THE UNIVERSITY OF MICHIGAN
SCHOOL OF SOCIAL WORK

Moving to Managed Care in Child Welfare

First Results from the Evaluation of the Wayne County Foster Care Pilot Initiative

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October 2003

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Evergreen Children's Services

Homes for Black Children

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Lutheran Child and Family Services

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RESEARCH SUPPORT RECEIVED FROM

The Aspen Institute
Michigan Nonprofit Research Program

W.K. Kellogg Foundation through the Global Program on Youth
University of Michigan School of Social Work

The Michigan Family Independence Agency

The Office of the Vice Provost for Research
University of Michigan

The Rackham Graduate School
University of Michigan

The Skillman Foundation

I. Introduction

In 2000, there were approximately three million reports of child maltreatment concerning the welfare of approximately five million children. Of these, approximately two-thirds were screened as warranting investigation, and about 879,000 of these reports were found to be valid (U.S. Department of Health and Human Service, National Clearinghouse on Child Abuse and Neglect Information, 2002). As a result of child abuse and neglect, approximately 568,000 children lived in foster care at the end of fiscal year 1999, and 826,000 children—more than ever before—lived in out-of-home care during that reporting period. In fiscal year 1999, 266,000 children entered the foster care system, the largest number of children ever to enter care in a single year (U.S. House of Representatives, 2000).

In response to increasing caseloads, escalating federal costs, and reports of state system failures, Congress passed the Adoption and Safe Families Act in 1997 (PL 105-89). Placing child safety as the paramount concern of the child welfare system, PL 105-89 changed previous law in a number of ways that legislators believed would move children through the child welfare system more efficiently without compromising their safety. Many of the precepts undergirding this federal legislation had been articulated and translated into law in a number of states prior to the passage of the federal statute. In Michigan, the Binsfield legislation (Craig, Kulik, James, & Nielsen, 1998) codified many of the principles that were eventually articulated in PL 105-89.

In response to these changes in federal and state child welfare statutes and their accompanying regulations, fiscal dilemmas, and caseload characteristics and dynamics, some states have reorganized the way in which they deliver child welfare services (Wulczyn, 2000a; Wulczyn, 2000b; U.S. GAO, 1995). Some jurisdictions have detached investigative from service delivery functions within their child welfare systems, and assigned the former to law

enforcement agencies (Kinney & Gelles, 2003; National Institute of Justice, 2003; Winterfield & Sakagawa, 2003). Other child welfare systems have embraced privatization or new purchase of service contracting arrangements, and have thus developed innovative ways to contract out portions of their public child welfare systems to private nonprofit agencies (U.S. GAO, 1998; Craig, et al., 1998).

Two purchase of service models that have been embraced by public child welfare systems are performance-based contracting and variations of a number of managed care models. In performance-based contracting approaches, public agencies provide incentives for nonprofit agencies to meet contractually specified outcomes. Managed care models are usually more comprehensive, in that they usually involve some combination of performance-based contracting, prospective payments, capitation, and/or the transfer of case management responsibilities (Malm, et al., 2001; Geen and Tumlin, 1999).

The Wayne County Experience

In 1997, the Michigan Family Independence Agency (FIA)—the public child welfare agency—adopted, on a pilot basis, a performance-based, managed care approach to its contracting for foster care with private nonprofit agencies in Wayne County (Detroit). Of a total of 19 foster care providers in Wayne County, four voluntarily contracted with FIA to provide services under this new arrangement. The number of agencies operating under this new system increased to six (the pilot agencies) in 2000.

The Wayne County foster care pilot included two fiscal features that are characteristic of managed care models: cost containment and risk shifting (Embry, Buddenhagen, & Bolles, 2000; Wulczyn, 2000b; Wernet, 1999). Rather than being reimbursed for administrative costs solely on a per child, per-diem basis, as had historically been the case, the six pilot agencies contracted

to provide services on a much reduced per diem basis. Pilot agencies' revenues, however, were supplemented by a substantial per child, up-front initial payment, and additional per child bonus payments if performance milestones were met. These bonus payments were tied to the achievement of permanent placements for children (i.e., return home, placement with relatives, attainment of guardianship, entry into independent living, or adoption) within specific time frames, timely termination of parental rights, and a reduction of recidivism in the system. The specific structure of this new reimbursement system, and how it differs from the traditional reimbursement structure, is detailed in Figure 1.

Figure 1

Performance-Based vs. Traditional Reimbursement Structure in the Wayne County Pilot Initiative

	Non-Pilot	**Initial Pilot**	**Current Pilot**
Administrative Per Diem	$17-$35	$13.20	$13.20
Performance Factors			
Initial payment	$0	$2,150	$2,210
Placement with parents, family member, guardian, or in independent living within 290 days	$0	$1,850	$1,900
Sustained placement of six months	$0	$1,250	$1,290
Sustained placement of twelve months	$0	$1,550	$1,600
Termination of parental rights (TPR) within 515 days	$0	$1,850	$1,900
Adoption within 7 months of TPR	$0	$1,250	$1,290

The fiscal logic undergirding the pilot initiative is that if agencies achieve performance benchmarks within preset guidelines they will benefit financially. However, if agencies are unable to achieve these benchmarks, they will incur a monetary loss.

The Study and Its Relevance to Nonprofit Practitioners and Researchers

In 2001, the research team began an evaluation of the Wayne County foster care pilot initiative that involved all six pilot agencies, and a control group of three non-pilot agencies, to examine the effects of the initiative on service providers and the foster children and families served by these nonprofit agencies. The evaluation contained both process and outcome components. The process evaluation, which was completed in 2002, examined private nonprofits' organizational adaptations to the initiative, as well as service delivery patterns for a sample of 244 foster children and their families. The impact evaluation, which is ongoing, has been tracking this sample of 244 children and their families on a quarterly basis in order to determine how and at what rates children move through the foster care system.

This report addresses four research questions from the process evaluation:

1. What organizational accommodations did the pilot nonprofits make when they shifted to this managed care contracting environment?
2. What organizational accommodations did the non-pilot nonprofits expect to make as they anticipated shifting to this managed care contracting environment?
3. What was the effect of the shift to this managed care contracting environment on the services provided to children and families in the first 300 days of foster care?
4. Should differences exist, which variables explain differential service patterns between the pilot and non-pilot agencies?

This report also addresses two research questions from the impact evaluation:

5. Which children reached the first pilot performance point of placement with a parent, relative, guardian, or in independent living within 290 days?
6. Do certain child, primary caregiver, and/or service delivery variables predict the likelihood of achieving of the first pilot performance point?

These questions are important to policy makers, administrators, practitioners, and researchers who are interested in understanding how nonprofit agencies, as well as children and families, fare within the "black box" of managed care (Simpson & Fraser, 1999). While some is known about the impact of managed care in the health and behavioral healthcare sectors, the diffusion of managed care arrangements into child welfare is new and has not been accompanied by an adequate body of empirically based evaluations. This study is one of the first to explore the impact of these new service arrangements on child welfare agencies and the children and families in their care.

This report is organized into six sections. The next section presents the methodology used in the process and impact evaluations. Sections III and IV describe the impact of the pilot foster care initiative on nonprofits' organizational functioning as well as on their service delivery to foster children and their families over the first 300 days in care. Section V examines the effect of the pilot initiative on the movement of foster children towards the first pilot performance milestone—placement with parents, relatives, or independent living. The report concludes with a discussion of the study's principal results and their implications for researchers and managers.

