotiable items were the contributing factors for providers to combine smaller agencies into a larger consortium. Missouri's Children's Division has established "mirror" units within the public realm to parallel private contractors in two regions, Springfield and Kansas City. The "mirror" units are Children's Division personnel who perform child welfare case management duties in a replicated environment similar to the private sector. That is, the environment includes criteria such as, pre-established base caseload size, rotation assignments, caseload caps, supervisor to worker ratio and staff development expectations. The establishment of the "mirror" sites lends itself to an exceptional comparative outcome analysis in the areas of permanency, stability, and safety. Additionally, this supports the opportunity for a cost benefit analysis of privatizing through performance-based contracting.

Project Activities

Several activities are in process to satisfy the needs of the cross-site evaluation and the unique needs of the state of Missouri. Such activities include surveys and interviews with frontline workers and supervisors from public and private agencies. Child welfare data outcome evaluation in the areas of permanency, stability, and maltreatment and the relationship to performance-based contracts is also being explored.

In addition to the activities described above, several meetings have been held with a goal of improving child welfare services in Missouri and the public/private partnership. They include: A practice summit which partnered case managers, supervisors, program managers, CEO's and Regional Directors from public and private sectors; A joint Quality Assurance/Quality Improvement (QA/QI) summit for sharing of best practice; A two day training of QA/QI specialists which provided an opportunity for these staff to collaborate, share ideas and share tools; Statewide oversight specialist

meetings for those individuals who provide daily technical support to the contracted providers; and an advisory board meeting comprised of CEO's and Regional Directors to gather input for future evaluation activities. Surveys and interviews of judges presiding over foster care cases, CEO's of private consortiums, and Regional Directors from the Children's Division have also been completed.

Future activities include statewide oversight specialist meetings; a second Practice Summit; and a second statewide QA/QI summit.

Private partners and other community stakeholders are participating in the CFSR planning process through CFSR prep meetings. In addition, the CFSR is discussed on-going during joint meetings with QA/QI staff from the public and private sectors. Private providers are also participating in the mock site reviews held in Cole, Greene, Jackson counties and St. Louis City. Finally, CFSR practice tidbits have been included in the In Focus Newsletter and are shared with all staff in both the public and private sectors.

Long-Term Benefit

Missouri's project will result in a well-tested model for the long-term maintenance of performance-based contracts that supports public/private agency collaborations in meeting the long-term needs of children in out-of-home care both effectively and efficiently. It will also provide an exemplary approach to expanding private/public collaboration across the child welfare service continuum and in human services in general.

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Co-Evaluator: Lynette M. Renner, Ph.D., MSW, University of Iowa

Missouri Foster Care Case Management Outcomes						
Re-entry Domain	Target 91.4%					
Regions	Year 1	Year 1 Mirror	Year 2	Year 2 Mirror	Year 3	Year 3 Mirror
Springfield	96.4%	100.0%	96.8%	94.1%	99.4%	92.8%
Kansas City	98.9%	94.5%	90.9%	85.3%	95.3%	96.2%
St. Louis	98.9%	N/A	96.4%	N/A	94.3%	N/A
Stability Domain	Target 82%					
Regions	Year 1	Year 1 Mirror	Year 2	Year 2 Mirror	Year 3	Year 3 Mirror
Springfield	95.3%	95.3%	86.6%	85.7%	83.4%	80.0%
Kansas City	93.7%	89.5%	85.8%	79.3%	79.7%	82.0%
St. Louis	91.7%	N/A	80.3%	N/A	78.5%	N/A
Permanency Domain	Targets: Springfield 24%; Kansas City 30%; St. Louis 32%					
Regions	Year 1	Year 1 Mirror	Year 2	Year 2 Mirror	Year 3	Year 3 Mirror
Springfield	24.0%	20.2%	27.0%	33.6%	26.6%	22.0%
Kansas City	36.7%	40.2%	33.0%	34.3%	34.2%	34.0%
St. Louis	26.0%	N/A	29.7%	N/A	27.2%	N/A
Safety Domain	Target 99.43%					
Regions	Year 1	Year 1 Mirror	Year 2	Year 2 Mirror	Year 3	Year 3 Mirror
Springfield	100.0%	99.6%	99.8%	99.6%	99.5%	100.0%
Kansas City	99.7%	100.0%	99.6%	100.0%	100.0%	100.0%
St. Louis	99.6%	N/A	100.0%	N/A	99.9%	N/A

