CHAPTER 2: FINDINGS FROM THE PROCESS/ IMPLEMENTATION STUDY

2.1 INTRODUCTION

In the course of the Waiver evaluation, the Process Implementation 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 and Chapter 3 describe the most important changes that have occurred and continue to evolve in PCSA operations.

In Year 5 of the evaluation, the Process Implementation Study team identified four topic areas that needed further exploration – prevention, mental health services, PCSA-juvenile court interactions, and interagency collaboration. These areas are discussed in Chapter 3. All the remaining Process Implementation Study concerns are covered in this chapter. Because this is the culminating report of the five-year evaluation, each section that follows summarizes the major findings from the entire evaluation. In addition, Table 2.1 highlights the results discussed later in this chapter and in Chapter 3.

Chapter 2 Topics:
- ✓ Overall Use of Managed Care Strategies
- ✓ Financing
- ✓ Internal Organization/ Case Management
- ✓ Provider Competition
- ✓ Utilization Review/QA

The Process Implementation Study addresses 18 of the 29 outcomes identified by the demonstration counties as being most central to their Waiver efforts (Table 2.2). Some of these outcomes –the eight related to service array, targeting and interagency collaboration—are discussed in Chapter 3. The other ten outcomes are discussed below.

2.2 METHODOLOGY

The process implementation study team has used a number of different strategies to collect the information presented in this report. Through a combination of site visits, focus groups, telephone interviews, and written surveys, the team has amassed a significant amount of qualitative and quantitative information. The methods used to gather this information are described below.

Site visits

In the first, second, and fourth year of the evaluation, the Process Implementation Study team collected information from the 28 evaluation counties through a series of site visits to each county. These two- to three-day site visits took place in the fall/spring of each year and were conducted by one or two-person teams from HSRI, IHSM, and our Ohio consultant. Prior to these visits, the evaluation team generally met for a retreat to determine which areas of interest should be pursued during the visits. From these discussions, the team developed a detailed interview guide to gather information consistently in all 28 counties. In Year 4, the site visits also included focus groups with front-line workers and PCSA clients. Findings from these focus groups are incorporated into various parts of this report as appropriate.

Table 2.1: Process Implementation Findings in Years 2-4		
Topic	**Annual Report**	**Summary of Significant Findings[1]**
Managed Care Overall		
Overall Use of Managed Care Strategies	2,3,4	Demonstration counties are more committed to using managed care strategies overall. Comparison counties have begun to become more focused on the use of managed care strategies, moving closer to demonstration counties as the Waiver has progressed.
Financing Methods		
Use of case rate contracting and risk-sharing	4	Despite Waiver flexibility, few counties have opted to use managed care contracting mechanisms. Three demonstration counties and no comparison sites have maintained managed care contracts throughout the Waiver.
Increased variation in use of IV-E funds	2,3	Some demonstration counties have concentrated efforts in one or two areas, while some have spread funding across a wealth of efforts. The areas of most activity include prevention services and staffing and training.
Case Management		
Use of team conferencing	2,4	Most demonstration and comparison PCSAs view team conferencing as a vital tool in improving communication and achieving better outcomes for children and families.
Increase in family involvement in case management	2,4	Limited data suggests increasing family involvement is a strong focus in the evaluation sites; no systematic difference appears between demonstration and comparison counties.
Changes in screening and intake processes	2,4	A majority of both demonstration and comparison PCSAs are making efforts to decrease the number of cases coming in during the screening process. Demonstration counties are somewhat more involved in altering screening processes, but it is not clear that this is a direct result of the Waiver.
Provider Competition		
Increased availability of foster/adoptive parents	4	PCSAs (both demonstration and comparison) have largely been unable to keep ahead of demand for foster and adoptive homes.

[1] Significant findings for the process measures are defined as differences of seven or more demonstration or comparison counties on each measure.

Table 2.1: Process Implementation Findings in Years 2-4		
Topic	**Annual Report**	**Summary of Significant Findings**
Utilization Review/Quality Assurance/Data Management		
Increased activity to control use of out-of-home care	4	Demonstration counties make slightly greater use of placement review mechanisms than do comparison counties.
Increased attention to outcomes	3,4	Demonstration counties have made a greater effort to measure outcomes and to use these outcomes to improve service delivery.
Improvement in county-specific data systems	3,4	While both groups of counties have recognized the importance of improving data management capabilities, demonstration counties appear to be somewhat more likely to have fiscal staff who use program data..
Greater implementation of CLA model	3,4	CLA counties have not fully implemented the CLA model. Thus far they do not appear to be experiencing any different outcomes than non-CLA sites.
Service Array		
Improved availability and quality of services	1,2	Demonstration and comparison counties are fairly similar in the types of services that they identify as being sufficiently available.
Development of new services	4	Slightly more demonstration counties have developed placement and non-placement services, and slightly more comparison sites have created mental health services.
Interagency Collaboration		
Improvement in PCSA interactions with other service agencies	1,4	Interagency collaborative efforts 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; more growth occurred during the Waiver in demonstration counties.
Improvement in relationship between PCSA and mental health	2,3,4	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.
Improvement in relationship between PCSA and juvenile court	2,4	The majority of demonstration and comparison sites have strong relationships with the court.

The purpose of the site visits was to gain a complete understanding of the dynamics of the PCSA and the local community. The site visit interviews usually included staff both internal and external to the PCSA: PCSA director and management, PCSA supervisors and workers, representatives from the local mental health board and the juvenile court, Families and Children First staff, as well as any other local stakeholders who could provide a perspective about changes in the PCSA since the Waiver. In these interviews, the team explored a broad array of topics and issues. Exhibit 2.1 provides a list of some of the topics typically explored.

Table 2.2: Primary Waiver Outcomes Addressed in Process Implementation Study	Chapter location
Financing Methods	
■ Use of case rate contracting and risk-sharing	2.4.1
■ Increase in variation in use of IVE funds	2.4.2
Case Management	
■ Increase in family involvement in case management	2.5.1
■ Use of team conferencing	2.5.1
■ Changes in screening and intake processes	2.5.2
Provider Competition	
■ Increase in foster/adoptive parents recruited	2.6.1
Utilization Review/ Quality Assurance	
■ Increased activity to control/rationalize use of out-of-home care	2.7.1
■ Increased attention to outcomes	2.7.2
■ Greater implementation of CLA model	2.7.3
■ Improvement in county-specific data systems	2.7.4
Service Array	Chapter 3
■ Improved availability and quality of services	
■ Development of new services	
■ Increase in service capacity relative to need	
■ Timely access to services	
Targeting	Chapter 3
■ Services targeted to areas of most need	
Interagency Collaboration	Chapter 3
■ Improvement in PCSA interactions with other service agencies	
■ Improvement in relationship between PCSA and mental health	
■ Improvement in relationship between PCSA and juvenile court	

Telephone interviews

Following the first two years of intensive site visit interviews, the study team chose to target its data collection in Year 5 through telephone interviews with key administrators in each of the demonstration and comparison counties. Through these telephone interviews, the team examined a smaller number of topics directly related to the Waiver, collecting more detailed information in these areas, and enabling the team to do a more thorough comparative analysis of selected PCSA operations.