II. Research Design and Methodology

This process and impact evaluation examined how the Wayne County foster care pilot initiative affected private nonprofits' organizational functioning, service delivery to children and families, and ability to move foster children towards permanent placements in a timely fashion. Nine nonprofit agencies were recruited to participate in the evaluation. All six agencies operating under the Wayne County foster care pilot initiative at the time the study began agreed to participate in the study. These agencies were joined by three non-pilot agencies that had been asked by the Michigan Federation for Children and Families to participate in the study as a control group. The nine participating agencies were (alphabetically): Catholic Social Services of Wayne County (pilot); Evergreen Children's Services (non-pilot); Homes for Black Children (pilot); Judson Center (pilot); Lutheran Child and Family Services of Michigan (pilot); Lutheran Social Services of Michigan (non-pilot); Orchards Children's Services (pilot); St. Francis Children's Services (non-pilot); and Spectrum Human Services (pilot). In total, these agencies provide nearly three-quarters of all child welfare services in Wayne County.

Over the past two years, the research team has led a collaborative, participatory evaluation of this initiative. The evaluation has included representatives from the University of Michigan School of Social Work, the State of Michigan Family Independence Agency, the Michigan Federation for Children and Families, and from each of the previously mentioned agencies. During the first year and a half, the research team and agency representatives met on a bimonthly basis in order to design and implement both a process and an impact evaluation. Over the last year, this group has met monthly to discuss and disseminate findings from this process evaluation, and to continue its work on the impact evaluation.

Study Design for Research Questions 1 and 2

In order to understand how nonprofits adapted or expected to adapt to this particular managed care contracting environment, structured telephone interviews were conducted between August and December 2001with administrators (N = 45), foster care supervisors (N = 19), and foster care line staff (N = 20) from pilot and non-pilot agencies. This sample was purposively chosen for their knowledge of foster care and the pilot. These qualitative data allowed the research team to assess managed care-related changes across various levels of agency employees and with employees who performed different functions within the agency. It also allowed the team to query subjects on a range of topics, including service delivery, interdepartmental and interorganizational relations, staffing patterns and staff training, staff roles and responsibilities, and financial management and technology use.

Personnel in pilot agencies were asked how moving to managed care had impacted their agencies and their roles within them; non-pilot respondents were asked to consider how moving to such a system might affect their job functions and their agency. Thus, for example, on questions concerning the effects of the pilot on organizational practices, comparisons between pilot and non-pilot respondents refer to comparisons between perceived changes due to the move to performance-based contracting as opposed to anticipated or expected changes that might have to be made as non-pilot agencies implemented this type of managed care.

Study Design for Research Questions 3 through 6

The study assessed the effects of managed care on the type and amount of services that agencies provided to foster children and their families, as well as the placement history of foster children, by following a sample of 244 children (175 children from the pilot agencies and 69 children from the non-pilot agencies). These quantitative data allowed for statistical

comparisons of the demographic characteristics, in-agency and out-of-agency service histories, and the placement status and duration of children served by pilot and non-pilot agencies.

Methodologically, this phase of the study took advantage of the conditions for a natural experiment in order to isolate the independent effect of this managed care model. Children entering foster care in Wayne County are assigned to nonprofit agencies through the Family Assignment System—a rotation procedure based on agency capacity. This system requires children entering foster care for the first time to be assigned to the next agency in the queue of private nonprofit agencies. If an agency is at full capacity, the next agency in the queue is contacted, and if a space is available the child(ren) is placed with that agency.

Because in this procedure the assignment of children to nonprofit agencies is based on rotation, random assignment equivalence was initially presumed between the pilot and non-pilot samples. This equivalence has subsequently been confirmed (see Section IV). Thus, the quantitative results presented in this report are derived from the equivalent of a true experimental design. Because of this, differences in service patterns and placement status between the pilot and non-pilot groups, where found, can be attributed to the type of agency responsible for the child rather than any confounding factor related to the children or families in the study.

Children were admitted into the study sample if they met all of the following criteria:

1. The child was a resident of Wayne County;
2. The child was under the age of 13 or was part of a sibling group in which there was at least one child under the age of 13[1];
3. The child was assigned to agencies through the Family Assignment System or was a "must take" for the agency[2];

[1] Initially, the incentive based reimbursement system was limited to children under the age of 12.

4. At least 365 days had passed since the child's last non-relative out of home placement (if the child had previously been in care and had come back to the agency);
5. The child was assigned to the agency that had supervisory responsibility of "first origin"; and
6. The child was ordered into foster care or to a relative at the preliminary court hearing.

In cases where a large sibling group entered the foster care system at the same time, two randomly chosen siblings became part of the sample to ensure that large families did not unduly skew the quantitative data. Sample selection began on May 1, 2001, stopped for pilot agencies on September 1, 2001, and stopped for non-pilot agencies on October 1, 2001.

Quantitative data on child and family demographics, in-agency and out-of-agency services, and child placement status were obtained by agencies by readings each child's case file. Agencies provided data on child and family demographics to the research team 30 days after the child's entry into foster care. Data on in-agency service provision to the child and family, out-of-agency (referred) service provision to the child and family, the demographic characteristics of workers responsible for the children and families in the study, and child placement history were provided to the research team 30 days after the child's entry into foster care (the ISP period), and then every 90 days thereafter (subsequent USP periods).

[2] A child reentering foster care is placed with the agency that had supervised his or her prior foster care stay. Agencies are contractually required to take ("must take") the reentering child back into supervised care.

III. Results from the Survey of Agency Personnel

The 84 telephone interviews with pilot and non-pilot agency staff were conducted in order to determine the impact of the pilot on the nonprofit agencies' internal operations and external relationships. Interview respondents were asked two types of questions regarding how their agencies adapted—or, in the case of non-pilot respondents, planned to adapt—to the pilot model. Respondents were first asked what barriers had existed (or might exist) in an organizational practice (e.g. the process by which staff training was carried out) or an organizational structure (e.g. staffing patterns) as their agency moved to the pilot model. Respondents were then asked to describe how the agency had changed (or expected to change) its organizational practices or structures in response to moving to this managed care contracting environment.

Similarities and Differences in the Perceptions of Staff at the Pilot and Non-Pilot Agencies

In comparing what agency personnel in the pilot and non-pilot agencies noted regarding what it took or what they thought it would take to successfully move into this performance-based, managed care environment, a number of similarities and differences can be discerned. The similarities between the pilot and non-pilot respondents tended to reside in general areas of change that needed to take place. However, in many cases, pilot agency respondents provided more detailed perceptions of organizational change than did non-pilot respondents.

Examples of similar perceptions between pilot and non-pilot personnel included:

- Service delivery-related barriers were of serious concern. Specifically, many respondents were concerned with accessing community services and staff-related barriers, including altering staff's philosophical beliefs concerning the appropriate

goals of foster care and the difficulty in moving to a service delivery system emphasizing speed and immediacy of service provision.

