CHAPTER 2: WHAT APPROACHES HAVE COUNTIES USED? FINDINGS FROM THE PROCESS IMPLEMENTATION STUDY

2.1 INTRODUCTION

In the course of the Waiver evaluation, the Process Study team explored numerous aspects of county child welfare practice. To provide a context for understanding changes in participant outcomes and fiscal outcomes, this chapter describes the most important changes that have occurred and continue to evolve in PCSA operations, specifically, the use of managed care strategies and the nature of the complex interagency environment of child-serving agencies in the county. Insights about overall systemic reform and leadership are also presented.

> **Chapter 2 Topics:**
> ✓ Internal Organization/ Case Management
> ✓ Individual Managed Care Strategies
> ✓ Overall Managed Care
> ✓ Interagency Collaboration
> ✓ System Reform and Leadership

This chapter addresses 10 of the 24 outcomes identified by the demonstration counties as being most central to their Waiver efforts (Table 2.1). Two of the primary outcomes related to service array, "increased service capacity relative to need" and "timely access to services," are not discussed here, but will be included in Year 5 work. In addition, one outcome domain, relating to Caseload Analysis (CLA), has been set aside for the current report, based on limited findings in prior annual reports. The end of this section briefly discusses that and other deferred topics.

Table 2.1: Primary Waiver Outcomes Identified by Demonstration Counties

Case Management
- Increase in family involvement in case management
- Use of team conferencing

Service Array
- Improved availability and quality of services
- Development of new services

Utilization Review/ Quality Assurance
- Increased activity to control/rationalize use of out-of-home care
- Increased attention to outcomes

Interagency Collaboration
- Improvement in PCSA interactions with other service agencies
- Improvement in relationship between PCSA and mental health

Each outcome addressed in this chapter represents some aspect of counties' use of managed care strategies. Central to the evaluation of ProtectOhio is how the managed care strategies ultimately affect children and families. For some demonstration counties,

the opportunity to use managed care techniques was a principal reason that they entered the Waiver. The underlying hypothesis in Ohio's choice to employ managed care technologies in its Title IV-E Waiver is that:

- Demonstration counties will employ differing models of managed care, characterized by varying service arrays, financing approaches, efforts to target services, case management arrangements, provider network configurations, methods of utilization review and information management, and quality assurance techniques;

- Over time, use of these differing managed care models will lead to families receiving more varied services;

- Receipt of more appropriate and more comprehensive services will lead children and families to better outcomes; and

- If the managed care efforts are family-oriented, families will be more satisfied with their experiences in the child welfare system and with their lives overall.
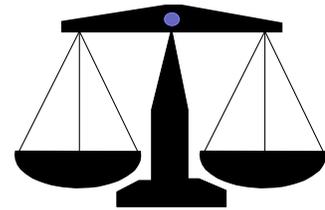
Because the focus of the Ohio Title IV-E Waiver is on encouraging child welfare agencies to adopt various managed care efforts, the evaluation team developed a list of managed care strategies that could be used by child welfare agencies, and then explored the extent to which the 28 evaluation counties are using these strategies.

To adapt the term "managed care" to the child welfare setting, the team broadly defined the use of managed care as a rational decision-making process to balance the competing forces of cost control, access, and quality. The study team then developed a list of eight commonly used managed care strategies that promote the balance of these competing forces. The eight primary areas of exploration include:

Managed Care Strategies
➢ Service Array/Care Criteria
➢ Financing Methods/ Capitation and Risk
➢ Targeting a Particular Population/Eligibility
➢ Case Management/Care Coordination
➢ Provider Competition
➢ Utilization Review
➢ Data Management
➢ Quality Assurance

- *Service Array/Care Criteria:* In traditional managed care, the phrase "care criteria" refers to the standards used to determine what services can be provided, or a list of allowable services. In child welfare, the pertinent concern is making available a comprehensive array of services that increase a PCSA's ability to appropriately serve its clientele.

- *Financing Methods/Capitation and Risk:* Capitation is a process whereby a fixed amount of money is paid in advance to cover the costs of services needed by eligible individuals or families. Associated with such a flat payment is a risk: in receiving a limited amount of money, the provider promises to provide all needed services regardless of whether the cost of those services exceeds the payment. Many options exist for establishing capitated, shared-risk service

arrangements, limited to a certain group of children and families or broadly applied to the general child welfare population.

- *Targeting a Particular Population/Eligibility:* Traditional managed care clearly defines the eligible population, and then perhaps sets more limits on access to particular services. By contrast, in child welfare, screening guidelines may change over time, as community needs shift and child welfare becomes more or less targeted to prevention. As child welfare redefines its role, it may become necessary to target special service initiatives to parts of the population who have particularly serious needs, or who have been overlooked in the past.

- *Case Management/Care Coordination:* Under conventional managed care, case management is a system in which a single professional ensures that a child or family obtains the mix and quality of services that are needed. In child welfare, this role is most often played by a caseworker. Key to success in case management is clarification of responsibilities and ensuring consistency in case management over time.

- *Provider Competition:* Managed care is often touted as a way to increase the competition, and thus the efficiency, of providers in a service network. The larger the provider network, the more potential exists for choice among services and among providers of a given service, thus affording greater opportunity to meet individual needs.

- *Utilization Review:* Utilization review is a formal process, often by an outside party, to ensure that the services being provided are necessary, appropriate, and at the lowest reasonable cost. Child welfare is beginning to more carefully scrutinize use of out-of-home placements and to think about the need for systematic parameters around use of other types of service.

- *Data Management:* The foundation for much managed care activity, especially utilization review, is a comprehensive management information system, containing sufficient historical data, having a strong tracking capability, and offering linkages between administrative and fiscal data sets. Child welfare agencies are beginning to pay attention to this need.

- *Quality Assurance:* Quality assurance can be seen as a broader activity, complementary to utilization review, geared not just to ensuring minimal safety of children but also to fostering performance improvements over time. In child welfare, quality assurance activities are slowly overcoming their exclusive process-orientation, and beginning to focus on child and family outcomes.

Throughout the course of the ProtectOhio evaluation, the study team has held numerous discussions with managers and policy-makers in the 28 evaluation counties, exploring their understanding of these managed care tools and their efforts to experiment with various techniques to improve the service delivery system. The team also has met with

groups of workers and supervisors, to learn their perspective on the changes being introduced.

The next section of this chapter explores how demonstration and comparison counties are using the managed care strategies, with a focus on what has been learned during Year 4 interviews. Following the discussion of the individual strategies, analysis is presented using the managed care index, an indicator of overall use of managed care strategies.

The final parts of the chapter discuss interagency collaboration and systemic reform. The Process Implementation study team has included interagency collaboration in each year's data collection effort for two reasons. First, child welfare does not exist in a vacuum. It must rely on the services and supports of other community agencies, particularly the juvenile court and the mental health system. To the extent that these systems do or do not work collaboratively with child welfare, they can affect the ability of the child welfare system to achieve its desired outcomes. Second, the fiscal flexibility offered by the Waiver gives the child welfare agency more opportunity to address or support community-wide issues, including prevention, and can affect how other systems see child welfare and their willingness to collaborate with the child welfare agency.

In the annual evaluation reports of the past 3 years, the Process Implementation study team has discussed several topics that are not included in this report. The decision *not* to discuss CLA, community impact, and risk assessment stems from the lack of clear indications that changes are likely to occur in one year's time. Thus far, the team has learned that:

- CLA counties do not appear to be experiencing any different outcomes than other demonstration or comparison sites; indeed, many of the discrete activities encompassed by CLA are occurring in non-CLA counties, thus making the effect of CLA as a whole harder to detect. (For more information about CLA, see the Second Annual Report, pg. 142-145, the Interim Implementation Report, pg. 85-88, and the Third Annual Report, pg. 50-52)

- Risk assessment has been adopted universally by the PCSAs, thus showing little if any variation across the study sites. The more interesting phenomenon is how counties have adapted their screening and intake procedures in response to the risk assessment requirements—this is discussed in Section 2.2, below. (For more information on risk assessment, see the Second Annual Report, pg. 41-43)

- Community impact data do not yet reveal any patterns related to Waiver participation, largely because the social indicators being measured are considerably broader than the child welfare system. As PCSAs succeed in making significant changes in their community role and in how they are perceived by the community at large, they may begin to have a modest impact on larger social trends in the county. (For more information, see the Interim Implementation Report, pg. 121-129, and the Third Annual Report, pg. 82-92)

These issues will continue to be considered in the fifth year of the evaluation, but are not expected to show any strong relationship to Waiver activities for several years. If ProtectOhio is extended, the evaluation team will continue to examine these issues.

2.2 INTERNAL ORGANIZATION AND CASE MANAGEMENT

A core strategy of the ProtectOhio Consortium since the start of the Waiver has been to modify the way casework units are structured and how case management is performed. Both demonstration and comparison counties have experimented with improving child and family outcomes through different staffing arrangements, screening methods, team conferencing models, and ways of involving families in case decision-making.

Case management is also a key managed care strategy and as such becomes a prime target for improved efficiency and expanded control over service utilization. In managed care language, the case manager is often referred to as a "gatekeeper," which alludes to their potential role in denying services to families in need. However, Ohio's PCSAs regard case management very differently—as the first line of contact with children and families, the point where the bond is formed or frayed. To the extent that the social worker/case manager communicates well with a family, and actively engages the family in the assessment and planning process, the outcomes for that child and family are likely to be more positive. Equally critical to the success of the case management function is the involvement of a team of professionals and other key players in a child's life. Indeed, two of the high priority outcomes for the Waiver are to:

- Increase family involvement in case management; and
- Use team conferencing.