Prepared July 2009

Findings from Final Site Visits with Performance-Based Contracting and Quality Assurance Systems**Research and Demonstration Projects****Methodology and Sample**

The QIC PCW Team conducted site visits to the three project sites regularly throughout the study period to develop a deeper understanding of the unique aspects of each project's intervention, monitor the progress of implementation and site-specific evaluation, observe relevant project activities, and collect data for the cross-site evaluation. During the final year, closing site visits were administered with a more structured format to enable conducting semi-structured key informant interviews and focus groups with individuals directly involved in the project planning and implementation (Appendix). The process was structured in order to enable collecting the perspectives of people in various roles (e.g. public agency staff, private agency staff, evaluators) separately to allow contrasting points of view upon analysis as well as promote free expression without concern of the comments made impacting future contracts or relationships. The discussion guide requested respondents reflect on the following: the planning process; issues around project administration; communication and collaboration; practice change; use of data; the performance-based contracting (PBC) and quality assurance systems (QA); system impact; lessons learned; and the impact of having been involved in a multisite project.

Across the three states, 55 individuals participated in the semi-structured interviews and focus groups, 21 of which were administrators and program management-level staff from private agencies, and fifteen public agency staff in similar positions. The remaining participants were evaluators (4), university collaborators (3) and a representative of a provider association. Overall, eight interviews were conducted in Florida, 15 in Missouri, and 22 in Illinois, which was roughly commensurate with the size of the overall project and the individuals involved in the planning and implementation of the interventions.

The study team relied on each project director to assist in scheduling the interviews. This factor as well as the overall number of individuals engaged in the intervention and size of the project impacted the number of individuals participating in the interviews. For example, despite repeated requests, no subcontracting private case management agencies were scheduled to participate in interviews in Florida. The study team did observe a meeting with administrative staff from the case management agencies facilitated by an external individual and where appropriate their expressed perceptions are included herein, but it should be noted that the study team did not conduct these interviews and questions asked of them did not follow the interview guide.

In addition, timing of the interviews is important to note. Final site visits were planned for spring 2010; approximately three months following completion of the official intervention in each state, recognizing that in truth the contracts and systems developed would remain in effect and continue to evolve. In the final year of implementation in Florida, local officials decided to go from four subcontractors to two during their annual rebidding process, the results of which were hypothesized to have a significant impact on perceptions unrelated to the implementation of the project. The site visit was scheduled to be conducted six months early so it could occur as late as possible in the intervention while just prior to the announcement of subcontract awards; however, awards were actually announced within a short time prior to the visit. In addition, six months prior to the site visit in Missouri, the state agency decided not to renew its contract with the QIC for a number of reasons, thereby terminating the external site specific evaluation while the actual contracts and quality assurance-related activities continued without the financial support of the QIC; the site agreed to facilitate final data collection for the cross-site evaluation as planned despite termination of the contract. Therefore, it is difficult to ascertain how these factors in these two states may have impacted data collected.

In addition to the individual interviews and role-specific focus groups, the QIC study team observed the project steering committee meetings in Illinois and Florida, and used part of this project to collect their perceptions using a separate discussion guide (Appendix). In Florida, six individuals participated in this steering committee meeting, including public and private agency staff and evaluators. In Illinois, this involved 12 individuals in similar roles. To a significant extent there was overlap in the individuals participating in individual interviews and role-specific focus groups, and the steering committee meeting. It was not possible to observe and collect data in a steering committee meeting in Missouri due to the premature termination of the contract.