- Many respondents suggested that their agencies engaged (or would engage) in increased communication, cooperation, and/or meetings with FIA, the court, and other private agencies.
- Nearly all types of respondents were apt to mention that understaffing and/or staff turnover was (or would be) a barrier to moving to the pilot model.
- All seemed to agree that there would need to be changes in the area of budgeting and financial management in implementing the pilot.
- All respondents noted that their agencies changed (or expected to change) their MIS and the way they tracked children in care.
- Administrators mentioned that cost centers and/or new accounts receivable and payable had to be (or would need to be) created.

The differences between the responses of those in the pilot and non-pilot agencies can be classified into five categories:

- Pilot respondents were more likely to see internal, systemic, operational changes in moving to this managed care approach. They noted more often than non-pilot respondents that there were more meetings, trainings, and communication involving different departments within the agency; that there was conflict between units within the agency; that new staff positions had to be created; that there was a need for discussion around MIS and for communication between MIS and other agency systems; and that the way services were delivered changed both within the foster care

departments and the way in which this department interacted with other agency departments.

- Non-pilot respondents did not anticipate the scope of operational changes in service delivery and agency administration it would take to move to the pilot. For example, they were less likely to anticipate that their agency would have to alter their procedures when dealing with foster care cases or the way new linkages within the agency would have to be created.
- Personnel in non-pilot agencies were less optimistic about the impact of the pilot on the clients it served;
- Those in non-pilot agencies tended to see the move to this system of reimbursement as more difficult than those in the pilot agencies;
- Those in non-pilot agencies had a fear of revenue loss that was not experienced by the pilot agencies.

Similarities and Differences among the Perceptions of Staff at Various Organizational Levels

There were some general areas in which administrators, supervisors, and line staff agreed that change had to take place in order to implement the pilot program. There was near uniformity in respondents' belief that service delivery-related barriers existed as agencies implemented this managed care approach, and that changes in the way agencies did business had to (or would have to) occur in order to succeed in the managed care environment.

Overall, there was agreement that inter-agency interactions increased as a result of entering the pilot process. There was also agreement that such increased interactions were not easy. Both administrators and supervisors saw the court as a significant, and possibly deliberate,

obstacle to progress. Problems with interactions with FIA were seen as being generally less severe and difficult to overcome.

There was also general agreement that supervisors' roles did not change regarding foster families among people at different operational levels in the agency, although this was not the case for supervisory responsibilities regarding children and families.

Generally, however, the barriers and changes noted by people at various organizational levels in the agency were quite different. As might be expected, administrators had a wider 'lens' on the movement toward managed care, and were more concerned than others in the agency about the fundamental changes that would have to take place within the agency and the systems with which it interacts. In contrast, supervisors (and line workers when they were queried) tended to focus more on service delivery issues and the ability to provide adequate service to their clients.

Illustrative of these differences was the fact that administrators were more concerned than supervisors with how the pilot required fundamental transformations in how staff viewed the goals of foster care and the primary target of foster care services; more likely than supervisors to mention that there were few avenues for interdepartmental communication; more concerned about conflict between various departments; and more concerned about the substantial changes in how services were delivered. On the other hand, supervisors were more likely than administrators to mention that there were changes in how the agency interacted with FIA, the court, and/or other agencies; that there were problems with accessing community resources and services; and more concerned about issues of efficiency and speed in assessment and service delivery.

The Breadth of Internal Operational Changes Needed to Move to Managed Care

In five areas, non-pilot agencies were unaware of many of the internal operational changes that would likely occur as they implemented the managed care contracting system. These included:

- Pilot respondents were more likely than non-pilot respondents to mention that departments in their agencies interacted (or would interact) with each other more intensively post-pilot.
- No non-pilot respondent mentioned that conflict might occur between the foster care and the clinical unit at the agency. In contrast, few pilot respondents mentioned that the foster care-clinical relationship was improved as their agency adopted the pilot model, and many pilot respondents noted the antipathy with which their agency's foster care and clinical staff viewed each other.
- Non-pilot respondents mentioned more frequently than pilot respondents that there would be (or were) changes in job foci and/or expectations, and mentioned focusing on making alterations within existing staffing patterns, whereas pilot respondents were more apt to mention that moving to the pilot necessitated creating entirely new staff positions.
- Pilot administrators were twice as likely as non-pilot administrators to suggest that the pilot process required (or would require) more MIS-related communication and discussion, particularly in terms of communication leading to a shared understanding between billing, foster care, and MIS concerning each department's pilot-related tasks.

- Pilot respondents were more likely than their non-pilot counterparts to describe changes in the way foster care cases were managed within the agency. They were more likely to note that their agencies altered intake and assessment procedures, the way in which they tracked cases once they were opened in the agency, and the way they accessed and managed flexible funds.

The Depth of Operational Changes Needed to Move to Managed Care

Pilot respondents suggested that significant changes were made to their service delivery procedures. Not only did they mention the changes in the way foster care cases were handled, but they were more cognizant of the very significant changes that would have to occur in the technical and financial capabilities of the agencies, particularly in areas such as budgeting, forecasting, tracking, and accounting systems.

Impact of the Pilot Program on Foster Children and their Families

While study respondents generally thought that more services were available under the pilot than under the standard fee-for-service contract, in some instances non-pilot respondents were less optimistic than were pilot respondents regarding how this managed care environment would impact clients. All levels of staff in the pilot agencies believed that the quality of agency services was better after the implementation of the pilot program, a belief that was less strongly held by the non-pilot personnel who were speculating about what the quality of services might be after the move to this managed care system of reimbursement.

Managed Care Phobia among Non-Pilot Agencies

There were three areas in which the results of the interviews suggest that non-pilot agencies might have anticipated or overestimated greater difficulties than they would encounter as they moved toward implementing the pilot: 1) non-pilot respondents expected to encounter

more staffing barriers (understaffing and changes in job focus) than were experienced by pilot agencies; 2) pilot respondents were twice as likely as non-pilot respondents to mention that they had not experienced changes in their roles and responsibilities as a result of moving to the pilot; and 3) non-pilot administrators were more likely than pilot administrators to suggest that they expected to experience (or experienced) reduced foster care revenue due to the pilot model.

Discussion

The interviews with pilot and non-pilot agency staff examined pilot agencies' adaptations in shifting to a managed care service delivery system, and compared the nature of these adaptations to changes that non-pilot agencies anticipated having to make in order to adjust to this specific managed care environment. Analyses of these interviews point to four areas of interest for researchers and practitioners in managed care child welfare systems: 1) the depth of operational changes needed by key departments within agencies; 2) the breadth or systemic nature of change occurring across departments and agencies; 3) altered organizational goals and the consequences of goal conflict for employees; and 4) "reinventing the wheel", or the problems and prospects associated with the enormous variation in agencies' responses to the pilot initiative.

The Depth of Organizational Change Involved in the Move to Managed Care.

While the foster care pilot affected all of agencies' departments either directly or tangentially, agencies' foster care and financial management departments were particularly transformed in response to the pilot initiative. Respondents often noted that service delivery changes were made in intake and assessment procedures, performance tracking, and managing flexible funds. These findings support previous research suggesting that managed care contracting requires service providers to *quickly diagnose clients' needs* (Simms, et al., 1999;

Emenheiser, et al., 1995), *focus additional resources on collecting client and service information in databases* (Simpson & Fraser, 1999; Wernet, 1999), *and pool funds to address the multiple needs of clients systematically and simultaneously* (Stroul, et al., 1998).