Collaboration Survey

The collaborative relationships between PCSAs and other child-serving agencies have been explored in-depth by the study team in previous years. For Year 5, the study team chose to examine these relationships from the perspective of the PCSAs' collaborative partners. Each PCSA was asked to provide a list of approximately five partners it considered to be its main collaborators. These main collaborators were then sent a survey asking them to rate the collaborative relationship they have with the PCSA. Key topics explored in the survey include the improvement of PCSA interactions with other service agencies and improvement in the PCSA relationship with the Juvenile Court or Mental Health Board.

Exhibit 2.1: Sample Topics Explored Through Site Visits:

- System reform
- Case flow
- Unit structure
- Team conferencing
- Service availability
- Managed care strategies
- Interagency relationships & collaboration

Case Study Site Visits

In Year 5 of the evaluation, the Process Implementation Study team conducted a series of site visits to a eight of the 14 demonstration counties. These site visits explored the Year 5 length of stay findings in further detail. A full discussion of the case study findings from some of these counties can be found in Chapter 7.

Data Management and Analysis

Data gathered during the site visits and telephone interviews were input into two types of databases. The quantitative information was entered into a SPSS database, a quantitative software package. Initial analysis used simple descriptive statistics – frequencies and cross-tabulations. As the study team became more familiar with patterns in the data, analysis was expanded create indices, scales, and apply other data reduction methods.

The qualitative data were analyzed using a different technique. To facilitate a systematic use of text collected in the interviews, the study team employed a software package called QSR-N6, which is designed to analyze qualitative data. N6 allows the Process Implementation team to quickly examine all the pieces of text that relate to a particular topic, enabling the team to explore differences between demonstration and comparison counties by accessing sections of the vast quantity of notes that were collected in each county.

These quantitative and qualitative methods were used collectively to assist the team in analyzing and reporting finding for the various reports submitted to ODJFS.

Caseworker Survey

In the fourth year of the evaluation, the study team conducted a survey of caseworkers in order to assess the impact of ProtectOhio on the children and families served by the child welfare system and the caseworker decisions made within the system. The written, self-administered caseworker survey examined the perspective and attitudes of caseworkers from the 14 demonstration and 14 comparison counties. The questionnaire asked workers about their personal backgrounds, education, and professional judgment. In addition, for one selected case,

the worker responded to questions about the cumulative types of services provided to the child during the current or most recent active case period.

In February of 2002, the evaluation team sent out 1,408 surveys and had 1,054 returned, for a 75% completion rate. The evaluation team examined the survey data to explore differences between demonstration and comparison counties. During this process, the team found it is important to understand the demographics of the sample, in order to better interpret some of the findings from the study. In examining the demographics of the workers who completed the survey, several patterns emerged:

- Demonstration workers were more often hired within the last five years;
- Comparison workers have more years of experience in social work in general, in child welfare social work, and in delivering foster care services;
- Demonstration workers have more years of experience in supervising others in social work;
- Demonstration counties have more workers with graduate study or with a Master's degree or higher.

Significant survey findings related to case outcomes are discussed in appropriate sections below. A detailed description of the caseworker survey methodology is included in Appendix V-4.

2.3 USE OF MANAGED CARE STRATEGIES

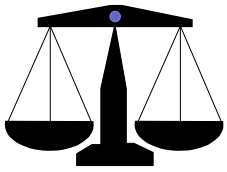
Managed care offers a broad array of technical mechanisms to improve and simplify service systems. These techniques are not new to child welfare; indeed, many are already being used in service systems around the country and in Ohio. What is new, however, is that managed care seeks to integrate the different 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.[2] A prime interest 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. This section examines the overall use of "managed care" in demonstration and comparison counties.

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;

[2] 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.

- 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.

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

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:

- *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. It is through these discussions and a thorough analysis of the data collected throughout the years of the evaluation that the study team presents the following findings.

2.3.1 Overall Use of Managed Care: the Managed Care Index

Using the eight categories of managed care activity described above, the study team selected a number of discrete data items to be collected during Process Implementation Study site visits in years 2-4 of the evaluation, creating a 'managed care index' for each year. The selection of the items, and the way in which they are combined to yield an index score, is subjective and open to modification. These indices are intended as a reasonable starting point for distilling the systemic reforms that PCSAs are adopting. Table 2.3 lists the components of the Managed Care Index for Year 4, providing a description of the topics included in the index, as well as how much each strategy is weighted in the overall managed care index.

It is important to note that the study team has broadened the exploration of some of the managed care strategies during the latter years of the evaluation (e.g. utilization review and data management efforts), because these were areas where counties had been more active in recent years. For example, in utilization review in Year 4, the team explored whether a PCSA had

developed processes to review non-placement services and added this variable to the managed care index in Year 4. Similarly, for data management, this year the team determined whether client data and fiscal systems were linked and made this a variable in the index. The new items are noted in Table 2.3 by "(Year 4)." The team has also added new variables to other categories in the index, thereby crediting counties who are adopting practices that facilitate more rational and systematic program management.

Table 2.3: Components of the Year 4 Managed Care Index		
Managed Care Category	**Specific Item (Year from which data is drawn)**	**Weighting[3]**
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 4) • Existence of specialized PCSA units (Year 2 and Year 4)	5.0%
Data Management	• Extent of use of automated management information and access to management information systems (Year 4)	7.5%

[3] 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 earlier versions of the managed care index, placing more emphasis on case management, competition and QA, with less emphasis on targeting and data management. The change in weighting reflects the greater importance that countries have given to particular managed care activities.

The evaluation team found that 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 services that are needed by children and families. Table 2.4 reveals the variation in effort among the demonstration and comparison counties in Year 4, across the eight spheres of managed care activity.

The data in Table 2.4 can be analyzed from two perspectives: (1) preferred categories of managed care activity and (2) areas of greatest contrast between demonstration and comparison groups. While the data presented in this table are for Year 4 of the evaluation, similar trends have been found in previous years and are discussed below.

Preferred Areas of Managed Care Activity

The first line of analysis in Table 2.4 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% (or more) of the possible points in Year 4 include quality assurance, service array, and case management. Conversely, three categories appear to be "less preferred" areas of activity: financing, competition, and targeting, with one of the county groups averaging 30% or less of the possible score.

These findings represent a continuation of the patterns seen in earlier years of the evaluation. Utilization review and services array were consistently in the 'most preferred' category, while financing and competition were the least used managed care strategies in Year 2 and Year 3. It is also interesting to note that case management appears to be the one area where more activity has been occurring in the later years of the Waiver.

Contrast between Demonstration and Comparison Counties

The second line of analysis for Table 2.4, compares the difference between 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 the area of financing, where the difference between demonstration comparison counties is 20%. This seems appropriate 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.

Table 2.4: Year 4 Managed Care Index Scoring			
Managed Care Category*	**Possible Score**	**Average Raw Score**	**Average as Percent of Total Possible Score**
Financing	13		
Demonstration		4.9	38%
Comparison		2.3	18%
Difference in %			+20%
Utilization Review	11		
Demonstration		6.4	58%
Comparison		5.6	52%
Difference in %			+6%
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		2.0	40%
Comparison		1.5	30%
Difference in %			+10%
Quality Assurance	16		
Demonstration		8.8	55%
Comparison		7.4	46%
Difference in %			+9%
Data Management	6		
Demonstration		2.9	48%
Comparison		2.2	37%
Difference in %			+11%
TOTAL	92		
Demonstration		43.6	47%
Comparison		36.1	39%
Difference in %			+8%

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

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% (Table 2.4). This likely reflects the fact that comparison counties reported higher levels of service sufficiency (see Chapter 3).