Three QIC PCW study team members took notes either on laptop computers or by hand during all interviews. Care was taken to record direct quotations to the extent possible. Individual sets of notes were compared for consistency and thoroughness prior to analysis for themes. Constant comparative method was used in analysis of this qualitative data using word processing software in order to identify themes across participants, and determine the extent to which such themes arose across multiple sites or were unique to individual locations. Color and font-based coding was used during analysis to enable contrasting the perceptions of individual sites and by individuals representing different roles. Themes are provided below, with quotations to illustrate some of the points. The quotes have been selected to avoid identification of specific respondents as was agreed upon during interviews.

Issues Associated with Project Administration

These comments were only observed in Florida and Missouri. There was reportedly some breakdown in day-to-day implementation of details. Both sites experienced changes in project directors which resulted in complications. Some regret was expressed in terms of lack of effective or consistent use of the advisory board. In addition, in Missouri, a lack of shared vision between the public child welfare agency and the university was noted and ultimately contributed to the premature failure to

renew the contract with the QIC. Furthermore, the Missouri project reportedly was intended to continue the work of the pre-existing pilot without introducing new features, so there was a disconnect with the QIC's expectation that an intervention would introduce new features that could be evaluated.

Planning Process

Across all sites, there was agreement across both sectors that the planning process was inclusive.

When we walked in the room we tried to establish a collegial environment, and level the playing field. Some things were more negotiable than others, things wouldn't be written in stone and over time as an agency we would be willing to make adjustments. In the beginning they were more cautious, but as they worked in committee structures, and saw recommendations coming from group were actually the ones being incorporated, they became more open. I thought planning process went well. —IL

Public

This process has been pretty inclusive. Not always agreement, but inclusion. —MO Private

The neutral facilitator was a great way to build consensus at first. —FL

However, it was also largely agreed that although for the most part the right people were at the table, representatives of frontline staff should have been included. One private agency participant from Florida stated, "We assumed it was being driven down to the line and it wasn't." In Illinois and Missouri, it was noted that the judiciary should have been involved. Others groups that were mentioned which could have been involved from the beginning included fiscal staff, community agencies, quality assurance staff and foster parents.

Participants noted that for varying reasons, the timing of the initiative was favorable and this furthered the process. In Illinois, reform of residential care had been discussed for some time, committee work was ongoing but uncoordinated to this particular effort, and with the right leadership in place the timing was right. Missouri had completed a pilot using PBC, was already seeking accreditation, and was looking to improve practice.

[The former director] helped shaped vision with pilot sites and comparison— his vision was bigger than just using PBC for accreditation; saw that the privates had expertise and thought that this

would move CW forward and to push best practice forward with privates and public partnership.—MO Public

In Florida, the lead agency had a history of undesirable child outcomes and a poor relationship between the public and private agencies, but new leadership set the stage for reform. It was noted that in all states a tremendous amount of planning meetings were held.

I went to all meetings, lots of meetings and there was a sense that you couldn't afford not to be at meetings; there was a lot of meetings beyond what was needed.—MO Private

I'm very proud of how quickly we did it early on."—FL Private

Responses varied regarding whether the timeline for planning was adequate. Some respondents indicated that the timeframe required by the QIC project helped keep the progress moving.

It helped that there were some external timelines that moved the process forward because it focused the efforts. We would have just stayed paralyzed if there weren't external deadlines – tolerance for ambiguity was good but so was a deadline.—IL Private

Others felt it did not take into account the philosophical shift that was required and that the project could have benefited from more time to plan and achieve buy-in.

Communication and Collaboration

An array of challenges was noted regarding communication, between and within sectors. A lack of a communication plan or consistent structures for this purpose was noted in two sites. In all states the lack of administrative processes and infrastructure such as agendas, minutes and consistent participation by leadership challenged the collaborative process. A few themes arose in two out of three sites: some existing issues not discussed in meetings, lingering trust issues, difficulty in maintaining momentum, and, incidents that did not involve the collaborative decision-making that had become

expected. Individual states experienced additional challenges, such as existing communication structures not reaching all necessary constituencies or differences in communication processes among providers.

