Table 2.10: Comparison of Capitated Contracts			
Dimension	**Franklin**	**Hamilton**	**Portage**
Case Management	Case management is transferred totally to provider, with no case management done by PCSA staff	Magellan: Case management continues by PCSA; care management done by Magellan care managers for therapeutic services	Case management continues by PCSA; NOAS works on specific adoption issues.
		IMPACT: Case management continues by PCSA; only intake, assessment and referral undertaken by contract agency	
		Creative Connections: Case management continues by PCSA; care management done by CC care managers for treatment services	
Population Covered	Newly opened cases, randomly assigned to each contractor	Magellan: Only those children and adults requiring therapeutic services, including therapeutic placement services	Children in permanent custody.
		IMPACT: Only those children and families requiring substance abuse services	
		Creative Connections: Only those children referred by county agencies, who consist of "deep-end" children, typically whose needs cross agencies	
Services Included	All services, except court representation, investigations, and adoption services	Magellan: All therapeutic services, including services not currently reimbursed through Ohio Medicaid	All adoption related services
		IMPACT: Intake, assessment and referral to substance abuse services only	
		Creative Connections: All services, including care management	
Type of Contract	Case rate contracts	Magellan: Management services only	Case rate contract
		IMPACT: Management services only	
		Creative Connections: Case rate contract	
Performance Bonuses and Penalties	Penalties for cases re-opened within 18 months	Magellan: Performance measures with both bonuses and penalties. A bonus provision for savings above 15% target on the cost of services	None
		IMPACT: Performance measures with bonuses and penalties	
		Creative Connections: Performance measures with both bonuses and penalties	
Risk Sharing	Risk sharing on individual cases when cost exceeds four times the case rate; a risk corridor on total expenditures (5% the first year, 10% second year)	Magellan: None	None
		IMPACT: None	
		Creative Connections: Risk sharing after the first $500,000, stop-loss protections, and individual client maximums	

Hamilton County

The Hamilton County Department of Job and Family Services (DJFS) has three managed care contracts, each addressing different issues. The *first*, and longest running (since 1994), is a contract for the provision of services to the 300 highest need, multi-agency, or "cluster" children. The contract is supported by the PCSA/DJFS, the county Alcohol and Drug Addiction Services board, the juvenile court, the MR/DD board, and the mental health board, each of whom can refer children to the program. The contract was initially administered by the Family and Children First Council. The original contract, with a not-for-profit organization established specifically to serve these children, was terminated due to significant overspending ($1.5 million in 1998). In the fall of 1998, Creative Connections, a program of Beech Acres (a non-residential service provider), took over the $13 million contract.

Creative Connections provides care management and services through a network of providers. Administrative services are capped at 14%, and case management costs are capped at 8% of total costs. They have a case rate of $3,130 per month per child. The contract includes a "no reject-no eject" provision, risk sharing after the first $500,000, stop-loss protections and individual client maximums (a ceiling on spending per client). The contract also includes performance measures with both bonuses and penalties. Creative Connections has incurred penalties in each year. Performance measures focus on both administrative and service functions (e.g., decreased average and median length of stay in institutional placements, face-to-face contacts, etc.).

Several issues have been raised since the beginning of this contract. Since 1998, the program has been through three directors and has had numerous vacancies in care management positions. The program has served a number of youth not originally targeted for the program (e.g., felons under age 12, youth ages 15-16 with conduct disorders). The program has also consistently operated over-budget, with the private provider, Beech Acres, using endowment or other privately-raised funds in the range of $100,000 per month to make up the difference. The costs have exceeded the budget by approximately 12% per year. During the first few years, the contract suffered with too many providers in the network and not enough central oversight. Tracking and managing expenses have continued to be problematic.

The contract will be renegotiated this year with significant changes made to address the perceived structural flaws in the design of the system. The biggest problem with the contract is that the population selected, deep-end children, are likely to always be high cost—by definition they are the outliers—hence, there is not much latitude for cost savings. And when a child *is* stepped-down to a lower level of care, he is removed from the project, and the provider is given another high cost child. Second, a large percentage of the children served have extremely high maintenance costs, even at their lowest level of care, with no families to return to, thus affording no cost savings/reductions. Third, children with low incidence conditions often must be placed out-of-county or state, with little opportunity for return because of their specialized conditions and care needs.

The management of the contract will shift to DJFS from FCF due to the fact that DJFS (with custody of approximately 85% of the clients) wants more control over the project. DJFS had concerns about the ongoing contract monitoring and care standards imposed by FCF.

Hamilton County's *second* managed care contract is with Magellan Public Solutions, a national for-profit, behavioral health managed care company. Magellan has a contract to provide administrative support services to DJFS for all therapeutic services, for both children and adults, for all open cases. The initial contract is for 5 years and was intended as a turn-key operation, where the contractor would turn the operation over to the county at the end of the contract.

Magellan receives an administrative fee only and passes through the cost of services to DFJS. Magellan is limited to a five percent profit. However, the contract includes a number of performance measures, each of which is linked to a financial incentive and/or disincentive. There are measures for the operation of the administrative services function (e.g., maximizing federal revenues, timely claims payments, training of staff, etc.) and measures for services (e.g., children and families receive services timely, continuity of care is provided, services are available to meet needs, services are culturally competent). Magellan has not earned more incentive funds than it has lost in penalties. Additionally, there is a bonus provision for savings above the 15% target on the cost of services, originally established in the contract. Magellan has never earned this level of savings and has suggested that a savings of four percent may be more realistic.

The project suffered initially because automated information, billing, and claiming systems were not adequate, nor were they implemented as quickly as needed. These systems have since improved greatly. Initial rate-setting strategies were aimed solely at cost cutting, without addressing provider costs or quality of care. Those issues were also addressed by Magellan in an effort to make rates more equitable across providers and to reasonably reimburse costs. However, the county's current unexpected fiscal crisis (leaving the county as much as $20 million short in the current state fiscal year) has taken its toll, with immediate and drastic contract cuts in both services and administrative costs. Much of the work to rationalize the rate system has been undone by these cuts. Further, Magellan is now being criticized for its failure to at least contain, if not cut, therapeutic service costs. While this goal was clearly stated in the RFP and contract, county staff acknowledge that Magellan has been given mixed messages: cut costs, but increase the proportion of the client population receiving therapeutic services. There had been so much fear by administrators and line staff in the agency that Magellan would cut services to clients who need them, that much effort has been made to *increase* access to services.

Additionally, Magellan is charged with serving clients who are referred, yet there is no mechanism for Magellan to refuse services or control intake. Another cost increasing problem is that there is no mechanism for Magellan to move children from treatment slots back to regular foster care slots after treatment has been completed (when they cannot return home). Magellan has also served a number of developmentally delayed children

and court referred youth, not originally included in the project design, and for a period of time, accepted Creative Connections children when its intake had temporarily shut down. Finally, when a child is ready to step-down from a high cost placement out-of-state (i.e., Kentucky), back into Ohio, Interstate Compact Placement issues can take several weeks to complete. From Magellan's point of view, a number of issues out of their control have increased service costs, but, at the same time, they believed the county's goal was to increase access to services. Magellan estimates that they have increased the provision of mental health services from one-third of the caseload to two-thirds of the caseload. The contract held no penalties for failure to cut costs by 15%, instead it contained a bonus for doing so. Magellan chose to forego the bonus in order to meet the county's need for increasing therapeutic services. County administrators agree with this assessment, having lived through a difficult lawsuit alleging failure to provide appropriate services, and have generally been satisfied with Magellan's performance and management of the contract. Even an audit done by the State auditor was relatively complimentary of the provider. However, recent fiscal realities have dramatically changed the county's priorities.

Magellan's contract ends in August, and DJFS is currently re-bidding the contract. Last year, DJFS decided against assuming the contractor functions in-house, as originally intended. Cost containment will become a higher priority in the new contract.

Hamilton County's *third* managed care contract was for the provision of substance abuse services. This contract is a quasi-managed care contract with the local Alcohol and Drug Abuse Services Board. It uses a single provider for the purpose of intake, assessment, and referral to services only. Staff are housed within the DJFS building. The intent was to improve assessment and access to services. DJFS has been less satisfied with this contract, and eventually hired its own assessment staff. The current plan is to fold the service referral functions into the contract for therapeutic services now provided by Magellan.

Portage County

Portage County has a case rate contract that predates the Waiver. Northeast Ohio Adoption Services (NOAS) is responsible for doing whatever is needed to secure a finalized adoptive placement for a specified number of children. NOAS' role includes training and recruiting adoptive families, child assessment, coordinating with DJFS to prepare the child, matching child to family, taking primary responsibility for the placement, and providing post-placement and post-adoption services. Because it is a small contract, Portage DJFS is able to resolve problems with individual cases as they arise, and to negotiate special rates if necessary, eliminating the need for any formal risk-sharing arrangement.

Portage was interested in expanding into case rate contracts with placement providers. They approached two local providers, who expressed no interest.

2.6.2 Counties that Discontinued Capitated Contracts

Two demonstration counties, Crawford and Lorain, had managed care contracts during the Waiver, but no longer do. The experience of both of these counties is discussed below.

Crawford

The Crawford County PCSA decided to explore managed care options as a way to reduce its skyrocketing placement costs. In 1997, the CSB contracted with Special Alternatives for Youth Inc. (SAFY), a network foster care provider, to serve high-need children, especially those needing out-of-county placements. In Crawford County, when a child needed placement and an agency foster home was not sufficient, the FCF clinical committee reviewed the case. After they exhausted all other options, they referred the case to SAFY. SAFY used supportive services to prevent placements, provided placement options ranging from regular foster care to residential treatment, and offered intensive wraparound services at reunification. SAFY's responsibility ended after the child had been maintained in a permanent setting for six months. In the first year, SAFY received a case rate of $38,325 per year, which increased to $45,000 in 1998. There was a group stop-loss of $225,000 and "no eject-no reject" provision. SAFY contracted with some of its providers using a case rate as well, thus sharing a portion of the risk.

The contract had been phased out by 2002. Staff were concerned that the case rate was too high, that they were not receiving adequate reports and case documentation, that communication was poor, and the costs were poorly documented. Changes in leadership at both the CSB and at SAFY may have exacerbated the problems.

Lorain

Lorain County, through its Integrated Services Partnership (ISP), developed a managed care contract in 1998 with Pressley Ridge to provide management services and intensive case management for multi-system, deep-end children who come through ISP (the county's clinical review committee or cluster). It was a performance-based managed care contract for 100 assessments, 50 placements, and 200 consultations (technical assistance with individual provider agencies). The $360,000 contract was not capitated but did include incentives, sanctions, and a hold-back of 10% (the portion of the contract that is not paid until certain performance criteria are met). Pressley Ridge had the potential of earning the hold-back, plus additional incentive funds, depending on how many of the 29 performance criteria were met.

The contract ran into problems in the first year. Case management numbers were as expected, but placements were much higher than expected, and the contract significantly overspent. The ISP decided not to continue with the contract.

2.6.3 Lessons Learned from Managed Care Contracts

The issues that have arisen in both the counties that have continued their managed care contracts and those that have not can be summarized along three dimensions:

- Problems with clarity of goals or conflicting goals,
- Problems with the design or structure of the model itself, or
- Problems with implementation of the contract.

The five counties that have engaged in managed care contracts since the beginning of the Waiver (one county has ended its managed care contract) are all risk-takers. These counties had very little experience to draw on when developing their contracts. They could look to managed care in the health or mental health fields, but there was little, and still is little, in child welfare that evaluates and analyzes of the limited child welfare managed care experiences that do exist. Ohio's nine counties' experiences probably represents close to a one-third of the national experience. For this reason, their experience with managed care contracts is significant. Their willingness to share the successes and failures of their experiences contributes substantially to the national debate.

Problems with Clarity of Goals or Conflicting Goals

The primary challenge in child welfare managed care contracts is to cut or curtail costs, while at the same time providing better quality and more individualized services, perhaps to serve more clients. The very best manager would have trouble meeting all of these expectations.

Hamilton County's contract with Magellan is a good example of how conflicting goals have resulted in problems. The contract included a bonus for cost savings, but no penalties for failure to cut costs. At the same time, the contractor was asked to serve more types of cases than originally planned and to serve a higher proportion of the client population. DJFS administrators, staff, and providers were initially concerned that Magellan, as a large behavioral health, for-profit managed care company would behave as expected—cut costs and reject clients for service. It may have been because of this fear that so much emphasis was placed on giving children and families the services that were needed. Magellan heard this message from DJFS and emphasized meeting client's needs, even though costs continued to increase. This behavior did not become a problem until the county ran into financial problems in the final year of the contract. When the financial problems became the primary issue, Magellan was criticized for not achieving the cost savings included in the contract. A change in leadership may have contributed to the changed assessment of Magellan's performance.

The lesson from this experience is to ensure that goals are clear, that they do not conflict, and to make sure the entire agency/ board/ county is in agreement with those goals.

Problems with the Design or Structure of the Model Itself

There have been structural or design problems in two major areas: the choice of the population covered by the contract, and when and how the population should enter or exit the managed care system.

Three of the nine managed care contracts in ProtectOhio evaluation counties selected high need, deep-end children as their population. The Crawford and Lorain County

contracts no longer exist; the Hamilton County Creative Connections contract has required significant levels of private funding, and will be changed.

The lesson from their experience may be that limiting a contract to deep-end children is likely to result in problems, if the goal is to curtail spending in any way. Managed care theory acknowledges this general rule: negligible savings can be achieved from the deep-end outliers—they will always be expensive. The biggest potential for savings is from the group falling within the mid-range of cost. This group spends a fair amount of resources and is likely to stay too long in care or receive a service too long. This is the group for whom attention to service utilization patterns has the greatest potential to make a difference.

Additionally, managed care works on the principle that over time, clients' needs change. Sometimes they will have expensive needs, sometimes they will not. The resources received for the portion of the clients with low needs at any given time can be spent on the portion of clients with high needs. If by design the contractor only assumes responsibility for a case when needs are high, there are no leftover resources from low need clients to reallocate to those with high needs. This problem continues to plague the Creative Connections contract, where children are removed from the contract when their needs decrease and are replaced with children whose needs are very high.

In contrast, Franklin County does not have this problem because the population selected for their managed care contracts represents the spectrum of needs across the child welfare population—some will need only family services, some will need high cost residential care.

Another problem experienced in some of the contracts is how to transition clients in and out of the managed care contract. Franklin County has had a problem with this issue. When a child has achieved permanency, a Planned Permanent Living Arrangement (PPLA) or permanent custody in Franklin County, how does that child get transitioned back into the non-managed care caseload? For Franklin County, the issue is the foster care payment. The contractor pays more than the CSB for foster care, so when the case returns to the CSB caseload, the foster caregiver loses a portion of the payment. Currently the contractor is supplementing the payment to the caregiver to hold her harmless.

The Hamilton County Magellan contract also has this problem. Children who are ready to step-down to basic foster care can only step down into network basic foster care (purchased from private providers), because there is no mechanism for them to step down into agency foster care (managed by the PCSA). The problem is that network basic foster care costs considerably more and is usually only used when agency homes are unavailable. This means that Magellan is bearing an unnecessarily high cost for a group of children who could be served less expensively.

Problems with Implementation of the Contract

A number of problems have emerged that are fairly typical of child welfare managed care contracts. These include lack of knowledge of safety, permanency, and legal issues and procedures; staff training and turnover; and the development of managed care systems and procedures.