Those in the pilot agencies also noted the need to create new type of positions within their foster care departments — case aides, family engagement workers, and relative assessors — whose jobs were specifically designed to provide a particular set of services to clients to move them more efficiently through the foster care system. Additionally, supervisors generally felt that they were required to increase how quickly foster care cases were assessed and served. This focus on specificity and speed of service provision implies that *new and existing positions in managed care-driven organizations are shaped by increased demands for accountability and performance.*

Respondents generally noted the need for changes in financial management and accounting procedures. They often mentioned the need to create pilot-specific payment tracking systems, cost centers, and accounts receivable and payable, and noted that they had experienced difficulties in budgeting and forecasting due to insufficient information, hidden costs, and other unexpected barriers such as tardy reimbursements from FIA. These results are quite compatible with empirical evidence concerning the *need, importance, and difficulty of installing systems that are capable of estimating per case expenditures and revenues in managed care situations* (Wulczyn, Orlebecke, & Martin, 2001; Rycraft, 1999; Wernet, 1999; U.S. GAO, 1998).

<u>The Breadth of Organizational Change Involved in Moving to Managed Care.</u>

Moving to the pilot model also required agencies' foster care and accounting departments to collaborate with each other as well as with other agencies in order to provide needed information, secure collateral services, settle financial issues, and resolve case-related concerns.

Respondents noted an increase in interdepartmental meetings, trainings, and communication. In some instances, these interactions occurred in response to administrative mandates establishing managed care-focused task forces and interdepartmental work groups involving departments that were historically familiar with one another (e.g., case review teams involving foster care, licensing, and clinical staff). In other instances, departments that had previously been ignorant of one another were required to collaborate on specific tasks. A number of respondents suggested how unusual it was that representatives from the foster care, accounting, and IT departments met in order to plan and implement new pilot tracking systems. These respondents suggested that *regular communication between departments reduced payment complications with FIA and maintained accurate client status* (i.e., days in care, days until next performance deadline) *and service information within the agency.*

Respondents also noted that the pilot necessitated increased communication and cooperation with FIA and the courts. These results are consistent with empirical studies drawn from the health and mental health sectors suggesting that managed care positively influences provider network development (Provan, et al., 2002; Scott, et al., 2000; Kohn, 2000; Emenheiser, et al., 1998; Beinecke, et al., 1997, Mordock, 1996). One result that is not anticipated by these empirical studies, however, is the high percentage of all respondents noting that *FIA, to some degree, and the courts, in particular, were barriers in implementing the pilot.*

At the organizational level, researchers have suggested that managed care may result in "mission collision" (Stroul, et al., 1998, p. 142), where child welfare agencies find it impossible to transition to managed care contracting in a way that is consistent with strongly held agency values and operational norms. According to this line of argument, those agencies committed to managed care may experience goal displacement and ultimately mission drift.

Pilot agency employees noted that there existed some degree of conflict between the pilot program's goals and employees' conceptions of the appropriate goals of foster care. Respondents associated managed care with the possibility of reduced lengths of stay for children in foster care and less service to children and their families, a prospect that was antithetical to what they considered the goal of child welfare practice. Respondents appeared to suggest that *managed care results in agencies returning children to biological families at the ultimate expense of child safety and well being, or terminating parental rights before parents have been given an adequate chance of rehabilitation through the provision of appropriate, longer term services.*

Most agencies depended on their staff training functions to respond to employees' concerns towards the managed care environment. Pilot agencies altered existing training programs in order to offer an overview of pilot-related specifics and introduce what many respondents termed the pilot "mindset"—a focus on more immediate service provision with the intent to reduce the number of days children spend in foster care. Respondents stated that agencies incorporated general discussions of how managed care requires a transformation of foster care principles. Based on the few respondents mentioning that staff were resentful as a result of the pilot-focused training, it appears that these *training sessions allayed most employees' fears.*

While there were some similarities in perspective in terms of what it takes to move to a performance-based, managed care system of foster care, the findings from the interviews with agency employees suggest that one's role and agency affiliation impacted what one saw as being important in this process. Administrators and supervisors differed in their emphases based, it seems, on the nature of their jobs, their responsibilities, and the roles they perform in the agency.

Pilot and non-pilot respondents often had similar responses as well, but their relative emphases were colored by the difference between “having been there” and “having to go there”.

What seems unfortunate in these findings is that there are only some themes that were mentioned by large numbers of people, both within the pilot respondents and between the pilot and non-pilot respondents. What this suggests is that each of the *agencies got to where they are on their own. Knowledge sharing, resource sharing, and common problem solving do not seem to be suggested by these data. Nor do the data suggest that detailed practice wisdom was shared between the pilot and non-pilot agencies,* which implies that new agencies entering this arena will have to reinvent the wheel.

Finally, it appears that the implementation of the pilot could have been more uniform if FIA, the state agency that oversees the child welfare sector, had worked with the nonprofits to install systems that would have smoothed their transitions to managed care. While it is clear that *FIA was fair in negotiating the terms of the pilot, it is also clear that technical assistance, beyond proscribing a paper trail, was not present in this process.*

IV. 300-Day Child and Family Service Delivery Patterns

This section describes the services received by a sample of children in foster care and their families. It presents analyses of quantitative data from 244 foster children and their primary caregivers to assess whether the children and families served by the pilot and non-pilot agencies were demographically equivalent, and therefore whether any differences found in the amounts and types of services received over their first 300 days in care could be attributed to whether they were in a managed care setting. Further statistical analyses presented in this chapter examine whether factors such as child, primary caregiver, and/or caseworker characteristics can explain the amount of service received by each of the groups.[3]

Characteristics of the Children in the Sample

There were no differences between the 175 pilot and 69 non-pilot children in the study on most demographic characteristics. The sample was about evenly split between male and female children. On average, the children were about six years old and most (80%) were African American. Just under two-thirds were too young to attend school; on average, those in school were in the sixth grade. Sixteen percent of the children were thought to need special education services. Few children in the sample (8%) had prior involvement with the foster care system, yet a significant number (34%) were prenatally exposed to drugs.

There were no statistically significant differences between pilot and non-pilot children in terms of gender, race and ethnicity, educational levels, prior involvement in social services, and 11 items from the worker-completed assessment of child needs and strengths. Pilot and non-pilot children were statistically distinguishable on only two of 27 (7%) variables: age (pilot children were about 1½ years older than non-pilot children) and their worker's assessment of

their medical/physical health (pilot children were more likely to be judged healthier). These results suggest that the equivalence of random assignment of children to pilot or non-pilot agencies was achieved through the FIA Family Assignment System.

Characteristics of the Primary Caregivers in the Sample

There were 164 primary caregivers in the sample, 116 of whom were related to foster children at pilot agencies and 48 of whom were related to foster children at non-pilot agencies. Because pairs of child siblings were allowed into the sample, there were fewer primary caregivers than there were children in the study.

Most of the caregivers (86%) were the child's biological mother. They averaged 33 years old and, as with the children, most (81%) were African American. About half had not completed high school, and the average family income was low ($629/month). Most of the children (60%) were in neglectful situations, with physical abuse present in about a third of the families. Drug abuse (37%) and inadequate housing (31%) were common situations in the homes from which these children were removed. Half (55%) of the caregivers had prior involvement with the child protective service system, and a quarter had involvement in the criminal justice system.