Various communication structures and strategies were created in each site to promote bi-directional exchange of information. In Illinois the steering committee arose from their pre-existing Child Welfare Advisory Committee (CWAC), and subcommittees thereof, which are co-chaired by public and private staff, as well as their provider association and a group of residential providers. While CWAC served as the vehicle for planning and the state provider association served as a primary conduit, a more ad hoc group of residential providers was enlisted as a key vehicle for information exchange. Data and provider summits were also held to bring in providers statewide, and an implementation team within the public agency was established to promote internal communication among units. Missouri utilized its established CEO meeting structure, but also created a regular program managers meeting that could focus on practice improvement rather than administrative issues. A new process for collaboration among quality assurance staff was created to promote integration of use of data and practice change. In Florida, the community board and provider CEO group was utilized but a neutral facilitator was added for planning and supervisor roundtables. In Florida when it was determined that the frontline was not engaged, town hall meetings were established to communicate at this level. The lack of a formalized communication plan was noted as a challenge. A theme that emerged across sites was the importance of leadership participation from both sectors so that decision-making was enabled.

Program managers meetings have been very positive and real partnership. We can bring up anything that may challenge a practice/policy – very cooperative, useful – all CD Regional Directors attend the meetings too. The CEO meeting is facilitated by CD – The Program Manager meeting is co-facilitated. This is a difference.—MO Private

The early meetings were purposeful. The measures weren't predetermined. We started fresh, and a lot of good discussion took place regarding defining measures. After several meetings we were more product-driven. — FL Public

Presentations at summits were done by providers to help build buy-in because private providers were honest about where they were and demonstrated collaboration. They had to admit to their peers in a public forum that their outcomes were not good.—IL Public

Collaboration challenges were noted in all sites, including the lack of administrative infrastructure and processes such as agendas and minutes-taking. Leadership in both sectors plays a critical role but cannot always devote enough time. Individual actions taken by partners that did not involve collaboration were noted as barriers to ongoing work in all sites. In Missouri and Illinois, it was noted that some existing issues were never discussed in collaborative meetings, and trust issues and tension remained between sectors. In Florida and Illinois, a slowing of momentum was observed.

I wish we could focus more systemically and strategically about how the partnership is functioning, data trends, and how we can address the resource issues. There are bigger issues that don't get on the table.—MO Private

There are still elements of fear and suspicion that don't really come out in the Steering Committee. Even now, there is belief that the Department operates behind closed doors. Failing to know the full story of internal processes, some providers are suspicious.—IL Private

We have had ups and downs with providers, but not a disconnection with them. They can say 'this doesn't feel like a spirit of collaboration now'. We were able to respond. The fact that they could say that says something.—IL Public

In individual sites additional issues were noted, such as the impact of the history of how prior administrations did not act in a collaborative manner as well as reactive rather than proactive planning at times.

Key Components for Implementation and Maintenance of Performance Based Contracting

Quality of the Data

A crucial component discussed extensively was the quality of the data system, both in terms of ability to measure outcome indicators as well as in continuous quality improvement. States experienced challenges in their current data systems, whether in reliability of the data in Florida and Missouri, or in use of historical data to forecast benchmarks. A primary challenge in Illinois was the integration of data housed in multiple universities. The need to carefully consider the selection of targets for outcome indicators was a theme that emerged, including whether to use the contracts to promote incremental change or threshold achievement. In all states, a necessary component of the process was a system for reconciliation of data and indicator measurement between sectors. In all sites an enhanced use of data-driven decision-making was noted, connecting practice to child outcomes.

Decisions Regarding Use of Incentives or Disincentives

Site visits did not reveal consensus on the comparative benefits of the use of incentives versus disincentives in the contracts. Some participants expressed that it is the healthy competition that drives performance. Others felt strongly that either penalties promote performance or alternatively that incentives do. A couple of themes did emerge, however. Many participants agreed that some form of fiscal consequence—which is of course the crux of true performance based contracting—focuses attention on outcome achievement and virtually all believed improvement would be demonstrated over

time. Second, concessions may need to be made in order to enable providers to commit given the risk, such as guaranteeing a set number of beds while requiring a no decline policy. Clarity regarding the outcome definition and how they would be measured is crucial. Attention was needed related to transition processes such as case transfer decisions. The system needs to use data regularly to revisit benchmarks, examine the relationships between the contract indicators and other desired practice and client outcomes, and identify unintended consequences such as certain types of providers or children who may be disproportionately impacted. Finally, thought needed to be given to how earned incentives could be used, and whether or not providers should be required to re-invest them in some way.