The major problem faced by contractors undertaking child welfare case management responsibilities within managed care contracts is their lack of knowledge of safety, permanency, and legal issues and procedures required of child welfare case managers. In spite of the fact that most providers feel comfortable with the children and families served, without exception, they underestimate the learning required to undertake child welfare case management. Among the demonstration counties, only Franklin County includes child welfare case management among the providers' responsibilities. Its providers, however, were no exception. The paperwork and the legal requirements alone are daunting, but when added to the focus on safety and permanency as paramount, before addressing children's treatment needs, the complexity of the job has overwhelmed the providers. The learning process has taken longer than providers assumed it would, and triggered additional problems such as staff training and turnover.

The few child welfare managed care contracts that exist nationally have all been affected by staff training and turnover issues. Staff must be competent in social work skills, but also must be knowledgeable about the law, the rules and regulations regarding child placement, safety issues, psychological and substance abuse issues, etc. People trained in all these areas are likely to be those who work in or have previously worked in the public child welfare system. Those who have not worked in the system are likely to require training in at least one or more of the areas noted above. Without the experience of the public child welfare system, providers have had difficulty finding qualified supervisors and trainers. This problem tends to slow start-up, and the Franklin County projects were no exception.

Staff turnover has also been an issue. Creative Connections in Hamilton and the Franklin County projects have had their share of staff turnover. It should be noted that staff turnover in the public sector is also high. The job is difficult, the resources are inadequate, and the pay is not great. The child welfare managed care projects have been no different. Staff do not know what the job actually is until they do it, when many discover it is not what they want to do. Added to the general problems of staffing in child welfare is the fact that these programs are new, with new supervisors learning new jobs, procedures and policies that may not yet be fully defined, and a structure that may change daily or weekly. Typically the first year or more can be quite chaotic, with shifts in direction or management. Such chaos always results in some level of staff turnover and should be expected. Often, the solution to these problems is to recruit and hire staff from public child welfare agencies, who already understand how the system works.

The final significant implementation issue has been the installation of automated information systems to track client costs on a real time basis. For the smaller contracts,

such as that in Portage County, tracking is not a problem. But for Creative Connections and Magellan, the systems issues have been substantial. Not only do these systems need to track clients and individual client costs, but they need to be able to bill for services, claim federal reimbursement, and pay vendors. Systems issues have been extremely time-consuming in each of the projects. And software packages developed for behavioral health do not necessarily translate well into the child welfare arena.

The main message to be drawn from these experiences is that having flexible funds enables counties to engage in risk-sharing contracts, but that is only the beginning of the challenges. Providers need to significantly raise their estimate of the time and energy it will take to develop a viable system. They should expect some level of disorder initially, as the structure develops. In addition, it would be wise for contractors to hire some staff with public child welfare experience in order to ease the process of developing policies and procedures.

2.7 UTILIZATION REVIEW

Utilization review is a formal process, often by an outside party, to ensure that the services provided are necessary, appropriate, and of the lowest reasonable cost. In child welfare, this additional scrutiny is most commonly given to placements, both because they are the most costly on a unit basis, and because they are seen as the most restrictive service option. However, child welfare agencies may also take a closer look at how other services are used, in order to ensure their availability as an alternative to placement. Ultimately, rational decision-making processes, supported by automated data systems, must be put in place to establish and maintain systematic parameters around service usage.

Two of the top priority outcomes that the demonstration counties believe will be affected by the Waiver are related to utilization review:

- Increased activity to control/rationalize use of out-of-home care
- Increased attention to outcomes

In the site visits, the study team explored the ways that PCSA managers limit access to particular services, through formal review processes or other decision-making guidelines. The study team also examined the ways in which the PCSAs collect and use automated data, especially outcome data.

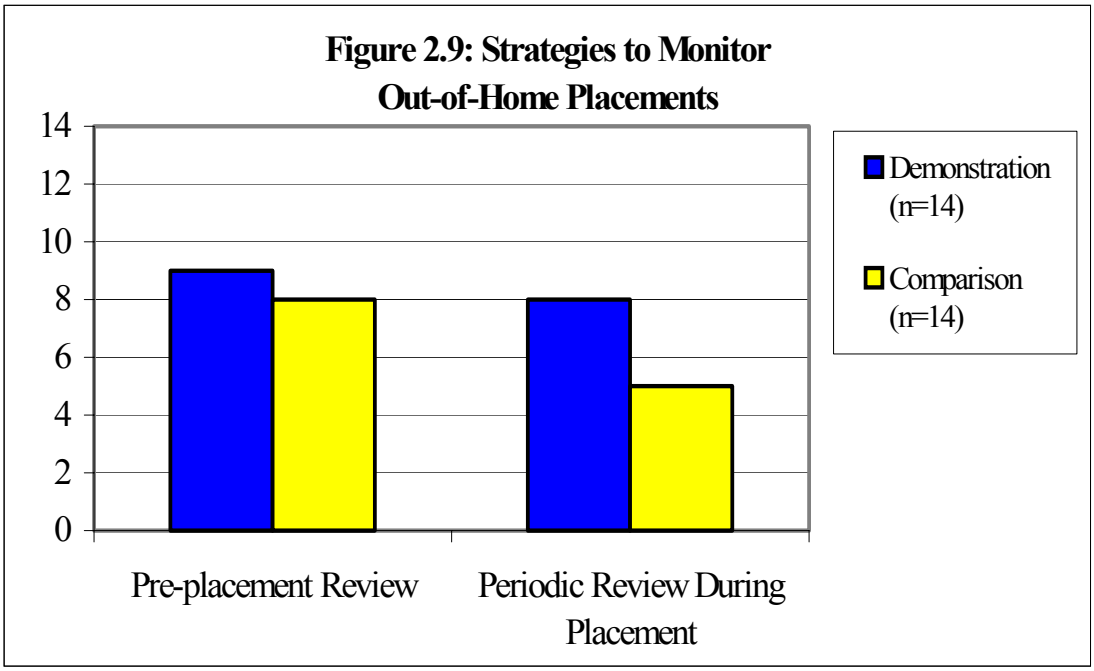
Summary: In general, demonstration counties are more active in this managed care arena. They make slightly greater use of placement review mechanisms than do comparison counties, but neither group is yet engaged in utilization review for other types of services. In the area of information systems to improve agency decision-making, both demonstration and comparison counties are trying to improve their data collection capabilities, although most counties still primarily rely on FACSIS and Micro-FACSIS, the state child welfare information systems. Demonstration counties have been

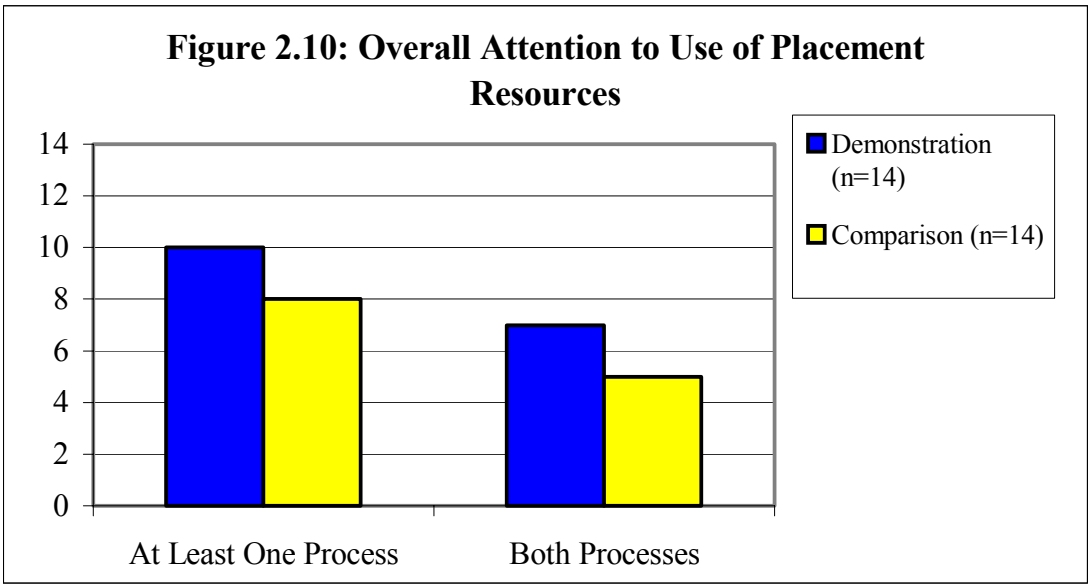
somewhat more conscientious about sharing program and fiscal data with managers, and have been much more active in giving case workers some sense of aggregate agency activities via data reports. Finally, demonstration counties are more committed to gathering outcome information, both internally and from providers.

2.7.1 Attention to Use of Placement Resources

Because of the Waiver emphasis on reducing placements, and all counties' awareness of the primary role that placement costs have in overall PCSA operations, counties are giving increased scrutiny to placements- to whether or not placement is needed, for how long, and at what cost. This often involves review processes that are more stringent for placement cases than for non-placement cases.

In both the Year 3 interviews and Year 4 site visits, the study team explored each county's use of pre-placement review and additional periodic reviews during the time the case is in placement. In Year 4, however, the team applied more specific definitions of placement reviews, gathering detailed information about the purpose, steps, and result of each process. Demonstration and comparison sites showed similar use of initial placement reviews—nine demonstrations and eight comparisons—but slightly more demonstration sites appear active in systematically keeping an eye on placements once the child is in care—eight demonstrations compared to only five comparisons. (See Figure 2.9).





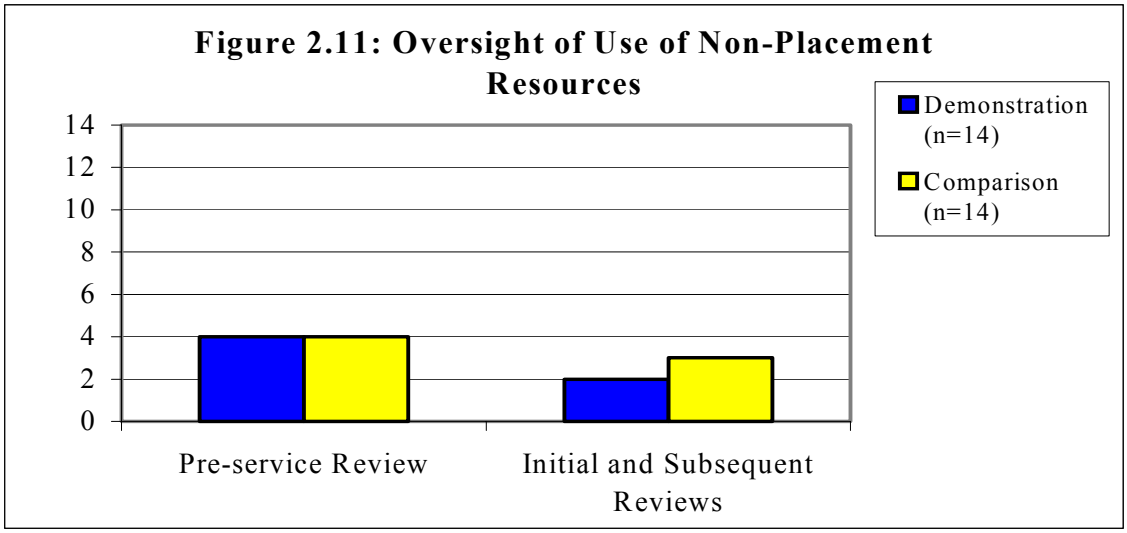
Overall, the demonstration counties are slightly more active in monitoring the use of placement resources (see Figure 2.10); this is the same pattern as appeared in Year 3 data, and may reflect the demonstration sites' natural tendency to guard their limited Title IV-E funds, while comparison sites can continue to bill Title IV-E for any eligible child.

2.7.2 Attention to Use of Other Services

For the first time in Year 4, the study team asked PCSA respondents about methods they use to control access to service resources other than placement settings. The intent of the questions was to learn about systematic efforts to limit service use to those cases where the service was most likely to have a positive result for the child or family. Excluded from consideration were processes that are largely fiscal authorizations; also excluded were county practices that applied to only certain providers.

As Figure 2.11 indicates, fewer counties impose controls on use of non-placement services—less than one-third of each group systematically conduct a formal review prior to providing non-placement services, and even fewer review service use mid-course. Overall, counties are just beginning to think about reviewing service appropriateness prior to providing the service, and they are only very gradually moving to do it on an ongoing basis once services are established in a case plan. It remains to be seen whether over time PCSAs will do more such reviews, or whether it will remain an uncommon process as long as spending on placement services is the dominant expenditure.

Counties paying attention to non-placement service usage tend to be those who more thoroughly control use of placement resources, suggesting that once a PCSA gets its placement use under control, it is able to turn its attention to other frequently used services. Table 2.11 reveals no difference between demonstration and comparison counties on use of non-placement service reviews, but in both groups the use of non-placement service reviews is related to whether the county has also addressed the use of placement resources. Counties engaged in non-placement service reviews are more likely



to also be paying attention to placement—75% of each group are simultaneously doing non-placement service reviews and placement reviews, indicating that very few counties (the remaining 25%) do service reviews but not placement reviews. This confirms the greater importance given to placement among all service interventions a PCSA might use.

Table 2.11: Use of Placement Reviews and Non-Placement Service Reviews

	Demonstration (n=14)	Comparison (n=14)
Percent of counties doing any non-placement service review	29%	29%
Percent of counties doing non-placement service review who also do some placement review	75%	75%

2.7.3 Management Information Systems

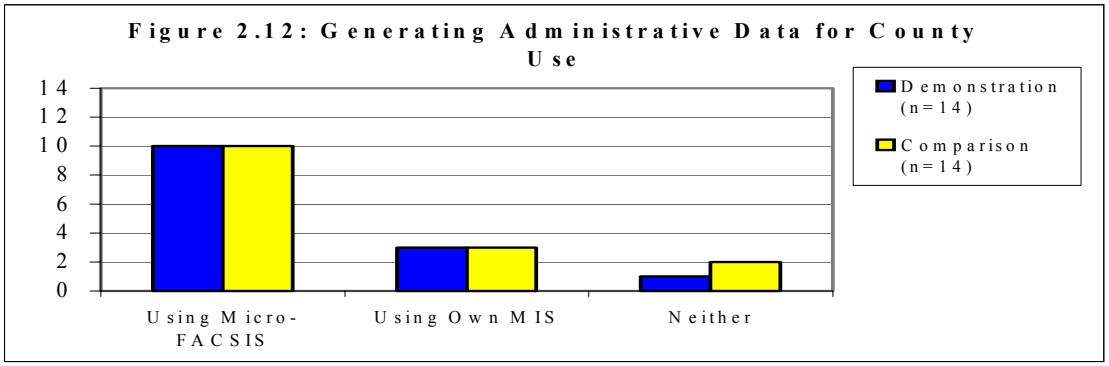
The key to managing service utilization is having automated systems that track aggregate usage patterns and even project long-term costs and capacity needs. The foundation for much of the managed care activity described in this section is a comprehensive management information system, containing sufficient historical data, having a strong tracking capability, and offering linkages between administrative and fiscal data sets. Indeed, one of the core hypotheses for the Waiver is that demonstration counties will make greater use of automated decision support systems and will become more systematic in measuring outcomes.