There were no statistically significant differences between pilot and non-pilot primary caregivers in terms of age, gender, race and ethnicity, educational levels, income levels, the factors leading to the removal of the child, prior involvement in social services, and the worker-completed assessment of primary caregiver needs and strengths. Only three of 52 demographic characteristics (6%) exhibited statistically significant differences between primary caregivers

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[3] For a full description of the results from these quantitative analyses, see Section V of the technical report, "Moving to Managed Care in Child Welfare: A Process Evaluation of the Wayne County Foster Care Pilot Initiative", which can be found at http://gpy.ssw.umich.edu/projects/foster/publications.htm.

from pilot and non-pilot agencies. Pilot caregivers were significantly more likely to be the child's guardian, to be living as a single caretaker, and to have more children. Thus, as with the foster children, primary caregivers can be considered randomly assigned for the purposes of analysis.

Characteristics of Foster Care Line Staff Serving the Children and their Primary Caregivers

Data concerning the pilot and non-pilot agency line staff who were directly responsible for the foster children in the study were also collected and analyzed. Almost two-thirds of the workers were white, and they averaged between 25 and 29 years of age. Over half (58%) had only a bachelors degree (not necessarily in social work), and averaged about three years of experience in child welfare and one and a half years at their current agency. On average, workers carried about 20 cases.

A number of statistically significant differences between line staff from pilot and non-pilot agencies were identified over the foster child's first 30 days in foster care (the Initial Service Plan (ISP)) and the foster child's 31st through 120th days in foster care (the first Updated Service Plan (USP)). There was greater continuity of line staff among children in non-pilot agencies than pilot agencies over the child's first 120 days in the foster care system. In terms of the age of foster care workers, non-pilot line staff were significantly younger than pilot staff at the ISP period but older than pilot staff at the first USP period. Finally, non-pilot staff had significantly larger caseloads than pilot staff at both the ISP and first USP periods. There was a statistically significant increase in the size of the caseloads at both pilot and non-pilot agencies after children were in care for more than 30 days.

Based on these descriptive statistics, it is clear that there were more differences between pilot and non-pilot staff that served the children and families in foster care than there were

between the children and families served by these agencies. Thus, while the children and their families served by the pilot and non-pilot agencies can be considered randomly assigned, they were served by workers who differed from each other.

In-Agency Services over the Child's First 300 Days in Foster Care

During each foster child's ISP period and subsequent USP periods, children, primary caregivers, and foster families could, either individually or together, be seen by agency workers or in-agency therapeutic providers such as clinicians and psychologists. Our analyses differentiated between contacts between agency staff, foster children, primary caregivers, and/or foster families that were routine or scheduled as opposed to those that were necessitated by crises or other unscheduled events.

A series of analyses suggested that these various types of in-agency service contacts could be condensed into six separate variables:

1. In-person services to the child and/or the foster family;
2. In-person, non-visitation services to the primary caregiver;
3. In-person supervised and unsupervised visitation services to the primary caregiver;
4. In-person services to a biological parent other than the primary caregiver;
5. In-agency therapeutic services to the child; and
6. Phone calls to FIA and other collateral contacts.

Analyses were conducted to determine whether pilot and non-pilot agencies provided different amounts of any of these six services to foster children and their families from the ISP through the third USP, which corresponds to the child's first 300 days in foster care. On average, non-pilot agencies provided significantly (at $p < 0.05$) more of most in-agency services over this time period than did pilot agencies.

Non-pilot agencies made an average of 85 in-person non-therapeutic service contacts for each foster child and/or foster family over the first 300 days in care, as opposed to 51 such contacts per child by pilot agencies. Non-pilot agencies had roughly six therapeutic service contacts with each foster child during this period, as opposed to one therapeutic service contact per child made by pilot agencies. Finally, non-pilot agencies made roughly 23 phone calls and other collateral contacts per child over this period, compared to 17 such contacts made per child in pilot agencies.

Out-of-Agency Services over the Child's First 300 Days in Foster Care

In order to comply with court orders for specific services that were not provided by agencies themselves, or to make progress on an FIA-approved foster care treatment plan, pilot and non-pilot agencies could contact external service providers (e.g. drug abuse treatment services) to initiate services for foster children and their families. Agencies reported these data on out-of-agency service provision using an FIA form that does not disaggregate the number of contacts or treatment sessions per service, but simply lists whether a referral was made, if and when the referral was started, and when the referral was completed.

Two summary variables were created to capture this information: the total number of referrals made over the first 30, 120, or 300 days in care; and the total number of out-of-agency services that had begun during these three time periods. There were no statistically significant differences between pilot and non-pilot agencies for either of these variables over any of these three time periods. On average, pilot and non-pilot agencies made three referrals for each foster child during the ISP period, eight referrals over the first 120 days in care, and 13 referrals over the first 300 days in care. The actual number of out-of-agency services that foster children and their families were actively participating in was much lower: on average, foster children and

their families were involved in one active out-of-agency services during the ISP period, four such services at the 120-day mark, and seven out-of-agency services at the 300-day mark.

Analyses Predicting the Amount of In-agency and Out-of-Agency Services provided to Foster Children and their Primary Caregivers

Multivariate analyses were conducted in order to examine the relationship between the amount of service that was provided to children and families from the ISP to the third USP periods and the characteristics of children, primary caregivers, and the agency caseworkers serving sample children and families. The research question that guided these analyses was: "What factors explain the amount and type of in-agency and out-of-agency services that sample children and families received over their first 300 days in care?"

Five measures of service receipt over the child's first 300 days in foster care were included in the analyses: 1) the number of in-person non-therapeutic service contacts received by a child, primary caregiver, and/or biological parent; 2) the number of in-person therapeutic contacts received by a child; 3) the number of telephone contacts staff made with FIA and collateral service providers concerning a child and primary caregiver; 4) the number of referrals foster care line staff made for out-of-agency services to a child and his or her family; and 5) the number of out-of-agency services provided to a child and his or her family.

Predictors of in-agency and out-of-agency service provision to children and their families were organized into four categories: 1) policy variables describing whether the child was in the care of a pilot or non-pilot agency; 2) variables describing the child as articulated above; 3) variables describing the primary caregiver as articulated above; and 4) variables describing characteristics of the foster care line staff serving the sample children and families.

Results of Regression Analyses. Pilot status was a powerful and consistently negative predictor of two of five dependent variables: in-person non-therapeutic services over the child's first 300 days in foster care; and in-person therapeutic services over this time period. For both of these major categories of services, controlling for other independent variables, children and families assigned to pilot agencies received significantly fewer in-agency services over the first 300 days in care.

In general, very few of the variables pertaining to the children or the primary caregivers were statistically related to any of the five types of service utilization. The reasons for which children were removed from their households were unrelated to service receipt. Demographic characteristics such as gender, race, family structure, education, income, and the index of child needs and strengths were also, by and large, not significantly related to any of the service variables.