Financing is the one area where there has consistently been significant differentiation between demonstration and comparison counties; this is a continuation of a pattern seen in Year 2 and Year 3. Conversely, service array and case management consistently appear to show the least differentiation between demonstration and comparison counties over the years measured. These trends indicate that the Waiver appears to enable demonstration counties to make more significant strides in a few specific managed care strategies, while most of the other managed care strategies are fairly accessible to both demonstration and comparison counties, suggesting that all the counties are becoming more attentive to rational management approaches.

Managed Care Index Rankings

The difference between demonstration and comparison groups provides a rich basis for the summary measure, the managed care index. This index combines the scores for each of the separate strategies, weighting them to create a composite measure indicating overall managed care activity. The study team created three groups based on the overall managed care index score for each county, as a percentage of total possible points (Table 2.5). The high-medium-low groupings offer a clearer picture of what is evident in Table 2.4: demonstration counties are using managed care strategies more than are comparison counties. Appendix V-5 shows each county's score on each of the eight managed care strategies, as well as each county's overall managed care score for both Year 2 and Year 4.

Table 2.5: Counties Grouped by Level of Overall Managed Care Activity in Year 4

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)*		Percent of Total Possible Score on MC index (range)*		Percent of Total Possible Score on MC index (range)*	
Demonstration	Comparison	Demonstration	Comparison	Demonstration	Comparison
Franklin Greene Hamilton Lorain Medina Richland	Montgomery Trumbull	Belmont Clark Muskingum Portage Stark	Allen Butler Miami Scioto Summit	Ashtabula Crawford Fairfield	Clermont Columbiana Hancock Hocking Mahoning Warren Wood

*Counties in the 'high' category received 52%-65% of the total possible points for the managed care index. 'Medium' counties received 42%-49% of total possible points. 'Low' counties received 18%-38% of total possible points.

While the use of Tukey's Quick Test[4] does not indicate statistically significant differences between the overall managed care index scores of the demonstration and comparison groups, it does suggest that comparison counties have lower managed care index scores in Year 4, with seven of the lowest eight scores being in comparison sites. Table 2.6 shows the full listing of scores, ordered from highest to lowest Year 4 managed care index scores. The Year 2 data reveals similar findings: the top eight managed care index scores were demonstration counties (a statistically significant finding), while the lowest six scores were comparison counties. These results continue to suggest that demonstration counties have focused more on the use of managed care strategies during the Waiver period.

Table 2.6 Tukey's Quick Test for Differences in Managed Care Index Score (Year 2 and Year 4)

County	Demonstration/ Comparison	Y2 Score	County	Demonstration/ Comparison	Y4 Score
Lorain	Demonstration	47.69	Montgomery	Comparison	59.43
Hamilton	Demonstration	46.09	Lorain	Demonstration	59.31
Medina	Demonstration	38.68	Hamilton	Demonstration	57.06
Richland	Demonstration	36.91	Medina	Demonstration	56.29
Portage	Demonstration	35.56	Franklin	Demonstration	53.17
Franklin	Demonstration	33.60	Trumbull	Comparison	49.31
Greene	Demonstration	31.66	Richland	Demonstration	47.55
Crawford	Demonstration	29.56	Greene	Demonstration	47.26
Trumbull	Comparison	29.48	Summit	Comparison	44.77
Clark	Demonstration	28.51	Scioto	Comparison	44.36
Muskingum	Demonstration	28.45	Portage	Demonstration	43.56
Montgomery	Comparison	28.20	Allen	Comparison	42.77
Summit	Comparison	28.04	Butler	Comparison	41.83
Scioto	Comparison	26.69	Clark	Demonstration	41.29
Fairfield	Demonstration	25.78	Muskingum	Demonstration	41.25
Stark	Demonstration	25.52	Stark	Demonstration	40.36
Butler	Comparison	25.45	Miami	Comparison	39.00
Hancock	Comparison	24.77	Belmont	Demonstration	38.46
Hocking	Comparison	24.77	Fairfield	Demonstration	34.56
Belmont	Demonstration	23.53	Ashtabula	Demonstration	34.46
Allen	Comparison	20.64	Mahoning	Comparison	33.83
Ashtabula	Demonstration	20.20	Hancock	Comparison	31.72
Warren	Comparison	19.75	Columbiana	Comparison	28.03
Mahoning	Comparison	17.66	Clermont	Comparison	26.80
Columbiana	Comparison	14.59	Wood	Comparison	23.26
Miami	Comparison	13.62	Hocking	Comparison	21.84
Wood	Comparison	9.02	Warren	Comparison	18.79
Clermont	Comparison	8.95	Crawford	Demonstration	16.47

[4] A description of Tukey's Quick Test is provided in Chapter 4, Section 4.2.2.

Change in Managed Care Activity from Year 2 to Year 4

The study team also explored whether evaluation counties continued to move forward in their use of managed care strategies in the later years of the Waiver. Because some variables in the managed care index were added and weighting was changed over the course of the evaluation, the team was unable to simply compare the number of counties with rankings of low, medium, or high from Year 2 to Year 4. Instead, the team examined 14 variables that had been gathered both in Year 2 and Year 4: the evaluation team found no significant difference between demonstration and comparison groups in terms of becoming more involved in using managed care strategies in the later years of the Waiver. This indicates that while demonstration counties were more active than comparison counties for each year, they did not change in relation to their comparison counterparts over time.

Summary: In examining demonstration and comparison county scores in each of the eight managed care strategies, several themes become apparent. First, utilization review has consistently been the most preferred managed care strategy adopted by both demonstration and comparison counties, followed by development of a county's service array. On the other hand, financing and competition have consistently been the areas where both demonstration and comparison counties are less often inclined to venture. Second, in terms of areas of differentiation between demonstration and comparison counties, financing is the one strategy which has consistently shown the most contrast between demonstration and comparison counties; demonstration counties attribute to the Waiver their ability to develop capitated contracts. On the other hand, in the areas of case management, utilization review, and service array, there has consistently been little distinction between demonstration and comparison counties. Lastly, in terms of overall use of managed care strategies, in Year 2 and Year 4, demonstration counties were more active than comparison counties in their overall use of managed care strategies; however, demonstration counties have not changed significantly, relative to their comparison counterpart, from Year 2 to Year 4.

The next sections of this chapter explore several of the individual managed care strategies. This discussion focuses on only four of the managed care strategies, those where counties have been most active and where the greatest distinctions exist between demonstration and comparison counties.

2.4 FINANCING METHODS

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 Ohio counties are experimenting with managed care contracts that employ both capitation and risk, in varying ways. Among the approaches being used are management services contracts and capitated contracts.[6]

This section summarizes the managed care financing arrangements in place during the Waiver and explores variation in the use of flexible IV-E funds.