Data gathered during site visits and telephone interviews in the past several years reveals that counties, especially demonstration counties, are moving in the hypothesized direction. Many PCSAs are beginning to pay attention to the data they already have, and are beginning to explore various software packages to help them understand what they have and what more they need. The Year 4 site visits examined the current practices of each PCSA in terms of:

- Case tracking with FACSIS;
- Basic analysis and report preparation beyond FACSIS, perhaps using the PCSA's own data system;
- Program staff using fiscal data;
- Fiscal staff using program data; and
- Computer modeling (caseloads, service packages, resource allocation).

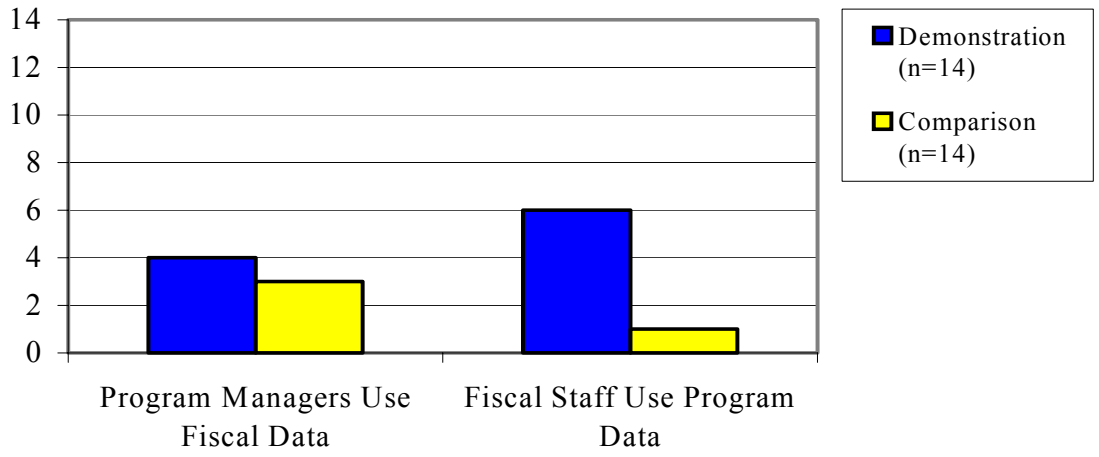
Demonstration and comparison counties are similar in their data management capability. Figure 2.12 shows that demonstration and comparison counties are identical in the ways that they generate administrative data. The vast majority (ten demonstration counties and ten comparison counties) use Micro-FACSIS to generate needed data reports, relying on various software provided by ODJFS. Three counties in each group, including all four metropolitan counties, have developed their own MIS, which they may use in addition to or in place of Micro-FACSIS. One demonstration and two comparison counties prepare little if any data beyond the state-required FACSIS submission.

Figure 2.12: Generating Administrative Data for County Use



Differences between demonstration and comparison sites do begin to emerge in the data about information sharing among PCSA staff. In Year 3, the study team asked about "linking" fiscal and program data. This is very difficult to accomplish because fiscal and administrative data are often maintained in separate data systems, so it is not surprising that few PCSAs were doing this (only three demonstration sites and four comparison sites). In Year 4, therefore, the study team asked a series of questions to assess whether fiscal and program managers were accustomed to dealing with each other's data, as a step toward perhaps linking the data sets in the future. The response was not much stronger than in Year 3, but it does show a contrast between the demonstration and the comparison groups. (See Figure 2.13). The somewhat greater use of data by demonstration county staff suggests that demonstration sites, because they have capped federal funding, are paying more attention to the financial implications of their program actions, with both program and fiscal staff working to understand the other's data. For example, in Lorain County, whenever management staff discuss potential new initiatives or changes in staffing patterns, they simultaneously examine the long-term fiscal implications of the shift. When the change would increase costs, it does not automatically mean the idea is shelved; on the contrary, the management team uses the information as a yardstick to

Figure 2.13: Use of Fiscal and Program Data



decide whether the value of the new approach is likely to be worth the cost increase, thus addressing cost-effectiveness in a practical fashion.

2.7.4 Use of Outcomes

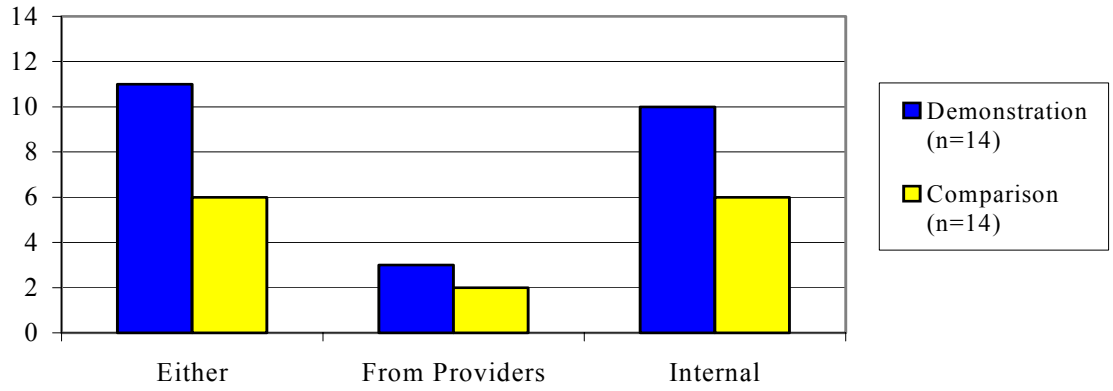
The next step beyond getting data systems in place and understanding what is happening on a day-to-day basis in the agency is to focus on outcomes. Most PCSAs talk about the importance of outcomes, and have good intentions of establishing outcomes for their own

and purchased services, but few efforts have been implemented at this point. In prior years of the evaluation, counties reported substantial use of data generated for the Child Protection Oversight and Evaluation (CPOE) Quality Assurance System (managed by ODJFS district offices), but little other attention to outcomes (Year 3 Annual Report, Figure 2.25, page 58). Demonstration counties at that time were more active than comparison counties, on all aspects of outcome data utilization.

In Year 4 site visits, the study team tried to probe more deeply, asking open-ended questions about gathering and using outcome information. What emerges is a pattern of more effort and attention in demonstration counties, especially in their internal use of outcomes data (See Figure 2.14). Some of the concrete ways that PCSAs are using the outcome data they have collected include:

- Both demonstration and comparison counties often mentioned using data to better understand placement trends, enabling them to focus on developing new options for particular groups of children or recruiting more placements of a particular type (e.g., agency foster homes for children under age five).
- Several demonstration counties mentioned sharing data with community partners to increase their understanding of PCSA efforts and how they can coordinate their own activities for the most cumulative effect in the community.
- Both demonstration and comparison sites spoke of studying patterns in the data to identify needs for staff training (e.g., in aspects of risk assessment, involving families).
- A few demonstration and comparison counties mentioned using outcome data to determine staff salary increases and bonuses, and for unit or departmental performance appraisals.
- In one demonstration county, data aggregated by neighborhood helped to identify locales generating the most referrals; in response, the PCSA has targeted more

Figure 2.14: Outcome Data Gathered by PCSAs



services there, and has worked with the city Planning Board to focus housing renewal efforts there.

- One comparison county noted using data to justify new staff positions.

Considering data on use of outcomes in Years 2, 3, and 4, it appears that counties who have been the most active in the past continue to pursue outcome information.

- Of the five demonstration counties that made the most use of outcomes in Year 2, four of them continued to be among the most active in Year 3, and one additional county joined this group in Year 3;
- Two of the original five demonstrations are among the most active in Year 4;
- The one comparison county that made the most use of outcomes in Year 2 is among the most active counties in Year 4, plus one additional comparison site.

These data suggest that it takes some time to really establish a solid outcome monitoring system. Perhaps the biggest struggle for PCSAs is obtaining outcome data from contract providers. It is difficult to write outcome requirements clearly enough to put into contract language providers find workable. In Year 3, half of the demonstration sites and four of the comparison sites moved in the direction of outcome monitoring (see Table 2.12), but this is a slow and involved process that needs a high degree of consensus if the outcomes information is to be meaningful. In Year 4, there is even less activity—in terms of actual collection of outcome data from providers—but where it does exist, it is being done by those who have worked on it in the past. All three demonstration counties who are now gathering outcome data from providers were among those who in Year 3 were using some type of performance-based criteria in contracts; two of them were even doing this in Year 2.

Table 2.12: Efforts to Monitor Performance of Service Providers

	Demonstration (n=14)	**Comparison (n=14)**
Year 3: Number of counties using outcome-based performance criteria in contracts	7	4
Year 4: Number of counties gathering outcome data from providers	3	2

2.7.5 Staff Access to Data

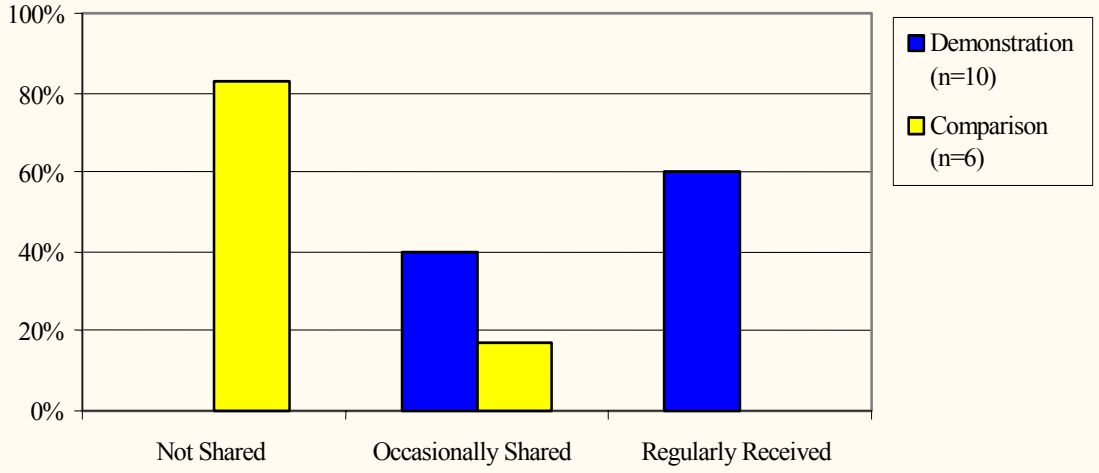
Having good data requires workers and supervisors take time and document what is happening for children and families. Often, those who have the greatest responsibility for recording data get the least feedback, reducing their incentive to do a complete and timely job of documentation. The site visit team explored this issue in focus groups with

caseworkers. However, the question was not always addressed very completely, as the groups sometimes spent more time on other questions, or the question did not stimulate much worker response. Sufficient information on this topic is available in ten demonstration counties and six comparison counties (See Figure 2.15). Staff impressions fall fairly naturally into three categories:

- Data are not shared with workers; workers tend to feel there is little purpose to sharing analytic findings because they are not empowered to make decisions, or because they feel their superiors think they do not need to know.
- Workers occasionally get data packets or highlights of the data analysis, but they generally do not understand the importance this material has for their work.
- Workers systematically receive data results, often in meetings when it is discussed so that they understand the trends.

The contrast between demonstration counties and comparison counties is marked, with workers in all demonstration sites saying they at least occasionally get the data, but workers in only one comparison county reporting even occasional activity.

Figure 2.15: Workers' Access To Outcome Data



2.8 QUALITY ASSURANCE

Quality assurance is closely linked to utilization management. Assuring the quality of services involves assuring that services are provided appropriately to those who need them. Counties' extensive efforts to review placements (discussed in Section 2.7.1) are the beginning of a Quality Assurance (QA) system. However, quality assurance should go considerably beyond assuring minimal levels of service delivery, to assuring basic compliance with regulations and minimal safety (quality control), plus efforts to steadily improve service delivery over time (quality enhancement). In recent years, quality

assurance efforts have largely focused on outcomes (discussed in Section 2.7.4), assuring not just that services are provided, but that they result in positive changes for children and families.

In Year 1, the site visit team explored county quality assurance activities very broadly, finding primarily a growing awareness of the need to think about quality assurance more systematically. In Years 2 and 3, the site visit team took a more targeted approach, detailing quality control and quality enhancement activities being pursued, exploring how quality assurance is structured, and examining the role of outcomes in counties' quality assurance efforts overall. In Year 4, the site visit teams explored the specific quality assurance activities being undertaken related to case management and purchased services. The discussion below highlights the findings.

Summary: Quality assurance activities for PCSA case management focus primarily on compliance issues, but three counties (two demonstration counties and one comparison

Table 2.13: Systematic Monitoring of State Requirements for Case Management		
	Demonstration Counties (n=14)	**Comparison Counties (n=14)**
Monitoring is the ongoing responsibility of supervisors, may be systematic at case transfer and other critical points in case	4	10
Monitoring is systematic, structured, and ongoing, addresses primarily compliance, done by staff with distinct QA responsibilities for at least a portion of the caseload	9	3
Monitoring is systematic, structured and ongoing, addresses compliance and quality of casework, done by staff with distinct QA responsibilities	1	1

county) are also looking at quality of casework provided in an ongoing, systematic way. The majority of demonstration counties have designated QA staff and systematic, structured, ongoing procedures to monitor caseworker compliance with state rules, while the majority of comparison counties rely on supervisors and a less structured process to monitor case management activities.

2.8.1 Quality Control of Agency Case Management Activities

Counties were asked whether they systematically monitored state requirements for case management. Eleven demonstration counties and six comparison counties stated they did so. However, in many cases the monitoring consisted of supervisors reviewing case

plans and dictation as a part of the ongoing supervisory responsibility. Further questioning attempted to determine whether counties had a procedure that involved *more* than ongoing supervision. Table 2.13 shows that more demonstration counties have formal, structured, ongoing quality assurance procedures than comparison counties, with 10 demonstration counties using staff with distinct QA responsibilities versus four comparison counties. The comparison counties are more likely to rely on supervisors or the management team to ensure that state case management requirements are met (nine comparison counties versus four demonstration sites). In addition, ten counties overall (six demonstration and four comparison) stated they were doing peer reviews of cases. Some of these reviews were periodic and others were ongoing.

The motivations behind the development of formal, structured QA system with designated staff seem to be related in part to accreditation and to past problems with CPOE compliance. Five demonstration counties and three comparison counties are accredited through the Council on Accreditation (COA), part of the Child Welfare League of America (CWLA), which requires a quality assurance/ continuous quality improvement process. Of these eight counties, one demonstration county and one comparison county use the less formal, supervisory monitoring for State rule compliance. Several counties that were not accredited have also developed QA monitoring procedures to help them improve their performance on CPOE outcome measures.

Overall, CPOE and COA accreditation efforts (for which, until recently, ODJFS offered an incentive) seem to have played a role in moving counties toward distinct, highly structured quality assurance activities undertaken by designated staff. Demonstration counties, perhaps due to their enhanced exposure to managed care techniques through the Waiver, have somewhat more aggressively implemented these procedures.