The following section explores how counties are pursuing these and other related efforts to improve PCSA internal organization and case management.

Summary:

Both demonstration and comparison counties have experimented with improving child and family outcomes through different staffing arrangements, screening methods, models of team conferencing, and ways of involving families in case decision-making. Both demonstration and comparison counties have changed unit structure by reducing time-consuming case transfers from one worker or unit to another, and by developing separate service tracks for cases that can be handled quickly. In spite of these innovations, however, most county agencies, both demonstration and comparison, continue their traditional unit structures, separating the intake, ongoing, and adoption/permanency functions.

Both demonstration and comparison counties have continued to fine-tune screening criteria and improve screening procedures and staff for the purpose of diverting cases from the system. Half the demonstration sites used flexible IV-E funds to raise the level of staff used to screen cases.

Only very small contrasts exist between demonstration and comparison counties in use of team conferencing on different types of cases. Demonstration sites are slightly more likely to systematically hold a team conference whenever a case opens to agency services. The two groups equally use team conferencing for cases headed for placement, reflecting the greater attention given to placement cases overall. Comparison sites give slightly greater attention to special cases, e.g., cases where sexual abuse is indicated, where the family is in danger of losing TANF benefits, where schools are actively involved, and when the child is ready to be adopted. Families appear to be slightly more involved in team conferencing activities in comparison sites than in demonstration sites.

2.2.1 Unit Structure

The clearest indicator of internal organization is PCSA structure (see Table 2.2). The unit structure in the majority of the 28 counties can be characterized as traditional. Eight demonstration counties and nine comparison counties are traditional in structure, indicating little difference between the two groups. "Traditional structure" was defined as having separate intake/assessment units, ongoing units, and adoption/permanency units. For this report, "ongoing" refers to all cases open to the agency, whether they are in-home or placement cases. Typically, as a case moves from the intake unit to the ongoing unit, and possibly to the adoption/permanency unit, a new caseworker is assigned to the case at each transfer point. This entails more time in the system and requires the family to encounter a multitude of workers over time.

Table 2.2: Type of Unit Structure		
	Demonstration (n=14)	Comparison (n=14)
Traditional: Separate Intake, Ongoing, and Permanency	8	9
Separate Intake; with Ongoing and Permanency Combined	3	3
Integrated: Intake and Ongoing Together	3	1
Integrated: Intake and Ongoing Together, including Additional Support Staff	0	1

A hybrid of this traditional unit structure model, the dual-track model, attempts to separate short-term from longer-term cases. Several Ohio counties, including many CLA counties, have implemented a version of this model, trying to deal with some cases within 90 days through their intake units or staff. Trumbull County has formalized this dual track model following the structure developed in Missouri. The theory behind this model is that most cases referred to child welfare are neglect cases, which do not warrant the stigma of an "investigation." Trumbull County has taken the model one step further: the agency does very little telephone screening, sending staff out to the home to "triage"

most calls, thus broadening their role from narrowly-defined abuse/neglect investigations to community outreach on a wider spectrum of family issues. Dispositions on cases that do not involve serious physical abuse or sexual abuse are made within 3-4 days, with a panel of supervisors and the worker. At that point, the case is either closed, transferred to a short-term services unit, or to an extended care unit.

A second possible unit structure combines the ongoing units with the adoption/ permanency units in order to provide continuity for individual cases through finalization. In Year 4, three demonstration counties and three comparison counties reported having this type of unit structure. One important result is fewer transfers for the child as the case moves through to case closure: in this structure, the ongoing unit carries the case to finalization or reunification.

A third unit structure model is one in which intake and ongoing functions are merged into a single unit. While intake and ongoing staff remain specialized, they work together in a single unit so that more than one worker in each unit has knowledge about the family and case issues, and the transfer process falls within the purview of a single supervisor. The purpose of merging the functions is continuity of care for families, allowing for familiarity of cases among caseworkers within the unit, the development of relationships between client and caseworker, and the elimination of time consuming inter-unit transfers. Three demonstration counties and one comparison county have integrated units. Some counties with this structure may also use the dual track model (described above), keeping short-term cases with the intake worker in the unit.

Lastly, Montgomery County is the only evaluation county configured into integrated units with additional support staff in each unit, such as case aides and permanency workers. This comparison county also uses the dual track model described above.
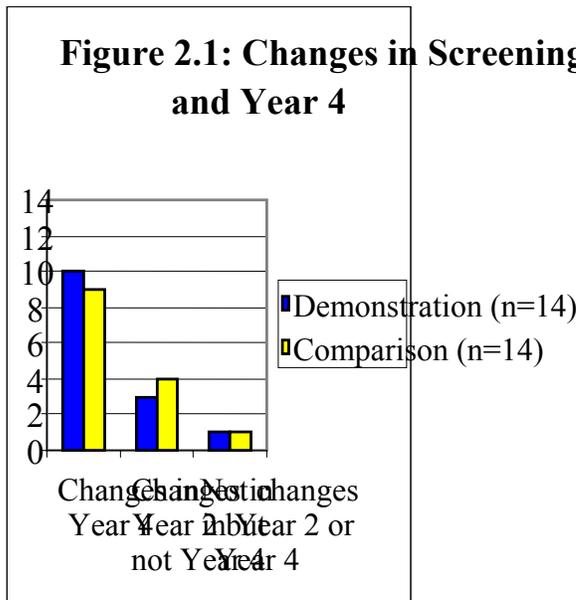
2.2.2 Case Flow/ Screening Processes

In the sequence of case flow, the opportunity to affect the number of cases coming into a PCSA begins during the initial screening process. From the time a referral is first taken, counties differ in how they gather the needed information in order to determine whether a case should be investigated. Some counties specifically concentrate on the "front door" of the system, setting up policies and procedures to collect more of the information needed to quickly and accurately determine if a referral should be opened for PCSA services. By focusing on the front door, the PCSA can avoid investigating (and expending resources on) cases that are not appropriate for PCSA services (e.g., head lice, truancy, referrals without sufficient evidence). However, such a narrowing of the PCSA mission may alienate community partners. On the other hand, opening the system to a broader clientele may support the community, but may dilute the agency's potential to effect change for mandated clients.

In particular, the decision to focus on the front door may be in response to the number of abuse and neglect incidents being reported to the PCSA. In examining the data from the Participant Outcome Study, the study team found that while there was an overall decrease in number of abuse and neglect incidents in demonstration counties (11%) and

comparison counties (38%) from FFY 1998 to FY2001 (Appendix II, Table II.1 and Section 3.3.1), significant variation existed among counties within these groups. Closer examination indicates that when a county experienced an increase in incidents during this time frame, it was more likely to respond by altering the screening process in some manner: in the eight counties (six demonstration and two comparison counties) with an increase in incidents from 1998 to 2001, all but one comparison county indicated that they had altered their screening process in Year 4 of the evaluation.

The Process Implementation Study team further examined PCSAs' attention to the front door screening process in all 28 counties, studying how the demonstration and comparison counties as a whole have altered their screening processes in some way to divert initial cases from entering the PCSA. As Figure 2.1 indicates, in Year 4 alone, ten demonstration counties and nine comparison counties changed their screening process for opening a case for investigation, indicating that screening is a concern to both demonstration and comparison counties. Of those counties that did not alter their screening processes in Year 4, three demonstration and four comparison counties made similar changes in Year 2 of the Waiver, indicating that only one demonstration and one comparison county made no changes to their screening processes since the beginning of the Waiver. This level of change indicates deliberate efforts by both demonstration and comparison counties to better define or refine the client population, in order to differentiate between those best served by the agency and those best served elsewhere.

Figure 2.1: Changes in Screening in Year 2 and Year 4

A variety of changes in screening processes were discussed during the course of the site visits. Counties mentioned conducting additional collateral calls and developing new screening tools or handbooks to provide more consistent criteria in the screening decision. The job of screening has also become more specialized: screening positions are more often staffed by individuals who are more qualified and experienced than in the past (e.g., Medina County uses more experienced social workers as screeners, and makes home visits in order to divert cases from opening). Some counties have eliminated

rotating screeners, preferring a single screener to ensure consistency. In some cases, the screeners look more closely at specific issues such as domestic violence and drug-affected infants. These changes are designed to ensure higher quality and more consistent screening.

Other methods of diverting cases from the system include community education. Two demonstration counties and one comparison county specifically mentioned developing programs with the schools in their communities in order to educate school staff on appropriate referrals. Four demonstration and three comparison counties also mentioned that their counties provide community education via screeners, other workers designated for the task, or even a full-time community educator employed in the agency.

Trumbull County, a comparison county, was one of the few counties to reduce the importance put on screening when they reorganized their system 2 years ago. They do very little screening. Instead, they send staff on a home visit to "triage" each referral, then make quick decisions (within 3-4 days) about whether to open a case or not. Through this process, they have widened the front door and narrowed the population for extended services (longer than 10 weeks). This system is very popular with the community, who see the child welfare agency following up on referrals.

Overall, it appears that the majority of both demonstration and comparison PCSAs are making efforts to decrease the number of cases coming in during the screening process. However, it is interesting to note that some counties are moving in the opposite direction, a trend to explore further in future years.

2.2.3 Team Conferencing

Reflecting their emphasis on team conferencing as a key outcome of ProtectOhio, demonstration counties believe that pulling together all parties involved in a case to develop a case plan will lead to better outcomes for the child and family. When professionals and families come together, opportunities are created to review what is currently being done for a family and to explore alternative options. These team conferencing meetings are often conducted to explore options other than placement or removal.