2.4.1 Managed Care Contracting

The evaluation counties have done relatively little experimenting with managed care contracts. As Table 2.7 indicates, in Year 2, five demonstration counties had managed care financing arrangements, but no comparison counties had such arrangements. By Year 3, one demonstration county had ended its capitated contract, and the extent to which managed care financing techniques were built into the four continuing contracts had decreased. No comparison counties had begun risk-sharing contracts.

In Year 4 of the evaluation, three demonstration counties had one or several managed care contracts in effect, addressing the needs of a particular population. All of these contracts have been in place prior to the Waiver. Franklin County had contracted with two private provider networks, randomly assigning open cases among the two providers and the PCSA. The Hamilton County PCSA had in place three different managed care contracts addressing very different populations: multi-system cases, behavioral health services, and substance abuse services. Portage County had developed a case rate contract for adoptive placements.

[6] Under a capitated system, payer and contractor share the financial risk; it requires accurate projections of costs to set appropriate payment rates. 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 without bearing the financial risk of service costs. In this way, accurate data on service costs can be collected, and eventually used to develop actuarially-sound capitated rates. For more details, see *Fourth Annual Report*, Section 2.6, August 2002.

Table 2.7: Demonstration Counties with Managed Care Contracts Over the Waiver Period		
Year 2	**Year 3**	**Year 4**
Crawford	Crawford	
Franklin	Franklin	Franklin
Hamilton	Hamilton	Hamilton
Lorain		
Portage	Portage	Portage

The three counties with current managed care contracts developed their contracts to address particular needs, but they have arrived at different solutions. Among the three counties, there are six contracts. The four case rate contracts include two in Franklin County and one each in Portage and Hamilton:

- 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 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, including responsibility for the placement of children. Once a case has been assigned to a managed care contract, FCCS no longer provides case management. FCCS maintains investigatory responsibility and continues to attend court hearings in conjunction with 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. To minimize re-entry in to the system, the managed care contractors continue to provide services after the case is closed.

- In 1994, Hamilton County Department of Job and Family Services (DJFS) contracted 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 contractor has changed once during the course of the Waiver, due to overspending. The current contractor, Creative Connections

(a program of Beech Acres) 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. Several issues have been raised since the beginning of this contract: since 1998 Creative Connections has been through three directors, has had numerous vacancies in management positions, and has consistently overspent the contract amount. The biggest problem with the contract is that the population selected, deep-end children, are likely to always be high cost.

- 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.

The two management-services-only contracts are in Hamilton County:

- In 1997, Hamilton DJFS contracted with Magellan Public Solutions, a national for-profit, behavioral health managed care company, to provide administrative support services to DJFS for all therapeutic services, for both children and adults, for all open cases. The initial 5-year contract 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 DJFS, as well as being limited to a five-percent profit. 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). The project suffered initially because automated information, billing, and claiming systems were not adequate; these systems have since improved greatly.
- 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.

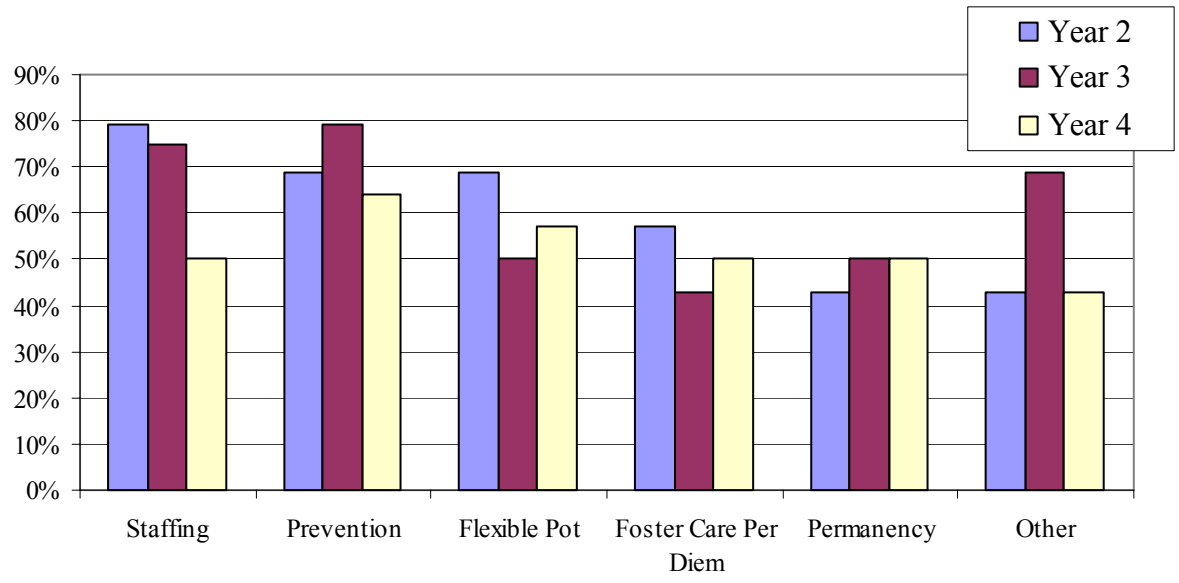
Summary: Despite the flexibility in funding available through the Waiver, few counties have opted to use managed care contracting mechanisms. Smaller counties have been reluctant to develop such arrangements primarily because they believe their caseloads are too small or too unpredictable (making cost 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. Only three demonstration counties have maintained managed care contracts throughout the Waiver. 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).

2.4.2 Use of IV-E Flexible Funds

In Year 2 and 3 of the evaluation, the study team examined how the demonstration PCSAs chose to focus their flexible funding opportunity. The amount of revenue available for spending on service other than foster care depended on the level of a county's foster care expenditures during the Waiver and the amount of money received as a result of the Waiver formula. Once the county used its Waiver award to pay all of what would have been the federal share of foster care expenditures, any remaining Waiver revenue was available for flexible spending. Chapter 4, Section 4.4.2, shows an estimate of how much flexible Waiver revenue was available in each county. Although it does not matter where the IV-E dollar is actually spent, it is important to identify the types of activities that are being funded because more flexible funds are available in nearly all the demonstration counties. Some counties have chosen to "spread the wealth," using non-categorical monies in a variety of new ways, while others have chosen to focus all the new flexible resources on just one activity.

The study team explored the specific efforts in which demonstration counties were engaged that would not have been possible without ProtectOhio dollars. Figure 2.1 displays the percent of demonstration counties that are pursuing various strategies using the increased non-categorical funds in Year 2 through Year 4.

Figure 2.1: Change in Demonstration Counties' Use of Flexible IV-E Funds Year 2 to Year 4



The following description provides some specific examples of how ProtectOhio counties are reinvesting their flexible IV-E Waiver dollars:

Prevention programs and services: Demonstration counties pursued prevention programming strategies vigorously using flexible funds. Prevention was the number two use of flexible funds in Year 2 and the number one use of flexible funds in Year 3 and Year 4. In Year 3, 11 demonstration counties funded diverse efforts ranging from true primary prevention to intensive intervention as a last-ditch effort to keep children from being removed from their homes: in Year 4, 9 counties reported similar efforts.

