ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Children, Youth, and Families

Child Welfare Privatization
Executive Summary

A report prepared by McCullough & Associates, Inc.
December 2005
EXECUTIVE SUMMARY

The Arizona Legislature required in Laws 2005, Chapter 286 (SB1513) that the Department of Economic Security “submit for review by the Joint Legislature Budget Committee options for the privatization of the case management duties for child protective services.” In response to this requirement, the Department (DES) secured the services of McCullough and Associates, Inc. to assess privatization options for Arizona through research and document reviews, and through interviews, surveys and focus groups with key stakeholders in the State. This report provides the results of that analysis.

National Trends in Privatization

Any consideration of options for the privatization of child protective service case management in Arizona requires an understanding of the national context of child welfare privatization. Privatization, generally defined as, “the provision of publicly funded services and activities by non-governmental entities,” has been widely used by child welfare systems across the United States. Three dynamics have characterized the great majority of these efforts to privatize child welfare case management services: 1) a focus on quality through the purchasing of results rather than services, 2) the development of outcomes related to state and federal mandates, and, 3) financing mechanisms that link implicit or explicit incentives to performance. The specific features of these privatization initiatives, however, have varied considerably. Wide differences exist in the geographical reach of these efforts, the range of services privatized, the population served, the degree of public agency involvement in ongoing case management, the structural design of these initiatives, the funding approaches utilized, and the specific mechanisms used to align financing with desired results.

When privatized initiatives are well designed with adequate funds, promising practices and innovations may emerge. For example, independent evaluations have noted that in some initiatives, the privatized case management system introduced best practice strategies that were not always apparent in the previous public system including: system of care designs that reflected Wraparound values/principles, family team conferencing for the development and revision of all case plans, the introduction of evidence-based practices and decision support tools, added supports for case managers and new case management approaches that ensure frequent contact and continuity in care for children and families, requirements that agencies meet national accreditation standards, expanded services created through community service networks, improved use of technology, and added training and supports for caregivers.

In spite of innovations in some initiatives, the privatization of case management services in child welfare has generally produced mixed results regarding both the effectiveness of these efforts in achieving improved outcomes for children and families and cost efficiency. Evaluations of existing privatization efforts demonstrate great variability in the extent to which these initiatives have succeeded in improving the safety, well-being, and permanency of children served by child welfare systems and the well-being of their families. When compared to non-privatized systems, the results have in some cases been far better and in some cases, poorer.
Research studies consistently describe a number of challenges that must be overcome in privatizing case management services in child welfare. In case studies, public child welfare agencies and private case management agencies most often cite difficulties in: developing an adequate data collection and analysis capacity; appropriately defining the roles of private agency case managers and public agency staff; developing needed service capacity; developing the “right” outcomes and appropriately aligning resources with expectations; crafting effective financing strategies; ensuring that private agencies have the requisite practice and business expertise; recruiting and retaining quality staff; and, ensuring that private agencies have an understanding of legal issues and are able to create and sustain effective relationships with the courts. Researchers have also noted other barriers that appear to be correlated with the lack of success of some privatization efforts including: limited funding, rigidity in procedures, problematically drafted contracts, overdone or underdone monitoring, limited consumer involvement, and lack of attention to cultural and linguistic issues.

Based upon national research findings and the interviews with private agency executives conducted as part of this study, key factors for success, across different designs, appear to relate to the sophistication of the purchaser in planning, procurement, and contract oversight; the alignment of resources with requirements; the adequacy of funding and contractor rates; the buy-in from stakeholders; the care with which system designs were developed; the clarity and appropriateness of the expected outcomes; and the infrastructure, leadership, and innovation of the contractor and the public purchaser. Successful privatization initiatives share a number of essential characteristics in common with effective public agency programs, including the following:

- Strong, steady and committed leadership
- Clear vision, goals, objectives, and performance criteria
- Sufficient staffing and other resources to implement the vision
- Continuous and meaningful performance monitoring
- Specific, measurable outcomes
- State-of-the-art information systems that allow private and public service providers to track progress and outcomes
- Resilient interpersonal working relationships between public and private agencies
- Strong ties to the communities they serve
- New business tools and innovative practices

It seems clear that privatization is best implemented through a broad-based planning process that engages stakeholders in a sustained dialogue for the purpose of reaching consensus on the goals of the privatization initiative. In summary, although privatization of child welfare services has been widely used throughout the nation, the privatization of case management services specifically is a much more recent phenomena and has had mixed results - both for its effectiveness in improving outcomes for children and families and in cost efficiency. Not surprisingly, many of the factors that are necessary for successful privatization are the same factors that characterize an effective public sector case management system. Although privatization of case management has in some instances improved results, privatization is not a panacea for an under funded or understaffed delivery system.
Current Performance, Capacity and Interest in Privatization

This assessment of the range of privatization options available to Arizona utilized two major methods: a review of documents relevant to privatization (procurement procedures, performance reports, the Governor’s Child Protection Reform Initiative, the Blue Print for Realigning Arizona’s Child Welfare Program, the 2005 Auditor General reports, and other internal and external evaluations of DES) and the conducting of focus groups, stakeholder surveys, and interviews with three major stakeholder groups: (1) DCYF staff (CPS specialists, supervisors, assistant program managers, and district program managers), (2) child welfare and behavioral health providers, and (3) external stakeholders (including CASAs, members of the Foster Care Review Board, parents [birth, kin, foster and adoptive], representatives from other state agencies and the judiciary, advocates, and tribal leaders).

Several key findings emerged from the assessment:

1. Arizona already has privatized a number of services and has many important reform initiatives underway. Arizona has privatized significant services through contracts with private providers, including but not limited to the following programs and services: Healthy Families Arizona; Family Support and Preservation; Intensive Family Services; Family Group Decision Making, meeting coordination and support; Parent Aide; Family Reunification; Intensive In-Home; Counseling, including individual and group for non-Title XIX clients; Arizona Families F.I.R.S.T., substance abuse treatment; non-therapeutic group homes and residential treatment; foster and adoptive home recruitment, home study, training and supervision; and, Independent and Transitional Independent Living.

DCYF is also partnering with the private sector on implementation of Arizona’s Title IV-E Waiver Demonstration Project, Expedited Family Reunification, approved by the U.S. Department of Health and Human Services (DHHS). This Project will enable children with a case plan goal of “return home” to be reunified to a safe home much sooner, with intensive support and wrap-around services and connections to family and community support systems. This project will initially begin in selected sites within Maricopa County (District I). DCYF and community contract providers will partner in providing a wide array of services, including counseling, family centered assessments, team decision making, parenting skills training, home management skills, referral to other services such as substance abuse treatment, supportive links to community resources, discharge and aftercare planning, and the availability of flexible funding to meet the individual needs of families.

In addition, Arizona has made significant system improvements over recent years in the areas of intake and investigation and case planning. Reform efforts include implementation of the Annie E. Casey’s “Family to Family” Team Decision Making process in selected sites in Maricopa County; creation of Family Connection Teams to integrate services across DES’ Divisions; participation in the Casey Family Programs “Breakthrough Services” on Kinship Foster Care and Reducing Disproportionality and Disparate Outcomes for Children and Families of Color; implementation of child safety assessment and family strengths based risk
assessment tools; provision of family centered practice skills training for CPS supervisors and case managers; and significant revisions to new case manager training provided by the Child Welfare Training Institute.

2. **Consensus is lacking as to the direction for future privatization efforts.** It was clear from the interviews, surveys, and focus groups that a true consensus about the privatization of case management in Arizona does not currently exist. Views were divergent about privatization itself and about the specific case management functions that lend themselves most effectively to privatization. In connection with the direction for potential future privatization efforts:

- There was broadest agreement in the rejection of any proposal to privatize the centralized Child Protective Services (CPS) report intake function (Hotline) and CPS investigations. After eliminating blank and neutral responses, the majority of all respondents (70%) believe that Hotline functions should not be privatized. Providers overwhelmingly “disagreed” or “strongly disagreed” with the privatization of the Hotline function (79%). Approximately two-thirds of external stakeholders (67%) and of DCYF staff (66%) “disagreed” or “strongly disagree” with privatization of the Hotline. There was even greater opposition in response to the privatization of CPS investigations. After eliminating blank and neutral responses, the vast majority (89%) of all respondents “disagreed” or “strongly disagreed” with the option of privatizing CPS investigations. DCYF staff were most opposed (93%); followed by providers (86%); and then external stakeholders (80%).

- After eliminating blank and neutral responses, the privatization of in-home case management elicited very divided responses. Whereas the vast majority of providers (92%) “agreed” or “strongly agreed” with privatizing in-home case management, the majority of DCYF staff (58%) “disagreed” or “strongly disagreed” with that option. The opinion of external stakeholders represented the middle ground between providers and DCYF staff, with the majority (63%) “agreeing” or “strongly agreeing” to the privatization of in-home case management.

- After eliminating blank and neutral responses, the privatization of out-of-home case management elicited almost equal responses at opposite ends of the spectrum. A slim majority (53%) of all respondents “agreed” or “strongly agreed” with the privatization of out-of-home case management while slightly less than half (47%) of all respondents “disagreed” or “strongly disagreed” with the option. Clear differences were evident across the different types of respondents. External stakeholders were somewhat evenly divided in their opinions, with more respondents agreeing (58%) than disagreeing (42%).

Providers and DCYF staff expressed diametrically opposite opinions. Eighty-nine percent (89%) of providers “agreed” or “strongly agreed” with privatization of out-of-home case management and 77% of DCYF staff “disagreed” or “strongly disagreed” with that option. Case management for out-of-home care proved to be an uneasy target for privatization, particularly for DCYF staff.
After eliminating blank and neutral responses, there was general endorsement of privatizing independent living, adoption and adoption subsidies, with approximately three-quarters of all respondents stating that they “strongly agreed” or “agreed” with privatizing these functions. There was also greater consensus among the stakeholder groups regarding the privatization of these areas than was the case with other potential areas for privatization. Caution is needed, however, in interpreting these findings. Many respondents indicated in the focus groups that they chose these areas for privatization simply because they felt the populations would be relatively small and easily identifiable or because they felt the case management privatization transition might be less disruptive to the overall system if these clearly defined functions, as opposed to others, were privatized.