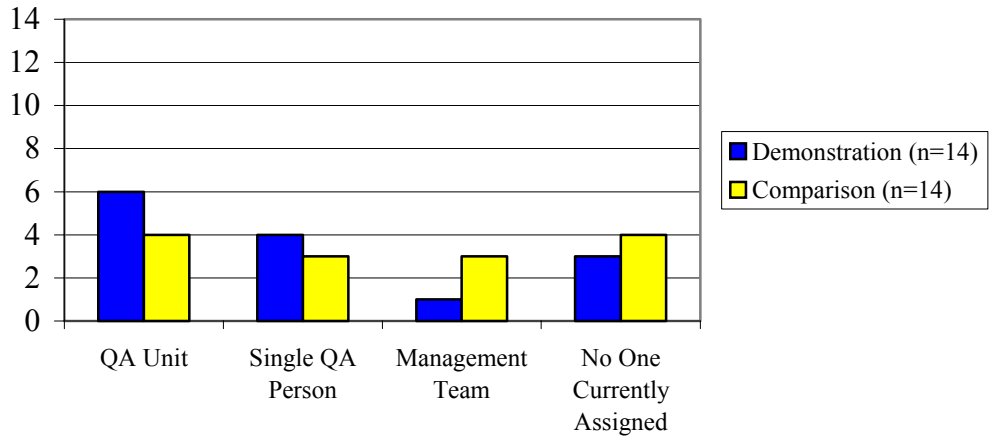
Automated Tracking of Mandatory Reviews

The ability to automatically track mandatory review dates simplifies management of the legal aspects of child welfare. Counties were asked if they had automated tracking capabilities. Nine demonstration counties and eight comparison counties undertake automated tracking of mandatory reviews. Those counties without automated tracking capabilities have developed mechanisms to track them by hand.

2.8.2 Internal Quality Assurance Responsibilities

Expanding on the data covered in Table 2.13, Figure 2.16 shows how counties handle QA responsibilities. The designated QA staff may be individuals or full units, with demonstration counties slightly more often using both arrangements. The QA units may focus on purchased services (Franklin and Summit); on in-house case management (Medina and Scioto); or on both (Hamilton and Montgomery). The remaining counties, with no specific QA staff, assign the QA responsibility to the management team (one demonstration site and three comparison sites) or leave it unassigned, with the responsibility thus falling to supervisors to perform on an individual case basis.

Figure 2.16: Responsibility for Quality Assurance within the PCSAs



In Year 3 of the evaluation, the study team gathered similar data on the way counties assign QA responsibility. Comparing Year 3 data with Year 4 data, it is evident that more comparison counties have made gains in this area. In Year 4, ten demonstration counties and seven comparison counties had designated QA staff (a unit or an individual), while in Year 3, nine demonstration counties and four comparison counties had designated staff. Year 4 also revealed that more counties had no one currently assigned to the QA function, suggesting some loss of focus on QA in a few counties.

The most sophisticated quality assurance system overall is in Hamilton County. Hamilton County has a quality assurance unit that focuses on agency services and a contract monitoring unit that focuses on purchased services. The quality assurance unit regularly reviews case records for both compliance issues and quality of casework, issues reports to supervisors, and publishes a newsletter identifying cases and workers where "best practice" has been found. Section chiefs (who supervise supervisors) must read cases from five workers each month. All hotline calls are recorded and supervisors and chiefs must review a sample of those calls each month as well, to assure appropriateness of and consistency in responses. The contract monitoring unit has established standards for contractors, develops performance measures for each contract (process-oriented), and does not process payments without submission of required reports within 45 days from the end of the month.

2.8.3 Types of Quality Assurance Activities Undertaken

QA staff in Ohio's counties undertake a variety of quality assurance activities. Examples of the types of activities used to monitor cases include the following.

- Allen County is measuring workers on a number of process measures (e.g., number of home visits, frequency of relative involvement in staffings and Semi-Annual Reviews (SARs);
- Scioto County QA staff is using State monitoring forms to review a sample of cases each month;
- Summit County is planning to survey parents regarding the SAR process;
- Greene County is beginning to do peer reviews looking at both compliance and quality of casework for the re-accreditation process;
- Medina County has developed compliance checklists, referred to as "report cards," which are completed by supervisors every month on every case. The data are entered into their system and reports generated monthly and shared with management and front-line staff.
- Richland County QA staff review a case from each worker each month, examining compliance and social work practice.

Quality assurance activities for purchased services included a wide range of activities as well. Some examples are provided below.

- Butler County meets annually with each provider to discuss strengths and weaknesses of their services;
- In Clermont County workers are informed of exactly what services a provider has contracted to provide when a child is placed with a private contractor;
- In Summit County, cluster children receive functional assessments at placement and periodically thereafter;
- Franklin County holds quarterly staffings for all children in residential care, which providers must attend;
- Franklin County has a "Contracts and Concerns Committee," which looks at trends across different foster care networks, or in residential facilities, and deals with concerns and complaints from workers and providers.

2.9 OVERALL USE OF MANAGED CARE

Managed care offers a broad array of technical mechanisms to improve and simplify service systems. These techniques are not new to child welfare; indeed, many are already being used in service systems around the country and in Ohio. What is new, however, is that managed care seeks to integrate the different components, packaging them into a coherent and rational plan to simultaneously contain costs, enhance service quality and expand the population served—in short, creating a "managed" system.[1] A prime interest

[1] Kimmich, M. and Feild, T. Partnering with Families to Reform Services: Managed Care in the Child Welfare System. Englewood, CO: American Humane Association, October 1999.

of the Ohio and federal stakeholders is to understand the extent to which PCSAs are turning to managed care, developing managed systems for child welfare. Indeed, one of the outcomes identified by the demonstration counties is increased movement toward managed care. The preceding sections of this chapter have discussed various managed care strategies; this section brings the findings together by examining overall care activity in the counties.

Summary: The Year 4 findings indicate that both demonstration and comparison counties have increased their use of managed care strategies from Year 2 to Year 4. However, while demonstration counties continue to increase their involvement in these activities, comparison counties are making significant changes in the way they offer services, pushing them further into the managed care framework so that they now more closely resemble the demonstration counties. In fact, when examining overall managed care scores, while comparison counties continue to move upward, fewer demonstration counties are making significant increases in overall managed care efforts. This suggests that (1) comparison counties may be following the lead of demonstration counties in experimenting with more rational management techniques, and (2) demonstration counties have, in fact, slowed in their advancement toward managed care. The study team will continue to monitor these trends over time.

2.9.1 Managed Care Index

Using the eight categories of managed care activity discussed in the above sections, the study team selected 28 discrete data items collected during site visits, creating a managed care index. The data used to compile this index are pulled from all 4 years of the process evaluation. The selection of the items, and the way in which they are combined to yield an index value, is subjective and open to modification. This index is intended as a reasonable starting point for distilling the systemic reforms that PCSAs are adopting. Table 2.14 below lists the components of the Managed Care Index.

It is important to note that the study team has broadened the exploration of utilization review (UR) and MIS efforts in Year 4 because, in the past, these were areas where counties had been more active. For example, in UR, the team explored if a PCSA had developed processes to review non-placement services; similarly, for MIS, this year the team determined whether client data and fiscal systems were linked. The new items are noted in the table by "(Year 4)." The team has also added new variables to other categories of the index, thereby crediting counties who are adopting practices that facilitate more rational and systematic program management.

Table 2.14: Components of the Managed Care Index		
Managed Care Category	**Specific Item (Year from which data is drawn)**	**Weighting[2]**
Financing	• Use of capitated contract (Year 4) • Nature of capitated contract conditions (Year 4) • Existence of a county levy (PCSAO data) • Title IV-E investment strategies used (Year 2 – Year 4) • PCSA control over spending (Year 1) • Access to PRC funds (Year 3)	17.5%
Utilization Review (UR)	• Use of placement review processes (Year 4) • Use of process to review non-placement services (Year 4) • Use of collaborative funds for non-placement services(Yr 4)	17.5%
Service Array	• Sufficiency of services (Year 3) • Extent of new services created (Year 2 – Year 4) • Reconfigured services: changes made in the way existing services are used (Year 2 – Year 4) • Diminished services (Year 4)	15.0%
Case Management	• Type of unit structure (Year 4) • Use of team conferencing (Year 4) • Screening/gate keeping (Year 2 and Year 4)	12.5%
Competition	• Importance of contracting (Year 4) • Expanding provider marketplace (Year 4) • Efforts to change availability of foster care (Year 2 – Year 4) • Efforts to change availability of adoptive homes (Year 4)	12.5%
Quality Assurance (QA)	• Quality control: systematic monitoring of compliance, automated tracking of mandatory reviews, and mechanisms to assure contract compliance (Year 4) • Use of quality enhancement mechanisms (Year 3) • Locus of internal quality assurance responsibility (Year 4) • PCSA focus on outcomes (Year 4)	12.5%
Targeting	• Number of special initiatives (Year 2) • Services are developed for a specific sub-group (Year 2 and Year 4) • Existence of specialized PCSA units (Year 2 and Year 4)	5.0%
MIS	• Extent of use of automated management information and access to management information systems (Year 4)	7.5%

[2] The various components of the managed care index have been weighted to create an appropriate composite measure of managed care activity, placing more emphasis on the true "managed care strategies". It should be noted that the weighting has changed from previous versions of the managed care index, placing more emphasis on case management, competition and QA, with less emphasis on targeting and MIS. The change in weighting reflects the greater importance that countries have given to particular managed care activities.

2.9.2 Utilization of Managed Care Strategies

Every demonstration county and every comparison county is using managed care strategies to some extent. The most obvious examples are the counties that have executed a capitated contract with an outside entity, delegating authority for serving a certain population of children. But this type of activity is atypical of the evaluation counties as a whole. Much more common is some type of oversight of the use of placement services, or a varied collection of quality assurance activities, or the addition of numerous services that are needed by children and families. Table 2.15 reveals the variation in effort among the demonstration and comparison counties, across the eight spheres of managed care activity.

The data in Table 2.15 can be analyzed from two perspectives: (1) preferred categories of managed care activity and (2) areas of greatest contrast between demonstration and comparison groups.

Preferred Areas of Managed Care Activity

The first line of analysis compares the average demonstration and comparison county scores (column 2) to the maximum possible score for each strategy (column 1). In Year 4, among all the managed care strategies, counties clearly preferred several categories for their experimentation. The two groups of counties tend to be most active in utilization review, reaching 58% and 52% of the possible score (column 3). Other categories where either demonstration or comparison counties achieved an average of almost 50% of the possible points include QA, service array, and targeting. Conversely, three categories appear to be "less preferred" areas of activity: financing, competition, and MIS, with one of the county groups averaging less than 30% of the possible score. Financing stands out as less used by comparison sites than any other managed care strategy.

Contrast between Demonstration and Comparison Counties

The second line of analysis for Table 2.15 compares the two county groups in Year 4 (as shown by the "difference in %" cells in column 3). On seven of the eight strategies, the average demonstration county score is higher than the average comparison county score. This contrast is most striking in financing and targeting, where the difference is 20%. This seems appropriate, especially for the financing area, since this is an area where flexible funding is vital. Case management, UR, and QA are the areas with least differentiation (i.e., demonstration counties score is less than 10% higher than comparison counties). In these areas, the performance of the comparison counties closely resembles that of the demonstration counties. These are areas where PCSAs may be able to focus their efforts, regardless of the availability of flexible funding streams such as the IV-E Waiver.

The only exception to the pattern of demonstration counties having higher scores comes in service array, with comparison sites reaching an average of 52% of the possible score but demonstration sites averaging only 45%. This likely reflects the fact that comparison

counties reported higher levels of service sufficiency. (See Third Annual Report, page 24.)

Table 2.15: Year 4 Managed Care Index Scoring			
Managed Care Category*	**Possible Score**	**Average Raw Score**	**Average as Percent of Total Possible Score**
Financing	13		
Demonstration		5.0	38%
Comparison		2.4	18%
Difference in %			+20%
Utilization Review	11		
Demonstration		6.4	58%
Comparison		5.6	52%
Difference in %			+7%
Service array	13		
Demonstration		5.8	45%
Comparison		6.8	52%
Difference in %			-7%
Case Management	11		
Demonstration		5.4	49%
Comparison		5.1	46%
Difference in %			+3%
Competition	17		
Demonstration		7.1	42%
Comparison		4.9	29%
Difference in %			+13%
Targeting	5		
Demonstration		2.6	52%
Comparison		1.6	32%
Difference in %			+20%
Quality Assurance	16		
Demonstration		8.7	54%
Comparison		7.5	47%
Difference in %			+7%
MIS	5		
Demonstration		2.0	40%
Comparison		1.4	28%
Difference in %			+12%
TOTAL	91		
Demonstration		42.9	47%
Comparison		35.2	39%
Difference in %			+8%

* Managed care categories in this table are ordered according to their weight in the managed care index.

The general lack of substantial difference between the average of the demonstration counties and the average of the comparison counties continues a pattern noted in prior

evaluation reports. In only two areas are demonstration sites notably more active; these areas also show the strongest contrasts in previous years. Similarly, the area with the least "difference in percent"—case management—showed the least contrast in Year 2. In general, both groups of counties are achieving higher scores (higher percentage of the total possible score) on the various strategies than they did in the past, suggesting that all the counties are becoming more attentive to rational management approaches.

2.9.3 Managed Care Index Rankings

The differences across managed care strategies, and between demonstration and comparison groups, provide a rich basis for the summary measure, the Managed Care Index. The index combines the scores for each of the separate strategies, weighting them to create a composite measure indicating overall managed care activity.

Reflecting the trends evident in the data on each strategy, the Managed Care Index suggests that while demonstration counties continue to be more active than comparison counties in reliance on managed care strategies, comparison counties are making progress to "catch up," perhaps learning from the experiences of the Waiver participants. The difference between the two groups has narrowed since Year 2, to an 8% gap in Year 4 (see Table 2.15, last row). These data suggest that (1) many demonstration counties have stabilized in their use of managed care strategies and are no longer pushing as hard as they did earlier in the Waiver; and (2) while comparison counties are still not achieving the same level of managed care activity as demonstration counties, they are making progress and moving closer to the demonstration counties.

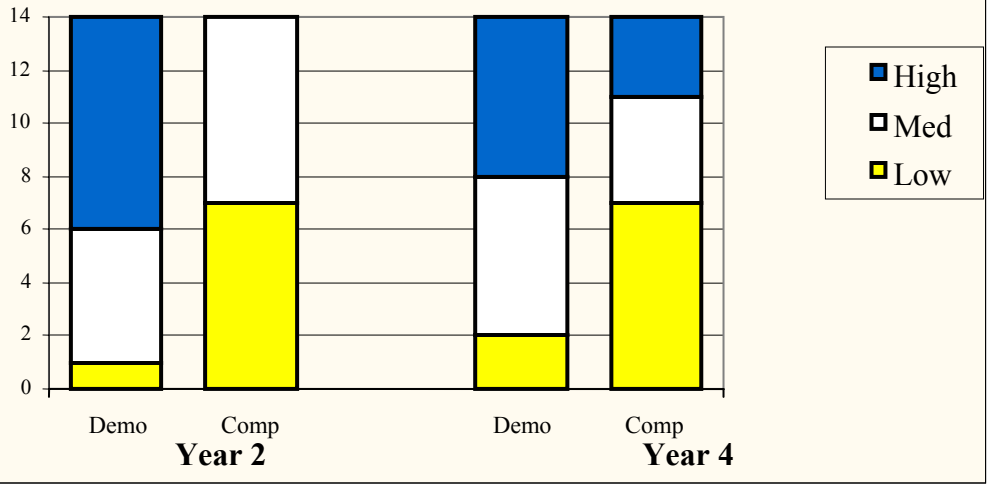
When the study team computed index scores for each county, three groupings emerged (See Table 2.16). These three groupings of the evaluation counties provide a clearer picture of what is evident in Table 2.18: demonstration counties are using managed care strategies more than are comparison counties. Appendix I-2 lists each county's ranking on each of the eight managed care strategies, as well as each county's overall managed care score.