Staffing, internal capacity and training: In Year 3, approximately three-quarters of the demonstration counties spent flexible funds on staffing-related needs. All the counties focused their funds on direct service staff: most often mentioned were new investigators and assessment staff to help control intake (and make appropriate decisions) when involvement with a family is just beginning, and new adoptive home finders and foster care recruitment staff. It is interesting to note that in Year 4, only half of the demonstration counties reported efforts in this category, an indication that many staffing needs had been filled in earlier years of the Waiver.

Flexible Funding Pots: In all three years, at least half of the demonstration counties were using flexible pots of money for their workers to use creatively to prevent removal from the home, support a foster care placement, or support reunification. Many of the expenditures are one-time-only emergency assistance, such as buying a bed for a child, paying a heating bill, or paying the rent.

Foster Care Per Diem Increases: Five demonstration sites spent flexible funds on increasing foster care per diems to attract more potential families in Year 3. These expenditures appear to

reflect the continuing significant 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. Four demonstration counties reported per diem increases in Year 4.

Permanency Initiatives: The demonstration counties have been actively using flexible funding to expand permanency options, primarily increasing adoption subsidies for hard-to-adopt children and creating assisted guardianship programs. These efforts supplement the staffing increases in adoption workers reported by many counties under the *Staffing* subsection discussed above.

Other: In Year 3, all nine of the demonstration counties in this category participated in placement cost-sharing arrangements in which the placed children are in the custody of another agency, where it appears the child and family are heading for a referral to the PCSA and can be diverted, or at least resolved more quickly. For this reason, in Year 4, the study team specifically asked demonstration counties if they were using IV-E flexibility for "services to children not in PCSA custody": half of the demonstration counties reported using IV-E funds in this manner.

The study team found that the demonstration counties were also able to fund a number of programming and staffing initiatives through the use of either flexible IV-E dollars or other non-categorical funding sources such as excess TANF funds, ESSA, PRC, Family Stability monies and occasionally undesignated levy monies[7].

The demonstration counties enthusiasm for trying new and more flexible uses of the money came through clearly, whether using Waiver funds or other sources. Many of the demonstration county respondents perceived a greater freedom than ever before, for example, to engage in preventive programming and hire new staff. The Waiver funds may indeed be spurring a spirit of innovation, a subtle but important effect that also may be significant in future years if the other sources of money dry up. If the study is extended, the study team hopes to explore more fully the use of Waiver funds more extensively and rigorously, using fiscal data and analysis if possible.

Summary: Demonstration counties have taken varying approaches in their use of IV-E flexible funds. Some counties have concentrated efforts on one or two areas, while others have spread funding across a wealth of efforts. The choices afforded by increased flexible funding have made demonstration counties more willing to experiment with new initiatives.

2.5 INTERNAL ORGANIZATION AND CASE MANAGEMENT

Another core strategy of the ProtectOhio counties 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.

[7] Some of the non-Waiver sources of funds are more "flexible" than others. For example, the leftover TANF and PRC monies carry an income eligibility requirement but could be (and were) used in a variety of ways to assist low-income families and children.

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, this is 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, three of the high priority outcomes for the Waiver (Table 1.3) are to:

- Use team conferencing;
- Increase in family decision-making involvement; and
- Change screening and intake processes.

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

2.5.1 Team Conferencing and Family Involvement

Overall, demonstration counties appear to use somewhat more team conferencing than comparison counties. Demonstration counties, reflecting their emphasis on team conferencing as a key outcome of ProtectOhio, 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.

Over the course of the evaluation, the Process Study team examined:

- 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.

Table 2.8 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. These demonstration sites tend to be those active in CLA, because systematic comprehensive case assessment is a core component (see discussion of CLA in section 2.7.4 below).

The two groups equally use team conferencing for cases headed for placement, reflecting the greater attention given to placement cases overall (see also Section 2.7.1, 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).

Additionally, findings from the Caseworker Survey show no difference between demonstration and comparison counties in the use of team conferencing models. While demonstration counties speak of the importance of team conferencing methods, the Caseworker Survey findings support the previous evaluation analysis that parallel efforts are occurring in comparison counties. This suggests that the Waiver does not enable a demonstration county to more easily utilize team conferencing models.

Table 2.8: 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

Another hypothesis of the ProtectOhio Waiver is that in demonstration counties, families will experience increased involvement in decision making processes at the case management level, as well in agency policy and planning. Over the course of the Waiver, the study team found little support for that theory: families in demonstration PCSAs do not appear to be more involved in decision making. Some support for the idea, however, emerged from Year 2 data analysis: in over half of the demonstration counties, but only a third of the comparison counties, concerted efforts were made to hold meetings where the primary focus is on the family.

Summary: Both groups of counties view team conferencing as a vital tool in improving communication and in achieving better outcomes for children and families. However, the study team does not have sufficient data to determine if the Waiver has had an impact on family involvement in decision making. The observed lack of family involvement in the evaluation counties is not surprising: while Ohio counties are trying to become more family-centered and family-based, such a big shift, both in terms of agency procedures and staff PCSA mindset, takes time.

2.5.2 Changes in Screening Processes

A crucial opportunity for managing the volume and mix of cases that a PCSA must handle comes 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 whether 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). Such a narrowing of the PCSA mission risks alienating community partners. On the other hand, opening the system to a broader clientele may support the community, but may dilute the agency's ability to effect change for mandated clients.

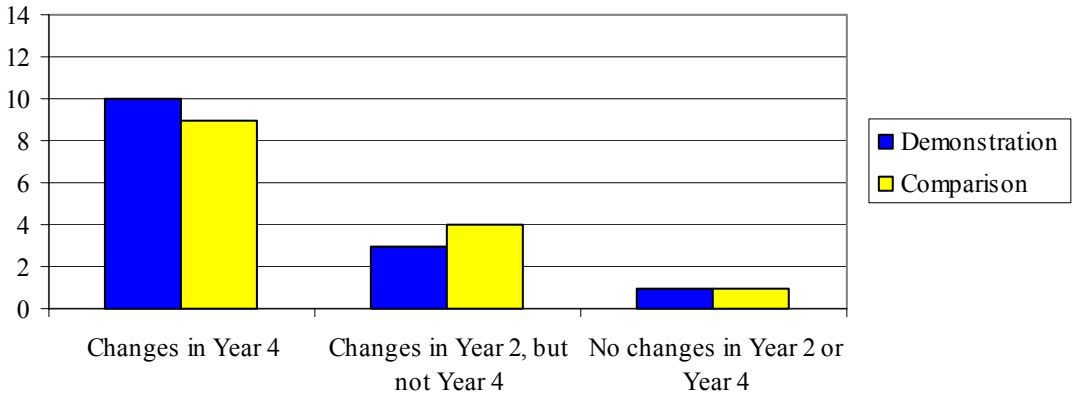
Throughout the evaluation, the study team has explored how demonstration and comparison counties have fine-tuned screening criteria and changed screening procedures and staffing. Although few strong differences emerged between the two groups, it is nonetheless interesting to note the variety of changes that have occurred:

- In Year 2, nine demonstration and seven comparison counties reported doing something 'out-of-the-ordinary' during the screening process. Practices included (a) developing new screening tools or handbooks to provide more consistent criteria for the screening decision, (b) conducting collateral calls to gather additional information, and (c) designating special screening staff, rather than rotating the responsibility among workers.[8]
- In addition to simply focusing on improving the screening process, in Year 2 several demonstration and comparison counties were using automated systems to track cases that are being screened in or screened out. Five demonstration counties and four comparison counties reported that data on referrals to the agency are systematically kept in an automated system, enabling them to better understand the types of calls they are receiving and the types of calls being screened in, so that they can more accurately target cases for investigation and immediate services.