Not all possible options for the privatization of case management were fully explored. Some respondents noted in the focus groups that rather than being asked to choose functions as they currently exist, they would have preferred a discussion about possible benefits of privatizing case management across service areas to improve overall coordination and provide continuity for children and families from entry to exit from the system.

3. **There are strengths in the current system’s business practices indicating readiness to plan and implement a future privatization initiative.** Strengths include:
   - Clearly articulated goals and objectives for the major improvement efforts underway.
   - Positive relationships among DCYF, the private agencies, and community leaders.
   - Familiarity on the part of DCYF with structuring contracts and aligning financing to achieve improved results.
   - The ability of CHILDS, the child welfare information technology system, to support many contract and payment functions.
   - An ability to track data on key indicators and aggregate data in the form of performance reports.

4. **Arizona faces significant challenges in improving current services and in moving to privatize case management for any portion of its child welfare service areas.**

   The assessment revealed that both DCYF and the private providers would need to invest time and money to prepare for the privatization of case management. Several areas needing remediation were identified:

   - **Procurement, negotiation and monitoring for compliance.** Several challenges were identified in this area: problems with DCYF’s contract negotiation process; the absence of adequate contract monitoring; and DCYF’s failure to hold providers accountable for contract compliance, including requiring the development and completion of corrective action plans when problems are identified. DCYF currently lacks adequate administrative staff and an infrastructure to fully remedy these challenges. In addition, there was
agreement that DCYF would need to reassess its approach to procurement to reward contractors who meet or exceed performance expectations.

Although these challenges were identified by all stakeholders (contracted providers, external stakeholders, and by DCYF staff) who participated in focus groups, it is important to note that over the last year DCYF has implemented several procurement improvement processes that include the following: (1) DCYF now conducts statewide Requests for Information (RFI) meetings to obtain potential provider comments and ideas about a proposed Scope of Work for a service prior to the official release of the Request for Proposals; and, (2) new or renewed requests for contracted services include performance-based contracting components.

To the extent possible with existing resources, DCYF does monitor contracts and attempts to hold providers accountable for contract compliance. DCYF acknowledges that this is an area that could be improved with additional staff capacity. Within the past several months in response to issues raised by the Protecting Arizona’s Family Coalition (PAFCO) whose membership includes the Arizona Council of Human Service Providers, DES began a process to improve internal procurement and contract monitoring. The DES Office of Procurement and the Director’s Office met with PAFCO and a number of providers, including DCYF providers, to discuss issues and provide education about the procurement process. This meeting resulted in implementation of a plan of Procurement Reform and Education, including further education of providers and DES staff. Planned DES Procurement improvements include the semi-centralization of the procurement solicitation process. By moving the solicitation responsibilities out of the program areas and into the centralized procurement office, some of the needed resources may be freed up to refocus the programmatic efforts on contract administration.

- **Access to a full array of quality services and placement options, including behavioral health services.** Privatization of case management will not remedy problems caused by inadequate or inappropriate services. Repeatedly, DCYF’s performance difficulties were attributed to the inability to access services or appropriate placements that the RBHA’s manage. There was agreement that the current access and capacity barriers would need to be addressed if a privatized DCYF case management initiative were to move forward.

- **The current work environment.** While internal and external stakeholders generally supported the many new DES reform initiatives, DCYF respondents also cited the difficulty in implementing so many reforms in such a short period of time. In addition, staffing shortages and higher caseloads have contributed to low morale and increased caseworker stress. The current DCYF work climate is not conducive to the implementation of any new privatization initiative.
• **Communication.** Ineffective or ill-timed communication was an issue of concern for all stakeholder groups. There was agreement that if privatization discussions continue, internal and external stakeholders must be kept informed as key decisions are made.

• **Provider readiness.** Because the private agencies are essential partners in any case management privatization initiative, it is essential that providers be ready to assume new responsibilities. The assessment revealed some wide differences in private agencies’ self-assessments of their readiness for privatization of child welfare case management. Of importance to any privatization effort will be the development of readiness criteria, systematic evaluations of providers’ readiness to assume responsibility for critical services, and the provision of adequate time and technical assistance, as needed, to ensure that providers have the infrastructure, personnel and competencies to proceed before cases are assigned. Given current DCYF staff capacity this type of support and technical assistance would be difficult if not impossible for DCYF to provide.

**Recommendations for Next Steps**

As evident throughout this report there are hurdles to overcome and no clear consensus on the best course of action. However, there is also strong support from the provider community and from some external stakeholders to plan and implement a pilot project to test the effectiveness of a privatized case management approach. Based upon this interest and the overall findings of the assessment, the following recommendations are made:

• Make this report widely available to internal and external stakeholders for comment, including those who participated in focus groups and completed surveys.

• Regardless of whether or not the State moves to privatize any case management duties, it is strongly recommended that a DCYF Public/Private Partnership Work Group be formed to build upon the previously described Procurement Reform and Education effort. The focus of the newly created Work Group would not only be to address the barriers identified in this report but also to improve current business practices. It is recommended that if a Work Group is created it be comprised of internal and external stakeholders, including providers, and that the work be organized through the creation of subgroups charged with responsibility for examining and crafting approaches to address the identified issues outlined in the report and in the following framework. Both DCYF and any potential future privatized case management system can benefit from such an effort.
It is recommended that DES expand its current internal procurement and monitoring improvements to specifically address DCYF challenges. Given the amount of funds that currently support DCFY contracts and the number of children and families already served by private agencies, it is imperative that resources be allocated and plans implemented to address identified quality assurance and monitoring weaknesses. It would be ill advised to expand contracting efforts to include case management until capacity is adequate to monitor and enforce compliance of current and future contracts. Resources may be needed to support needed improvements, which may necessitate Legislative support.

It is recommended that DES explore any potential legal, financial and risk impacts of privatizing any portion of case management services. Other states have privatized child welfare services, including case management, and have not encountered difficulties regarding their claims for reimbursement for foster care expenses under the federal Title IV-E program. Nonetheless, given the lack of explicit guidance from the U.S. Department of Health and Human Services regarding the impact of privatization on states’ claims for reimbursement under Title IV-E, it would be prudent to seek clarification of federal policy in this area. There is also a lack of clarity in state law and court rules that may preclude the private agencies from presenting the "State’s" recommendations to the courts as agents of the state. If DES is required to have a state employee present to represent the department in all court appearances, this would result in considerable duplication of effort and expense. It is not clear if the Office of the Assistant Attorney Generals’ attorneys would be able to represent the private agency case manager in these court proceedings as this Office does for CPS staff.

A Framework for Arizona Decision Makers

If privatization is to move forward and if the intent of any future privatization of case management is improved results and cost efficiency, significant energy will need to be devoted to planning the effort and to overcoming the previously described challenges. This framework is provided as a technical assistance resource for decision makers and the recommended Public/Private Partnership Work Group to use in improving current practices and weighing privatization options. The following principles provide guidance and raise issues in ten areas that would need to be addressed:

1. View privatization as a method to improve case management practices and recognize that planning for best practice takes time. The process would need to acknowledge and expect that DCYF staff and providers need time to plan and perhaps additional resources to implement any case management privatization initiative. Any privatization plan that may emerge from the Public/Private Partnership Work Group would need to be supportive of and consistent with other State reform goals, strategies and initiatives. Key Central Office and District DCYF staff, providers and other external stakeholders would need to be included in the planning process.
2. Define success. DCYF staff, provider agencies and external stakeholders would need to be engaged in dialogue to reach agreement on the purpose of any privatization effort and to determine how private agency performance would be measured over time.

3. Have a clear rationale for selecting the target population and the case management model. Planners would need to take into consideration current initiatives and examine a range of options for serving the target population, including the development of an integrated system of care. Once the target population and focus are clear, decisions would need to be made about the size of the population to be served and the geographical area(s) for the initiative(s). Pilots in several regions can provide critical information on effectiveness in serving children and families in both urban and rural areas.

4. Define the roles of DCYF staff, RBHA caseworkers, and the private providers. Planners would need to look at case management functions throughout the life of a case and, depending on the target population and the case management model, clearly define the respective roles of DCYF workers and private agency case managers, including the RBHAs.

5. Ensure service capacity. Gaps in service capacity and access barriers, including those in behavioral health services, must be eliminated prior to the launch of any privatized child welfare case management initiative. Many of the problems faced in child welfare result from a lack of resources and supports for children and families. Privatization will not solve these resource problems.

6. Design and implement a Quality Assurance/Quality Improvement (QA/QI) and contract monitoring system. Decision makers would need to draw upon the "lessons leaned" from other communities that have struggled to find the right balance in monitoring contracts. DCYF would need to develop standards and quality assurance processes that promote contract compliance and the private agencies’ achievement of defined results without stifling the providers’ ability to innovate.

7. Assess data technology needs. Decision makers would need to examine the State’s current information technology capacity and identify enhancements that may be required. Steps would need to be taken to ensure that private providers have the technological and human resource capacity to meet specified data collection and reporting requirements.

8. Identify funding sources and financing options. Decision makers would need to determine the funding sources and level of resources that would be needed to support a privatized case management initiative. DCYF would need to work with providers to assess current provider capacity in relation to risk-based financing approaches and carefully weigh the pros and cons of different financing models with that capacity in mind. It would be essential for planners to ensure that control over key case management decisions be balanced with the level of risk assumed by the provider.
9. **Consider staffing and training issues.** Planners would need to assess the impact of any future case management privatization on the DCYF and private agency staff perceptions regarding job security and job satisfaction and the effects of privatization on issues related to salary, benefits, pensions, staff qualifications and training needs.