Client age, however, was a significant and negative predictor of two categories of service receipt. Children with older primary caregivers received fewer in-person non-therapeutic services, and older children received fewer in-person therapeutic services. Additionally, children whose primary caregivers had been diagnosed with chronic mental health problems, and children whose primary caregivers had previously been involved with child protective services, received more in-person non-therapeutic services and in-person therapeutic services, respectively. Finally, more phone calls to FIA and collateral contacts with other agencies were made on behalf of children whose primary caregivers scored low on the worker-completed assessment of primary caregiver needs and strengths.

Nearly all variables pertaining to foster care workers were unrelated to service provision. The number of months that foster care line staff had been employed at their agencies was

unrelated to all measures of service. Similarly, the presence of a social work degree was, in all instances, unrelated to service utilization. The sole exception to this trend concerns workers with an advanced degree. Children whose workers had an advanced degree received more overall out-of-agency services as of the first 300 days in care.

Comparison of 300-Day and 120-Day Regression Results. The regression results concerning service receipt at the 300-day mark are considerably different from the results of regression analyses of service receipt over the child's first 120 days in care.[4] While the effect of pilot status had a comparable negative effect on service provision at both the 120-day and 300-day marks, certain child and primary caregiver variables were significant predictors of service receipt at 120 days but not at 300 days. In the analyses of service receipt at 120 days, older and African American children received more services in certain areas, including in-person non-therapeutic services as well as therapy. Additionally, at the 120-day mark, children from drug-impacted homes, and children whose caregivers had abandoned them, received fewer non-therapeutic services. In contrast, these variables were not significant predictors of service receipt over the child's first 300 days in foster care.

Discussion

In summary, pilot agencies provided less of most major categories of in-agency services to children and families than did non-pilot agencies over the first 120 and 300 days in care. There were no statistically discernable differences between pilot and non-pilot agencies in the number of out-of-agency services provided to children and families over this time period. Multivariate analyses confirmed that pilot status was a significant and negative predictor of these

[4] For a full description of the results from these quantitative analyses, see Section V of the technical report, "Moving to Managed Care in Child Welfare: A Process Evaluation of the Wayne County Foster Care Pilot Initiative", which can be found at http://gpy.ssw.umich.edu/projects/foster/publications.htm.

two operational measures of service utilization, controlling for child, family, and caseworker characteristics.

The finding that over the first 300 days in care children from pilot agencies received on average fewer in-agency non-therapeutic and therapeutic services and no more out-of-agency services than were provided to children in non-pilot agencies lends credence to the argument, supported by a number of empirical studies (Buescher & Wernet, 1999; Segal, 1999; Stroul, Pires, & Armstrong, 1998), that agencies provide fewer services as a result of managed care. Given the demographic similarity of the children and families in pilot versus non-pilot agencies, this result cannot be attributed to differences in the composition of agencies' foster care caseloads.

There are four possible explanations for this result which cannot be empirically dismissed at this early stage of this research.

1. Pilot agencies either formally or informally choose to bring services to bear only as performance deadlines approach.
2. Pilot agencies provide only those services that are seen as absolutely necessary to achieve performance payments and/or improve client outcomes.
3. Pilot agencies choose to save the initial lump-sum payments rather than spend them on out-of-agency services.
4. Pilot contracting leads to service rationing.

These alternative hypotheses for the differences in service provision will be examined in future analyses. The burden of proof for the fourth hypothesis—that managed care results in service rationing—is the most stringent of all. Only if all other alternative explanations for the

differences in service provision are exhausted is it possible to suggest that the pilot contracting process encourages agencies to limit service provision to foster care cases.

Turning to the other results of the regression analyses, the fact that at 120 days older and African American children seemed to receive more services in certain areas makes sense in the practice world. These children are often those who have difficulty exiting the foster care system, and it appears that workers may be putting forth additional efforts on their behalf. Similarly, the findings at this time period that children from drug-impacted homes, and children whose caregivers have abandoned them, receive less service is also not surprising is also not surprising. Such families are extremely difficult to find and engage, and thus often cannot be reached by workers striving to help them early in the placement process.

At 300 days, the fact that children with primary caregivers that had either previously been involved with child protective services or had been previously diagnosed with a chronic mental health condition received more of certain sorts of in-agency services also makes sense in the practice world. Such caregivers often face a variety of other family- and health-related difficulties, and it appears that workers may be putting forth additional efforts on their behalf over an extended period of time in order to help them achieve timely permanence and/or comply with court orders.

Finally, at all time periods, it appears that workers with advanced degrees (not necessarily in social work) do a better job in attempting to serve their clients by making more referrals for out-of-agency services and actually connecting to these services. This suggests that such workers may have a greater sense of the therapeutic (as opposed to the case management) needs of their clients, and attempt and often succeed in bringing these services to bear on their clients.

V. 300-Day Child Placement Patterns

Quantitative data from the sample of 244 foster children and their primary caregivers were also collected in order to examine the movement of children in and out of the foster care system. Analyses of these data over the first 300 days is particularly important, since the first incentive payment to agencies takes place at 290 days in care. That is, agencies received a cash payment of $1,850 if they returned a child to their caregiver, or placed a child with another family member, a guardian, or in independent living, within 290 days of their entry into the system.

Child Placement Patterns over the Child's First 300 Days in Foster Care

In order to examine whether there were significant differences between the number of children from pilot and non-pilot agencies that reached this first performance point, data were gathered on each foster child's living situation, and any changes in placement status, over the first 300 days in care. Statistical analyses allowed for the examination of the relative frequency with which pilot and non-pilot children reached this first performance milestone as well as other child placement outcomes.

A set of analyses examined whether children served by pilot and non-pilot agencies experienced any differences in their placement history across their first 300 days in foster care. In general, there were no statistically significant differences in the placement status of children from pilot and non-pilot agencies. A little over half the sample (52 percent, or 126 children) achieved the first performance point. While 55 percent of the children served by pilot agencies and 45 percent of children served by non-pilot agencies reached this first pilot payment milestone, this difference was not statistically significant. Over this time period, 36 percent of the sample was returned to a relative and 21 percent was returned home to a parent. Only six

foster children were placed with a guardian during this time, and there were no placements into independent living.

While there was no difference between pilot and non-pilot agencies in the frequency of termination of parental rights, there were statistically significant differences in the frequency with which pilot and non-pilot agencies had their agency supervision, as well as court supervision, terminated. In comparison to non-pilot agencies, pilot agencies were significantly more likely to have their agency supervision terminated (15% as opposed to 3%) on a child in their foster care program. Additionally, children from pilot agencies were also more likely to have their court supervision terminated than were children from non-pilot agencies (19% versus 4%).

Finally, while only two children reentered care from permanent placement over this time period, the fact that these two children were from nonpilot agencies contributed to the significant difference in reentry rates between pilot and nonpilot children.

Children Experiencing Multiple Placements. Of the 244 children in the sample, 30 (12%) experienced more than one placement with parents, relatives, or guardians by the end of their 300th day in care. While children from pilot agencies were roughly twice as likely as children from nonpilot agencies to have more than one placement with parents, relatives, or guardians over this time period (14% versus 7%), this relationship was not statistically significant.