In prior annual reports, the Process Study team examined whether team conferencing occurs among multiple agencies in the community or simply involves PCSA staff. This distinction has become less significant over time, as more and more agencies have recognized the importance of including external parties. Two issues have emerged as more important: the extent to which team conferencing methods are used consistently, and the degree of family involvement in any of the team conferencing approaches used by the PCSA.

In site visit interviews, the Process Study team gathered detailed information about every form of team conferencing that regularly occurs in the PCSA—including any meeting that brings together more than the worker and unit supervisor. Team conferencing may be systematic or on an "as needed" basis; it may be used for all cases that open to agency services, or only for cases at risk of placement, or only for special types of cases. County

activity in each of these areas is discussed below. Excluded from the analysis are two types of conferencing: meetings whose sole purpose is to set up a visitation schedule for parents with a child in care and the required Semi-Annual Review (SAR), because all counties conduct these meetings.

Table 2.3 reveals fairly modest contrasts between demonstration and comparison counties in use of team conferencing on different types of cases. Demonstration sites are slightly more likely to systematically hold a team conference whenever a case opens to agency services, with six demonstration sites doing so compared to only three comparison sites. The demonstration sites tend to be those active in CLA, because systematic comprehensive case assessment is a core component.

The two groups equally use team conferencing for cases headed for placement, reflecting the greater attention given to placement cases overall (see also Section 2.7, on utilization review for placement cases). Comparison sites give somewhat greater attention to special cases, with ten comparison counties and seven demonstration counties offering team conferencing opportunities for such cases—for example, cases where sexual abuse is indicated (three demonstration and four comparison sites) where the family is in danger of losing TANF benefits (two comparison counties), where schools are actively involved (one demonstration and two comparison), and when the child is ready to be adopted (two demonstration counties).

Table 2.3: Use of Team Conferencing		
	Demonstration Counties (n=14)	**Comparison Counties (n=14)**
Team conferencing on all open cases	6	3
Team conferencing on all cases going to placement	9	8
Team conferencing for special issues (other than multi-system kids)	7	10
Families involved in team conferencing:		
Rarely	4	6
Moderately	7	4
Seriously	3	4

Family Involvement in Team Conferencing

Families appear to be slightly more involved in the team conferencing activities in comparison sites than in demonstration sites, although the differences are minor. "Rarely" indicates that families are not systematically involved; "moderately" reflects family involvement in some of the team conferencing approaches in the county; "seriously" indicates that the county is making a conscious, consistent effort to engage families in most if not all team conferencing activities. The three demonstration counties who are seriously involving families in team conferences have been active in CLA, in which family involvement is a central focus. For example:

- Greene County has four distinct forms of team conferencing, and families are a vital part of all of these; the family team meeting, used for all cases where the child is potentially going to be removed, includes not only the parents but all relevant family members, and any other people the family asks to have there.

- Among the six different forms of team conferencing in Medina County, only one involves families systematically; however, this family group conferencing is done on any case where staff believe it could make a difference, and staff take it very seriously. A contracted facilitator is specially trained; the typical meeting has a large attendance, and lasts several hours, and includes a period of time when the family members meet alone to develop a plan.

- Stark County has long-established methods of team conferencing, but it is in recent years that the commitment to family involvement has fully emerged. Family advocates and family members regularly attend Creative Community Options, focused on multi-system children headed for placement; family group conferences occur for all types of cases, bringing together service providers and natural parents, relatives, and foster parents (if the child is in care).

The four comparison sites that are seriously committed to family involvement in team conferencing follow a wide variety of practices:

- Hocking County has held family team meetings since 1997 for children with multi-system needs, but use has increased recently as the focus has expanded to preventing the child from coming into PCSA custody. Hocking also uses school-based team conferences, again to prevent involvement with the PCSA, mental health and/or juvenile court.

- Montgomery County has greatly increased its use of team conferencing, as part of the overall agency redesign effort; it now engages in numerous team conferencing models, most of which systematically include families—for initial case planning, quarterly reviews, and placement reviews close to the time of placement.

- Scioto County involves families in team conferences on cases likely to go to placement, and as needed once the child is removed. These team meetings are fairly new, designed as "early intervention" to establish a comprehensive plan from the start.

- Trumbull County has numerous team conferencing approaches, several of which involve families. Families regularly participate in cluster meetings, and Family Unity Meetings are held for all children coming into care, to assess the birth family's need for supports and to identify possible relatives who could take the child.

While these seven counties stand out in their efforts to involve families in case-level decision making, the other counties in the evaluation have not yet developed methods to systematically involve families in decisions about their cases. In addition to the above mentioned counties, seven demonstration and four comparison counties are doing *some* team conferencing, but it is generally less systematic and less deliberate than the above-described sites. Further, efforts to involve families outside of these team conferencing models do not seem to be occurring in any of the evaluation counties.

In talking about how PCSAs are trying to involve families more, counties identified several issues that make family involvement in decision-making difficult. Counties noted that workers often have a difficult time making the transition to involving families: some agencies are developing training around this issue, but many mentioned that it is a difficult transition because workers feel uncomfortable letting go of the control of these case decisions. Counties also mentioned that families are often unwilling to attend meetings and be involved in decisions: in mandated cases, the family often has too much hostility toward the PCSA. Overall, many agencies say family involvement is an agency philosophy, but systematic examination of the extent to which it is actually happening, based on objective questions and from the worker perspective, indicates that counties are only beginning to involve families in any consistent manner.

For families to become truly engaged in case decision-making will require a major commitment by the PCSA – in terms of training of workers, hiring of trained facilitators, and often lowering caseloads to allow workers to take the time needed for such in-depth work with extended families. Insofar as many counties expressed substantial interest in increasing the involvement of families, and as counties learn from each other and from their own successful (and unsuccessful) efforts to actively engage families in team meetings, it is expected that these counties will increase their efforts in the coming few years. It remains to be seen whether they will become serious adherents of family involvement in team conferencing.

2.3 SERVICE ARRAY

The availability of services is critical to PCSA's ability to appropriately serve its clientele. At the same time, openly offering a comprehensive set of services to all families may be highly successful for some clients, but achieve little for others. Effectiveness as well as efficiency requires that services should be made available in relation to the needs of the particular children and families. The challenge for child welfare administrators is to have ready access to "core services," those typically and frequently needed, as well as to encourage the creation of innovative, alternative approaches.

Of the top priority outcomes that the demonstration counties believe should be affected by the Waiver, two measures related to service array are discussed here:

- Improved availability and quality of services;

- Development of new services.

In Year 2 and Year 3 of the evaluation, the study team asked respondents to judge the sufficiency of a list of standard services for children and families served by PCSAs. Some of these services may be provided by or paid for by the PCSA, while others may be the purview of mental health, human services, or other community agencies. The team also explored the creation of new services in Year 4 as well as in previous study years.

The context for exploring changes in service array in Year 4 is based on two factors. First, in Year 3 of the evaluation, demonstration and comparison counties similarly saw placement services as insufficient, while non-placement services were viewed as more often adequately available (Third Annual Report, page 20). This finding indicates that in Year 3, both demonstration and comparison counties continued to remain reliant on placement settings to serve PCSA clients. Second, caseload trends for the same time period indicate that both demonstration an comparison counties are similar in using in-home services for a large proportion of their of caseload: approximately 75-80% of PCSA cases are served in-home, as opposed to being served in placement settings (Appendix II, Table II.2 and Section 3.3.2). This data also indicates that the variability among demonstration and comparison counties is relatively similar: seven demonstration and six comparison counties have slightly decreased their use of in-home settings since the Waiver began, while five demonstration and six comparison slightly increased their use of in-home services. The proportion of clients being serviced in-home does not appear to have changed significantly since Wavier began, perhaps because no new services had been created to better serve clients in their homes. It is in this context that the Process Implementation team examines what new services were created in Year 4 by service type, to see exactly where changes in services array are occurring.

Summary:

Overall, demonstration and comparison counties have made similar efforts to increase their array of available services, by creating new services or reconfiguring existing ones. Both groups of counties experienced service losses, most often due to reduced PRC funding, and demonstration counties' losses appear to be more concentrated in the counties that had relied on TANF-related funds in prior years.

Both demonstration and comparison counties have increased their use of relative caregivers. Kinship care may increase the likelihood that children return home, and can often reduce the administrative and casework burden of the PCSA. However, a recent federal policy change has all Ohio counties concerned about the potential loss of administrative reimbursement for children placed with unlicensed relative caregivers. Since licensure of relative caregivers is uncommon in Ohio, the more successful a county has been at developing relative caregivers, the more the county stands to lose under the

new policy. Demonstration counties could be disproportionately affected because they would also pay foster care stipends to relative caregivers out of their capped Waiver funds.

2.3.1 New and Reconfigured Services

In the Year 3 Annual Report, the study team explored the sufficiency of services in five areas—placement services, mental health services, substance abuse services, other non-placement services, and other services (see Table 2.4).

In the Year 4 site visits, the team examined whether counties are creating new services or reconfiguring existing services (using existing services but in a different way, or for a different target population) especially to meet some of the needs identified in the prior years. Figure 2.2 shows the number of counties creating new services in each of the five service areas, and Figure 2.3 shows similar data on reconfigured services.

The following list describes some of the new services created in each category:

- New placement services such as residential treatment for sexual abuse perpetrators, a residential step-down initiative, and group homes (one of which designed for pre-teens with emotional disturbances).

- New mental health services such as assessment units, especially assessment of sexual abuse offenders; in-home counseling/therapy, and behavioral support in foster and adoptive homes.

- New substance abuse services such as assessment units in the PCSA, drug courts, and substance abuse treatment facilities.

- Other non-placement services for children and families such as kinship support services, respite programs, school-based staff and teams, visitation centers, and post-adoption services.