10. **Chart the course from planning to implementation.** Planners would need to have a process for translating the vision for a privatized case management initiative into a sound procurement and implementation strategy. DCYF would need to determine the best means of engaging district offices and community stakeholders in planning for the transition, without jeopardizing the integrity of a competitive procurement process, and engaging them in the ongoing evaluation and continual refinement of the initiative. A detailed transition plan would need to address the impact of privatization on current DCYF operations (including its capacity to recruit and retain staff), and assess the additional supports, if any, that might be needed in the short term to successfully transition to a privatized system.
ARIZONA DEPARTMENT OF ECONOMIC SECURITY  
Division of Children, Youth, and Families

Child Welfare Privatization

A report prepared by McCullough & Associates, Inc.  
December 2005
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Summary</td>
<td></td>
</tr>
<tr>
<td>Part 1: National Trends: A Synthesis of Research</td>
<td>1</td>
</tr>
<tr>
<td>Part 2: Assessment of Arizona Readiness</td>
<td>26</td>
</tr>
<tr>
<td>Part 3: Recommendations &amp; A Framework for Decision Makers</td>
<td>55</td>
</tr>
<tr>
<td>Appendix 1: Case Studies &amp; Interviews</td>
<td></td>
</tr>
<tr>
<td>Appendix 2: Stakeholder Survey Instruments</td>
<td></td>
</tr>
</tbody>
</table>
**PROJECT SUMMARY**

Laws 2005, Chapter 286 (SB1513) requires the Department of Economic Security (DES) to "submit for review by the Joint Legislative Budget Committee options for the privatization of portions of the case management duties for child protective services."

DES procured the services of McCullough & Associates to complete the research, facilitation, data collection, and analysis necessary to identify options for privatization of certain case management functions of the Division of Children, Youth and Families (DCYF).

The project required the consultants, Charlotte McCullough and Kathleen Penkert to: (1) provide a history of privatization efforts, including best practices in other states or jurisdictions; (2) provide an analysis of Arizona's readiness for privatization; (3) create a framework for weighing privatization options, including delineating next steps to address issues identified in the assessment phase of the project.

**Organization of the Report**

The document contains three sections and attachments:

Part 1 contains an overview of the history of privatization, with a synthesis of research trends and findings and commentary on challenges, successes, and recent developments. While this section of the document distills findings from various privatization studies, it is adapted primarily from a CWLA Issue Papers funded by the Center for Health Care Strategies, a study conducted by Children's Rights, and from interviews conducted in September 2005 with private agency executives with extensive experience managing privatized case management contracts. Interviews were supplemented by primary source documents including Requests for Proposals (RFPs) and contracts. (Appendix 1 contains detailed descriptions of the case management models obtained through the interviews.)

Part 2 of this document is an assessment of Arizona’s readiness to launch a successful privatized case management initiative. Findings presented are the result of focus groups and interviews conducted in October 2005 and a review of various policies, procedures, and performance reports and independent evaluations of different aspects of DES practice. Appendix 2 contains the readiness assessment survey tools used to obtain feedback from three types of Stakeholders: DCYF workers, providers, and other non-provider external stakeholders.

Part 3 of the document contains recommendations for next steps and a framework for decision makers to use as a technical resource guide to further consideration of privatization.
PART I. NATIONAL TRENDS: A SYNTHESIS OF RESEARCH

This section places privatization in an historical context; defines elements that differentiate current efforts from traditional arrangements; and, provides a synthesis of research findings on the prevalence and types of privatization initiatives, including a discussion of key design features and changes that have occurred over time. Examples are inserted to illustrate different aspects of various privatized models. The section concludes with commentary on challenges, opportunities, and recent developments.

1. The Evolution of Privatization

Although there is no single definition of privatization, the term generally has come to refer to a range of strategies that involve the provision of publicly funded services and activities by non-governmental entities.

Even before the publicly funded child welfare safety net was developed, sectarian and non-sectarian agencies created and funded various services analogous to today's child protection, congregate care, and foster care services. Since the emergence of publicly funded child welfare in the 1880s, state and local governments have paid private, voluntary agencies to provide services. Historically, relationships between private and public agencies were non-competitive quasi-grant arrangements, but over the past decade, public-private agency relationships have taken very different forms.

In the current environment, contracting (also called “outsourcing”) is the most common form of privatization in the areas of child welfare, behavior health and juvenile justice. Unlike the former informal, noncompetitive arrangements between public agencies and nonprofit providers, today’s contracts are typically awarded after a competitive procurement process.

The services that are privatized and the manner in which payment is made also have changed. Until the past decade, public agencies typically retained case management decisions and control over the types, amount, and duration of non-case management services that were delivered by the private sector. Under this traditional child welfare per diem or fee-for-service contracting model, the private agency simply agreed to provide placement or non-placement services to a certain number of children in return for payment based on a pre-determined daily or fee-for-service rate. The contractor was paid to deliver units of service and rarely was reimbursement linked to any measures of effectiveness of the services provided. Such a payment approach offered few incentives for service providers to control costs, to build a more suitable array of services as an alternative to placement, or to more quickly return children to their families. In fact, these contracts provided incentives to continue delivering more of the same service whether it was needed or not.

In recent years, over half of the state’s public agencies have moved away from these traditional arrangements to a variety of risk or performance-based contracting options, often resulting in the contractor being given case management responsibility and greater flexibility and autonomy in determining how funds are used to meet the needs of individual children and families. The new privatization models are varied, but certain features have characterized most of these efforts, including the following:
PART 1: NATIONAL TRENDS

- Public agencies have shifted case management responsibilities to private agencies;
- Public agencies are more likely to purchase results rather than services; and,
- Financing mechanisms increasingly link implicit or explicit fiscal incentives to performance.

Privatization in child welfare takes many forms, with the respective roles of the public and private sectors varying, depending on the financial arrangements and the nature of the service that is being privatized. In addition to the term privatization, these reforms have been called a variety of names: public-private partnering, managed care in child welfare, community-based care, and results- or performance-based contracting. Regardless of the term, most of these initiatives have placed an increased emphasis on outcomes, or value for money spent, with a goal of getting improved results for the same or less money.

By most accounts, the privatization of child welfare services, especially case management, appears to be on the increase. Some observers argue that the trend has brought higher quality and greater efficiency, but others have raised concerns about its appropriateness. Still others contend that the essential issue is not whether but how privatization should be accomplished. While the federal government does have a policy indicating that inherently government functions should not be contracted out federal law has not addressed the nature of state public agency/private agency child welfare contracts. Instead, child welfare public-private contracting has been governed by state law and regulation. The U.S. Department of Health and Human Services Children's Bureau recently awarded funding to support a Quality Improvement Center on Child Welfare Privatization with the intent of building the knowledge base about effective privatization practices, particularly in relation to adoption services, that may result in improved outcomes for children and families.

There are abundant sources of information about child welfare privatization. There have been periodic national or targeted surveys of public administrators conducted to collect both quantitative and qualitative information on the types and prevalence of changes; identify barriers and any perceived or actual successes; track trends over time and identify emerging issues; and report and disseminate findings, often including recommendations for change.

Other researchers have used case studies to look in-depth at one or more initiatives. Case studies have used combinations of document review and data analysis, phone interviews, and site visits. One of the most thorough and recent efforts to advance understanding of the current use of privatization, including the extent to which privatization achieved benefits or resulted in unintended consequences, was completed by Madelyn Freundlich of Children’s Rights. Freundlich accomplished this in three ways: 1) by describing the concept and purported purposes of privatization; 2) using a case study approach to look at six different jurisdictions; and, 3) synthesizing the lessons learned and offering guidance to communities considering privatization.

Detailed information on individual initiatives is found in independent evaluations (including evaluations of the two most comprehensive, statewide privatized systems, Kansas and the University of South Florida’s evaluation of Community-Based Care in Florida). According to the last CWLA management, finance, and contracting survey, over half of the 39 initiatives described in the report were planning, in the midst of, or had completed independent evaluations. One of the most comprehensive was the evaluation of Colorado’s pilot capped allocation projects.
2. National Trends

For nearly a decade, the Child Welfare League of America (CWLA) conducted periodic surveys of all 50 states and the District of Columbia (and a number of counties) and published findings related to the types of changes, if any, public agencies were making in how they managed, financed, or contracted for services. Survey responses were often supplemented by documents provided by the public agency respondents, including planning documents, RFPs, contracts, and evaluation studies.

The last published report in 2003 was based on responses from 45 states and the District of Columbia obtained in 2000-2001. The reports provided detailed profiles and aggregate analysis of 39 initiatives from 25 states.¹³

Broad Goals & Impetus for Change

In all of the CWLA surveys, public agency respondents described overarching goals that related to legal mandates of safety, permanency, and well-being. Many also cited goals related to increasing accountability or purchasing results. Since the introduction of the federal reviews, the Child and Family Service Reviews (CFSRs), it seems likely that as states weigh privatization options, they will introduce initiatives that respond to CFSR findings and link privatization efforts to the State’s Program Improvement Plans. A range of factors has motivated privatization initiatives. Some were made possible by the Title IV-E waiver program that allowed states more flexibility in how they spent federal funds. Others were a direct result of lawsuits, settlement agreements, or an overall negative public perception of how the public child welfare agency was performing. Increasingly, initiatives appear to be driven by legislative mandates (41% of the CWLA initiatives). No state has a broader legislative mandate than Florida.

Impetus for Change

Kansas’ statewide initiative was implemented as a result of a lawsuit as well as pressure from the governor and legislature to privatize services.

The performance-based contract reform in the District of Columbia is part of the federal court settlement agreement that allowed the public agency to emerge from receivership.

Most recently, in 2005, the Texas legislature passed a bill requiring the public agency to develop and gradually implement a plan for privatizing foster care, adoption, and case management services for children requiring out-of-home care (SB6).

Legislative Mandates in Florida

In 1996, the Florida Legislature mandated four pilot programs that privatized child welfare services through contracts with community-based agencies.

In 1998, HB 3217 mandated statewide privatization of all foster care and related services. Related services included family preservation, independent living, emergency shelter, residential group care, therapeutic foster care, intensive residential treatment, case management, post-placement supervision, adoption, and reunification.

Child protective service intake and investigations remain in the public sector to be managed by DCF or by the sheriff’s departments.
PART 1: NATIONAL TRENDS

The Scope

Most privatization initiatives are limited to a particular region of a state or a subgroup of the child welfare population. Some initiatives are small, contained pilots that stay small. Others eventually expand. A few projects from the onset were intended to cover most or all of the statewide child welfare caseload. Florida and Kansas are the two best-known examples of the latter.

The Range of Privatized Services

Services included in the 39 initiatives described by CWLA varied depending on the target population.

The Hotline function and the initial child protective services (CPS) investigation were retained by the public child welfare agency (or in some locales by law enforcement) in all of the 39 initiatives. Beyond those initial intake and investigation functions, however, the full range of child welfare services has been the focus of different privatization initiatives.