Table 2.16: Counties Grouped by Level of Overall Managed Care Activity					
Counties with High Managed Care Activity		**Counties with Moderate Managed Care Activity**		**Counties with Low Managed Care Activity**	
Percent of Total Possible Score on MC index (range): 49%-65%		Percent of Total Possible Score on MC index (range): 38%-47%		Percent of Total Possible Score on MC index (range): 17%-36%	
Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Franklin Greene Hamilton Lorain Medina Richland	Montgomery Summit Trumbull	Ashtabula Belmont Clark Muskingum Portage Stark	Allen Butler Miami Scioto	Crawford Fairfield	Clermont Columbiana Hancock Hocking Mahoning Warren Wood

Because the study team has developed a managed care index in both Year 2 and Year 4 of the evaluation, it is possible to examine shifts in use of managed care strategies over the course of the Waiver. Figure 2.17 provides an interesting visual representation of rankings of demonstration counties and comparison counties over time.

This figure indicates that demonstration counties continue to show more overall involvement in managed care strategies than comparison counties. However, the number

Figure 2.17: Overall Managed Care Ranking: Year 2 and Year 4



of demonstration counties ranked as high has actually decreased in Year 4. This can be explained by the fact that the study team has "raised the bar" on the score needed to get into the "high" ranking. In Year 2, a county had to have earned 44% of the total possible points to be ranked as "high" in the managed care index. This year, the county must have

earned at least 49% of the total possible points. This was a conscious effort to make the standard higher, given that the counties have had 4 years to move in the direction of these managed care strategies. On the other hand, while no comparison counties ranked high in Year 2, this year, three comparison counties achieved this "high" ranking, indicating that comparison counties are picking up the momentum in use of managed care strategies.

Overall, it appears that demonstration counties who committed themselves to using managed care strategies from the beginning of the Waiver have continued to be committed to these efforts—the six demonstration sites that ranked high in overall managed care in Year 4 have remained in the high managed care group for all 3 years (Years 2 through 4). Few other demonstration counties have made significant movement in this direction. In contrast, comparison counties have begun to become more focused on managed care strategies, resulting in several comparison counties moving up into the "high" overall managed care ranking.

The findings of this section are intriguing. It seems clear that some major trends keep surfacing, using a number of different angles to examine the data. First, for both demonstration and comparison counties, there has been an increase in the use of managed care strategies individually and overall. Second, demonstration counties continue to be more involved in many of the managed care strategies than comparison counties. This is also true of overall involvement in managed care activities. Third, over the last 2 years, comparison counties have begun to use more managed care strategies, moving closer to the demonstration group as a whole. As the evaluation proceeds, the study team will continue to monitor changes in the level of managed care activity in the counties, and will systematically examine what impact the level of managed care activity has on participant and fiscal outcomes.

2.10 INTERAGENCY COLLABORATION

Interagency relationships can affect how successful a PCSA will be in reducing placement days and unit costs with or without flexibility in Title IV-E funds. Poor relationships with the court, or a court that is bogged down with cases and runs inefficiently, can increase placement days. The lack of services from other systems, primarily mental health, or a weak Family and Children First Council, can affect the ability of the PCSA to provide in-home and community-based services to reduce placement days and costs. In addition, interagency collaborative efforts to make the system more responsive to the needs of children and families are often impeded by the categorical nature of federal funds. Prime among the categorical programs is Title IV-E. The Process Study team hypothesized that the flexibility of funds offered through the Waiver would lead to improved interagency collaborative efforts and relationships because the categorical nature of Title IV-E funding would no longer be a barrier to meeting child and family needs. This section covers two of the high priority outcomes for the Waiver (see Table 1.1):

- Improvement in PCSA interactions with other service agencies, and
- Improvement in relationship between PCSA and mental health.

This section reports on the nature of the interagency relationships and changes in collaborative efforts.

Summary:

The majority of demonstration and comparison counties have strong relationships with the courts. However, the issue of inappropriate court referrals has been and continues to be an issue for a few counties in both groups. That the problem is not more widespread is perhaps due to the fact that about half of both groups of counties have implemented strategies to divert inappropriate referrals from the child welfare system.

Relationships between the PCSAs and the local mental health boards are strong in most demonstration and comparison counties and have not changed significantly over the course of the Waiver. However, these strong relationships do not necessarily translate into adequate services for PCSA families and children. A number of issues have emerged over the course of the demonstration to make access to appropriate services difficult, including the requirement for cash match mandated by MACSIS implementation (Ohio's automated billing system for mental health and substance abuse services), a shortage of providers who will accept Medicaid, and turnover and vacancies at provider agencies. Because of this, many PCSAs, in both demonstration and comparison counties, are developing and purchasing their own mental health services, and/or paying some or all of the non-federal Medicaid match in order to access services.

Interagency collaborative relationships through the Family and Children First Councils continue to dominate joint programming in most counties. Shared and pooled funding for individual cases continues to be used in over half of both demonstration and comparison counties. Themes in interagency collaborative efforts in Year 4 focused on mental health/child welfare, juvenile sex offenders, coordinated investigations of sex abuse cases, school truancy/alternative schools, Family-to-Family, domestic violence, and programs for unruly/delinquent youth.

2.10.1 Juvenile Court

The relationship between the PCSA and the juvenile court varies considerably from county to county. Yet the court is the single most important outside entity that can affect the ability of the PCSA to reduce placement days and costs. Besides controlling child welfare custody issues, the courts have the ability to assign the local PCSA custody of unruly and delinquent youth, adding to the PCSA's placement days and costs. Since many of these youth cannot be placed in regular foster family homes because of their behaviors, their costs can be considerable. PCSAs are not funded to serve the unruly/delinquent population, nor do most feel competent to address unruly/delinquency issues. For this reason, the study team examined court-related issues.

Strength of Relationship between PCSA and Juvenile Court

In both Year 2 and Year 4, the study team examined the strength of the relationship between the PCSA and the juvenile court. Table 2.17 shows that there has been little

change in the strength of those relationships over the two-year period. Over half of demonstration and comparison counties reported strong or very strong relationships in both Year 2 and Year 4. One demonstration county reported a strong relationship in Year 4 but not in Year 2, and one comparison county reported a strong relationship in Year 2, dropping to a weak relationship in Year 4. Overall, slightly more comparison counties than demonstration counties have weak relationships between the PCSA and the court.

Table 2.17: Comparison of the Strength of Relationship between PCSA and the Juvenile Court, Year 2 and Year 4

	Demonstration Counties (n = 14)		Comparison Counties (n = 14)	
	Year 2	Year 4	Year 2	Year 4
Strong or Very Strong	8	9	8	7
Neutral or Mixed Opinions	5	4	3	3
Weak or Very Weak	1	1	3	4

Inappropriate Referrals from the Court of Unruly/Delinquent Youth

One issue that has emerged over the course of the evaluation is that counties differ in the number of unruly/delinquent youth referred by the court to the PCSA for placement. Typically, these youth are adjudicated dependent by the court, with custody given to the PCSA. A more recent trend is for courts to adjudicate youth delinquent, suspend commitment of the youth to the Department of Youth Services (DYS), then place the youth with the PCSA for residential treatment services. Court personnel do not necessarily agree that referrals of unruly/ delinquent youth are inappropriate. The volume of inappropriate referrals has not changed in the course of the Waiver period, in neither demonstration nor comparison sites. Year 4 data shows that four demonstration and 3 comparison counties feel unable to control placement days due to inappropriate referrals from court. The number of inappropriate referrals seems linked to the philosophical position of the court regarding youth and the PCSA. These positions seem to fall in levels, with successive levels associated with additional referrals:

- *Youth who can't go home/ throwaway youth who must be adjudicated dependent*: For this group, courts vary on how lenient they are toward parents who wish to abdicate responsibility for their children, and whether probation officers actively encourage this abdication for some youth in order to obtain therapeutic services for the youth and/or family through the PCSA.
- *Young offenders*: Some courts place young unruly/delinquent youth with the PCSA for treatment, primarily because they have no programming for children under 12.

These courts see the PCSA, rather than the court system, as the appropriate system for serving unruly youth.

- *Youth with backgrounds of abuse/neglect, or family dysfunction*: Courts vary in how recent the abusive/neglectful behavior has been in order to consider them appropriate for this category. Some courts will place youth with the PCSA if there was *ever* an abuse/neglect incident, even if there are no recent (within several years) problems. Others will place youth with the PCSA if the family seems highly dysfunctional, so the family can receive services.
- *Unruly/delinquent youth needing private placement or treatment*: Some courts feel that any unruly/ delinquent youth needing a placement outside of detention, community corrections, or training school, including all residential treatment, should be placed with the PCSA. Some courts do not believe that the court should be a custodial agency; other courts admit that placement with the PCSA is a purely financial issue.

In some instances, the magistrates who deal with child welfare cases are not the same as the magistrates who deal with delinquency issues, resulting in PCSA custodies of unruly/ delinquent youth without any involvement or prior knowledge of PCSA staff or legal counsel. As noted in previous reports, the actual volume of inappropriate referrals cannot be identified because FACSIS data do not distinguish dependency referrals that originate with the court from other dependency cases, and because an "inappropriate" referral is difficult to define. Without such precise data, what appears in this section are perceptions of the nature of court referrals. These perceptions will be colored by the general relationship with the court and by any efforts made to ameliorate the problem. It should also be noted that there was a fair amount of disagreement between PCSA management and direct service staff about the extent of the problem, with managers tending to believe that inappropriate referrals were less of an issue than line staff believed them to be.

The most egregious example of the problem, raised by a group of workers in a comparison county, was that the workers felt as if probation officers were referring a flood of youth to the PCSA for placement in high cost treatment facilities. Probation officers seemed to be coaching parents to abdicate responsibility, or going directly to court to have youth adjudicated dependent with custody given to the PCSA. At the end of the year, the PCSA had over spent its placement budget. However, the probation department had under spent its placement budget, and management proceeded to give bonuses to probation officers with the leftover funds.

IV-E Court Arrangements

One alternative to making inappropriate referrals is a IV-E court agreement with the juvenile court. Five courts in the evaluation have obtained Title IV-E funds for directly placing unruly/delinquent youth. This number has not changed since the Waiver began. Several years ago, all courts were given the option of billing placement costs to Title IV-E, but few chose to participate. Many judges chose not to participate because they

believe Title IV-E placement to be an executive branch function. Of course, by adjudicating youth dependent, courts still have the placement paid, without the case management requirements of Title IV-E, which are assumed by the custodial agency.

For the demonstration counties, the advantage of court billing for IV-E is that direct court billings are reimbursed separately from the funds received through the Waiver. The potential increase in funds coming into the county was apparently responsible for convincing the Clark County court to participate in the direct billing process. That decision has increased the county's revenues by $400,000 annually. Presumably, the availability of the new federal reimbursement to courts for placement costs would reduce the number of inappropriate referrals to the PCSA. Of the five counties that bill IV-E for placements, Clark County was the only county to report a decrease in inappropriate referrals. The court created new services with its annual reimbursement, including services for the unruly population, and contracted case management services for delinquent youth in placement.

It is interesting to note that some courts in the evaluation counties are expressing renewed interest in becoming a IV-E court, as state DYS budgets shrink.

Strategies Employed to Reduce Inappropriate Referrals

Including direct court claiming for placement costs (through IV-E Court arrangements) as a strategy for reducing inappropriate referrals, 15 counties have employed a variety of strategies to address the problem. The strategies included in Table 2.18 represent actions more substantive than a formal notification of referrals or regular meetings with the court, both of which serve to alert the child welfare agency to an impending referral (thus enabling the PCSA to perhaps find an alternative before getting the referral).

Table 2.18: Strategies to Reduce Inappropriate Referrals

	Demonstration (n=14)	**Comparison (n=14)**
Court bills placement costs of unruly/ delinquent youth to Title IV-E	4	1
Creation of new services by the court designed to reduce inappropriate referrals	2	0
A formalized position or unit to help divert cases from the child welfare system	4	6
Other initiatives	1	1
Total unduplicated counties	8	7

Of the strategies listed, the most frequently used are the formal liaison positions or units of staff who work with unruly/ delinquent youth at the court who would otherwise be

referred to the PCSA. This strategy is used in four demonstration counties and six comparison counties. In some instances, family stability or TANF funds are used to pay for these staff rather than PCSA funds. In at least one demonstration county without such staff, the PCSA talked about developing these capabilities through the new state diversion program (H.B.57) when funding is available. Other initiatives include: in Lorain County, the PCSA offers a fixed number of assessments per month to the court to assist the court with dispositions of youth; and in Allen County (a comparison county), the PCSA changed from a part-time private attorney to represent its cases in court to a full-time prosecutor, and believed this change has helped reduce inappropriate referrals. The biggest difference between the two groups is that there are six demonstration counties and only one comparison county where the courts are either actively engaging in billing IV-E or developing other diversion-type services.

Table 2.19 shows that in four of the eight demonstration counties where strategies were used, inappropriate referrals are not considered an issue. In three of these demonstration counties, the courts are billing IV-E for placements. In six of the seven comparison counties where strategies were used, inappropriate referrals continued to be an issue.

Table 2.19: Extent of Inappropriate Referrals

	Demonstration Counties (n=14)		Comparison Counties (n=14)	
	Strategies Used	**Strategies Not Used**	**Strategies Used**	**Strategies Not Used**
Inappropriate referrals not considered an issue	4	0	1	2
Inappropriate referrals acknowledged and contained	3	3	4	4
Inappropriate referrals leaves PCSA feeling unable to control placement days	1	3	2	1
Total	8	6	7	7

One of the primary diversionary strategies used by counties is establishing court liaisons or diversion teams. These have been given a range of responsibilities. Typically, they conduct child and family assessments to provide additional information to the court,

home visits, referral to services, and limited case management. They also can provide mediation services and behavior modification services, or other therapeutic interventions.

Another interesting dynamic that has emerged over the course of the Waiver has been a series of other court-related issues that have affected PCSA ability to control placements and costs, and leave front-line staff and managers feeling frustrated and powerless. These issues seem to be important enough to affect staff morale and were raised during front-line worker focus groups:

- The judge/ magistrates may not agree with PCSA law (H.B. 484) or policies (use of relative placements) on some issues;
- The judge may not give PCSA issues any priority thus children remain in custody longer than necessary;
- The judge/ magistrates have low regard for PCSA caseworkers, making their own judgments, with little input from caseworkers;
- The magistrates may be poorly trained in law and policy;
- The judge/magistrate is more likely to listen to Guardian Ad Litems (GALs) and prosecutors, who have had little contact with the child and family, than to PCSA caseworkers who have had significantly more contact with the child and family; or
- Prosecutors (whose role is to represent the PCSA) make decisions about custody actions based on their own judgments with little input from caseworkers.

Workers in 25% of the PCSAs noted problems with one or more of the above issues. These included two demonstration counties and five comparison counties. All four of the populous urban counties had one or more of these problems. Several counties provided examples of decisions being made about custody and services with little to no input from anyone who had first-hand knowledge of the child and/or family. These included instances of decision-making occurring in court chambers with no one but attorneys present, none of whom had first-hand knowledge of the child and family.

In spite of these examples of poor working relationships between casework staff and court-related personnel, there were also examples of interesting and innovative collaborative relationships that seemed to be working for involved professionals as well as for children and families. Some of these exemplary practices are described below.