- Other services such as an emancipation program, truancy prevention programs, and many other efforts.

Table 2.4: List of Services Examined in Each County

Placement Services
- Foster Family Care (PCSA)
- Foster Family Care (network)
- Therapeutic/Specialized Foster Care (PCSA)
- Therapeutic/Specialized Foster Care (network)
- Adoptive Homes
- Group Care
- Residential Treatment

Mental Health Services
- Child Mental Health In-patient
- Child Mental Health Out-patient
- Psychologist Services
- Counseling
- Adult Mental Health In-patient
- Adult Mental Health Out-patient

Substance Abuse Services
- Adolescent Substance Abuse In-patient
- Adolescent Substance Abuse Out-patient
- Adult Substance Abuse In-patient
- Adult Substance Abuse Out-patient

Other Non-Placement Services to Children and Birth Families
- Short-term intensive intervention with family
- Teaching parenting skills, family dynamics, child developmental stages
- Mentoring and/or providing home management and parenting (e.g., Homemaker/ parent aid)
- Counseling and support to family and child
- Providing information services, advice to families and facilitating family networking (e.g., family resource center)
- Non-curricular services and supports offered at school locations for students and their families (e.g., school-based)

Other Services
- Teaching teens daily living skills, financial management, college prep, etc. (e.g., Independent Living)
- Assessment and intervention for children aged 0-3 (e.g., early intervention)
- Non-traditional educational options for children with special needs (e.g., alternative education)
- Services by court, law enforcement, etc. to meet needs of adolescents to prevent placement (e.g., adolescent diversion)
- Transportation

Figure 2.2: Range of New Services
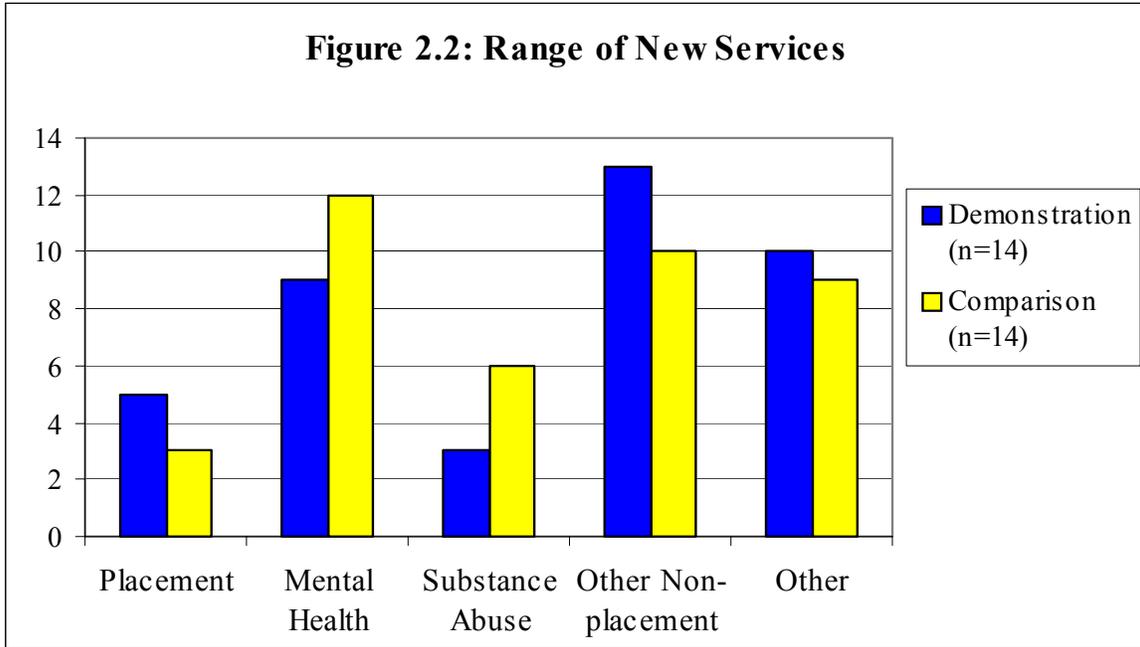
Demonstration and comparison counties show fairly comparable development of new services across the five areas, with slightly more demonstration sites being active in placement and non-placement services, and slightly more comparison sites creating new services in the mental health area.

Much less effort is evident in reconfiguring existing services, with demonstration and comparison sites again fairly comparable (see Figure 2.3).

**Figure 2.3: Range of Reconfigured Services**
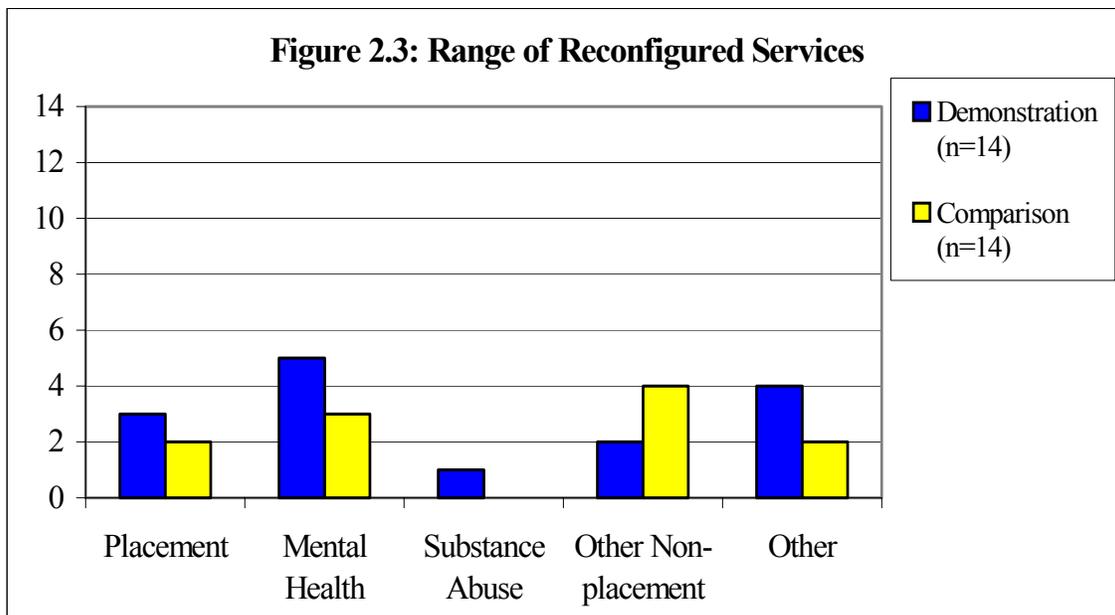
Examples of reconfigured services are included below:

- A 20-bed substance abuse facility in Montgomery County reconfigured ten beds into a unit for emotionally disturbed youth.

- The Allen County mental health provider reconfigured some clinic-based services to home-based services to better meet the needs of the PCSA.

2.3.2 Diminished Services

In the Year 3 Annual Report, both groups of counties demonstrated fairly equal levels of activity in creating new services – eleven demonstration and eight comparison counties had "some" new services and two demonstration and six comparison counties had "many" new services. Despite their lack of flexibility around Title IV-E funds, the comparison sites were able to expand their service array. The explanation seems to rest with the generally strong economy and the availability of non-Waiver sources of flexible funding, such as PRC, Emergency Services Assistance (ESA), TANF and Family Stability (see Year 3 Annual Report, page 43).

In Year 4, the study team specifically explored whether any services were lost and, if so, whether the loss was due to PRC/TANF-related changes in flexible funding. Figure 2.4, below, indicates that nearly all counties experienced some service losses in Year 4.

Figure 2.4: Counties Experiencing Loss of Services
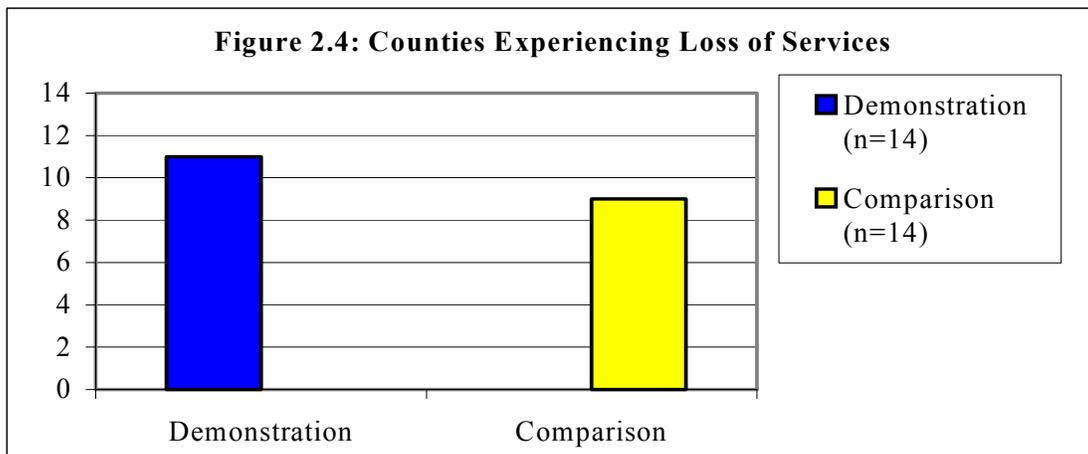
The Year 4 data do not support the hypothesis that the loss of these other flexible sources would affect comparison counties more than demonstration counties because comparison sites do not have Title IV-E flexibility to replace the loss. Most counties that spoke of diminished services mentioned TANF-related funding streams. However, Table 2.5 reveals another aspect to this dynamic. Demonstration counties who relied on TANF-related flexible funds appear to be suffering more than comparison sites that received such funds. Both groups lost the funding source, but perhaps the comparison sites also had other losses of flexible funding, making the TANF-related loss less daunting.