Merging data from Year 2 and Year 4 of the evaluation, it becomes clear that screening is a continuing concern for both demonstration and comparison sites. As Figure 2.2 indicates, in Year 4 alone, 10 demonstration counties and nine comparison counties changed their screening process for opening a case for investigation.

[8] Half the demonstration sites reported using IV-E funds to raise the level of staff assigned to screening positions.

Figure 2.2: Changes in Screening in Year 2 and Year 4



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, leaving only one demonstration and one comparison county who made no changes to their screening processes since the beginning of the Waiver. This level of change indicates deliberate efforts by both groups of PCSAs to better define their client population, differentiating between those best served by the agency and those best served elsewhere.

A counterpoint to the prevailing trends described above is provided by Trumbull County, a comparison county. When they reorganized their system in 2000, Trumbull reduced the focus on screening. They now 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 (anything longer than ten weeks). This system is very popular with the community, who see the child welfare agency following up on referrals.

Summary: 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 at least one county is moving in the opposite direction, a trend that may merit further exploration. While demonstration counties are somewhat more involved in altering screening processes, it is not clear that this is a direct result of the Waiver.

2.6 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).

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.

Over the course of the evaluation, the study team has examined changes in the availability of foster homes and adoptive homes because they are the biggest concern in service delivery. Other issues such as rates and preferred provider relationships have also been important over the course of the Waiver evaluation.

2.6.1 Efforts to Increase the Number of Foster or Adoptive Homes

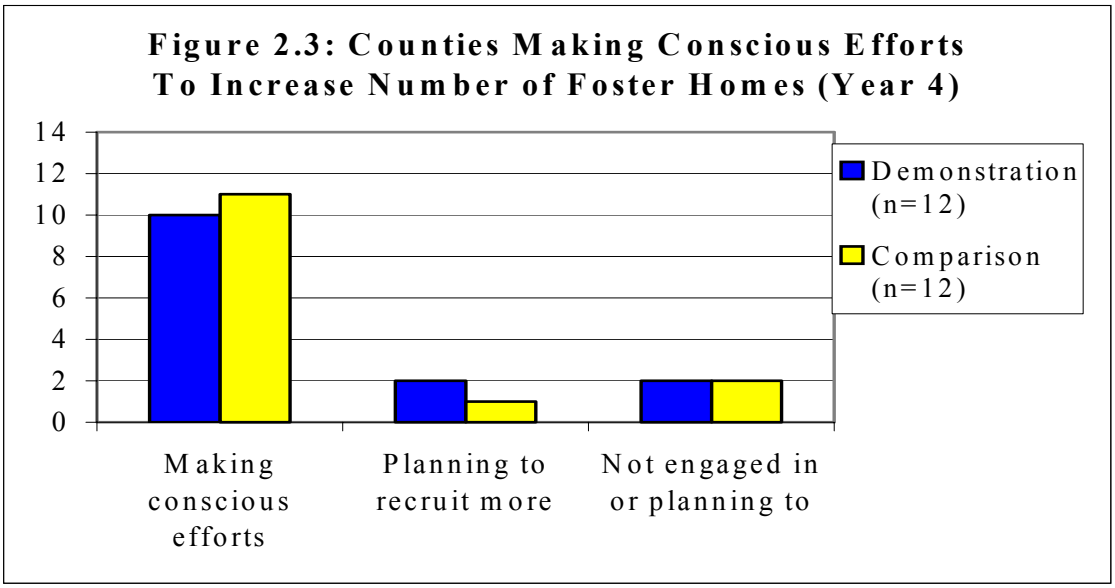
The availability of foster and adoptive homes is critical to the service continuum in child welfare. It has been a focus over the course of the evaluation because of the greater emphasis on adoption due to the Adoption and Safe Families Act (ASFA).[9] The study team explored whether PCSAs had made conscious 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 ASFA, PCSAs have been losing foster homes to adoptive parents. In Year 4 of the evaluation, PCSAs were asked if they are making conscious efforts to increase the number of foster homes (Figure 2.3). 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. It should be noted, however, that some of these inactive counties may have conducted serious recruitment initiatives in prior years of the study.

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. Of the 10 demonstration and 11 comparison counties working to increase foster homes, nearly all are attempting to increase agency regular foster homes. Additionally, approximately one-third of both groups are attempting to increase agency treatment foster homes.

[9] A more detailed description of ASFA is provided in the *Interim Implementation Report*, Section 2.4.1, August, 2000.



Also in Year 4, the study team asked about the strategies PCSAs were using or planned to use to increase the available number of foster homes. As Table 2.9 indicates, the predominant strategy was a formal recruitment campaign (67% of each group). Half of the counties responding had implemented or were planning to implement foster care per diem rate increases. 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. Eight demonstration and six comparison counties focused on other strategies, primarily adding recruitment staff, 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.

Table 2.9: Strategies Used or Planned to Increase the Number of Foster Homes

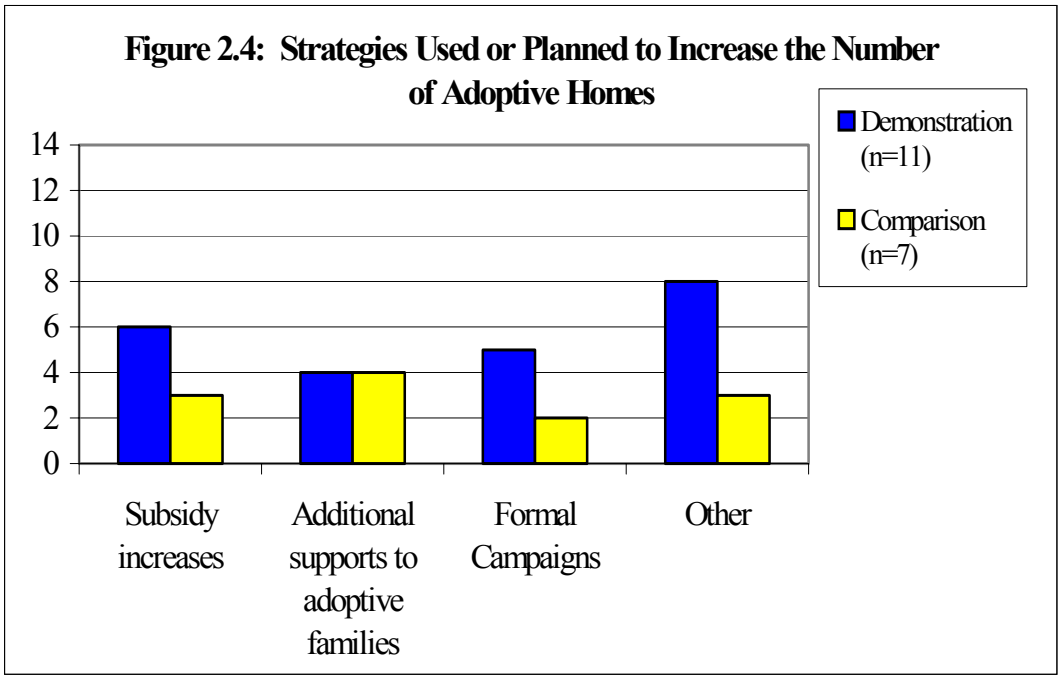
	Demonstration Counties (n=12)	Comparison Counties (n=12)
Formal campaign	8 counties (67%)	8 counties (67%)
Per diem rate increases	6 counties (50%)	6 counties (50%)
Recruitment of new networks	1 county (8%)	1 county (8%)
Development of preferred provider arrangements	1 county (8%)	1 county (8%)
Other	8 counties (67%)	6 counties (50%)