Selection of Contract Indicators

In all sites participants had differing opinions on whether the contract indicators they had selected were the right ones. Some felt strongly that the right indicators were being used in all states, and others in each disagreed. Some of the factors associated with selection of indicators were feasibility, accessibility, simplicity and timing.

Overall I'm fine with them, but they are timing out. It is time to shift. We have been incentivizing this for a long time; probably have seen as much improvement as are going to. —FL Private

We have been talking about this for 5 years but there has been no change in the contract to address [outcomes for older youth] or other issues we agree need to be tracked. As a state our system should support other outcomes than the federal outcomes. We have a cookie cutter approach. —MO Private

I don't know. There are a number of ways to get at what we are trying to do. Whether there are better ways to get at this, I don't know. The ones we selected are too complex. Are we changing practice to the extent we can sustain practice over time? That will be the measure of whether these are the right outcomes. —IL Private

A number of challenges were noted with established measures. Illinois and Missouri did not measure whether children were getting “better” as a result of the services. In Illinois they were described as complex, somewhat out of control of providers, and the fact that the same provider could receive an incentive based on one indicator and a penalty based on the other were mentioned. Florida participants noted that indicators may have time-limited impact, and that the approach taken should have focused on incremental change. In Missouri challenges discussed included lack of buy-in from judges, frontline complaints regarding emphasis on numbers, and the fact that some measures were impacted by the passage of time. An array of alternative indicators was mentioned by one or more participants across states: youth perceptions of quality of care, length of stay in care, clinical improvement, placement stability permanency, and indicators of success for older youth.

Components of the Quality Assurance System

Themes related to key components of the quality assurance system were also illuminated through the interviews. In all three sites, over the three year process emphasis shifted from compliance and oversight to technical assistance and developing a continuous quality improvement approach. The value of data sharing across providers to promote practice improvement was mentioned. Illinois and Missouri participants talked about developing processes for quality improvement for low performers. Florida and Missouri utilized peer case review processes. It was noted that providers have varying capacity for quality assurance processes despite accreditation, and attention may need to be paid to moving the system forward in this regard. The need to establish clear technical assistance for providers early on was emphasized.

Mistakes Noted or Changes Recommended

The themes associated with this topic are largely site-specific because many aspects of the process were different in different states. One topic of interest to all states was the need to consider

how funds or incentives are used and interest was expressed in promoting reinvestment to improve performance.

In Illinois it was mentioned that a shared vision needed to be developed regarding residential care as a part of an overall system of care. There was a need for emphasis on gaining buy-in from the frontline. They state did not accurately estimate incentives to be earned. Others felt a full year in which providers were held harmless was needed. Accountability should be promoted in the public sector as well as the private. In addition, lessons learned from prior initiatives should be taken into account when new processes are begun.

In Missouri, others were offered. The state decided to directly incentivize permanency, and build a truer linkage between outcomes and payment. Their care transfer process needed revision, and their original system for re-building caseloads for agencies annually was to be abandoned. The role of business decisions on the part of private providers needs to be explored. Some participants indicated the contract was overcomplicated and included excessive oversight.

Florida decided to incentivize outputs or “practice drivers.” It was noted that it was time to statistically assess whether these indicators truly were linked to outcome improvement. They found that some providers perceived their failure to earn an incentive as a penalty. Finally, they needed to build a system based not on categorical but incremental improvement.

Impact of Performance Based Contracting on Outcomes

Participants largely agreed in all sites that progress had been made toward practice change within the child welfare system as a result of the projects. Due to project emphasis, this looked different across sites. In Florida some agencies had demonstrated practice improvement and use of supervisor review in this regard. In addition their supervisory roundtables became more focused on practice solutions. Missouri participants noted that the program managers, practice summits and QA meetings

focused on collaborative sharing of best practice across agencies based on their review of outcome data. In Illinois some providers were recognized for re-thinking their treatment process to focus on evidence-based methods. Practice protocols were created to address challenges such as centralized matching of youth to facilities and a transition protocol for stepping youth down into the community, as the achievement of outcomes required it.