Table 2.5: Reliance on TANF-related Funds in Year 3 and Loss of Services in Year 4		
	Demonstration Counties (n=14)	**Comparison Counties (n=14)**
Number of counties receiving PRC allocation in Year 3	9	10
Number (and percent) of counties above experiencing loss of services in Year 4	7 (78%)	7 (70%)
Number of counties receiving PRC-Developmental Reserve (DR) in Year 3	10	5
Number (and percent) of counties above experiencing loss of services in Year 4	9 90%	2 40%
Number of counties receiving both PRC allocation and PRC-DR in Year 3	8	4
Number (and percent) of counties above experiencing loss of services in Year 4	7 88%	2 50%

Some counties in both groups talked about having carefully "invested" their time-limited TANF-related funds, not using them for ongoing programs or staff positions. Such actions may have mitigated the negative effects of the losses. Another possible explanation is that perhaps the magnitude of the dollar loss was greater in the demonstration sites—the local Department of Job and Family Services (DJFS) may have more readily cut funds to demonstration PCSAs, knowing that they had some capacity to replace the loss with Title IV-E flexible funds. It is also possible that some counties have not yet felt the full magnitude of the cuts in PRC funds. This issue will be explored more fully in the coming year of the evaluation.

2.3.3 Use of Relative/Kinship Placements

The major service area for PCSAs is placement services, and, among those, foster family care is the most commonly used. As counties have focused on minimizing the time a child spends in temporary foster care, attention has turned to using relatives as temporary caregivers. Such arrangements typically keep a child closer to the birth family and, should termination of parental rights become necessary, the child could maintain family ties. Both demonstration and comparison PCSAs are encouraging caseworkers to explore

opportunities to place children with kin/relatives. Placing a child with kin or a relative is viewed as supporting the best interests of the child, as well as enabling the county to become less involved in the case and ultimately reduce placement days.

While many demonstration and comparison counties stated that use of relatives for placement options is an ongoing emphasis of the agency, the degree of formalization of this effort varies greatly among PCSAs. Many counties are training workers to more quickly explore the possibilities of relative placements, including increasing use of the risk assessment tool and genograms to identify potential relatives for placement options. In more targeted efforts to encourage relatives to take a child, several counties are using flexible funding resources (i.e., IV-E Waiver and PRC dollars) to support the needs of relative placements and pay for goods and services. These funds are used to provide day care or respite, pay utility bills, purchase furniture, and in some counties, pay a per diem. Counties have also developed support services/groups for kinship providers so they are able to talk with other relative caregivers and make better use of benefits that are available. One comparison county, Summit, has even created two kinship care units that parallel the foster care services to provide equal support to relative caregivers. Kinship providers who participated in the Summit County focus group expressed great appreciation for this new resource. Clearly, counties are taking a number of different approaches to both identify and support relative placements in order to make better use of these placement options.

A new initiative, the Kinship Navigator program, has also impacted the amount of support that is provided to relatives. This program is "a statewide network of 'kinship navigators' who serve as the point of contact for kinship caregivers who are seeking information regarding services and benefits available at the state and local level and assist caregivers in accessing the benefits and services for which they may be eligible."[1] Approximately half the counties mentioned this program during the Year 4 site visit. Some PCSAs have hired a Kinship Navigator internally, while others have contracted with a local private provider to develop these services. The overall goal of the program is to support and maintain relative placements, primarily by providing information and referrals for relatives, as well as some more targeted services, such as legal assistance on obtaining custody.

Another important issue that came up in discussions of PCSAs' focus on the use of relative care is a serious concern about the PCSAs ability to keep using relatives for placements, given the recent federal policy interpretation (ACYF-CB-PA-01-02) scheduled to go into effect October 1, 2002. This interpretation says that states can only claim administrative cost reimbursements for children placed in licensed relative care. Since most relative care in Ohio is unlicensed, this policy interpretation is likely to reduce administrative reimbursement, especially for counties that have been successful at increasing the portion of children placed with relatives. This policy change provides a fiscal disincentive for placing children in non-licensed relative care. Administrative

---

[1] http://www.state.oh.us/odjfs/kinship.htm

reimbursement may be claimed for children placed with relatives in the process of licensure for a period equivalent to the normal time period for licensure. In Ohio, however, as in a number of other states, many relatives prefer not to be licensed because they prefer not to be formally involved with the child welfare system. Additionally, some perfectly acceptable relative caregivers would not meet licensure standards (e.g., due to an old felony conviction for a household member). And some prefer to keep the arrangement less formal in order to placate the birth parent relative.

In the second year of the evaluation, the study team determined that slightly more than half of the counties (eight demonstration and eight comparison counties) will, under certain conditions, license a relative's home. Since federal policy requires that all relative caregivers be allowed to become licensed foster caregivers, counties will license them if requested to do so. But, typically, relative caregivers do not choose to do so, or are not specifically offered the opportunity.

All of Ohio's counties that use relative caregivers face some loss of administrative funds as a result of the new federal ruling. Simply licensing these homes, even if caregivers were willing and qualified, requires additional resources for the licensure process. Not licensing them will cost the counties administrative (case management) reimbursement. Demonstration counties are in a double-bind; to license relative caregivers will cost them more for the licensure process, and more importantly, foster payments will have to be paid from capped Waiver funds. The more successful a county has been at placing children with relative caregivers, the more that county stands to lose if it licensed those caregivers now. Unfortunately, their better financial option is to simply forego the administrative reimbursement. Doing so, however, means that the time and energy spent case managing children placed with unlicensed relative caregivers will not be federally reimbursed. With the increasing emphasis on relative caregivers as the best option for children, both in the short term and in the long term, and with the increasing awareness that those placements must be supported, all Ohio counties are faced with a tough dilemma.

2.4 PROVIDER COMPETITION

Provider competition is one of the major tools of managed care, since managed care is often seen as a way to increase the competition, and thus the efficiency of providers in a service network. The larger the provider network, the greater the potential for choice among services and among providers of a given service, thus affording greater opportunity to meet an individual's needs. Without competition, providers may feel little pressure to keep services at a high quality, or to meet the specific individualized needs of clients or payers (the PCSAs). Provider competition, as a managed care tool, is one of the key elements of the managed care index discussed later in this chapter.
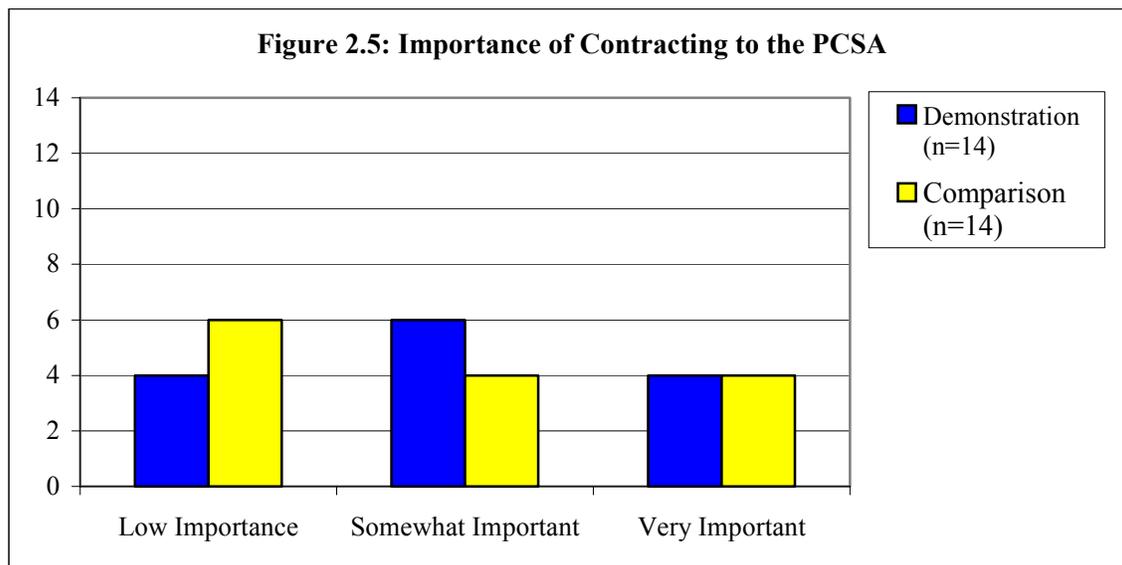
As child welfare agencies become more accustomed to the concept of cost effectiveness and to making the best use of resources, provider competition becomes more important. Historically, child welfare has suffered from the misconception that the goal of

competition is to reduce cost, rather than to improve quality. But in recent years, child welfare agencies seem to be more aware of the potential for provider competition to improve services to children and families. In this section, elements of provider competition are examined more fully. Specifically, this section will examine contracting, efforts to increase foster and adoptive homes, and other efforts to stimulate provider competition.

Summary: A huge variation exists across the evaluation counties in the attitude toward, importance of, and sophistication in provider competition. Even among demonstration counties, with more flexibility in contracting possibilities, the variability is significant. First, much of the emphasis across all the counties was to increase competition in the substitute care arena by shifting from the current seller's market to a buyer's market. Strategies to accomplish this shift included a focus on increasing and improving agency foster care, in order to rely on private providers less, by improving contracting and monitoring capacity for private foster and residential care. However, efforts to increase the number of agency foster homes have generally been unsuccessful. Second, demonstration counties have been more aggressive in identifying innovative ways to improve their bargaining position in a competitive market place by developing preferred provider networks, using Request For Proposals (RFPs) for services, better specifying requirements and expectations in contracts, and working on cross-county mechanisms to improve the PCSAs' competitive position. Third, a small number of demonstration counties have attempted to improve competition for mental health and substance abuse services by adding internal assessment and monitoring capacity, and by providing fiscal incentives.