- In Lorain County (a demonstration county), a consultant was hired to improve the relationship between the court and the CSB. Monthly and quarterly meetings have resulted in a sense of children belonging to all, rather than one agency against another. The court has established a family drug court and a juvenile drug court. The CSB is extremely active on family drug court, and all referrals are from the CSB. The court, CSB, and providers meet weekly with family members to address progress. The court feels the CSB is always available to help informally find support for children the court is serving and, in return, the court has made its domestic violence shelter available to CSB youth.

- In Fairfield County (a demonstration county), the PCSA was having difficulty getting court papers served and getting promptly on the docket. This was causing children to remain in custody longer than necessary. So the PCSA used flexible IV-E funds to help the court hire a process server to expedite the process.
- In Trumbull County (a comparison county), the CSB pays the salary of one magistrate, so that a single magistrate can be dedicated solely to PCSA cases. This CSB also processes some of the paperwork for the court to minimize delays. With the implementation of family unity meetings in the county, the magistrate only hears contested cases and otherwise forwarding the journal entry for case plans without a hearing. The court will not re-use GALs who do not become actively involved in their assigned cases. The court refers all domestic violence cases and many domestic relations cases to the CSB for home studies, which is consistent with the CSB's triage structure. PCSA staff and management and court personnel all perceive the relationship to be extremely effective, respectful, and positive.

While court issues remain problematic in many of the study counties, it appears that many counties have successfully employed strategies to at least contain the level of inappropriate referrals. It also appears that demonstration counties have been slightly more successful than comparison counties at improving relationships with courts between Years 2 and 4. Several courts acknowledged that cuts in their DYS funding levels (particularly Reclaim funds) will reduce the availability of funds for unruly/delinquent community programs and placements. On the other hand, the new program for unruly youth, contained in H.B. 57, should offset some of these losses. However, it should be noted that the funding to pay for services to unruly youth is from TANF, meaning that it is not new funding. A portion of TANF funds has been designated as available for services for unruly youth, based on each community's plan. In some communities, Family Stability funds have been used for services for unruly and delinquent youth. While H.B. 57 will focus attention on services to unruly youth, and will likely require some funds be spent on services to this population, it does not provide new funds for these services. It is entirely possible that PCSAs will see no financial relief from inappropriate referrals based on the new program.

2.10.2 Mental Health

The relationship between the PCSA and the mental health system is critically important to the child welfare population. Increasing numbers of children and parents served through the child welfare system are in need of mental health and substance abuse services. In Ohio, the majority of Medicaid therapeutic services are accessed through local service delivery systems developed by local mental health boards and by alcohol and addiction service boards, or by combined boards. These boards are separate in larger counties, combined in smaller counties, and may cover multiple counties in smaller counties as well.

Issues Affecting the Relationship between PCSAs and Mental Health

A number of issues appear to have gotten worse over the course of the demonstration project. Ohio's mental health system has not been systematically successful in meeting the needs of the child welfare service population for a number of reasons:

- *Unfunded Mandate*: Most local mental health boards and child welfare administrators agree that these systems are based on the concept of an unfunded mandate, meaning that services developed at the state level are supposed to be available to both Medicaid and non-Medicaid clients based on the medical necessity of the client. Yet the funding to pay for these services primarily consists of locally-generated funds, which are not available in sufficient quantity to meet the demand for services. Further, the per capita level of funding available for both mental health and substance abuse services varies tremendously across counties.
- *Any Willing Provider*: State law allows "any willing provider" meeting the provider qualifications to determine medical necessity and provide allowable services. This provision makes it difficult for the local boards to do any "gate-keeping." Without this ability, providers are relatively free to serve and bill for whomever they determine to be medically in need of services, as long as the provider has been certified as a community mental health provider by the local board. The result is that the local boards have little control over access to services, little ability to triage clients based on need, and marginal ability to budget or plan their expenditures, particularly for services provided in a county other than the client's county of residence. A provider who provides community mental health services to a child placed in a county other than his residence, or who provides services to a client who travels to another county for services would have full control over the services provided and billed. The mental health board in the county of residence would only find out about the services provided afterward, when billed for the service.
- *Requirement for Cash Match*: During the course of the Waiver, the state implemented MACSIS, an automated billing system for mental health and substance abuse services. Included in MACSIS is the requirement for a cash match for all community mental health services. The matching process for the child welfare population used to consist of a "certification of match," a legitimate process used in many states, but one which was originally designed poorly in Ohio. The result of the new system is that community mental health services are paid by the local board in the county of residence. As a result, therapeutic services provided to children in residential treatment are billed back to the mental health board in the child's county of residence. Since these services are usually quite costly, and medical necessity is determined by the residential treatment provider, the cash match requirement, unpaid in previous years, can be substantial. The uncontrollable impact of these costs appears to be significantly draining resources from services to the general population, and from funds previously used to support services to children with problems crossing multiple agencies.
- *Focus on Medicaid-Eligible Clients*: Because of the problems noted above, fewer resources are available for non-Medicaid eligible clients. This has been a difficult

and undesirable outcome for many of the mental health boards, which believe their mission is and should be, unrelated to income.

- *Emphasis on Services to Adults*: Most local boards appear to focus most of their resources on services for adults, in particular, adults with chronic mental illness. Many of the child welfare administrators complained that children are a low priority for the mental health boards. This may be due, in part, to the fact that local mental health boards know that the child welfare system will provide services to its clientele; hence the boards can focus resources on those without another service system to rely on.
- *Shortage of Qualified Mental Health Providers*: The shortage seems to be increasing in three areas: the number of qualified providers who accept Medicaid (for both physical and mental health), the number of qualified child and adolescent providers, and the number of qualified child and adolescent providers who have any experience or training in abuse and neglect issues. Further, the reduced availability of qualified child and adolescent- certified psychiatrists, who can monitor medications, was particularly noted in Year 4. Several administrators report that child and adolescent inpatient units had closed due to the lack of qualified psychiatrists. Many PCSA administrators and staff also noted the high turnover in mental health professionals, and the high level of unfilled positions, resulting in unacceptably long waits for service.
- *Rigidity and Lack of Creativity of Service Options*: The willingness of the local mental health boards to meet the needs of the child welfare population varies considerably from county to county. The rules defining the procedure codes used by the community mental health system are relatively broad, but their interpretation varies. Some counties have run into significant barriers to accessing community mental health services. For example, the requirement that the child be designated "severely emotionally disturbed" virtually eliminates all young children and many others in need of services[3].

The Strength of the Relationship between the PCSAs and Mental Health

In spite of the issues described above, in Year 4, the relationship between the mental health board and the PCSA was characterized as "strong" or "very strong" by seven of the demonstration counties and by nine of the comparison counties, as shown in Table 2.20, below. The relationship was characterized as "weak" or "very weak" by three of the demonstration counties and one comparison county.

[6] Two other common problems are the implementation of overly restrictive audit standards, which seem to go beyond the limitations of the published rules, targeted toward some counties; and the limited use of flexible procedure codes in favor of traditional services such as individual counseling, diagnostic assessment, and medication/somatics. The most flexible procedure code, community support, which is a service that could be used in a variety of settings and seems particularly relevant to the child welfare population, is the least accessed because of a narrow interpretation of its purpose in many counties.

Table 2.20: Relationship between PCSA and Mental Health in Year 2 and Year 4				
	Demonstration (n=14)		Comparison (n= 14)	
	Year 2	Year 4	Year 2	Year 4
"Strong" or "very strong" relationship	7	7	8	9
"Neutral" or "mixed" view of relationship	4	4	5	4
"Weak" or "very weak" relationship	3	3	1	1

As Table 2.20 indicates, little change occurred between Years 2 and 4 in the nature of the relationships between the PCSA and mental health. Only one additional comparison county moved up to a "strong" or "very strong" relationship between the PCSA and mental health between Year 2 and Year 4. While the relationships with mental health are very similar for demonstration and comparison counties, slightly more demonstration counties reported weak relationships than did the comparison sites, and these figures did not change between Year 2 and Year 4.

Access to and Availability of Mental Health Services to PCSA Clients

Even though seven demonstration counties and nine comparison counties characterized their relationship with mental health as strong or very strong in Year 4, these relationships did not necessarily translate into adequate or priority services for the child welfare population. In fact, a more in-depth analysis of responses resulted in the findings in Table 2.21. The findings are listed in order from the most desirable to least desirable situation.

Only two comparison counties reported good, collaborative relationships with the mental health boards and adequate services, with a clear priority placed on the child welfare population. Four demonstration counties and four comparison counties reported good, collaborative relationships with the mental health boards, but experienced long waits for services and too few mental health resources.

Table 2.21: Relationship between PCSA and Mental Health and Adequacy of Mental Health Services for PCSA Clients		
	Demonstration (n=14)	**Comparison (n=14)**
MH Board collaborative/responsive, good/priority services to PCSA population	0	2
MH Board collaborative/ responsive, but too few resources, long waits for services, cuts anticipated	4	4
Strong relationship, but serious concerns about funding issues	0	3
Relationship with MH Board has had problems, but seems to be getting better, still problems getting appropriate services	7	3
Relationship with board strong, but relationship with providers poor and unresponsive with long waits for services, or relationship with board poor, relationship with providers may or may not be poor, unresponsive system with long waits	3	2

The remaining categories point to serious problems with agency relationships, service availability, or both. Three comparison counties reported strong relationships with mental health, but serious concerns with the level of funding available. Seven demonstration counties and three comparison counties reported that relationships seemed to be improving, but there were still problems getting appropriate services. Three demonstration counties and two comparison counties reported either poor relationships with the mental health providers or poor relationships with the mental health board, which resulted in poor access to appropriate services. PCSA directors in both demonstration and comparison counties routinely acknowledged their understanding of the limitations of mental health services based on local funding availability.

In spite of the overall lack of mental health and substance abuse services, six demonstration counties and only two comparison counties have mental health or substance abuse board or provider staff out-stationed at the PCSA at least part of each week. Out-stationed staff focus primarily on assessment/diagnostic activities, but are involved in case review and actual therapeutic services in some jurisdictions. Access to services overall has not generally improved due to out-stationing, but small improvements accessing particular types of services, or getting assistance from MH/SA staff were reported due to the out-stationing. For example, Hamilton County, with out-

stationed AOD staff, reported better access to AOD services. The bigger problem for accessing services is lack of resources.

The study team also examined the extent to which mental health services are being purchased or provided directly by PCSAs. These services include any therapeutic interventions that could be fully or partially reimbursed through Medicaid. PCSAs mentioned several reasons that these services are not currently reimbursed through Medicaid, including:

- Wait lists are too long through mental health board;
- Experienced providers will not accept Medicaid reimbursement;
- Needed service does not fit within the Ohio Department of Mental Health (ODMH) allowable procedure code restrictions; or
- Board does not have enough non-federal match to cover cost of needed services.

Six demonstration counties and five comparison counties were providing or purchasing their own diagnostic or therapeutic services (Table 2.22). Nine demonstration counties and seven comparison counties were providing a portion or the entire non-federal Medicaid match for some or all therapeutic services provided through the mental health/ alcohol and addiction service boards. Since some counties were doing both, a total of 12 demonstration counties and 10 comparison counties were paying at least some of the cost for therapeutic services. Additionally, five demonstration counties and five comparison counties mentioned using other program funds (e.g., TANF-PRC, Family Stability) to pay for diagnostic or therapeutic services that could have been partially reimbursed through Medicaid.

Those PCSAs providing or purchasing their own diagnostic or therapeutic services are paying the full cost of these services without benefit of federal reimbursement. Certainly the demonstration counties are using flexible Title IV-E Waiver funds to support some of these costs, while comparison counties are using other flexible funds, such as levy funds, Title IV-B funds and Title XX funds.

In theory, of course, diagnostic and therapeutic services needed by Medicaid-eligible children *should* be funded through Medicaid, according to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions established in the Omnibus Budget Reconciliation Act of 1989. This law mandated that *any federally-allowable* Medicaid service needed by an eligible child must be provided to that child *regardless of whether that service is included in the state plan.* Since these services are not available or not accessible (lack of providers or timely service provision) in Ohio through Medicaid, PCSAs are using whatever flexible funds they have, including Title IV-E Waiver funds, to purchase needed diagnostic and therapeutic services. The problem is that these services should have been available without the Waiver. The result is that in the Waiver counties, Title IV-E funds may be used to address the design and funding flaws in Ohio's mental health/ Medicaid system. While the Waiver allows for this

flexibility, the Title IV-E Waiver was not intended to address, nor intended to fix, systemic Ohio Medicaid mental health problems. For Ohio's PCSAs, the prevention of placement or the timely reunification of families may be impeded by the lack of home and community-based diagnostic and therapeutic services (reimbursable through Medicaid). Hence using Waiver funds to pay for these services is a reasonable and thoughtful response to reducing placement days and costs.

The Waiver per se does not appear to have significantly affected relationships with the mental health system in Ohio. What it may have done is provide additional flexible funds with which PCSAs can purchase mental health services. However, the distinction between demonstration counties and comparison counties is not significant, perhaps signifying that the need for mental health services is important enough to warrant the expenditure of flexible funds in most counties with or without the Waiver.

Table 2.22: Diagnostic or Therapeutic Services Fully or Partially Paid by PCSA

	Demonstration (n=14)	Comparison (n=14)
PCSA providing or purchasing own diagnostic or therapeutic services	6	5
PCSA paying a portion of the cost of mental health board services	9	7
Unduplicated number of PCSAs providing or purchasing own diagnostic or therapeutic services or paying a portion of cost of mental health board services	12	10

2.10.3 Family and Children First Council and Other Interagency Collaborative Efforts

The Family and Children First Councils (FCFC) were established to serve as coordinating bodies for services to children and families in each county. They also serve as repositories for discretionary and special funds for children and families (e.g., Family Stability, the Wellness block grant). One of their primary functions is to coordinate services to multiple-agency or "cluster" children. The cluster process has been in place since the mid-1980s, and is well established in most counties. The ability of these councils to coordinate services and planning for children and families, and to generate additional grant funds, affects the ability of the PCSA to obtain services from other service systems for its clients. A strong, energetic and effective FCFC could help the PCSA reduce placement days and unit costs.

The study team examined the effectiveness of the Councils by looking at shared or pooled funding for individual cases, shared or pooled funding for programs, and out-stationed or shared staff across agencies.

Shared Funds for Individual Cases

The cluster concept was developed in the mid-1980's to promote shared funding for individual cases across agencies. It came about because PCSAs were unable to get cooperation and services from other service systems for children in custody, despite the fact that a child's problems clearly crossed agency lines. At the time, both the local MR/DD system and mental health systems were problematic. At that time, ODHS filed a rule allowing PCSAs to petition the court to order other systems to participate in funding or providing services to individual children. The other service systems were outraged by this action, leading to the rescission of the rule and the development of the cluster system. The cluster system required county agencies to meet to discuss how they would contribute to addressing the needs of children whose needs crossed systems. Once these agencies developed a plan, with reasonable contributions (cash or in-kind) from each local agency, they could apply to the state cluster for additional financial support.

Since the development of the Councils, some counties have moved beyond shared funding arrangements and toward pooling funds to cover the cost of children referred to the local group. Because of the categorical nature of funds within the local agencies, pooling of funds is typically more difficult, but is clearly a strategy open to the Waiver counties. Year 4 data shows that slightly more than half of the counties in the demonstration and comparison groups (9 of each) have shared funding arrangements, and 7 counties in each group have pooled funding.