Arizona is not the only State exploring privatization of case management services. In fact, case management services were the most likely services to be included in the initiatives reported by CWLA. Each initiative defined case management services in its RFP or contract with great variation among initiatives. In some initiatives, private agencies have assumed some or all of the core case management functions from the time of referral until the achievement of permanency.

The responsibilities of the private agency might include placement and service delivery functions in addition to case management. In Florida, for example, the private community-based lead agency receives the case during the investigation when it becomes clear that ongoing services (either in-home or placement services) are needed during or post-investigation, and the lead agency retains the case until the case is closed. Case management is privatized for all children post-investigation regardless of whether the child is served in-home or out-of-home and whether services are provided under court supervision or under voluntary services. The private agencies work with families to develop and implement the case plan and set permanency goals; manage court related processes; make placement and discharge decisions; and recruit, train and support foster and adoptive families.

In many states, case management is fully or partially privatized only for a defined subset of the child welfare caseload, again with great variation. In some states, the focus of the privatized case management agency is on diverting low-risk children from the formal child welfare system during or following the investigation that is conducted by the public protective service worker (or, in some jurisdictions, by the sheriff’s department). Arizona’s Family Builders was an early example of an early intervention model. More recently, in 2005, Iowa launched a similar community diversion initiative for children and families in need of services (but not an open CPS finding).
PART 1: NATIONAL TRENDS

case) to be served by community-based providers. Under that model, the public agency retains case management for all other cases.

In other states, the emphasis has been on privatizing case management and services for children at the deep-end of the system, usually those who present with complex needs and require placement in therapeutic levels of care. Many of the early models tracked by CWLA were focused on that small percent of cases that consumed a disproportionate share of resources. The rationale was that if children with complex needs could be better managed and stepped down or out of the system sooner, more children could be served for the same or fewer resources. Some efforts were more successful than others in achieving this goal. The Commonworks initiative in Massachusetts is an example of a successful effort. For nearly a decade, a portion of the State's children in need of residential care were referred to private agencies who coordinated care and provided or purchased services from other community providers. In this dual case management model, the public agency caseworkers retained final decision-making in terms of permanency goals and other key decisions, working in tandem with private case managers. (Appendix 1 contains more detail on Commonworks and an interview with a lead agency executive who describes the recent dismantling of Commonworks as part of the launch of a new initiative, thoughts on dual case management systems, and the lessons learned).

In some initiatives, children with complex service needs who are served by multiple public agencies are the focus of the privatization effort. Cross-system funds are blended to support a coordinated case management and service delivery system. The Missouri Interdepartmental Initiative is a good example of this approach. In that model, a private agency was given total case management responsibility for a limited number of children referred in a specific region of the state. (Appendix 1 contains a description of the initiative and an interview with the lead agency executive).

Some states have privatized case management for children in need of traditional foster care or home of relative care. The performance-based contracts in Illinois and Michigan described later in this section provide examples of how States aligned payments with desired results in specific program areas.

Many states have privatized case management for children with adoption as a permanency goal - with variation in the time the transfer of case management occurs (pre-or post termination of parental rights) and in the financing mechanism. Michigan was one of the earliest States to structure its payments to private agencies to reward timely achievement of adoptions with payments decreasing the longer the agency worked to find and place a child with an adoptive family. (See Appendix 1 for examples of privatized adoption contract provisions from Massachusetts and Kansas).

With few exceptions, initiatives that privatized case management also have included the provision or management of many other services in addition to case management. For example, an agency responsible for case management might also be responsible for providing in-home and out-of-home care placement services, recruiting and licensing foster families, and providing pre- and post adoption services.

As noted in the examples, the degree of public agency involvement and ultimate authority in case management decisions has varied from one initiative to another. In some states, the public
agency has delegated virtually all control to the private contractor (See Florida, for example, in Appendix 1). In other initiatives, the private agency has control over certain decisions but the public agency retains control and requires prior notification for significant milestones and has veto power over key decisions.

When private agencies assume responsibility for core functions, the public agency retains responsibility for oversight. The public agency must set the standards, define the outcomes and performance expectations, and then monitor performance through contract monitoring and quality assurance and improvement activities.

**Structural Designs**

There is no one "business model" or structural design for privatization that has been proven to be superior to another. When public agencies contract for case management and other services, they typically rely upon private, nonprofit contractors. Fewer than 10% of the initiatives described by CWLA, for example, contracted with for-profit entities.

CWLA reported the majority of initiatives are using a lead agency model (51%) supported by a provider network or other collaborative service delivery arrangement. The lead agency model is what is being used under Florida’s Community-Based Care plan and the Kansas privatization model. Under this type of arrangement, the public agency contracts with one or more agencies within a designated region to provide or purchase services for the target population from the time of referral under the obligation ends -- often at case closure. Some lead agencies provide most, if not all, services with few or no subcontracts. Others may procure most

### Lead Agency Responsibilities in Florida

In the last five years Florida has transitioned to a community-based child welfare system. The Department has contracted with 22 regionally defined lead agencies and each must have the capacity to:

- Develop a comprehensive array of in-home, community-based, and out-of-home care options through a provider network;
- Manage the funds and address cost overruns;
- Provide or subcontract for the direct provision of all services needed by all children referred by the PI: in-home services, foster or kinship care, adoption, Independent Living;
- Approve, review, authorize, and pay provider’s claims;
- Design and implement a comprehensive, individualized case management system;
- Develop 24/7 intake and referral capacity;
- Ensure child & family involvement and satisfaction at all levels of case management and service delivery;
- Handle all court-related processes;
- Establish a quality assurance system to ensure continuous improvement;
- Meet all specified safety, permanency, and well-being outcomes and system performance indicators as required by the contracts; and,
- Gather and report all information required for quality and performance oversight.
services from other community-based agencies and directly provide case management and/or limited services. Some contracts impose a cap on the services that the lead agency can deliver if it assumes case management.

Some lead agencies are single agencies that have long histories as child welfare service providers, while others are newly formed corporations that were created by several private agencies for the sole purpose of responding to the contract opportunity. A few lead agencies were created through collaboration between nonprofit agencies and one or more for-profit organizations.

Performance-based contracts between the public agency and private providers are found in nearly a quarter of the CWLA initiatives. In this model, either payment amounts or schedules are linked in new ways to performance or achievement of certain case milestones, or the providers are given case rates for certain populations and expected to achieve specified results. Illinois was among the first states to implement performance contracts for kinship and foster care providers. In FY 2000, slightly more than 21,000 children were served statewide using performance contracts. This shift was accomplished by redesigning how new children are referred to foster care agencies for placement. Performance contracting (initially implemented only in Cook County), requires all agencies to accept an agreed upon number of new referrals each month with the expectation that a certain number of children in care would exit care to permanency each month. Falling short of target percent of children exiting care means serving more children without additional funds. In Illinois, agencies must absorb the costs of any uncompensated care. If the number of children in excess of the payment level exceeds 20% of the number served, the agency risks the loss of the contract. By exceeding the benchmark in permanency expectations, an agency can reduce the number of children served without a loss in revenue. Agencies also receive $2,000 for each child moved to a permanent placement beyond the contract requirement.

Finding
In all of its various forms the lead agency model has been the most common in child welfare privatization.

Performance-Based Contracting in Michigan

Michigan began the Foster Care Permanency Initiative as a pilot project in 1997 in Wayne County (Detroit). The goals were to reduce the length of stay in foster care and increase the numbers of children who achieved permanency within the specified time frames.

The planners created the funding structure to provide foster care providers with flexibility. The principal design is a reduced per diem rate and a reallocation of the resulting savings into three lump sum incentive payments tied to performance goals.

There are few strings attached to the lump sum payment—allowing providers to purchase or provide whatever services or supports are needed to achieve the results.

Lump sums are paid at designated milestones of each case—an initial referral payment, a performance payment, and a sustainment payment. The daily rates and the incentive amounts have changed multiple times since the project was first launched.
PART 1: NATIONAL TRENDS

Public agencies are increasingly using performance-based contracts with both lead agencies and with single providers. In some instances the performance-based trend is a direct result of legislative action or litigation. In Iowa, for example, the Better Results for Kids Initiative calls for the State to move towards performance-based contracts with all service providers. Similarly, for the past three years, the District of Columbia has been transitioning to performance-based contracts for the requisition of all services as a requirement of its settlement agreement approved by the federal court.

Quality, Accountability & Performance Expectations

Regardless of the structural model, public agencies are focused on improving quality—with all initiatives including some methods to collect and manage utilization, quality, outcomes, and fiscal data. Perhaps the most important change with privatization relates to what gets monitored. In many traditional child welfare programs, monitoring mechanisms, to the degree that they existed, focused almost exclusively on process issues, i.e., were certain tasks performed (assessments, number of visits, therapy sessions, etc.). The new initiatives are part of a broader trend that seeks to follow client outcomes in addition to or instead of process indicators.

Most initiatives specify performance standards, improved functioning indicators, and client satisfaction requirements in their Requests for Proposals (RFPs) and their contracts. Specific outcome measures vary according to the target population served by the initiative but initiatives are most likely to include indicators related to child safety, recidivism/reentry, and achievement of permanency within the timeframes required by the Adoption and Safe Families Act (ASFA).

States and counties use multiple methods to collect and manage data on their privatization initiatives. Many plans appear to rely heavily on reports generated by the contractor or from the State’s automated MIS. However, both the findings of the independent evaluators and the responses to the 2001 CWLA survey indicate that data collection and management remain challenges for public and private agencies across the county.

The CWLA survey also asked whether the Statewide Automated Child Welfare Information systems (SACWISs) were used to collect and report cost, outcomes, and utilization data for the initiatives described. Twenty-eight respondents (71.8%) answered this question, and of those, only five (17.9%) stated that they were using SACWIS for the initiative. Many others indicted that they had plans to adapt their SACWIS to collect this type of information.

Respondents also were asked whether their state or county had the ability to track the overall effect of the child welfare initiative on other child-serving systems. Only four of the initiatives reported this capability. The lack of ability to track utilization, costs, and outcomes for children and their families across child-serving systems is problematic. There is also a gap between information that is tracked and information that is actually used for system planning and improvement. Child welfare initiatives appear to have difficulty generating data in a form and in a time period that is relevant and helpful for planning and decision-making.