2.4.1 Contracting

In Year 4 the study team explored the importance of contracting to the PCSAs' service delivery system. Wide variation exists among the evaluation counties, in part based on the size of the county, with the large urban counties seeing contracting as very important to them. The smaller (less populated) counties show some level of divergence, with several smaller counties preferring to do as much "in house" as possible, and others preferring to purchase services. Those agencies with a preference toward purchased services noted that purchased services can be increased or decreased more quickly, don't require additional staffing levels, and don't "spread the agency too thin." Those agencies preferring not to contract felt that quality was better controlled and better overall when services are provided in house. As can be seen in Figure 2.5, slightly more demonstration counties than comparison counties believe that contracting is somewhat or very important (ten demonstration counties compared to eight comparison counties).

Figure 2.5: Importance of Contracting to the PCSA

A bar chart titled "Figure 2.5: Importance of Contracting to the PCSA" with a y-axis ranging from 0 to 14. The legend indicates Demonstration (n=14) in blue and Comparison (n=14) in yellow. The categories on the x-axis are Low Importance, Somewhat Important, and Very Important.

- Low Importance: Demonstration = 4, Comparison = 6
- Somewhat Important: Demonstration = 6, Comparison = 4
- Very Important: Demonstration = 4, Comparison = 4

For some counties, the importance they place on contracts was affected by their perceived ability to monitor the contracts. Many PCSAs, particularly smaller ones, commented that they are unable to get many providers to submit regular child or family progress reports on those served, and they had concerns about the quality of service provided. In further examining systematic contract monitoring efforts, the study team found that slightly more demonstration counties than comparison counties had some type of systematic contract monitoring (six demonstration counties compared to four comparison counties).

Counties were considered to have systematic monitoring efforts if they did something beyond matching placement days to placement costs. Most counties considered their efforts in this area as weak, and many were relying on the PCSAO (the coalition of public children services agencies in Ohio) standard contract to help them get a better handle on what they buy and pay for, at least for out-of-home care.

Counties with some type of systematic monitoring undertook a range of activities including:

- Efforts to monitor quality of care, such as child functional assessments measured at intake and throughout treatment;

- Efforts to monitor quality of service provided, by having a mental health professional review therapeutic progress reports;

- Satisfaction surveys with clients of services;

- Fiscal auditing of contracts by agency and contracted accountants;

- Inclusion of performance measures in each contract, which must be reported before payment occurs; and

- Surveys of caseworkers regarding conditions and care provided in network foster homes.

The study team also examined the importance of contracting compared to systematic monitoring efforts (see Table 2.6). One would assume that the more importance placed on contracting, the more systematic contract monitoring efforts would be. In general this assumption held true. Only two counties (one demonstration, one comparison) of the 18 counties with no systematic monitoring efforts place a "high" importance on contracting (11%). Conversely, only two of the ten counties (one demonstration, one comparison) with systematic contract monitoring efforts place a "low" importance on contracting (20%).

Table 2.6: Importance of Contracting Compared to Systematic Contract Monitoring Efforts				
	No Systematic Contract Monitoring Efforts		Systematic Contract Monitoring Efforts	
	Demonstration Counties (n=8)	Comparison Counties (n=10)	Demonstration Counties (n= 6)	Comparison Counties (n=4)
Contracting has "low" importance	3	5	1	1
	8 counties (44%)		2 counties (20%)	
Contracting is "somewhat important"	4	4	2	0
	8 counties (44%)		2 counties (20%)	
Contracting is "very important"	1	1	3	3
	2 counties (11%)		6 counties (60%)	

It is surprising that two counties consider contracting important yet do not have systematic contract monitoring efforts in place. However, there seemed to be a difference between contracts with other public agencies for services and contracts for placement services. PCSAs were generally more concerned about monitoring contracts for placement services than for locally-provided services, where they felt they had more immediate and hands-on oversight.

2.4.2 Efforts to Increase the Number of Foster or Adoptive Homes

The availability of foster and adoptive homes is critical to the service continuum in child welfare. It has been a focus over the course of the evaluation because of the greater

emphasis on adoption due to the Adoption and Safe Families Act (ASFA)[2]. The study team explored whether PCSAs had made conscious decisions to try to increase the availability of foster and adoptive homes in their community, developing competition and choice among these placement options.
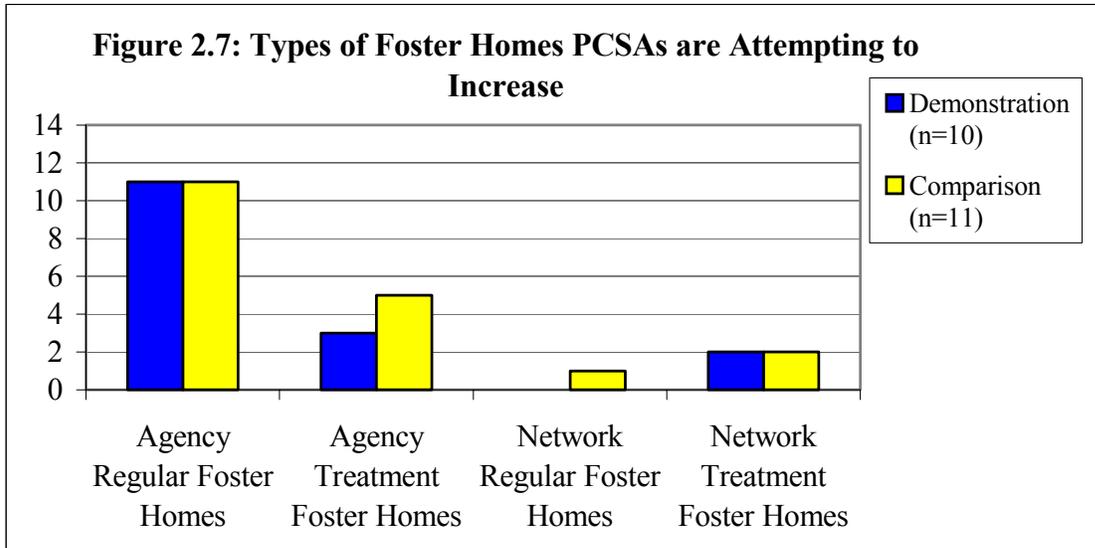
Efforts to Increase the Number of Foster Homes

With the emphasis on foster-to-adopt, and the requirements of H.B.484/ASFA, PCSAs have been losing foster homes to adoptive parents. PCSA were asked if they are making conscious efforts to increase the number of foster homes (Figure 2.6). Ten demonstration counties and 11 comparison counties responded that they are making conscious efforts to do so. Two demonstration counties and one comparison county responded that they were planning to increase recruitment efforts. Only two demonstration and two comparison counties were not actively engaged in or planning activities to increase the number of foster homes. (Note: some of the inactive counties may have conducted serious recruitment initiatives in prior years of the study.)

Figure 2.6: Counties Making Conscious Efforts To Increase Number of Foster Homes
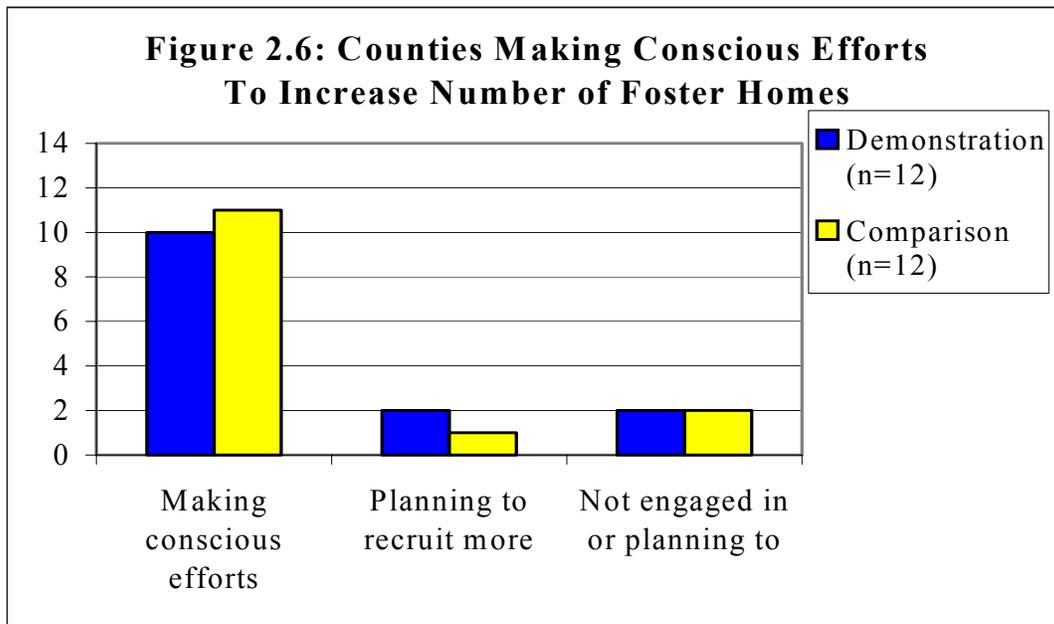
Most counties expressed a strong preference for agency foster homes over network foster homes, feeling better able to control quality and cost when children are in agency foster homes. Figure 2.7 shows the types of foster homes included in efforts to increase the number of foster homes. Of the 10 demonstration and 11 comparison counties, nearly all are attempting to increase agency regular foster homes. Additionally, approximately one-third of both demonstration and comparison counties are attempting to increase agency treatment foster homes. Two demonstration and two comparison counties are attempting

---

[2] A more detailed description of ASFA is provided in the Interim Implementation Report, p. 38-39.

to increase network treatment homes, and only one county is interested in increasing the number of network regular foster homes.