A comparison was made of shared and pooled funds for individual cases between Years 2 and 4. Little difference exists between demonstration and comparison groups, and only minor changes have occurred over time. Similarly, demonstration and comparison counties make equal use of out-stationed or shared staff, with the vast majority of counties doing so (10 demonstration and 11 comparison sites); and most counties also contribute funds to support joint service programs (10 demonstration and 9 comparison counties).

Other Interagency Collaborative Efforts

Numerous examples of interagency collaborative efforts were provided by both demonstration and comparison counties. There were seven basic themes to these efforts:

- Mental health/ child welfare,
- Juvenile sex offenders,
- Coordinated investigations of sex abuse cases,

- School truancy/ alternative schools,
- Family-to-Family,
- Domestic violence, and
- Programs for unruly/ delinquent youth.

Table 2.23 shows the number of counties involved in interagency collaborative efforts during the last year. At the time of the site visits, interviewees mentioned these efforts as being planned or underway. Some additional local coordinated efforts (e.g., coordinated investigations of sex abuse cases) may be so established in the counties that respondents failed to mention them. The predominant collaborative efforts are those around child welfare/ mental health services (ten counties), school truancy/ alternative schools (seven counties), and coordinated investigations of sex abuse cases (five counties).

Table 2.23: Other Interagency Collaborative Efforts

	Demonstration Counties (n=14)	Comparison Counties (n=14)
Mental health/ child welfare	6	4
School social workers/ truancy/ alternative schools	3	4
Coordinated investigation of sex abuse cases	3	2
Programs for unruly/delinquent youth	3	1
Juvenile sex offender	1	2
Family-to-Family	2	0
Domestic violence	2	0
Total number of counties with at least one of these activities	11	11

Overall, while some variation exists between demonstration and comparison counties in relationships with the court and mental health, and some variation in the level of interagency collaborative efforts, these variations do not seem to be related to the presence of the Title IV-E Waiver. Since most counties have levies or other funds that can be used flexibly, they have been able to address coordinated community services and programs without having to rely solely on flexible Waiver funds. Several changes in funding could affect this pattern over the next several years. Cuts in DYS funding to the courts, the effect of Medicaid matching requirements, and the reduction in PRC funds that should be felt later this year could reduce the ability of the courts, the local mental health systems, FCFC and DJFS/PCSA to support collaborative efforts.

2.11 SYSTEMIC REFORM AND LEADERSHIP

In the Year 4 site visits, the study team explored with PCSA managers and with the directors of the other major child-serving agencies in the county their perceptions of efforts toward systemic reform in the local child welfare system. It was an opportunity for county leaders to reflect on activities during the five-year period of the Waiver, giving a sense of coherence (which hindsight often can provide) to the initiatives fostered by the PCSA. With the "big picture" in mind, the study team proceeded to examine how the PCSAs pursued their macro-vision of change: demonstration counties' flexible use of Title IV-E funds, and all counties' reliance on leadership to keep activities on target. Finally, the study team investigated some of the more subtle effects of multi-faceted change on workplace conditions, including morale and office environment.

Summary: Ten distinct themes characterize the focus of demonstration and comparison counties' efforts toward system reform: increasing retention of qualified staff, organizational restructuring, training, reducing inappropriate case openings, intensifying in-home services, increasing use of less restrictive placements, increasing permanency, expanding utilization review and quality assurance (UR/QA), enhancing public relations, and engaging in managed care contracts. In only two of these areas—increasing in-home services and UR/QA—the demonstration counties appear to have been somewhat more active. Consistent with the focus on in-home services, most demonstration counties have capitalized on their flexibility with IV-E funds to develop preventive services and to create discretionary funding pots for one-time family needs. All of this appears to relate to the strength of PCSA leadership, which in turn contributes to staff morale. Demonstration counties seem to have slightly stronger leadership and somewhat better workplace environments than comparison sites.

2.11.1 Focus of System Reform Efforts

In the Year 4 site visits, the study team examined child welfare system reform efforts from the perspective of managers in the PCSA and in the other major child-serving agencies in each county. See Table 2.24. The information revealed ten broad themes across PCSA reform initiatives[4]:

- *Increasing Retention of Qualified Staff:* Six demonstration counties and eight comparison counties discussed efforts to address staffing issues in their agencies. Most of these counties have struggled to deal with staff turnover and retention. In these counties, efforts have been made to hire and maintain a qualified workforce, often through the development of a new salary structure and better supports for

[4] For each theme, the description includes the number of demonstration and comparison counties that identified this theme as a focus of their agency. These themes were generated from open-ended questions so the number of counties identified provides an idea of how many counties articulated these efforts as themes, but is not an indication that other counties are not involved in similar efforts or have not focused on these efforts in the past.

workers (e.g., cell phones, agency cars). In addition to achieving full staffing, some agencies have sought to develop a more qualified workforce by providing educational opportunities or simply by developing higher standards for workers and dismissing non-qualified workers. Several counties stated that these efforts have resulted in a rejuvenated staff. PCSAs have also tried to support workers better by improving supervisor/worker ratios, clarifying the roles of various positions, and hiring more support workers to assist front-line caseworkers in doing their jobs. Lastly, in addition to enhancing agency staffing levels, several counties have spent a significant amount of time and energy dealing with management changes, stabilizing the agency following the change of a director, and dealing with union issues.

- *Intensifying In-home Services:* Nine demonstration counties and three comparison counties have focused on developing more services to support children in their own homes. These efforts entail the PCSA conducting a thorough assessment of each case, understanding the needs of the family, and then providing the more short-term intensive services that support the family and enable the child to remain in the home. PCSAs have developed supportive services both in-house and in the community. Some examples include parent aides, parent educators, respite services, and wrap-around services. One county described these efforts as a shift toward providing more social work services rather than simply providing traditional case management services. Several counties have also created mental health and substance abuse assessment services within the PCSA to guarantee clients easy access to these needed resources. Demonstration counties focusing on this area indicate that they have been able to use the flexibility of the Waiver to develop more of these intensive service opportunities for PCSA clients than would have been possible without the Waiver.
- *Organizational Restructuring:* Four demonstration counties and five comparison counties have gone through a major restructuring effort over the last several years, most often transitioning from a traditional structure to an integrated team approach. This has led to a major shift in the way front line workers do their jobs. Staff need time to learn their new roles and relationships with other workers in their units. Even in counties that have maintained their traditional unit structure, restructuring has meant the addition of new staff or units and redefinition of roles and responsibilities. All of these efforts require time and clear management commitment to help staff adjust and to fine-tune the new structure.
- *Expanding Utilization Review and Quality Assurance (UR/QA):* Seven demonstration counties and two comparison counties have engaged in recent efforts to improve the quality of PCSA services and gather data to identify agency trends. These activities fall into three categories. First, several counties focused energy on expanding quality assurance: increasing QA staff, standardizing agency practice, holding workers to a higher standard, and creating more accountability. Second, counties have focused on utilization review: developing case review practices to better monitor cases, gathering outcome data, and paying more attention to data to modify agency practice. Lastly,

several counties have spent a significant amount of time and resources becoming accredited, or going through other "continuous quality improvement" processes, to ensure that QA findings are formally used to improve agency operations (Sections 2.7 and 2.8 offer more detail).

- *Reducing Inappropriate Case Openings:* Four demonstration and four comparison PCSAs spoke of efforts to reduce inappropriate case openings by working with families prior to transfer to an ongoing caseworker, and sometimes prior to opening the case in Intake/Assessment. In some counties, this effort to "control the front-door" has led to the creation of diversion positions, by placing PCSA workers in the juvenile court to avoid inappropriate referrals, or by placing social workers in schools to do preventive work. Other counties have limited the cases coming into the agency by providing some up-front services to families who, without this assistance, might need PCSA involvement in the future—for example, using flexible funding streams to provide one-time assistance with finding housing, paying utilities, etc. Several counties noted that they have fully implemented the Family Risk Assessment Matrix (FRAM), enabling intake workers to make more systematic decisions prior to case opening. All these efforts are viewed as helping the PCSA narrow the range of cases that enter the agency, diverting cases that could be served in the community.
- *Enhancing Public Relations:* Two demonstration counties and six comparison counties emphasized specific efforts to improve community relations and public perceptions of the PCSA. Several counties created public relations (PR) positions within the PCSA to be a link to the outside community. These efforts often developed following a period of agency turmoil (i.e., change in leadership, agency audit, etc.) that had evoked negative images of the PCSA in the community. The agency desired to rebuild its reputation, ultimately to develop community support for preventive initiatives.
- *Training:* Four demonstration and two comparison counties have focused on developing training opportunities for their staff in order to increase professionalism. These efforts have involved training in leadership development, experiential learning in cultural diversity, and joint training with other agencies on how the PCSA can improve its casework services (e.g., training on the most appropriate way to prepare and make presentations in court).
- *Increasing Use of Less Restrictive Placements:* Three demonstration and three comparison counties have focused on reducing PCSA use of more restrictive placement settings and increasing staff awareness of the cost of such placements. In particular, several counties have developed new placement options, by increasing the foster care per diem and other strategies. (See Section 2.4.2 for details.) This enables the PCSA to step-down children from expensive settings (often out-of-county residential) to local foster homes. In addition to developing less restrictive placement options, several PCSAs described efforts to educate staff on the financial implications of various placement options and to develop systems to monitor the use of placement

settings. These agencies are clearly communicating to their staff the importance of reducing placement days and controlling placement costs.

- *Increasing Permanency:* Three demonstration counties and two comparison counties spoke of the impact of HB484 and the resulting agency push to develop permanency options earlier in lifespan of PCSA cases. In particular, these agencies have made efforts to monitor case progress more closely, provide services more quickly, develop more adoption and alternative permanency options (i.e. kinship placements), utilize concurrent planning more consistently, and make earlier decisions about which direction to take with a case. Although they were moving in this direction prior to HB484, many PCSAs have found that the legislation has led to intensified activity in this arena.
- *Engaging in Managed Care Contracts:* Three demonstration counties spent a significant amount of time dealing with their managed care contracts, one cleaning up after the end of a difficult contract, the other two continuing to modify and expand their managed care efforts (see Section 2.6 for more details).

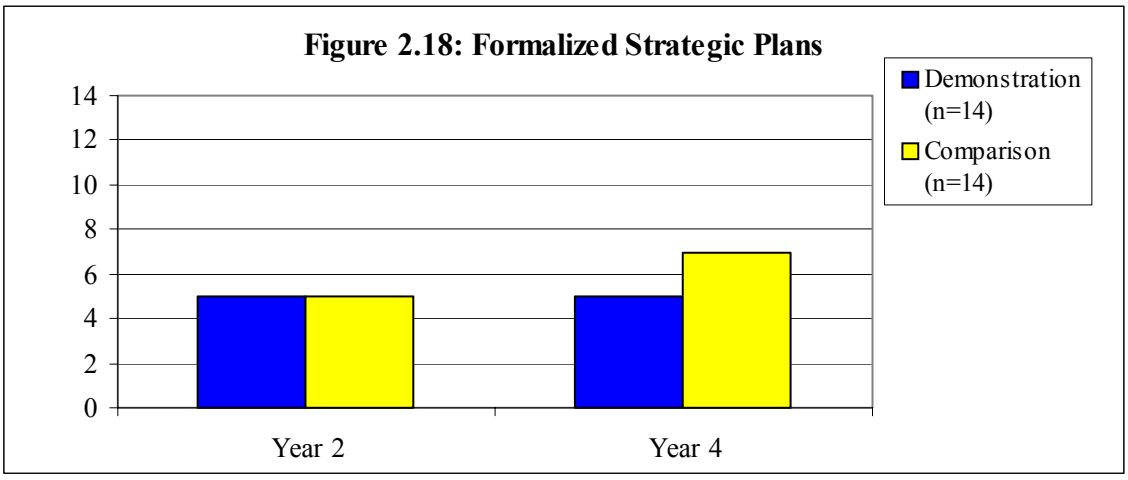
Table 2.24 summarizes the extent of PCSA focus on the themes described above. While this information is qualitative in nature (based on open-ended questions and sometimes lengthy discussion with county leaders), the categorization of responses nonetheless provides interesting insight into differences between demonstration and comparison counties. In many areas, demonstration and comparison counties are quite similar in the focus of their reform efforts. However, a few areas show notable differences. More demonstration counties have worked to increase in-home services, which may reflect their flexibility in use of IV-E funds. Another difference appears in demonstration counties' UR/QA efforts, perhaps showing how these PCSAs have become more careful about making long-term financial commitments when operating under a limited IV-E budget.

Table 2.24: Themes in PCSA System Reform			
	Number of Demonstration Counties	**Number of Comparison Counties**	**Total**
Increasing retention of qualified staff	6	8	14
Intensifying in-home services	9	3	12
Organizational restructuring	4	5	9
Expanding UR/QA	7	2	9
Reducing inappropriate case openings	4	4	8
Enhancing public relations	2	6	8
Training	4	2	6
Increasing use of less restrictive placements	3	3	6
Increasing permanency	3	2	5
Engaging in managed care contracts	3	0	3

Strategic Planning

While all study counties identified some system reform themes, only some counties have actually developed more formalized strategic planning processes, involving community members to help the PCSA develop goals, objectives, and timelines for action. The priority areas of these strategic plans vary widely, but common issues appear in several counties: development of financial resources, QA focus, service enhancement, and community relationships. Figure 2.18 indicates that approximately one third of the demonstration counties now have formalized strategic plans, while half of the comparison counties have developed these plans, a slight increase from Year 2 of the evaluation. Two demonstration counties and three comparison counties have developed strategic planning processes since the Year 2 site visit.

The relatively modest use of formal strategic planning processes gives rise to the question: what factors lead a PCSA to engage in strategic planning? The study team found that, of the five demonstration and seven comparison counties with strategic plans, all but one county ranked strong or very strong on the leadership index (described in Section 2.11.3). Further, of the nine (six demonstration and three comparison) counties who ranked high on overall use of managed care strategies, all but two of these demonstration counties have strategic plans in place.

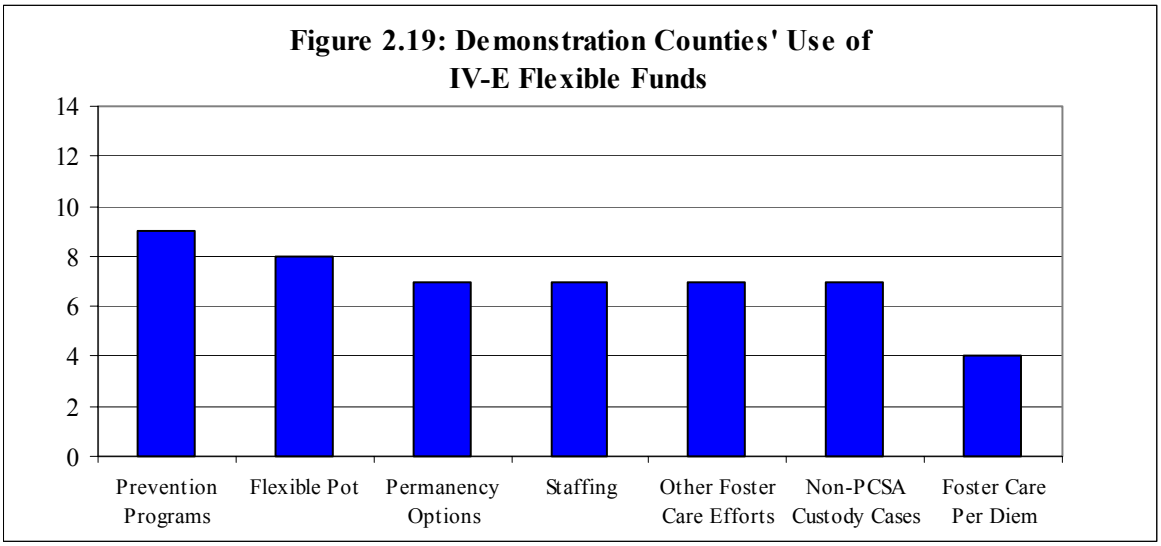


2.11.2 Flexible Uses of Title IV-E Funds

For the ProtectOhio counties, the Title IV-E Waiver provides substantial flexibility to pursue system reform efforts that might not otherwise be possible. Throughout the evaluation, the study team has explored how demonstration counties have used this flexibility to modify child welfare practices. Not surprisingly, the types of activities discussed below parallel many of the system reform themes, because, for demonstration counties, the Waiver flexibility gave momentum to those initiatives. The findings presented below reflect patterns of use of Title IV-E funds not only in the fourth year of the evaluation but also over the entire course of the Waiver.