Finding:

There is a premium placed on data collection to support QA/QI and contract monitoring but there is also evidence that many current automated systems may not be up to the task.
PART 1: NATIONAL TRENDS

In addition to data obtained from the MIS and standardized assessments, states and counties reportedly use a variety of approaches to monitor performance. Frequently cited methods for collecting outcome and performance information include:

- Reviewing quarterly reports,
- Reviewing case records,
- Using quality assurance protocols,
- Using monthly problem-solving meetings,
- Making scheduled and unscheduled site visits,
- Reviewing disrupted placements and critical incidents, and
- Conducting independent evaluations.

Funding Sources

The bulk of federal child welfare funding is disproportionately directed toward out-of-home care—the very part of the system that public agencies are seeking to minimize. Given the complexity of child and family needs and the inadequacy of child welfare funds to support preventive, home-and community-based care, and therapeutic services, child welfare agencies have traditionally tapped other federal, state, or local funds. Each funding source may come with different program eligibility and match requirements.

As child welfare agencies strive to rearrange fiscal relationships, payment mechanisms, and introduce risk based contracting, they have to also ensure that the proposed changes will not negatively affect their ability to access funds from sources outside child welfare or to maximize federal revenues. To accomplish these goals, some States (like Arizona) have operated under a Title IV-E waiver allowing the state to spend Title IV-E funds on a range of alternatives to foster care as long as the overall expenditures are cost-neutral to the federal government. Other States have attempted to maximize federal revenue and gain greater flexibility over limited dollars by changing the funding mix—combining child welfare, TANF, Medicaid, and

An Integrated System of Care

Wraparound Milwaukee has been in existence since 1995. Wraparound currently serves about 1000 children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential placement; children with behavioral health problems who are referred by child protective services who have not yet been removed from home; and, a population of mothers (and their children) who are involved with the substance abuse, welfare-to-work and child welfare systems.

A combination of federal, state, and county funds is used to finance the system. A pooled fund is managed by Wraparound Milwaukee, housed within the Milwaukee County Mental Health Division, which acts as a public care management entity. Wraparound Milwaukee utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case rate financing, service authorization mechanisms, provider network development and utilization management, in addition to coordinated care management, provided by private agencies.

The overall reduction in expenditures from 1996 to 2000 has resulted in $8.3 million in savings for the County.
behavioral health block grant dollars in new ways to support children and families involved with
the child welfare system. When multiple funding sources are used, the child welfare agency has
had to reach agreement across child serving agencies on how funds will be included in the child
welfare contract or made available to the child welfare contractor or public agency by some other
means.

The 2001 CWLA survey explored the sources of funds
used by child welfare agencies to support their child
welfare initiatives. Most initiatives were supported by
diverse funding sources. For example, of the 36
initiatives that identified funding sources, 26 of them
(72%) reported using funding from outside the child
welfare system. Consistent with findings in 1998,
Medicaid and mental health funds were the most
likely sources of funds to be used in combination with
child welfare funds to support the initiatives. The use of TANF funds was on the increase. In
1998, less than 17% of the initiatives included TANF funds, compared to 30.6% in 2001. There
is, however, a continuing downward trend related to the use of substance abuse and education
funds in these initiatives. In 2001, only 11.1% of the child welfare initiatives reported that they
used substance abuse funds, despite the need for access to early intervention and treatment
services, especially for the parents of children served by the child welfare system. This level is a
slight decrease from the 1998 finding, in which 13% of the initiatives reported using substance
abuse funds. Education funds were the least likely funds to be used in the initiatives.

There was a slight increase in 2001 in the number of initiatives that were described as Integrated
Systems of Care projects. In many instances, projects were initiated with various federal and
foundation planning funds with the explicit purpose of integrating services across public systems,
maximizing federal revenue, and creating seamless and flexible systems for children served by
public agencies. Many of these new models are publicly managed but with innovative privatized
contract arrangements that also create incentives at the service level.

**Risk-Based Financing Options**

As in previous years, the CWLA 2001 survey revealed
significant variations in financing arrangements among
the child welfare initiatives. The arrangements may even
vary within the same initiative over time or between
different county initiatives within the same state. The
level of risk ranges from global budget transfers, to
capped allocations or capitation, to case rates, to
discounted Fee-For-Service or per diem arrangements
that include bonuses and/or penalties based upon
performance or case milestones.

Each of these options, as it is typically used in child welfare, is described below.
PART 1: NATIONAL TRENDS

Capitation, Capped Allocations, & Global Budgets

In the purest managed care financing model, a contractor is prepaid a fixed amount for all contracted services for a defined, enrolled population on a monthly basis. This per member, per month, population-based payment arrangement is referred to as capitation. In this type of arrangement, the contractor is at risk both for the number of children who use services and for the level or amount of services used. The contractor receives the predetermined amount based on the number of enrolled children regardless of the number of children who actually use services or the level of services that enrolled children require during the month. If the contractor enrolls children who subsequently underutilize services, the contractor will make a profit. Conversely, the contractor is exposed to significant financial risks if the plan is not adequately priced or if the eligible enrolled population uses more services or more costly services than projected.

There are a number of reasons cited by child welfare administrators for not extensively using pure capitation models in child welfare. Part of the challenge has been the lack of accurate data that can be used in an actuarial model to project for the general population what percent will require services from the child welfare system, at what level, for what period of time, and at what cost. Another serious challenge is the relatively small number of children who will be enrolled as compared, for example, to covered lives under a public sector managed health care plan, making capitation for child welfare very risky.

Several public agency child welfare initiatives include reimbursement methods that resemble capitation. For example, in many of the county-administered initiatives, the state provides the county a capped allocation, and the county assumes responsibility for managing and delivering (or purchasing) child welfare services under this block grant. Under such arrangements, the county agency is often also given increased flexibility and control over resources and the ability to retain savings. The county agency may decide to share risks and case management responsibilities with individual service providers or lead

Florida’s Global Budget Transfer

The Department of Children & Families (DCF) contracts with twenty-two lead agencies for a fixed dollar amount that approximates the appropriation that district offices previously received to provide all child welfare services with the exception of investigations and the Hotline. Lead agencies are expected to access other funding sources, such as Medicaid for therapeutic services and local funding for prevention. In addition to the funds to support services, DCF transferred administrative and management resources (including capital equipment) to the lead agency based on a calculation of the pro-rata share of public agency positions eliminated as a result of privatization.

Prior to the introduction of lead agency contracts, DCF acknowledged that fiscal inequities existed in its methodology for allocating funds, which resulted in greater allocations to districts that had higher placement rates and longer lengths of stay. Over time, DCF has attempted to more equitably distribute funds and reward performance related to permanency, safety and well-being. Equitable funding is not yet fully evident, resulting in some lead agencies getting higher levels of funding than others.

When fully implemented, there will be over $400 million in contracts with lead agencies.
PART 1: NATIONAL TRENDS

There are also several lead agency models that include financing arrangements that resemble capitation. In Florida, nonprofit lead agencies operate under a global budget transfer. They are given a predetermined percentage of the state’s annual operating budget and asked to provide all services, in whatever amount needed, regardless of how many children and families in their geographic area may require services. The allocation is based in part on historic caseload size and previous spending for the geographic area covered and in part on assumptions of how the new privatized community-based care systems will affect future utilization patterns and outcomes.

Case Rates

Under this arrangement, a service provider, private lead agency, or other managed care entity (MCE) is paid a predetermined amount for each child referred. The contractor is not at risk for the number of children who will use services but is at risk for the amount or level of services used. For the contractor, if the case rate amount is adequate, it is a less risky financing arrangement than capitation.

In child welfare contracts, the case rate could be episodic or annual. An episodic rate means the contractor must provide all the services from initial entry into the plan until the episode ends. The point at which payments stop and risk ends varies from one initiative to another. However, it is common for the contractor to bear some risk until specified goals are achieved, whether it takes days, weeks, or years. For example, a typical case rate contract for foster care services might extend financial risks for up to 12 months after a child leaves the foster care system. If a child reenters care during that time, the contractor may be responsible for a portion (or all) of the cost of placement services.

Under an annual case rate, the provider receives the case rate amount each year the child is in the child welfare system and the contract is in effect. In both annual and episodic case rate arrangements, the payment schedule could be a monthly per child amount or it could be divided into lump sum payments that could be linked to

Finding

The most common risk-based model in child welfare is a case rate.

Episode of Care Case Rates

The Cuyahoga County, OH child welfare agency uses an episode of care case rate in a pilot that targets a portion of the county’s caseload of children, from birth to age 14, who are in specialized foster care or higher levels of care. Only children who have behavioral or health care needs and their siblings are in the pilot. The case rate amount ($50-53,000) was established through an RFP process.

The case rate is designed to cover the period of custody to permanency, plus 9 months (12 months for children who are adopted) and assumes that at least 50% of children achieve permanency within 12 months.

The payment schedule for contractors calls for 18 equal monthly payments for each child/family. The payments are made whether the child remains in care the entire 18 months or longer or achieves permanency sooner. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the contractor must take responsibility for the child’s care and services within the original case rate.
attainment of various outcomes. An episode of care case rate is far riskier for the contractor than an annual case rate due to the many factors outside of the contractor’s control that may extend the time it takes for the episode to end.

Bonuses and Penalties

As noted with the performance-based contract description, more public agencies appear to be aligning payment schedules and/or payment amounts to outcomes or results.

A number of states with fee-for-service arrangements, case rates, or other financing arrangements are also adding bonuses and penalties based on performance. Initiatives differ widely in the selection of performance measures and in the incentives that are provided. Some initiatives include only bonuses; in others, only penalties; and in yet others, both bonuses and penalties.

A number of other states and counties are experimenting with bonuses, penalties, or both that are added to case rate payments if the provider meets expectations.

Mechanisms Used to Limit Risks and Savings/Profits

Before examining the mechanisms used to limit risks, it is necessary to understand what the risks are. Every fiscal strategy, even a traditional fee for service arrangement, has risks -- the potential for revenues and expenditures to vary. When revenues exceed expenditures, there is a surplus, which can be taken as profit or reinvested in the system. When expenditures exceed revenues, there is a loss. The risks can be found in the number of children who use services, the unit costs, the case mix, the volume, and the duration. Risk-sharing is a function of determining who is responsible for each type of risk. There are different inherent risks associated with each of the previously described risk-based financing options.
PART 1: NATIONAL TRENDS

Because of the newness of risk-based contracting, the uncertainty in calculating the rates, and the likelihood that the contractor will be a nonprofit agency with limited capital reserves, most child welfare risk-based contracts also include mechanisms to ensure that contractors remain solvent and stable. The most common mechanism in child welfare initiatives is a risk-reward corridor. In addition to protecting contractors from excessive loss, the purchaser may also limit the contractor’s ability to retain profits or savings.