I think these changes are for the better. They can look at similar providers and show the facilities that are doing a better job treating youth and stepping them down. One program is re-doing their entire philosophy and treatment process because of the data we have been able to provide them on length of stay and other indicators. —IL

Although there is competition among consortia, there is coordination and cooperation of practice at the program manager level. The QIC process can take credit for setting up the program managers as a body for CQI—these program managers do share openly on practice. —MO

The supervisors talk more and share best practices. No longer just complaining, they are bringing up issues and developing solutions together. They know each other now. —FL

Responses were mixed regarding the level of understanding of the performance based contracting process on the frontline. Some providers make a conscious decision not to discuss the contract or its fiscal aspects with staff. Projects may not have emphasized the connection between desired client outcomes and contract indicators being tracked as well as practice changes being emphasized. A need for more effort in this regard was noted by some as well as consideration of the type of information that should be discussed with the frontline, based on the kind of services provided.

An impact strongly noted in Illinois and to a lesser degree in Missouri was a significant increase in the use of data within the system. In the former, data-driven decision-making had been implemented, and trust in the data had increased in the provider community. The latter experienced a linkage between

data and outcomes for children, and an emphasis within the system to determine what is working to improve outcomes.

Learning from the outcomes, meaning when there are good outcomes, what is helping that occur and sharing that. We recognized the need to bring the private agencies in on the CQI process.

Action plans develop from that.—Missouri Public

In all sites, a major theme was that the collaborative process had resulted in an improved child welfare system and outcomes for children. Relationships and understanding of the roles and strengths across sectors had improved. The combined performance based contract, and the use in a more integrated quality assurance and improvement process was believed to have resulted in enhanced evidence-informed practice and data-driven decision-making.

Are we better now than when we started? Yes, we are much more active, we understand things more deeply, have common goal of the health of the child and family. The system is better off. It has uncovered a lot that we had to do, it is forcing us to move forward.—IL Private

Our system is stronger and we have better outcomes for kids. We think more critically about our work.—MO Private

This CBC went from a bottom dweller to one of the top performers.—FL Public

Another theme noted in all states is improved collaboration and relationships across the sectors.

Moving from ‘us vs. them’ to ‘they are us.’—MO Public

Project has strengthened the relationship with the local DCF. It was not this way when we started.—FL Private

For whatever missteps we might have made in judgment on the frontend, the good will that was bought as a part of the process, the flexibility we demonstrated, living up to what we committed to—over the long haul it will serve us well.—IL Public

In addition, individual themes were noted in each site. Florida participants mentioned that some of their project components had been adopted statewide. There was a sense of improvement in supervisory practice. In addition, they mentioned that an evidence-based practice approach had developed, although this project was seen to be one of several initiatives that contributed to this outcome. Illinois participants noted increased understanding of performance data, and a data-oriented, accountable system. In Missouri, some indicated they were making progress toward an integrated QA/QI system across sectors and the use of outcome data to promote practice change. The private sector's role in the CFSR process had increased, and it had a better understanding of the public agency and its responsibilities.

A few comments were made regarding negative impact or missed opportunities. For example, focus on this initiative may have diverted attention from other important reforms, or that not enough emphasis in the local evaluation was used to answer important questions the state had regarding their system. However, no themes were identified across states.

Facilitators of Success

As described in the methodology, in Florida and Illinois the study team had the opportunity to observe implementation team meetings and questioned participants based on a different discussion guide (Appendix). A number of factors were identified by implementation team members to have facilitated the success they achieved. The evaluation was seen to have provided critical information to the process and refinement over time, as well as accountability. These states benefited from collaborative structures that were already in place, and states without this would be challenged to develop this. Also noted was the level of commitment expressed by both sectors and the demeanor with which they approached the process. The use of an inclusive planning process that allowed enough

time for thorough development was noted. It was necessary to discuss in this process the definition of terms. In addition, the quality of top leadership was noted in both sites as a facilitator of success.