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. Eleven demonstration counties and seven comparison counties responded that they are making special efforts to do so. The most common strategies, shown in Figure 2.4, include subsidy increases and additional supports to adoptive families. Two of these categories necessitate more discussion:

- Many PCSAs commented about the size of the state adoption subsidy, and how the disparity between foster subsidies and adoption subsidies is growing and serving as a disincentive to adopt. That is why counties are supplementing those subsidies, especially demonstration counties with their IV-E flexibility. 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.

Figure 2.4: Strategies Used or Planned to Increase the Number of Adoptive Homes



Summary: Despite adopting varied strategies, PCSAs (both demonstration and comparison) have largely been unable to keep ahead of demand for foster and adoptive homes, even though majority of both demonstration and comparison counties have made efforts to increase the number of foster care and adoptive homes in their county.

2.7 UTILIZATION REVIEW, QUALITY ASSURANCE AND DATA MANAGEMENT

Utilization review is a formal process, often conducted 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 management systems, must be put in place to establish and maintain systematic parameters around service usage.

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 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, assuring not just that services are provided, but that they result in positive changes for children and families.

Four of the top priority outcomes central to the ProtectOhio evaluation (see Table 1.3) are related to utilization review and quality assurance:

- Increased activities related to controlling/rationalizing the use of out-of-home care;
- Increased attention to outcomes;
- Improvement in county-specific data management systems; and
- Implementation of Caseload Analysis.

Throughout the evaluation, the Process study team explored several of these key areas of PCSA activity: methods used to limit access to particular services, including formal review processes or other decision-making guidelines; data collection and data management, especially outcomes information; and quality control and quality enhancement activities, especially related to case management and purchased services. Findings related to these topics are summarized below.

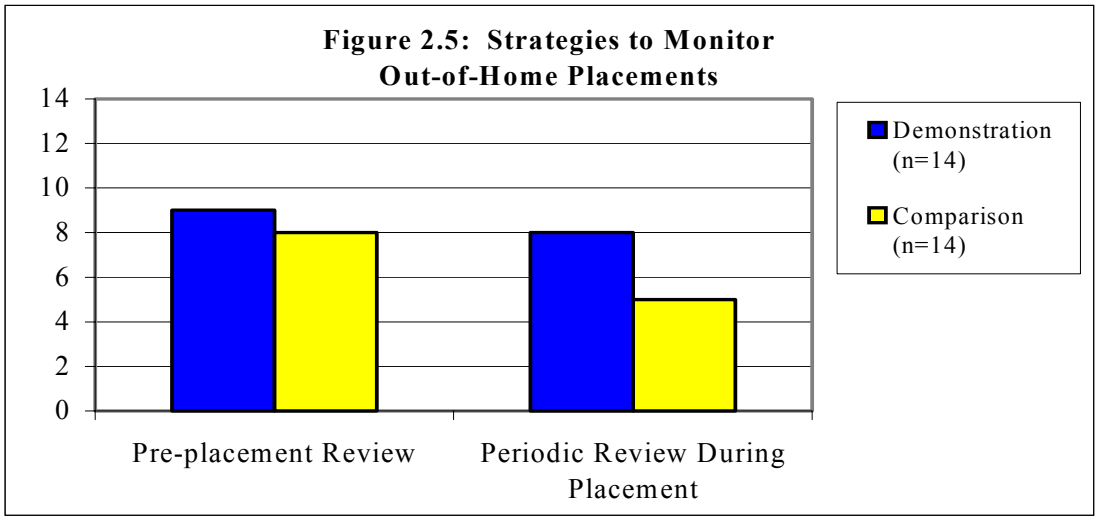
2.7.1 Increased Oversight of Placement Utilization

Because of the Waiver emphasis on reducing placements, and all counties' awareness of the effects of placement costs on the overall operation of each PCSA, counties are giving increased scrutiny to placements: to whether or not placement is needed, for how long, and at what cost. These monitoring activities can be characterized as utilization review.

The most common ways to control utilization of foster care are pre-placement reviews and periodic reviews after placement has occurred. By Year 4 of the evaluation, most evaluation counties indicated they used one or both review processes. As Figure 2.5 indicates, demonstration and comparison sites made similar use of initial placement reviews—nine demonstrations and eight comparisons—but slightly more demonstration sites appear to

systematically oversee placements once the child is in care—eight demonstrations compared to only five comparison sites.

Beyond these fairly traditional utilization review methods, PCSAs report very little activity to contain use of particular services. Restrictions on out-of-state placements do not appear necessary in most counties – half of the study counties say such placements are rare occurrences.



Only one demonstration county and one comparison county have formal limitations on the number of placements that can be made, and only one demonstration county and two comparison counties limit access to particular services via rational decision rules built on outcomes, best practice, or provider capacity information. However, it is important to emphasize that counties *do carefully consider* the need for residential, therapeutic, and other special placement services, on a case-by-case basis.

Summary: In general, demonstration counties are slightly more active in this managed care arena. They make slightly greater use of placement review mechanisms than do comparison counties.

2.7.2 Increased Attention to Outcomes

Most PCSAs talk about the importance of outcomes and have good intentions of establishing outcome guidelines for their own and purchased services. In prior years of the evaluation, nearly all counties in both groups reported using data generated for the Child Protection Oversight and Evaluation Quality Assurance System (CPOE, managed by ODJFS district offices), but few comparison sites moved beyond that basic attention to outcomes. In contrast, substantially more demonstration counties reported efforts to measure client outcomes, use outcomes data to modify practice, and incorporate outcomes-based performance measures in contracts.[10]

[10] For more details, see *Third Annual Report*, September 2001 Section 2.2.5, June 2001.

In Year 4 site visits, the study team probed more deeply into how the PCSAs gather and use outcome information. The results reinforced the earlier observation of more effort and attention in demonstration counties, especially in their internal use of outcomes data: 10 demonstration counties and six comparison sites reported systematically gathering outcome information from staff.