Child welfare purchasers have found other methods of limiting a contractor’s risk. For example, some child welfare case rates cover certain services typically reimbursed under Title IV-E funds, but the contractor is expected to bill Medicaid under fee-for-service arrangements to supplement the case rate. Or, in an attempt to better match level of risk to level of need, purchasers might propose risk-adjusted or stratified rates for children with different levels of service needs. Using a similar logic, in a few initiatives the purchaser allows the contractor to be reimbursed outside the risk arrangement on a fee-for-service basis for a certain number of children.

In some instances, the contract includes aggregate or individual stop-loss provisions that limit the contractor’s losses when expenditures exceed a certain amount for an individual child or for the entire covered population. Another method that is infrequently used in child welfare is a risk pool that can be accessed to cover unexpected costs under specified circumstances. The degree of exposure to risk and the potential for reward can also change over time within the same initiative.

Pricing the System and Adjusting the Rates

Child welfare initiatives have varied in their approaches to pricing the overall system, establishing rates for contractors, timing the introduction of financial risk, and adjusting rates over time. Some child welfare initiatives introduced financial risk during the initial implementation; others phased-in risk after some period of time—often after the first year of cost and utilization data collection and analysis. In some initiatives, the public agency allowed the competitive bidding process to set the price and establish the rates. In other initiatives, the rate was specified in the RFP.

In most instances, the overall budget for the initiative is initially based upon estimates of what similar services cost under the traditional system. The risk-based rates are also calculated on the basis of rates paid under per diem and fee-for-service arrangements. Many respondents to the CWLA surveys reported difficulty in accessing accurate historic data to guide them in pricing the system or establishing the rates. For example, few child welfare agencies have had the ability to estimate with confidence the costs of serving a child from entry to exit from the system as a foundation for developing an episode of care case rate. As a result of the initial guesswork, it has
not been uncommon for states to err in pricing the overall initiative or in setting rates, with, at times, mid-course corrections being made.

Anecdotal evidence suggests that at times, rates are adjusted based on state or county fiscal or political factors that do not necessarily reflect evidence of the sufficiency of the rates. In other instances, the changes are made in response to fiscal audits or independent evaluations. For example, as a result of higher than expected expenditures after the privatization contracts were introduced, Kansas undertook an independent audit that revealed the following:

- Start-up issues caused costs and lengths of services to be greater than anticipated. The auditors attributed many of the cost overruns to implementation problems, including difficulty attracting experienced social workers, larger numbers of referrals than expected, key infrastructure problems (including MIS development), and the individual learning curve of each provider.

- The largest variable in the overall cost of services was the type and amount of residential services used. The auditor noted that the renewed emphasis on family foster care appears to be reducing aggregate costs.

- The monthly cost was much greater than the bidders' projected estimates. The auditors estimated that cumulative costs were 65% higher than originally projected for foster care and 13.5% higher for adoption.

As a result of the under-estimation of costs and inadequate case rates, the Kansas foster care lead agencies experienced severe shortages in the first years of operation. By March 1999, one contractor (Kansas Children's Service League) had an operating deficit of $1 million; another (Kaw Valley Center) had a deficit of $6.5 million; and the third (United Methodist Youthville, which subsequently went into bankruptcy in June 2001 and since has reorganized) had a $7.5 million deficit. In an effort to address these issues, the Kansas legislature transferred approximately $50 million from the federal welfare-to-work program to foster care.

Fiscal Assumptions and Actual Performance

While cost containment or the re-direction of resources may be among the goals of the child welfare initiatives, many of the respondents to CWLA surveys indicate that the risk-based features they have incorporated also mirror best practice in child welfare. In fact, fiscal and purchasing changes do not appear to reflect a shift in ideology but rather recognition of the power of financial incentives to change practice.
Although child welfare respondents have rarely indicated that containing or reducing overall child welfare costs is the principal goal of the initiative, most initiatives do, however, have expected budget neutrality and the redirection of resources to provide more appropriate services to more people with the same dollars. In most initiatives, there were built-in assumptions about what effect the proposed change would have on costs. CWLA survey respondents were asked to compare actual fiscal performance data (if available) to fiscal assumptions that were made when initiatives were designed. Based on child welfare respondents report, no one-to-one relationship was found between fiscal assumptions and performance. Some initiatives were not designed explicitly or intended to save money, but they have (Illinois, for example), whereas others were intended to be cost neutral and have, in fact, cost more (Kansas, for example). Only three states expected the initiative to cost more than the previous system, but fiscal performance data indicate that 10 initiatives cost more than the previous system. In some instances, States reported they were pleased with results because funds had been re-directed, enabling more children and families to receive services at the same or slightly more costs.

There is little in the way of comparative analysis of risk-based initiatives with different structural designs to indicate that one structural or financing model is superior to another or, for that matter, superior to traditional contract arrangements.

It is important, however, that a public agency fully understand the pros and cons of each type of risk-based option and the potential opportunities afforded by different structural designs before making decisions. Some of the issues that must be considered are fairly straightforward; others require a full appreciation of how all the design pieces need to fit together to achieve results. It is also important to recognize that the ultimate success of an initiative may relate to many factors separate from the structural model and the risk option chosen.

3. Summary & Commentary

What is clear across published reports is that there is broad interest in privatization; there is great variation in the scope of current initiatives (in terms of geographical reach, target population, the number of clients served, and structural design); there is variation in financing mechanisms but with a common thread that attempts to link improved performance to reimbursement amounts or payment schedules; there are different approaches to defining and monitoring results but most initiatives are focused on outcomes related to state and federal mandates; and, there are mixed findings as to actual success related to effectiveness and efficiency (costs).16

Overall, the child welfare privatization initiatives have been consistent in some aspects since they first emerged a decade ago. Public agencies are still partnering predominantly with nonprofit agencies. The driving forces have also been consistent but with a broader involvement of the legislature in more recent years. States appear to be focused on improving quality and are increasingly turning to independent evaluations to confirm results. Risk-sharing arrangements are commonplace, but with new twists that more directly link payment schedules or amounts to performance.

Every child welfare initiative has had to wrestle with basic design and procurement questions relating to the type of risk or results based financing arrangements that will be used and the types of organizations that will be allowed to participate in the bidding process. There appear to
be many reasons why some initiatives succeeded and were later expanded and others failed to achieve fiscal and programmatic goals and were dismantled. At times, plans failed because they had design flaws from the outset or because there was not a balance between expectations, authority for decisions, and resources. It is encouraging that many initiatives appear to focus on increasing family involvement, cultural competency, and wrap-around approaches to service planning and delivery. Less promising is the fact that many states and private agencies still struggle to track basic utilization, cost, and outcome data within child welfare and across other child-serving systems to analyze the effect of various privatization initiatives.

In the past few years, more initiatives have undergone fully independent evaluations. However, the evidence is mixed. For example, the University of South Florida’s evaluation of twenty-eight Florida counties in which community-based care (CBC) was operational found great variability in the performance of the CBC sites on different indicators related to safety, permanency, and well-being, in part due to the different stages of the implementation process and in part due to the significant variability in their designs and the level of funding. The overall conclusion about expenditures per child contained good news but also pointed to the need for patience in finding improved results. CBC and non-CBC counties experienced similar average expenditures per child for the first four years of CBC, but not for the last three years, where average expenditures per capita were lower for CBC counties than non-CBC counties. Additionally, CBC counties spent a lower proportion of their total budget on out-of-home care than non-CBC during FY 02-03. The Florida cost findings are similar to those of other independent evaluations, including the Colorado and Kansas evaluations.

In regards to achieving specified outcomes, evidence is promising but still inconclusive in many areas. Again, the Florida evaluation found that the privatized CBC sites performed, for the most part, as well or better than the non-privatized sites. However, there was variability among the CBC sites with some performing far better than others on certain outcomes but poorly, in comparison, on others. The most difficult areas to improve were those areas that are most difficult for public agencies as well—namely, moving children safely into timely permanency without having an increase in re-entry or other undesirable outcomes.

**Best Practices in Privatized Case Management Systems**

Research studies have identified a number of promising approaches found in various types of privatization initiatives including the following:

- **Wraparound values/principles.** Many initiatives appear to be grounded in system of care principles. For example, the majority of the Florida Community-based Care plans described an approach to case planning and services delivery that reflects core values of cultural competence, family involvement, and individualized plans that addressed identified needs.

- **Family team conferencing.** The majority of initiatives that have included privatized case management require the contractor to use a shared family decision making model to develop and revise case plans. Many initiatives include standards and timeframes for convening teams and completing and revising plans. Providers are monitored to ensure that providers are meeting standards.
PART 1: NATIONAL TRENDS

• **Evidence-based practices & decision support tools.** A few initiatives have specified a particular practice that the contractor is required to use (MST, for example). More often, the contractor has had to describe the clinical protocols or decision support tools that would be used to ensure quality and appropriate, individualized services. The public agency typically signs off on protocols before implementation.

• **Continuity in case managers.** Under traditional child welfare systems, it is not uncommon for a child and family to have different caseworkers depending on the services and case plan goals. For example, a child might have one caseworker if services are provided in-home and then be assigned a different caseworker if placement is required. If the goal becomes adoption, a different caseworker might take over the case. Under many of the new initiatives, a single case manager (or a case management team) is assigned to the case and the same caseworker retains responsibility from the time of assignment until achievement of permanency and case closure. Specialists might be assigned to assist the worker (adoption or independent living specialists, for example), but the child and family experience continuity in case management from entry to exit. This model is the dominant model in Florida.

• **National accreditation standards.** A number of states require contractors to be accredited by a national accrediting body (COA, CARF, JACHO) and they mandate that nationally recognized caseload standards be met. (It is not clear in some cases that the funding is sufficient to support the required caseload standards.) Florida, Kansas, Missouri, and Illinois, for example, require accreditation.