Multivariate Analyses Predicting the Achievement of the First Pilot Performance Payment

Multivariate analyses were carried out to determine whether the achievement of the first pilot milestone was related to child and primary caregiver characteristics, foster care line staff characteristics, and/or service provision. The dependent variable for these analyses was whether or not a child was placed with a parent, relative, or guardian within 290 days of the child's entry

into foster care. Independent variables included: 1) policy variables describing whether the child was in the care of a pilot or non-pilot agency; 2) variables describing the child as articulated above; 3) variables describing the primary caregiver as articulated above; 4) variables describing characteristics of the foster care line staff serving the sample children and families; and 5) variables describing the in-agency and out-of-agency services provided to the child and/or family.

These analyses revealed that pilot status was not a statistically significant predictor of the achievement of the first pilot milestone, and that, in general, very few of the variables pertaining to the child, the primary caregiver, or service provision to the child and/or family were statistically associated with the achievement of the first pilot performance payment.

Children that had experienced prenatal drug and/or alcohol exposure were less likely to reach the first performance point. Children that had been neglected or abandoned were also less likely to achieve the first pilot milestone. Finally, children whose primary caregiver scored highly on the worker-completed assessment of needs and strengths were more likely to reach the first performance point.

Four additional multivariate analyses were conducted to determine which factors predicted four major child placement outcomes over the first 300 days in foster care: (a) the return of a child home; (b) the placement of a child with a relative; (c) termination of parental rights; and (d) the termination of court supervision.

Children were less likely to be returned home over this time period if they had been neglected, if they had been removed from a drug-abusing household, or if they had been abandoned. Children were also more likely to be returned home if their primary caregivers scored highly on the worker-administered assessment of primary caregiver needs and strengths.

Older children, and children whose primary caregivers had previously been involved with child protective services, were more likely to be placed with a relative over the first 300 days in foster care.

Children from pilot agencies were less likely to have their parental rights terminated as of the 300-day mark. Also, the more in-person non-therapeutic services that were given to children and their families, the less likely were parental rights terminated. Finally, court supervision was less likely to be terminated if the foster child had been removed from a drug abusing household or a household with inadequate housing. Court supervision was more likely to be terminated if children had primary caregivers scored highly on the worker-administered assessment of primary caregiver needs and strengths. Additionally, the more in-person non-therapeutic services that were given to children and their families, the less likely it was that court supervision was terminated by the 300-day mark.

Discussion

In summary, pilot status was not a statistically significant predictor of the achievement of the first pilot performance payment. Multivariate analyses confirmed that, controlling for child and primary caregiver demographic factors as well as in-agency and out-of-agency service receipt, a child from a pilot agency was no more or less likely than a child from a non-pilot agency to reach the first pilot milestone. Having had prenatal drug and/or alcohol exposure, having been neglected or abandoned, and having received more therapeutic services were associated with a lower probability of reaching the first pilot payment point.

These results suggest that children from non-pilot agencies were being placed with parents, relatives, or guardians at rates comparable to that of children from pilot agencies. This result sits awkwardly beside recent studies of the effects of managed care and performance-based

contracting, in which children and adults served in managed care settings experience shorter lengths of stay than those in service systems where performance is not financially rewarded (IDCFS, 2001; Pheatt, et al., 2000; Orr, 1998). Because this study is the first controlled examination of the effects of managed care on child welfare outcomes, it is impossible to know whether these early placement findings are anomalies that apply only to this particular sample, or whether there is something about the child welfare system and its client population that causes managed care arrangements to lead to different outcomes in this service system than in other health or behavioral health care systems.

It is also unclear why children from pilot and non-pilot agencies experienced comparable rates of returning home or to relatives. One possible explanation is that non-pilot agencies made unusually intense efforts to reunify children with parents and assess potential relative placements—the classic issue of compensatory rivalry that emerges when one is aware that they are dealing with the control group (Cook & Campbell, 1979). Another alternative explanation concerns the large amount of staff turnover experienced by pilot and non-pilot agencies, which might possibly have limited agencies' ability to carry out aggressive and sustained treatment and placement plans. Additionally, as often noted in the qualitative interviews with agency staff, it is possible that the courts were unable or unwilling to rule expeditiously on petitions brought by pilot agency staff.

Two final alternative hypotheses for these findings suggest that pilot agencies were either unable to effectively coordinate the necessary resources to place children with parents and relatives by the 290-day mark; or were simply unwilling to do so, possibly because stable, nurturing placements had not yet been located for children. These alternative hypotheses will be examined in future analyses, and it is currently impossible to dismiss any of them.

Regarding the multivariate analyses of other major child placement statuses, children were less likely to be returned home over their first 300 days in care if they had been neglected, had come from drug abusing households, or had been abandoned. A child that was removed from a drug abusing household, or a household with adequate housing, was less likely to have his or her court supervision terminated at the 300-day mark. These reasons for the removal of the child, where present, may often coexist with other difficult material, physical, and psychological conditions that are difficult to ameliorate in 300 days.

In addition, as children received more in-person non-therapeutic services, the likelihood of termination of parental rights, as well as of the termination of court supervision, decreased. While initially this may seem counterintuitive, upon reflection it may suggest that children who need more services are often those who also need sustained monitoring by agency staff and court personnel.

Finally, children whose primary caregivers scored highly on the worker-completed assessment of needs and strengths (i.e., these primary caregivers had more strengths than needs) were more likely to be returned home or to have their court supervision terminated within the first 300 days in foster care. Because this assessment captures emotional, health, behavioral, social, as well as coping resources, high-scoring mothers may be better able to fulfill the agency and court requirements that must be met prior to reunification. As importantly, it demonstrates that these initial worker assessments, and the instrument that captures them, show some predictive validity, which can support the increase of their use and help guide case planning in child welfare settings.

VI. Conclusions and Implications

In 1997, a prominent public health researcher wrote, "Researchers struggling to make sense of the managed care revolution are like monks in the mid-1400s trying to interpret the Renaissance. They have merely glimpsed it and the nature, scope, and extent of change it represents can only be speculated about" (Hurley, 1997, p. 679). If the "black box" of what performance-based managed care is and what it does has only recently been opened, then there is consequently little information available to guide researchers and practitioners seeking to understand the effects of managed care on nonprofit child welfare agencies and children and families in foster care.

To some degree, this dearth of research and practical guidance concerning managed care in child welfare is surprising, given the extent to which states and other jurisdictions have embraced managed care principles. McCullough and Schmitt (2000) reported that as of 1998, 29 states were operating one or more managed care child welfare initiatives, for a total of 47 different managed care child welfare programs. Data on some of these managed care innovations should become available in the near future, as independent evaluations are part of roughly half of the 47 state initiatives. Some of these evaluations will be rigorous and focus on important questions related to the effects of managed care on service providers as well as children and families (e.g. Harrington, et al., 2002). However, many are likely to emphasize the collection of benefit cost data (e.g., the average cost of services per case and/or the percentage of performance indicators met) rather than process or outcome data (McCullough and Schmitt, 2000). And others are likely to be incomplete case studies that are impressionistic rather than empirical, and that may lead the field to unwarranted conclusions regarding the impact of managed care on child welfare systems (e.g. Freundlich & Gerstenzang, 2003)

This evaluation of the Wayne County foster care pilot initiative provides some early data that might be of use to practitioners and researchers interested in the effects of managed care contracting systems on nonprofit foster care agencies' organizational structures and processes, the in-agency and out-of-agency services provided to foster children and their families, and the movement of children through the foster care system.