Figure 2.7: Types of Foster Homes PCSAs are Attempting to Increase

Strategies Used to Increase the Number of Foster Homes

PCSAs were asked what strategies they were using or planned to use to increase the available number of foster homes. The study team obtained this information from twelve demonstration and twelve comparison counties. The results are shown in Table 2.7. The predominant strategy was a formal recruitment campaign. Among counties attempting to increase foster homes, 67% in each study group were undertaking or planning to undertake formal recruitment campaigns.

Table 2.7: Strategies Used or Planned to Increase the Number of Foster Homes		
	Demonstration Counties (n=12)	**Comparison Counties (n=12)**
Formal campaign	8 counties (67%)	8 counties (67%)
Per diem rate increases	6 counties (50%)	6 counties (50%)
Recruitment of new networks	1 county (8%)	1 county (8%)
Development of preferred provider arrangements	1 county (8%)	1 county (8%)
Other	8 counties (67%)	6 counties (50%)

Fifty percent of those attempting to increase the number of foster homes (six demonstration counties out of twelve and six comparison counties out of twelve) had implemented or were planning to implement foster care per diem rate increases. This compares to five demonstration counties and five comparison counties in Year 3, and to eight demonstration counties and three comparison counties in Year 2. Several counties mentioned that they are on three-year rate increase cycles, which could account for a portion of the variation from year-to-year. Since 58% of the cost of foster per diem increases is federally reimbursed for IV-E eligible children in comparison counties, lack of IV-E flexibility is not seen as a significant deterrent to providing these increases.

A number of other efforts are occurring in the evaluation counties. A small number of counties (one demonstration and one comparison county) were attempting to recruit new network providers and attempting to develop preferred provider arrangements. Eight demonstration and six comparison counties focused on other strategies, primarily adding staff to recruitment, doing home studies, and incorporating activities that support foster homes. Foster home support activities include hiring additional staff to liaison directly with foster parents, providing respite, reimbursing childcare and/or mileage for foster parents, and adding or increasing social activities for foster families. Two demonstration counties and one comparison county provide fiscal incentives to current foster parents to recruit new foster parents. Two demonstration counties have revised or are planning to revise their rate structures for foster care. For example, Medina County's new rate structure has one rate for children 0-11, another rate for children 12 and over. They also added incentive payments to the basic rates. Incentives are earned for years of service, additional training, provision of independent living services, stay-at-home parents, exceptional transportation requirements, etc.

Efforts to Increase the Number of Adoptive Homes

Most PCSAs have joint foster/adoptive home recruitment/licensing procedures and encourage foster-to-adopt, so that efforts to increase foster homes also increase adoptive homes. Nevertheless, PCSAs were asked if they are making special efforts to increase the number of adoptive homes. 11 demonstration counties and seven comparison counties responded that they are making special efforts to do so. The most common strategies, shown in Figure 2.8 below, include subsidy increases and additional supports to adoptive families.

- Many PCSAs commented about the size of the state adoption subsidy, and how the disparity between foster subsidies and adoption subsidies are growing and serving as disincentives to adopt. That is why counties are supplementing those subsidies. With the current emphasis on adoption, many noted concerns about the long-term costs of the adoption subsidies.

- Efforts to support adoptive families are focused primarily on additional staff to speed the licensing process and to support families through the process, and social activities and supports for adoptive families.

Other efforts include those listed for increasing foster care homes in the previous paragraph.

Figure 2.8: Strategies Used or Planned to Increase the Number of Adoptive Homes
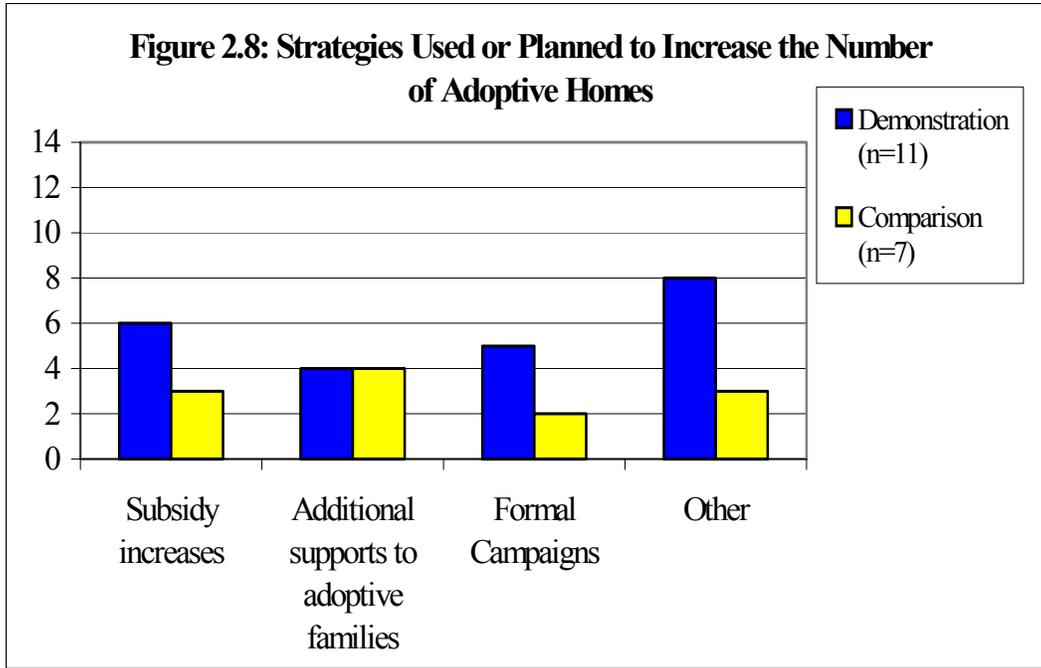
Success of Efforts to Increase Foster and Adoptive Homes

PCSAs were asked whether efforts to increase foster or adoptive homes had succeeded. Out of the 21 counties that had implemented recruitment strategies, two demonstration counties (10%) and two comparison counties (10%) reported they had increased the number of homes due to these efforts. One demonstration (5%) and one comparison (5%) reported that it was too soon to tell if their efforts had succeeded. In short, despite varied county efforts, PCSAs have largely been unable to keep ahead of demand for foster and adoptive homes.

2.4.3 Other Efforts to Increase Competition Among Providers

The PCSAs were working on a number of other efforts to increase competition in their jurisdictions. Table 2.8 shows the demonstration counties as more active than the comparison counties in efforts to increase provider competition. Nine of the demonstration counties have been involved in other efforts, while only four of the comparison counties have been involved in other efforts.

Preferred providers or preferred provider networks are special arrangements with a single provider or network to provide services to the county, typically at a discounted rate. Expectations are usually well-documented in the agreements. Examples of these arrangements are described below.

Table 2.8: Other Efforts to Increase Provider Competition		
	Demonstration Counties (n=14)	Comparison Counties (n=14)
Developed or working on preferred provider arrangements or preferred provider network	4	3
Developed or working on RFPs, or better specifying contract requirements	2	0
Working on cross county efforts to leverage rates with other counties	2	1
Developed or worked on efforts to address competition among mental health providers to obtain services more appropriate for clients	3	0
Unduplicated count of counties involved in these efforts	9	4

- Richland County, a demonstration county, has a preferred provider network to undertake care management of high-cost children. The contract establishes a set rate based on a standardized assessment of severity. The contract also includes standardized monitoring and reporting procedures to assess effectiveness of services.

- Warren County, a comparison county, has an arrangement with a residential facility located within the county. The PCSA gets a discounted rate, and, in exchange, provides case management to its own cases.

Two demonstration counties are trying to better specify their contracts. For example, Clark County, using the model PCSAO contract, is attempting to build in requirements for providing clothing, unbundling costs, submitting monthly progress reports, and other accountability measures to assure that they receive the services they pay for, and sanctions for failure to adhere to the standards. Their goal is for these improved specifications to result in a preferred provider network, composed of providers who meet the higher standards.

Two demonstration counties and one comparison county are working with other counties to share information about rates they are paying to providers, possibly to establish levels of care and to negotiate volume discounts across groups of counties. These discussions are in the early stages, but they demonstrate the PCSAs' interest in shifting the balance of power away from the sellers and toward the buyers of services.

Three demonstration counties have been attempting to improve mental health services by purchasing services outside of the current mental health board provider system. For example, Ashtabula County has helped pay a fiscal incentive to retain a psychiatrist who

was planning to leave the county, has offered to cost share with any provider who can recruit a certified child psychiatrist, and is willing to give them services appropriate to their needs. Lorain County has established in-house mental health/ substance abuse staff to do assessments and referrals and to monitor the quality of services provided, both of which have led to improved quality and service from community providers.

2.5 TARGETING

For most PCSA cases, a standard continuum of services for the families served in the child welfare system. However, the PCSAs may sometimes identify particular subpopulations of their caseload that have needs that differ from those of the typical PCSA client. In particular, a PCSA may "target" those who are traditionally underserved or are particularly expensive to serve. By targeting these clients and providing more specialized services to meet their needs, the child welfare agency may be able to avert more serious and costly interaction with these families, or perhaps divert these cases from the PCSA altogether.

Summary: While interviewees were able to identify subpopulations within their counties with needs differing from those of the traditional child welfare population, only a few PCSAs actually developed services to address the needs of these subpopulations. In these instances, the new services tended to address the needs of geographic areas within their counties.