• **Expanded services through community service networks.** An explicit goal in nearly half of the initiatives described by CWLA was to expand the current array of services available to children and their families through the creation of a provider network. Often, the public agency specified the services and supports that had to be included in the network but allowed the contractor flexibility in developing network standards and contracts with service providers. In some instances, the private agency that is responsible for case management is also responsible for network development. In other instances, the case management agencies and agencies responsible for network development are different and are linked by contracts or interagency agreements.

• **Improved use of technology.** As noted previously, while many initiatives still struggle to build and maintain adequate IT, many have built capacity that has resulted in improved data collection and use of data at the case level and as a guide for future system improvements. With better data on outcomes and costs, many initiatives have succeeded in getting additional support from legislators.

• **Added training and supports for caregivers.** Many initiatives have given extra attention to recruiting and supporting caregivers (foster, adoptive, and kinship families). Many have added formal and informal supports, including additional respite, bonuses for recruiting other families, mentors or resource families for new families, and networking/communications mechanisms.

In summary, while privatization may offer real opportunities to improve results, the development and implementation of these arrangements present a host of challenges.
In order to better understand initiatives of particular relevance to Arizona’s focus, in September 2005 interviews were conducted with private agency child welfare executives responsible for different types of case management services in five states. The sites were selected to represent the most common types of initiatives described in previous studies—namely, those involving case management and services for children and youth in or at risk of out-of-home care and those with adoption as a permanency goal. The interviewees noted a number of challenges that were similar across the different projects and consistent with national research including the following:

- **Inadequate data collection and analysis capability.** Data are needed to guide decisions about the structure, programmatic directions, and financing methods; to develop appropriate outcomes and benchmarks; to assess whether those outcomes/benchmarks are being met; and to make decisions regarding needed changes. Typically, neither the information systems nor the data they produce are adequate for the public purchaser or for the contract providers, especially those operating under risk-based contracts. Data collection and analysis was an area of concern for three of the five agencies interviewed (MS, FL, KS).

- **Lack of role clarity between private agency case managers and public agency staff.** Public agencies do not relinquish legal responsibilities when they enter into contracts. It has been difficult in many initiatives to find the right balance in public and private agency roles and responsibilities. Efficiency has been undermined because the public and private sector roles were not clear or were duplicative. Private agencies have been placed in untenable positions under risk-based contracts when they do not have control over key decisions that impact risk. This issue was raised by four of the five interviewees (MA, MO, OH, and KS).

- **Inadequate service capacity.** Without adequate and appropriate services, privatization is not likely to achieve, safety, permanency, or well-being goals regardless of the management, contracting, or financing model. Yet, in many cases, the contractor has not had the authority or resources to fill service gaps that pre-dated the initiative. Resources outside of traditional child welfare funding sources are often needed to build the capacity needed. Lack of service capacity was an issue for four of the five interviewees (MA, MO, OH, FL).

- **Poorly defined or the wrong outcomes.** The importance of outcomes in privatization efforts has been emphasized consistently. However, it is not always evident that outcomes included in contracts are the *right* ones or that they are defined in ways that are meaningful or measurable. Challenges related to outcomes were raised by three of the five states (MA, MO, Fl).

- **Resources that are not aligned with expectations.** When public agencies develop their privatization plans, the performance expectations are often higher than performance in the current system, while the resources are the same or less, making it difficult to achieve either programmatic or fiscal goals. This struggle was of concern to two of the five interviewees (MO, KS).

- **Problems with financing.** Significant variation exists in financing arrangements, with various approaches to pricing the initiative, establishing rates, timing the introduction of financial risk,
and adjusting rates over time. Issues arise in relation to the underlying sources of funding, the fiscal methodology, and the mechanisms to address the potential impact of risk-sharing. After a decade of experimentation, there is still no compelling evidence of the efficacy of one financing approach over another. Recent evidence might indicate that the dominance of the case rate may be giving way to other performance-based contracting options. Challenges related to financing were raised all interviewees.

- **Lack of private agency expertise in family-centered practices, evidence-based innovations, or new business processes.** A downfall of many initiatives is the lack of knowledge or experience of the private agencies in managing risk, creating provider networks, introducing appropriate utilization management, adapting and using protocols and decision support tools to better match services to needs and improve services, and meeting the requirements of legal mandates that are at the heart of child welfare case management. Program and business expertise was an issue for all of the executives interviewed.

- **No magic bullet for staffing.** Private contractors have had to come to terms with the same challenges the public agency faces -- namely the difficulty recruiting, supporting, and retaining workers and caregivers. Three of the five executives raised this as a primary concern.

- **Lack of understanding of legal issues and experience engaging the courts.** Significant difficulties have arisen when privatization plans failed to recognize the need for judicial buy-in. Court-related issues are especially important for public agencies to consider when balancing the level of risk with the degree of autonomy contractors have in decisions that affect risk. The Kansas experience with the initial launch of privatization should have been a clear warning for other States. Unfortunately, this issue continues to be a challenge in many initiatives. In other initiatives, as noted in the case studies, even though the case management is privatized, many states have ensured that the public agency’s legal staff remain in place and in some instances, the public agency staff attend hearings with the private agency case managers.

Various researchers using different methodologies have identified additional challenges, including the following:

- **Limited funding sources fail to meet complex needs.** Despite the higher prevalence of poor physical health and mental health and substance abuse issues among children and families, many privatization contracts are funded primarily with child welfare funds and have failed to include arrangements for accessing health, dental, and behavioral health services that fall outside the contract. This funding issue has been a challenge for Florida CBC agencies and the solutions have varied.

- **Adherence to rigid procedures.** By accident or design, some projects have struggled because there were inherent barriers to innovation. Contracts often require adherence to day-to-day operating procedures required of public agency staff that were not flexible enough to allow contractors to succeed. Simply changing from a public agency to a private agency will not result in improved outcomes or efficiencies.
PART 1: NATIONAL TRENDS

- **Flawed contracts.** In many initiatives, the RFPs and contracts are fraught with problems. In some cases, expectations are framed in ambiguous terms, making it impossible to determine what the private agencies were expected to do, what clients were expected to receive, and what results were to be produced. According to Madelyn Freundlich, “In sum, in many privatization initiatives, the dynamic was one of an inexperienced purchasing agent attempting to develop at-risk contracts with inexperienced sellers.”

- **Overdone or underdone monitoring.** Most public agencies have struggled to find the appropriate level of monitoring and oversight. Researchers have noted a tendency for micro-management in some initiatives, while in other initiatives, the level of monitoring seems woefully inadequate. Over time, the public and private agencies in many Florida CBC sites have struck an appropriate balance and have created some promising practices that merit further study. The HFC case example in Appendix 1 describes the model used.

- **Limited consumer involvement.** Organizations that have studied the essential features of privatization consistently have highlighted the importance of consumer involvement. Though it is a value articulated in most RFPs and contracts, it is unclear whether (and how) consumer involvement is actually occurring in the planning, implementation, monitoring, or evaluation of child welfare privatization.

- **Lack of attention to cultural & linguistic competence.** Nationally, systems of care for children are attempting to respond effectively to the needs of children and families from culturally and linguistically diverse groups. Again, though a principle in all child welfare policies, it is unclear whether cultural and linguistic competence is being considered or is improving under child welfare privatization. Given the large Native American population in Arizona attention to cultural competence and engagement of the Indian Tribal Councils would be particularly important.

### Lessons Learned & Advice from the Field

As depicted in Table 1, the structured interview protocol for private agency executives in five States asked the executives to prioritize the most important issues for both public and private agencies to consider in planning for a privatized case management system.

Table 1: Advice from the Field

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Advice</th>
</tr>
</thead>
</table>
| **What are the top three things public agencies should consider in contracting for case management?** | 1. If both public workers and private agency case managers have case management responsibilities, make sure there is clarity in public and private roles.  
2. Make certain that the public agency retains the responsibility for legal services.  
3. Include fiscal incentives aligned with results -- but make sure you have IT and quality assurance capacity to monitor both costs and outcomes. |
## PART 1: NATIONAL TRENDS

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Missouri Interdepartmental Initiative</strong></td>
<td>1. Build a real partnership with the private sector to get the political clout needed for hard times.</td>
</tr>
<tr>
<td></td>
<td>2. Make sure the financing option gives flexibility in funding and specifies the outcomes/results desired.</td>
</tr>
<tr>
<td></td>
<td>3. Require accreditation as an added protection for quality.</td>
</tr>
<tr>
<td><strong>Cuyahoga County, OH. Case Rate Pilot</strong></td>
<td>1. Get “buy in” from all levels of the public agency staff.</td>
</tr>
<tr>
<td></td>
<td>2. Clearly define roles and responsibilities between the county staff and the case management organization.</td>
</tr>
<tr>
<td></td>
<td>3. Have mechanisms to avoid and manage the risk of abuse and neglect of children while in the system.</td>
</tr>
<tr>
<td><strong>Florida Lead Agency Heartland for Children</strong></td>
<td>1. The importance of data accuracy, accessibility, and integrity.</td>
</tr>
<tr>
<td></td>
<td>2. The complexity of financial reporting (merging governmental accounting into traditional non-profit accounting systems).</td>
</tr>
<tr>
<td></td>
<td>3. The importance of strong leadership and the requirement of critical, analytical thinking to ensure viability of the lead agency.</td>
</tr>
<tr>
<td><strong>Kansas Privatized Adoption, foster care, and in-home</strong></td>
<td>1. The impact on federal requirements for documentation.</td>
</tr>
<tr>
<td></td>
<td>2. Knowledge of expenses (including direct and indirect costs)</td>
</tr>
<tr>
<td></td>
<td>3. A plan to develop “buy-in” from all stakeholders</td>
</tr>
</tbody>
</table>

### What are the top three things private agencies should consider in developing the capacity to provide case management services?