Having quality data available was seen as critical as well as identifying personnel who understood how to use it. In all states this is a continuing challenge. Paralleling their QA process alongside their performance based contracting system was noted as important. Establishing deadlines for completion of key tasks was beneficial. There is a need to take time to examine the data and progress of the project, and discuss what it may mean. Finally, involving frontline supervisors in the change process is critical as it is a challenge to bring change to the frontline.

Lessons Learned

Participants were asked to reflect on important lessons that they had learned through their project that would be useful to other states and localities. An array of specific recommendations was made by individuals that are notable:

- Marry finance to outcome development at the start;
- Put equal emphasis on reform in both the public and private sectors;
- All providers are different entities, and they don't operate the same;
- There may be a need to be more direct and prescriptive with the private sector;
- One needs a fluid peer record review across sectors;
- Don't have dual case management system;
- If phasing in geographical regions, a structured plan should be developed for new sites using lessons learned from experienced sites;
- Be flexible in contracts and allow innovation;
- Use a fidelity checklist for implementation; and,
- Develop a longer term plan than the current contract.

Other lessons were identified by multiple participants and will be discussed in order of frequency along with illustrative quotes.

- Planned collaborative and communication structures are critical.

If you get the right people to the table and a willingness to go beyond self interest and be part of a process that requires collaboration and compromise; and if you have the right data and enough resources, then you may succeed – absence of any of those components would doom a project.

- This is an evolutionary process that takes time and is affected by policy change and contextual variables.

Our expectations were different. We have had to change our expectations as things evolve. Think in a couple of years we'll be in really good place.

- Shared vision development and inclusivity is important in planning and on an ongoing basis.

We are still learning to remember to be inclusive. This has improved a lot but we still sometimes forget to consider the contractors or bring them to the table. We need to continue to be inclusive with privates and collaborative as issues arise...We are paying the price for not involving everyone at the beginning. If they aren't at the table for some of the discussions they don't understand why decisions are made, and they tend to assume a competitive stance or blaming.

- Use quality data in an integrated quality assurance/quality improvement approach.

Have the data. It takes the mystery out of the decision-making. Not everyone wants to interpret it the same way, but at least everyone is looking at the same data. Not operating on anecdotal information. When they first started presenting the risk adjustment, people didn't understand it. Now

everyone is talking the data language, quality improvement. In some ways we have co-opted the researchers. They were trying to think like caseworkers, the practice folks thinking like researchers.

- The role of the frontline is important. Involve them early on.

[You] need to think about how to best bring operations and frontline staff along in the process to trickle message down. Next month we kick off cross-training ... It looked good when designed. On the ground it is complicated.

- Pay attention to relationships and the role of each sector.

Some competition methods are divisive, and [our state] took a middle ground on the public/private approach –you need to balance the public/private partnership. That is the strongest model... the work has to come first and what’s good for kids.

- Not all private agencies will get on board.

Some agencies are angry because they are not making the changes and are blaming and waiting for the next [child welfare director] to come along. They are waiting it out. It behooves us to institutionalize this quickly and deeply so it becomes the ongoing thing.

- Leadership is important in both sectors.

A high level of commitment is required. We need to be less concerned with who is in control, public vs. private, competition—but on moving the entire system forward for kids. Partnership. Leadership is needed on both the public and private sides.

- Have sound cost data and a broad spectrum approach to calculating savings.

Cost and how to measure cost savings is very important and someone needs to look across the broad spectrum not just bottom line – have to look at all costs down in the system to understand the true

impact; ...There are many variables in the equation and an agency needs to think through and strategize what they are. I think we do save money but it's slow getting there.