Some of the concrete ways that PCSAs are using the outcome data they have collected include:

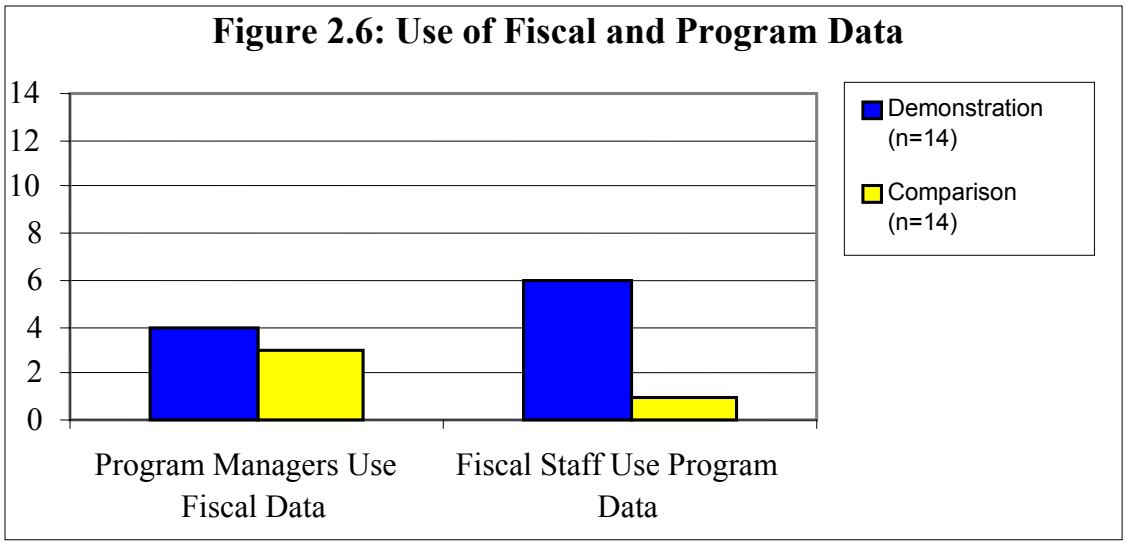
- Both demonstration and comparison counties reported using data to better understand placement trends, enabling them to focus on developing new options for particular groups of children or recruiting more placements of a particular type (e.g., agency foster homes for children under age five).
- Several 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 services there and has worked with the city Planning Board to focus housing renewal efforts there.

These data suggest that it takes some time to 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 reported efforts to use outcome-based performance criteria in contracts, but this is a slow and involved process that needs a high degree of consensus if the outcomes information is to be meaningful.

Summary: Demonstration counties have made a greater effort to measure outcomes and to use these outcomes to improve service delivery.

2.7.3 Improvement in County-specific Data Management 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.



Although the discussion above suggests that demonstration counties are more attentive to outcomes than are comparison sites, little evidence exists that more demonstration counties have taken steps to enhance overall data management. Many PCSAs in both groups 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. In Year 4, a moderate difference emerged between demonstration and comparison sites regarding use of program data by PCSA fiscal staff; this could be a step toward linking fiscal and program data sets in the future (Figure 2.6). This somewhat greater use of data by demonstration county staff suggests that perhaps 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 together to understand the other's data.[11]

Summary: While both groups of counties have become more cognizant of the importance of improving data management capabilities, demonstration counties appear to be somewhat more likely to have fiscal staff who use program data.

2.7.4 Implementation of Caseload Analysis

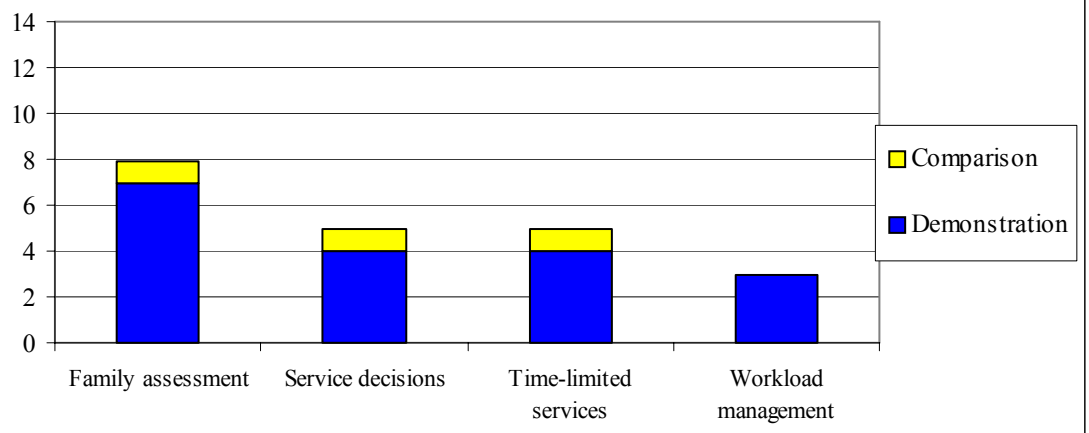
Caseload analysis (CLA) can be viewed as one particular form of utilization review, although it has elements of other managed care strategies embedded within it. CLA is a standardized methodology that fits within an overall managed care framework of service delivery. As ODJFS has defined CLA, its goal is to categorize needs of families by intensity and duration, in order to equitably distribute cases among workers. It also serves to provide standardized guidance to caseworkers regarding case duration based on type of needs. The ODJFS model of CLA consists of: (1) family assessment, using risk assessment, genograms and ecomaps, and family strengths and concerns, (2) decision-making regarding families, which includes classifying families' needs, categorizing levels of service effort, and determining duration of service, and (3) providing time-limited outcome-based services. These three steps are pursued through use of a

[11] It is important to note that improvements made do not yet translate into reliable and comprehensive methods to tie budgetary and programmatic decision-making. See Chapter 4 for a more detailed discussion.

workload capacity management system, designed to distribute cases equitably among staff and to assist in managing the workload.

During the Waiver, half of the demonstration counties have pursued CLA; implementation of the CLA model is a high priority in these seven counties and hence merits special attention in the evaluation. As of Year 3 of the study, the CLA counties that are part of the evaluation (seven demonstration sites and one comparison site) showed varying levels of usage. CLA is typically implemented in stages, beginning, logically, with cases entering the system and needing assessment. Figure 2.7 illustrates the sequential nature of the key elements. All but one demonstration county had implemented the family assessment elements, including use of risk

Figure 2.7: Usage of Key Elements of CLA in Year 3



assessment[12], genograms and, sometimes, ecomaps. Five counties (four demonstration and one comparison) had progressed to the next levels, utilizing service decision-making processes and/or providing time-limited services. Only three demonstration counties reported that they had begun to use the workload management part of the model.

Because CLA has not been fully implemented, it is unreasonable to expect that child and family outcomes would be better in CLA counties than in other evaluation sites. Indeed, analysis of Year 2 data revealed no differences between CLA counties and non-CLA counties in (a) change in the number of child abuse/neglect reports, (b) change in placement day usage, or (c) number of children placed with relatives.

In time, as all eight participating counties move to full implementation of CLA, differences in outcomes may become apparent. However, it is important to note that 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. In addition, some of the CLA outcomes concerning use of relatives and use of community are not easily discernable in FACSIS data.

[12] It is interesting to note that date from the Year 4 Caseworker Survey suggests fairly high use of the Family Risk Assessment Module (FRAM), which is an integral part of CLA. Eighty-eight percent of the workers reported that they completed a FRAM on their sampled case.

Summary: CLA counties have not fully implemented the CLA model and do not appear to be experiencing any different outcomes than non-CLA sites.