During the fourth year of the evaluation, the study team asked interviewees if there were subpopulations with particularly high needs or that were particularly underserved. Several subpopulations were consistently described during these discussions:

- *Geographic subpopulations*: Seven demonstration counties and six comparison counties described geographic areas within their county where needs are high and service availability is inadequate. While some of these areas are in the population center of the county, most often they are in outlying communities. These tend to be areas of higher poverty that lack services such as transportation, making access to needed services even more difficult. Several counties described more remote regions where the Appalachian culture plays a role in people's attitudes about obtaining help from county agencies.

- *Adolescent subpopulations:* One demonstration and three comparison counties discussed the specialized needs of the adolescents in their community, in particular the service needs of those adolescents who have had interactions with the juvenile court. Another group that was commonly identified as having particularly high needs that are often unaddressed is the juvenile sex offender population, leaving the PCSA struggling with what to do with these cases (three demonstration and three comparison counties).

- *Mental health & Mental Retardation/Developmental Disabilities (MR/DD) subpopulations:* Another group consistently described as underserved, and where

services were lacking, is the population with dual diagnosis issues (two demonstration and two comparison), as well as the group with serious emotional or behavioral issues (one demonstration and three comparison). In these counties, needed mental health services are difficult to access, and these cases often ended up in with the PCSA because services in the community are insufficient.

Once subpopulations in a county were identified, the study team asked whether the PCSA had developed any services to target the needs of these groups. This would indicate an effort to develop resources to work more closely with these clients, providing more specialized services with the hope of eliminating some future involvement with these cases. The study team found that PCSAs are not necessarily creating specific units or workers to work specifically with these targeted populations, but are more often simply creating services that these subpopulations need.

Overall, it appears that most targeted PCSA efforts tend to be in response to the needs of geographic subgroups, the most easily identified subpopulations. PCSAs have responded to the needs of these geographic subpopulations in several ways. Three demonstration counties and two comparison counties are involved in family-centered, neighborhood-based services efforts. One approach originating out of the Annie E. Casey program, called Family-to-Family, encourages child welfare agencies to work "with neighborhoods to develop partnerships with families, foster families, local service providers, and community leaders to address problems and issues contributing to child abuse and neglect."[3] In addition to these efforts, one demonstration and one comparison PCSA have located social workers at the schools in these targeted areas to work toward prevention and early identification of issues that, if left unaddressed, might result in PCSA involvement. In one demonstration county, the mental health board allocates resources for serving an identified geographic area, specifically requiring private providers who have a contract for mental health services to serve this geographic area. Other targeting efforts include out-stationing staff in these areas, developing one-stop shops, and developing after-school programs in these neighborhoods.

There is less evidence that PCSAs have specifically targeted services to fill the needs of the other subpopulations described above. Only a handful of counties are trying to develop services for these subpopulations. In Montgomery County, a comparison county, the African-American community has few services available and the PCSA has recently been involved in a collaborative effort to create a multi-service center in this community. In two comparison counties, the PCSA has developed staff positions specifically to address the needs of the adolescent population who might otherwise come into PCSA through the court. One demonstration and three comparison counties spoke of efforts to address the needs of the sex offender population, but these efforts, at this point, are still in the discussion phase of figuring out how best to serve the population. Lastly, two counties (one demonstration and one comparison county) have developed their own

---

[3] ODJFS: Family to Family: Ohio Family-Centered, Neighborhood-Based Services – Background, 1998.

mental health services internally to address the needs of the population with mental health issues who otherwise would have difficulty accessing services in the community.

While the study team found these isolated examples of PCSAs targeting services and supports for these subpopulations, the targeting efforts still appear to be rather limited for both demonstration and comparison counties.

2.6 FINANCING

At the heart of the Title IV-E Waiver is fiscal flexibility. Title IV-E is a categorical program with highly structured procedures for earning federal reimbursement, all linked to out-of-home care. The Waiver, however, offers fiscal flexibility that allows experimentation. Capitation and risk are important tools of managed care, which are difficult to use without the flexibility in funding offered by the Waiver. Capitation is the primary principle behind managed care: it is the process whereby a fixed amount of money is paid, usually in advance, to cover the cost of services needed by eligible clients. Risk is the financial risk that either the payer or the managed care contractor carries if the payment is not sufficient to meet the cost of services required for all clients.

Under a capitated system, the payment rate must be projected with a fair degree of accuracy or one of two undesirable outcomes will occur. First, if a contractor is bearing the financial risk, he is likely to cut costs, in spite of clients' needs, in order to live within his fixed payment. Second, if the payer is bearing the financial risk, he is likely to face cost overruns on the contract. The goal is for the rate to be sufficient to meet all clients' needs exactly, without wasting any resources by providing services that are not needed, or by providing them longer than needed. This balance is difficult to achieve, and typically requires several years of historical cost information on which to base a sound rate.

Cost history in child welfare is difficult to obtain or highly suspect in its reliability. For this reason, a strategy used in the health care field in the early days of managed care for welfare recipients was to phase into capitation through the use of administrative or management-services-only contracts. Under these arrangements, contractors undertake managed care functions (i.e., single point of entry, care management, utilization management, quality assurance, focus on outcomes and performance, financial incentives and penalties, etc.) without bearing the financial risk of service costs. In this way, accurate data on service costs (controlled through the use of managed care techniques) can be collected, and eventually used to develop actuarially-sound capitated rates. Hence, these administrative services or management services contracts may be viewed as precursors to capitated contracts. In ProtectOhio, demonstration counties are using both management services contracts and capitated contracts.

This section describes the three demonstration counties operating managed care funding arrangements in Year 4, discusses the reasons why two other demonstration counties that had managed care contracts discontinued them, and reviews lessons learned from all of the managed care contracts.

Summary:

Despite the flexibility in funding available through the Waiver, few counties have opted to use managed care contracting mechanisms. Smaller counties have been reluctant to develop such arrangements primarily because they believe their caseloads are too small or too unpredictable (making cost and risk prediction difficult) to attract providers. In addition, few counties have sufficient historical cost information to feel comfortable projecting costs across a group of clients.

Three demonstration counties currently have one or several managed care contracts in effect, addressing the needs of a particular population. Franklin County has contracted with two private provider networks and randomly assigns open cases between the two providers and the PCSA. The Hamilton County PCSA has developed three different managed care contracts addressing very different populations: multi-system cases, behavioral health services, and substance abuse services. Portage County has developed a case rate contract for adoptive placements.

Two demonstration counties discontinued capitated contracts in the last 2 years of the evaluation. Both Crawford County and Lorain County had developed capitated contracts to serve the high-need multi-system children in their system, but encountered unexpected costs due to high placement numbers and implementation issues.

The key difficulties that have emerged from these contracting experiences include problems with clarity of goals or conflicting goals, problems with the design or structure of the model itself (targeting the deep-end population and transitioning cases in and out of the managed care contract), and problems with implementation of the model (case management responsibilities, staffing issues, and information systems).

2.6.1 Managed Care Contracts Still in Effect

The history of managed care funding arrangements over the course of the Waiver is detailed in Table 2.9.

Table 2.9: Demonstration Counties with Managed Care Contracts Over the Waiver Period			
Year 1	**Year 2**	**Year 3**	**Year 4**
Crawford	Crawford	Crawford	
Franklin	Franklin	Franklin	Franklin
Hamilton	Hamilton	Hamilton	Hamilton
	Lorain		
Portage	Portage	Portage	Portage

Three demonstration counties have had managed care contracts over the 4 years of the Waiver evaluation. Two additional demonstration counties had capitated contracts for a short period of time, but these contracts are no longer in effect.

All counties with current managed care contracts—Franklin, Hamilton, and Portage—developed their contracts to address particular needs, but they have arrived at different solutions. Among the three counties, there are six contracts: four are case rate contracts, and two are management-services-only contracts. Each of the counties' contracts is described below and in Table 2.10.

Franklin County

In FFY 1999, Franklin County Children Services (FCCS) contracted with two different provider networks: Ohio Youth Advocate Program (OYAP, primarily a foster care network) with numerous subcontractors, and a consortium called Permanent Family Solutions (PFS). When cases are opened, they are randomly assigned to FCCS staff, OYAP, or PFS, with a total of 15 to 20% of the total caseload included in the contracts. Intake, investigation, and adoption continue to be the responsibility of FCCS, while the contracts include ongoing case management and services. Once a case has been assigned to a managed care contract, FCCS no longer provides case management. FCCS maintains investigatory responsibility and continues to provide court representation for cases assigned to the contractors.

The case rates are $23,074 for OYAP and $20,515 for PFS, with incremental payments at referral, three months later, and at closure. The contract includes sanctions for reopening a case within 18 months; risk sharing on individual cases when the case cost exceeds four times the case rate; a risk corridor on total expenditures (five percent the first year, ten percent the second year); and a set-aside of $970,000 to protect against cost overruns.

The major difference between the two managed care services (OYAP and PFS) and FCCS services is that the managed care contractors continue to provide services after the case is closed, in order to minimize re-entry into the system. The major difference between the two contractors is that OYAP has two staff assigned to each case, a treatment coordinator and a treatment advocate, and provides more services in-house. PFS purchases more services.

Since the contracts began in FFY 1999, some changes have been made. The residential center associated with the PFS consortium, Buckeye Boys Ranch, is now carrying the risk of the contract alone, with the former partners serving as subcontractors. Seven amendments have been made to the contracts since they began. Some of those changes include: an 18-month warranty on cases so that contractors wouldn't get re-opened cases after FCCS service, the elimination of a procedure giving disproportionate numbers of particular types of clients to the contractors, and the inclusion of a stop-loss provision, limiting the financial risk of the managed care provider.