The Impact of Sites Participating in a Multi-site Project through the QIC

The perceived impacts were generally site-specific. In Illinois and Florida it was noted that the QIC provided external pressure to keep moving forward or the initiatives might have derailed. In Missouri and Florida participants mentioned that the QIC promoted cross-state dialogue and information sharing. In Illinois it was discussed that the QIC provided national credibility and the ability to become leaders. It was useful to use information gleaned from implementation research and to have the additional resources. Missouri participants indicated that the QIC promoted accountability, a critical look at their data, and pushed innovations in their quality assurance and improvement process. The external impetus caused the state to examine its communication and collaboration structures.

The implementation team meetings in Illinois and Missouri revealed additional themes in this regard. Specifically, the use of conference calls and all project meetings were useful in keeping states on track and promoting information sharing. Site visits helped states make some critical decisions during the project.

In summary, the site visits revealed a broad array of themes regarding successes and lessons learned by projects. Site differences prevented direct comparison in many ways; however, the number of themes identified across sites was striking despite these local differences. These final quotes are offered to summarize points emphasized during the interviews and focus groups.

The commitment everyone has shown to make sure it has been on a successful path. The public side was able to sit at the table and let go of a tremendous amount of control. There were lines drawn in the sand, and then smudged and re-drawn where people could come to consensus and agree not to step over it.—Illinois

Evaluation keeps you honest. We are typically good at planning and initial implementation and not so good at sustaining. —Florida

You need robust data, outcomes, and evaluation to determine what it means and how to use it because you need it to improve practice. —Missouri

True public private partnership is a very rewarding way to work even though it is uncomfortable at first. —Florida

There was a culture that existed where everyone could cut their own deals and a lack of transparency on how we worked with the provider community. To get the group to see we could be transparent, look at each other's rankings, and still come out a whole—we had to build trust and good will. —Illinois

I am supportive of the QIC model. It drives the amount of accountability ...There have been times I have been uncomfortable between demands for accountability but it gets a far better product. Technical assistance and consultation makes you modify what you are doing, be critical of what you are doing in a way you would do under normal funding. —Illinois

Final Site Visit Interview and Focus Group Discussion Guide

And

Implementation Team Meeting Discussion Guide

Final Site Visit Discussion Guide

Planning process

In retrospect, were meetings and information exchanges during the implementation of PBC/QA appropriately scheduled, or should additional improvements have been made? Please describe.

In retrospect, was the planning process for implementing performance based contracts and quality assurance the best possible process, or was there a better planning process that could have been used? Please describe.

Contextual Variables

Are there essential contextual variables that independently appear to promote contract and system improvement employed?

Evolution over time

In retrospect, was the selected target population the correct one to select?

In retrospect, was the selected service delivery the correct one to select for PBC/QA?

In retrospect, were the selected contract mechanisms (incentives/ disincentives) the correct ones to select?

In retrospect, were the selected financial risk structures the correct ones to select?

In retrospect, was the selected means of mitigating financial risk the correct ones to select?

In retrospect, were the selected items monitored the correct ones to select for PBC/QA?

In retrospect, were the selected measures used the correct ones?

What factors facilitated your project's success?

What were your challenges in the planning and implementation of the PBC and QA?

What would you have done differently?

What was the impact of your involvement in a multi-site project?

What are your most valuable 'take-aways' from this project?

How will you sustain the work of this project?

What local and non-local dissemination activities do you have planned/are you planning? (conference presentations, group presentations, article submissions, etc.)

What could the QIC have done to support the work of your project?

Implementation Meeting Discussion Guide

What factors facilitated your project's success?

What were the main challenges you experienced?

What would you do differently?

What impact, if any, did participating in a multisite project have on your project?

What are the most valuable takeaways from your project?

What are your plans for sustainability?

What dissemination activities do you have planned?

What could the QIC have done additionally to support your work?

ⁱ Collins-Camargo, C., McBeath, B., & Ensign, K. (in press). Privatization and performance-based contracting in child welfare: Recent trends and implications for social service administrators. *Administration in Social Work*.

ⁱⁱ McBeath, B., & Meezan, W. (2010). *Governance in motion: Service provision and child welfare outcomes in a performance-based, managed care contracting environment*. *Journal of Public Administration Research and Theory*, 20, pp. 101- pp 123.