This study found pilot agencies made considerable formal and informal changes in order to adapt to the managed care environment. Agencies' foster care service delivery, financial management and accounting, and IT and MIS processes were transformed to improve how quickly foster care cases were assessed, service plans were developed, and case-related financial information was relayed within the agency as well as to FIA. These changes were facilitated by the creation of new formal positions within the foster care department, by interdepartmental meetings and trainings, and increased interorganizational communication and cooperation with FIA and the courts.

This study also found that pilot agencies provided fewer in-person non-therapeutic as well as in-person therapeutic services to children and families than did non-pilot agencies over the first 300 days in care. There were no statistically discernable differences between pilot and non-pilot agencies in the number of out-of-agency services provided to children and families over this time period.

Finally, at the first incentive point, this study found that a child from a pilot agency was no more or less likely than a child from a non-pilot agency to reach the first performance milestone. Having had prenatal drug and/or alcohol exposure, having been neglected or abandoned, and having received more therapeutic services were associated with a lower probability of reaching the first pilot payment point.

These results offer a portrait of the adaptations that agencies made in transitioning to the pilot as well as the effects of the pilot on the services that foster children received and the movement of foster children towards permanent placement over the first 300 days in care. In some respects, the analyses presented in this report suggest that, as of the 300-day mark, pilot agencies did serve foster children differently, both in terms of the organization of their foster care services and in terms of their in-agency service delivery. Moreover, pilot agencies were more likely to have their agency and court supervision terminated by this point in time.

In other respects, however, pilot and non-pilot agencies were indistinguishable, principally in their efforts to provide out-of-agency services to foster children and in the proportion of children reaching the first pilot performance milestone by being returned to family or to relatives. It remains to be seen if these similarities and differences in service delivery and outcomes will change over time, particularly as the pilot agencies approach other pilot performance milestones.

Because the impact evaluation is continuing to gather data, the quantitative analyses reported in this interim report will be supplemented in the future by analyses of child service receipt and placement history through each sample child's 900th day in care. Therefore, to some degree, the 300-day analyses of child service receipt and placement patterns presented in this report offer only incomplete answers to the question, "Do agencies with managed care contracts serve foster children differently than do agencies with traditional per-diem contracts?"

Future analyses through the 900-day mark will answer additional questions such as "Is there a difference in the ability of the two groups of agencies to terminate parental rights by the 515-day incentive payment?" These additional data will also allow the research staff to track the receipt of combinations of incentive payments for children who have additional positive

outcomes, such as children who return to their own or a relative's home within 290 days and stay there for one year, and children who reach termination of parental rights in 515 days and are adopted within seven months. They will also allow the research team to look at children who do not leave the system in a timely way and children who reenter the system and what factors, including receipt of services, contribute to this. In addition, future analyses will be able to determine the characteristics of the pilot children and non-pilot children who 1) miss all incentive deadlines; 2) have a psychiatric placement or go AWOL from the foster care system or after they achieve a permanent placement; 3) have unstable placement histories in the foster care system; and 4) escalate to more restrictive settings over the course of their stay in foster care?"

Despite the need to continue to collect and analyze data to answer these additional questions and make definitive recommendations, the information presented in this report, and the literature reviewed in its preparation, do allow us to make some tentative suggestions for administrators as they consider the implications of our findings to date. While our empirical understanding of managed care contracting in child welfare is limited to what has been learned in Wayne County, we believe that our recommendations are sensible for managers in other locales and organizational sectors.

Service Delivery

- Organizations should be sensitive to managed care-based threats to their missions. Goal displacement may result and a myriad of costs may accrue if managed care increases employee turnover and/or endangers an agency's community identity and reputation.
- Contract incentives, as seen in performance deadlines or capitation, directly influence the work environment, employee behavior, job satisfaction, and employee retention.

- Performance deadlines must be set up with enough time to allow employees to conduct thorough assessments, provide necessary in-agency services, access community resources, and place children in living situations that promote safety, permanency, and positive well-being.
- Examine whether staff can adequately transition to a new model of service delivery without additional supports.
- As early as possible, identify the person(s) who will have direct oversight of and the responsibility for service delivery changes, and prepare them appropriately.
- Monitor in-house service delivery to ensure that decreased client contact, if it occurs, is warranted by efficiencies achieved in service provision rather than cost considerations dictated by the new contracting environment.
- Consider formalizing relationships with collateral service providers in order to bring necessary services to bear in a timely way.
- Assess the availability of high-demand, out-of-agency services. If such services are unavailable, document this shortage and convey this information to court officials and the public agency so that the managed care contract can reflect this reality.

Financial Management and MIS

- Agency managers need to agree on what information is important and must be collected, how this information is to be collected, whether agency staff have the resources and knowledge necessary to input such information in a timely and accurate manner, whether the requisite expertise exists to analyze trends in the data (both retrospective and prospective), and how the results of these analyses will be

disseminated. Each one of these steps requires careful, deliberate planning involving necessary stakeholders.

- Agencies should not pour effort into establishing "tickler" based systems—in which workers and accounting staff are reminded of impending performance and billing deadlines—without first carefully considering how staff behavior will respond to such a system. Tracking systems should not be a surrogate for careful case planning and the implementation of appropriate case plans for all clients.
- Public agency managers must recognize that overdue reimbursements jeopardize private agencies' cash flow, and possibly impact the type and amount of services that agencies are able to offer clients. Public and private managers should work together to identify the source(s) of late reimbursements, and seek practical solutions to eliminate this problem.
- Public agencies, in conjunction with the nonprofit sector, should consider establishing different performance expectations for more difficult-to-serve children.

Interdepartmental Relations

- Managed care requires increased vertical communication. Executives must listen more often and more closely to front line staff in all departments to ensure that managed care service delivery strategies are working as intended and are not jeopardizing the quality of service provided to the client.
- Managed care requires increased horizontal communication as well. Key departments—foster care, IT, and accounting in particular—cannot operate on "opposite sides of the hall." Consider implementing interdepartmental meetings and

other mechanisms so that staff can gain a holistic sense of how departments must balance competing pressures and responsibilities

Interorganizational Relations

- Joint strategic planning may help contracting agencies better understand the common problems they will encounter.
- Joint agency education and training programs at all levels might lead to efficiencies in the transition to managed care.
- Managed care may not promote a “one size fits all” strategy where agencies respond uniformly to new fiscal and programmatic challenges. Agencies should recognize that the wholesale adoption of other agencies’ service delivery, MIS, and training programs may result in both benefits and costs.
- Managed care contracts should be negotiated rather than dictated. Agencies should perceive the playing field to be level, and all parties’ voices should be heard in contract negotiations.

In the end, however, a successful move to managed care contracting cannot be achieved without buy-in and trust that children will be well served. It is critical that child welfare agencies work with staff to provide them with the supports necessary to ensure that they will, whenever possible, be able to reach their safety, permanency, and well-being goals with any family or child regardless of the timelines that are set. Foster care must be seen as a temporary situation in which decisions are made within a child’s sense of time (Goldstein, Freud & Solnit, 1973). Therefore, it is critical to serve families in an efficient and effective way in order to craft the best possible plan for the children in a timely manner.

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