Uses of Flexible IV-E Funds

The study team identified seven specific areas in which flexible funds might be spent. Demonstration counties identified the areas where they were spending flexible funds, *which they would not have pursued in the absence of Title IV-E flexibility*, even when they did not specifically track the use of the IV-E dollars to that initiative. Figure 2.19



indicates that, in the fourth year of the Waiver, demonstration counties used flexible funds quite broadly.

The following section provides a more thorough description of the types of activities that characterize each of these areas:

- *Prevention Programs and Services:* Nine demonstration counties developed new prevention programming. This included services to prevent referrals to the PCSA and assist families who might otherwise need PCSA involvement in the future, such as social workers in the schools and mentoring programs. Demonstration counties also developed programs and services, including in-home services, wrap-around services, in-home therapists, and parent educators, to prevent the removal of a child or to support a family to enable reunification to occur more quickly. Lastly, counties developed services to help decrease the time a case might spend in the PCSA system, including a clinical psychologist to conduct prompt initial assessments, process servers to cut delays in court, and a detective to quickly investigate abuse cases and begin prosecution efforts more promptly.
- *Flexible Funding Pots:* Eight demonstration counties used flexible IV-E funds to contribute to the pool of funds which workers tap to prevent removal, support less restrictive placements (i.e., regular foster care), or support reunification. Agencies spoke of this pot as a resource to do "whatever it takes" to assist a family. This has enabled workers to pay utility bills or rent, purchase furniture, or repair a car to enable the parent to maintain a job. In some extremes, these funds have been used to fly in potential kinship caregivers from out-of -state.
- *Permanency Initiatives:* Seven demonstration counties have used IV-E funding to expand permanency options, primarily increasing adoption subsidies for hard-to-adopt children. One demonstration county implemented an assisted guardianship program. Demonstration counties in this group stated that they were seldom able to offer more than the $250/month adoption subsidy prior to the Waiver, creating a disincentive for foster parents to adopt a special needs child in their care. With the Waiver, four demonstration counties indicated that they have been able to offer an increased subsidy based on the needs of the family. Specifically, one county described now being able to offer up to $1,500 per month for special needs children. Counties in this group have also been able to offer one-time assistance to modify a potential adoptive home to enable it to pass the home study.
- *Staffing, Internal Capacity and Training*: Seven demonstration counties use their IV-E flexibility to enhance their staffing and internal capacity. Often this simply entailed hiring more caseworkers, support staff, and supervisors, to reduce caseload size and provide increased support to front-line workers. In other counties, while no new staff was hired, the counties were able to modify salary structures in order to retain current staff and recruit more qualified staff. Other counties were able to purchase items such as cell phones and increase worker access to agency cars.

- *Services to Children not in PCSA Custody*: Seven demonstration counties spend resources on children who are not in their custody to reduce the likelihood that these children will come into PCSA care in the future. This may be accomplished through an informal agreement with another child serving agency, often the court, to help pay for services to a child without the PCSA having to take custody. Alternatively, it may be through a more formal arrangement, such as when the PCSA shares some of the court's administrative burden in becoming a IV-E court. Some of these demonstration counties also note that the Waiver enables the PCSA to contribute more to pooled funding for multi-system children who often are not in PCSA custody.
- *Foster Care Per Diem Increases*: Four demonstration counties spent flexible funds on increasing foster care per diems to attract more potential foster families. These expenditures appear to reflect the continuing need across all counties for more foster homes and the desire of many Ohio PCSAs to move away from network homes and open more agency homes. (See Section 2.4.2 for more detail.)
- *Other Foster Care-related Efforts:* Seven demonstration PCSAs spent IV-E flexible funds on efforts to recruit and train new foster parents in their county. In some counties, this meant hiring foster care staff to develop more formalized recruitment campaigns in targeted areas. Others have created more resources for foster families to help them feel more supported by the PCSA. Lastly, several counties have begun to offer a financial incentive to current foster families who successfully recruit new foster families for the agency.

2.11.3 PCSA Leadership

A key factor in implementing any broad-ranging reform in the child welfare system is the nature of the PCSA leadership. An effective leader guides the development of a vision for change, and motivates others to participate in bringing the vision to reality. In Year 4 interviews, the study team explored perceptions of PCSA leadership both within the agency, among staff at various levels, and within the peer group of the PCSA director, comprised of the leadership of child-serving agencies in the community.

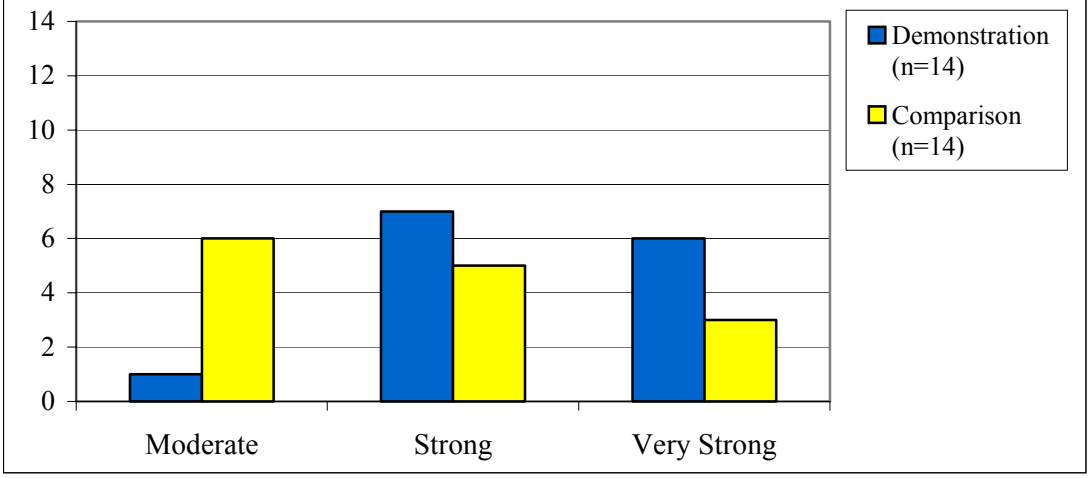
Little difference emerged between demonstration and comparison counties in response to a direct question about the strength of PCSA leadership: nine demonstration counties and eight comparison counties have PCSA leaders who are considered to be strong or very strong. However, the study team further pursued this issue of leadership, believing that leadership is based on more than simply a perception of leadership strength. The study team developed an index of PCSA leadership, using a number of different variables (see Table 2.25). These factors all contribute to the strength of leadership in terms of the PCSA director's ability to create a positive atmosphere in the agency, conducive to fostering reform.

Table 2.25: Variables in the PCSA Leadership Index:

- ✓ Change in PCSA leader
- ✓ Perception of strength of the PCSA leader (Years 2 and 4)
- ✓ Pursuit of system reform efforts
- ✓ Morale of supervisors and workers
- ✓ Perception of PCSA environment and atmosphere

The study team combined and weighted the above-mentioned variables to create a scale of internal PCSA leadership, displayed in Figure 2.20. Use of this index brings to light more notable differences between the demonstration and comparison counties. PCSA leaders in demonstration counties rank somewhat higher on this overall scale than do comparison counties, indicating their ability to balance the level of organizational changes being introduced with staff needs for feeling supported and appreciated by the agency administration.

Figure 2.20: PCSA Leadership Index



This comprehensive view of PCSA leadership may be associated with other factors affecting the agency's ability to implement systemic reforms. For example, a PCSA leader may be strong internally, but may or may not also have the ability to foster collaborative relationships and efforts within the local child-serving community. Preliminary findings indicate that many of the PCSAs with "strong" directors are similarly skilled in dealing with key players outside the agency: nine of the 13 "strong" or "very strong" demonstration counties ranked high on the interagency collaboration index and six of the eight "strong" or "very strong" comparison county directors ranked high on this index. Conversely, in only a handful of counties (four demonstration and two comparison counties), the internal leadership did not translate into strong interagency collaboration. There appears to be a relationship between a county having a strong leader, as ranked on the index, and having good external collaboration, suggesting that strong leaders are able to foster better external collaboration.

2.11.4 Staff Morale

The leadership index presented above includes items representing staff morale, reflecting the thesis that a strong leader not only enunciates the reform agenda but also is able to encourage staff to feel positive about their job, in the midst of reform activity which can be disruptive. In the Year 4 site visits, the study team conducted focus groups of workers

and group interviews for line supervisors. In general, the groups ranged in size from three to ten individuals, representing a variety of units within the PCSA. In two of the comparison counties, the study team was unable to convene any meeting with caseworkers; however, information was obtained from supervisors in both of those counties. The team asked direct questions about morale, but also inferred the general level of morale in the agency by observing the group dynamics and the nature of the specific comments offered by participants. The five areas comprising the assessment of morale at each agency included supervisor morale, worker morale, cohesiveness among workers, office atmosphere, and physical environment.

Table 2.26: Morale Ratings

Items	**Demonstration Counties (n=14)**	**Comparison Counties (n=12)**
Positive supervisor morale	71%	43%*
Positive worker morale	64%	25%
Good office atmosphere	79%	42%
Good physical environment	64%	42%
Cohesiveness among workers	93%	100%

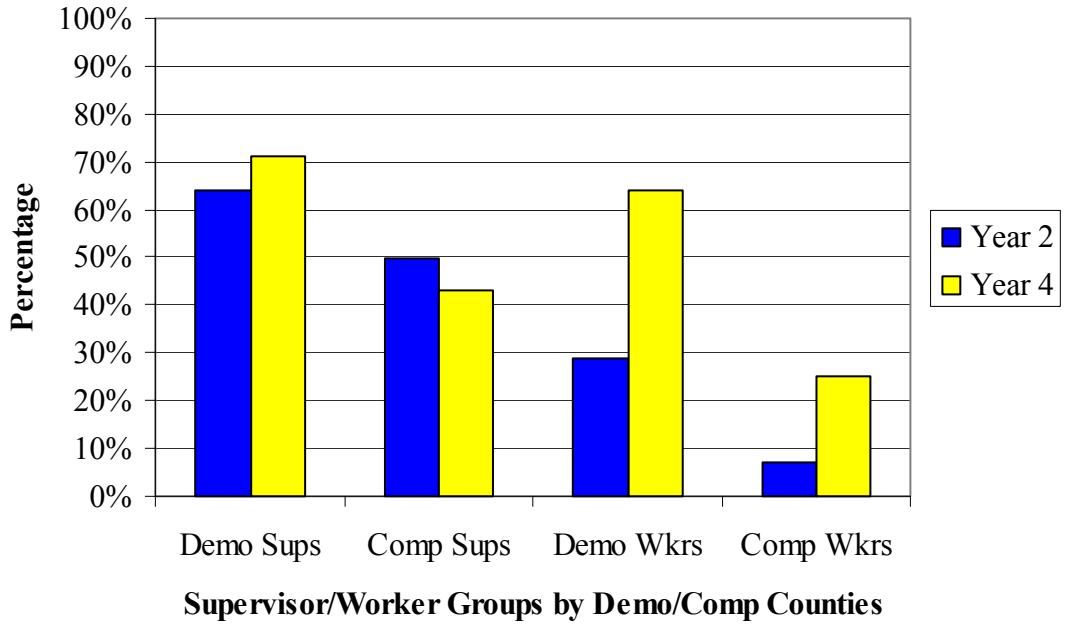
* n=14 for this item. Although in two counties worker focus groups were not available to meet, supervisor groups gave their input.

Overall, the demonstration counties tended to have a somewhat higher level of morale than the comparison counties on four of the five questions (See Table 2.26). Cohesiveness among workers was approximately equal for both groups. It is interesting to note that workers in both groups of counties were less likely to judge morale as positive than their supervisory counterparts.

In Year 2 of the evaluation, the study team similarly explored staff morale. Figure 2.21 highlights changes over time in worker and supervisor assessments of morale. For supervisors, it appears that morale has improved slightly in demonstration counties (64% to 71%), while dropping slightly in comparison counties (50% to 43%). It should be noted that these changes are based on a difference of only one county in each case. Perhaps more significant is the general trend of more counties with positive supervisor morale in the demonstration group than in the comparison group. For workers, more differentiation is evident, both between demonstration and comparison groups as well as over time. First, there was an overall improvement of worker morale from Year 2 to Year 4: the percentage of demonstration counties with positive morale of workers doubled (29% to 64%), while comparison counties increased from 7% to 25%. Second,

there is a consistent pattern of more counties with positive morale among workers in the demonstration group, compared to those in the comparison group.

Figure 2.21: Reports of Positive Morale in Year 2 and Year 4 for Workers and Supervisors



This finding of improved morale over time is reinforced by findings from the worker focus groups: in general, workers expressed that they feel supported by their immediate supervisors despite the fact their work is difficult, their caseloads are heavy, and there is an abundance of paperwork. This improvement in staff morale may be attributable to an increased management emphasis on communication and support of staff.

Some consistent themes emerged from the focus groups with front-line workers. Regarding the strengths of the PCSA, many interviewees discussed a sense of support within units, in terms of support from supervisors as well as between workers. Some counties described their supervisors as understanding and respectful of workers' input, and as having an open-door policy. Most worker groups were quick to mention that their peers were always helpful and there was a strong sense of "going the extra mile" for one another. Another strength that was mentioned in these focus groups was the development of new services to make workers' jobs easier. A primary example was the development of a transportation options, shifting the burden of transporting clients from the case workers to case aides or a transportation program.

Consistent themes also arose when workers discussed challenges that they face in their jobs. One common challenge is high staff turnover, which also affects morale: vacant positions mean increased caseloads for the remaining staff. One worker focus group, in Ashtabula County, saw itself as the exception, attributing their low turnover rate to good pay, good benefits, and flexible work schedules. Another challenge mentioned frequently was paperwork: workers are often frustrated with the amount of documentation required, the frequent changes made to forms, the impact of increasing caseloads on paperwork volume, and the unrealistic deadlines involved in many PCSA paperwork processes. A third challenge often noted was communication: while management generally characterized communication as strong, the front-line supervisors and workers tended to characterize communication and support as poor. However, staff in five demonstration counties expressed a contrasting view, with supervisors and caseworkers feeling supported by upper management. They described their agencies as communicating well, including front-line staff in decision-making procedures, listening to front-line staff, making resources available for families, and making workers feel empowered by those above them.

Clearly, workers and supervisors in the demonstration and comparison counties have wide-ranging views of agency morale. However, the overall pattern seems to be that demonstration counties support staff who generally feel positive, even though individual demonstration and comparison counties may continue to struggle with this issue.