| Massachusetts Commonworks                        | 1. Look at this as an opportunity but also recognize what you don’t know and hire the people who know case management from the public agency perspective. |
|                                                 | 2. Look at staffing: recruitment, training, and then build capacity to respond to the public agency’s need for immediate responses. |
|                                                 | 3. Have an attorney review liability issues and prepare the Board.     |
| **Missouri Interdepartmental Initiative**        | 1. First, they need to build the expertise. Start by hiring experts to guide them through all they don’t know about the system’s obstacles. |
|                                                 | 2. Get a handle on costs and if the money isn’t there, don’t bid.     |
|                                                 | 3. Philosophy of care. Many providers will need to embrace family-centered practices, build child/family strengths that will help to achieve permanency, while also acquiring new business tools & skills. |
| **Cuyahoga County, OH. Case Rate Pilot**         | 1. Make sure that they have enough referrals that fit the project criteria -- Is the target population big enough? |
|                                                 | 2. Understand risk. Risk can be created by actions outside of the control of the case manager (ie. court, school). |
|                                                 | 3. Make sure they have the services that will meet the needs of the population that will be included. |
PART 1: NATIONAL TRENDS

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Florida Lead Agency</strong></td>
<td>1. Prevention capacity- Prevention is an investment strategy. When properly administered, it will realize cost avoidance.</td>
</tr>
<tr>
<td><strong>Heartland for Children</strong></td>
<td>2. Service capacity- Utilization Management is a core business strategy in the system of care to manage resources, increase choice and promote cost efficiency.</td>
</tr>
<tr>
<td></td>
<td>3. System capacity- A true “system” of care includes the best characteristics of structure, process, subsystems, information, growth and integration.</td>
</tr>
<tr>
<td><strong>Kansas</strong></td>
<td>1. The private agency needs to have an MIS system that captures the type of data that is needed to track cases and provide fiscal and other management reports.</td>
</tr>
<tr>
<td><strong>Privatization of foster care, in-home, and adoptions</strong></td>
<td>2. A utilization management system which authorizations of all out of home placement and services and payment.</td>
</tr>
<tr>
<td></td>
<td>3. Be prepared to pay mid-level managers higher than average salaries.</td>
</tr>
</tbody>
</table>

Key Success Elements

Based upon national research findings and the interviews with private agency executives, key factors for success, across different designs, appear to relate to the sophistication of the purchaser in planning, procurement, and contract oversight; the alignment of resources with expectations; the adequacy of funding and contractor rates; the buy-in from stakeholders; the care with which system designs were developed; the clarity and appropriateness of the expected outcomes; and the infrastructure, leadership, and innovation of the contractor and the public purchaser. Successful privatization initiatives share a few essential characteristics in common with effective public agency programs, including the following:

- Strong and steady leadership
- Clear vision, goals, objectives, and performance criteria.
- Sufficient staffing and other resources to implement the vision
- Continuous and meaningful performance monitoring
- Specific, measurable outcomes
- State-of-the-art information systems that allow private and public service providers to track progress and outcomes
- Strong and committed leadership
- Resilient interpersonal working relationships between public and private agencies
- Strong ties to the communities they serve
- New business tools and innovative practices.

It seems clear that privatization is best implemented through a broad-based planning process that engages stakeholders in a sustained dialogue for the purpose of reaching consensus on the goals of the privatization initiative. Reaching agreement on difficult decisions later in the planning process will be far easier if all parities are united in a shared vision.
PART 1: NATIONAL TRENDS

At the outset of planning for privatization, it is also important for policymakers and decision makers to recognize that positive results will not be immediately evident. States should not expect to save money through privatization—at least not in the short-term. Greater efficiency and improved outcomes for children and families will not be achieved simply because private agencies assume primary responsibility for case management but rather because all of the agencies involved are committed to working together over the long haul to identify and remove barriers that stand in the way of achieving a shared vision.

Privatization Continues to Evolve

While the previously described national trends information accurately reflects research on initiatives that were underway at the time the studies were conducted, it is important to note that initiatives are not static. Changes may be made in financing arrangements or in the overall design of an initiative when it becomes clear that the contractor does not have control over the factors that result in unacceptable risks or when results are not as expected. As states and contract agencies fully assess the costs and benefits of their financing and contracting arrangements, it is not unusual for State and local initiatives to alter their initial plans. Some initiatives that were included in the CWLA 2000-2001 survey report, for example, have made significant changes in various aspects of the model subsequent to the 2003 report. Several initiatives, selected from the 39 described in the CWLA report, are highlighted to illustrate the types of shifts that have occurred:

◊ In Missouri, child welfare functions are the responsibility of the Division of Family Services (DFS) of the state Department of Social Services (DSS). DSS also includes the Division of Medical Services (Medicaid) and the Division of Youth Services (DYS) for juvenile corrections. There is a separate Department of Mental Health (DMH). In 1997, the then-Directors of DSS and DMH formed the Interdepartmental Initiative for Children with Severe Needs with funding from The Robert Wood Johnson Foundation, the Center for Health Care Strategies, and pooled funding from dollars provided by DSS and DMH. At the end of the original contract period (February 2002), two of the original Initiative agency partners elected not to participate in the contract extensions. DMH, citing budget difficulties, withdrew, as did DYS, which believed that it already provided the services provided by the lead agency. These developments occurred shortly after the departure of the DSS and DMH Directors who were responsible for the creation of the Initiative. While the initiative continues with the original contractor (through six contract extensions), the blended funding is now reduced to Medicaid and child welfare funds. The contract is due to expire at the end of 2005 and with a new performance-based contract reform underway, the future of the Interdepartmental Initiative is unclear. It appears that in the latest privatization effort in Missouri, the State has taken core elements from the previously described Illinois model.

◊ In Hamilton County, Ohio, an inadequate case rate caused the contractor (Beech Acres) to use its own endowment to subsidize (more than $10 million) an interdepartmental system of care initiative that targeted cross-system children with complex needs. At the time of renewal, Beech Acres’ refusal to accept a continuation of what it believed was an inadequate case rate ultimately led to termination of contract re-negotiations. The county re-bid the initiative and a new provider (from out-of-state) took over the contract.
The Franklin County, Ohio Children Services Project was based on the Franklin County Children Services (FCCS) agency agreement with the county Alcohol, Drug Abuse, and Mental Health (ADAMH) Board and was intended to facilitate better access to behavioral health services by children and families in the child welfare system. The agreement fell apart in 2002. Several reasons were given for the termination of the ADAMH agreement. Among other issues, a recent case study, cited ongoing underfunding of the ADAMH Board and the arrival of a new ADAMH director who did not support the agreement.

The Permanency Achieved Through Coordinated Efforts (Project PACE) initiative in Texas, managed by the Lena Pope Home, targeted children with therapeutic needs and their siblings who entered the foster care system from counties that surround Fort Worth. At the time of the CWLA survey, the contractor was expecting to serve approximately 500 children with a budget of approximately $14M under a fixed rate contract of $77/day per child, regardless of the level of out-of-home care. The project was dismantled shortly after the CWLA survey report was published. More recently, in 2004, Governor Rick Perry declared the condition of the system an emergency issue and called upon the 79th Legislature to act decisively to provide the resources and reforms. Senate Bill 6 established a framework for reform by requiring among other things that the Department to privatize substitute care and case management services.

The Commonworks initiative in Massachusetts was one of the earliest case rate lead agency models that served children with intensive needs. The original financing was no-risk for 18 months to allow the agencies and the State to track actual costs and outcomes. The case rate that was introduced was based upon that assessment. In recent months, Commonworks has been dissolved and absorbed by a new initiative. The previous case rate (that also included bonuses and penalties) has been abandoned for a non-risk cost-reimbursement model solely for case management services, with direct services being reimbursed by the State agency. (The model is described in Appendix 1)

It is unknown how many other initiatives reported by CWLA or other research projects have modified their original privatization project. Some of the early initiatives were abandoned due to changes in the State’s overall priorities, changes in leadership, or a natural evolution brought about by increased knowledge about what worked and what did not. Some initiatives introduced strategies to ensure sustainability in the face of leadership changes or economic downturns, including creating legislatively mandated bodies to oversee the initiatives, serve as a voice for the community, and identify and access the resources needed to support the initiative. Florida is a good example.

Research has helped to identify both promising approaches and challenges in various current initiatives across the country. However, it is important to recognize that privatization is continuing to evolve and with each evolution there are new lessons to be learned.
PART II. CURRENT PERFORMANCE, CAPACITY, AND INTEREST IN PRIVATIZATION

Laws 2005, Chapter 286 (SB1513) requires the Department of Economic Security (DES) to "submit for review by the Joint Legislative Budget Committee options for the privatization of portions of the case management duties for child protective services." In response to this requirement, an assessment of Arizona's readiness to expand its current privatization efforts to include case management services was completed in October and November 2005. The assessment is based upon findings from focus groups, stakeholder surveys, interviews, and document reviews (including procurement procedures, performance reports, the Governor’s CPS Reform Initiative, the Blueprint for Realigning Arizona's Child Welfare Program, and various DES evaluations, including those conducted by the Arizona Auditor General).

This section has three parts: 1) an introduction to the readiness assessment process and current DES organizational structure and activities; 2) the results of surveys and focus groups and interviews conducted over a two-week period in October 2005; and, 3) a summary of overall findings.

1. Introduction

The assessment of DCYF readiness involved focus groups, surveys, and interviews with the DES Director, a District Program Manager, Central Office Administrative Staff, child advocates, and legislative staff members.

Twenty-two focus groups were held with 205 individuals who also completed surveys that posed a range of questions regarding privatization. The focus groups and surveys were designed to assess the level of understanding of privatization, perceptions about challenges and opportunities, and views about current DCYF performance and its capacity for privatization, and to identify the issues that stakeholders felt were most important for Arizona policymakers to consider in weighing privatization options. The individual interviews were designed to develop an understanding of current DES operations and the scope of current privatization and to examine some of the administrative areas that are critical to management of privatized contracts, including but not limited to IT, fiscal, procurement and monitoring, and quality assurance capacity.

In addition to these information gathering efforts, an extensive review of documents was conducted. These documents included procurement procedures, internal performance data, external DES evaluations, a number of reports produced by the Arizona Auditor General, and various reform plans, including the recently released Blueprint for Realigning Arizona's Child Welfare System.

DES Organizational Structure

DES is divided into nine divisions, including six program divisions, three administrative divisions, and a Central Administration that includes the Director’s Office.

The Division of Children, Youth and Families (DCYF) manages child protective services, including
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

child protective investigations, foster care services, kinship care, independent living services for young adults, adoption services, in-home family services, intensive family services, and substance abuse treatment services for families whose children are at imminent risk of out-of-home care.

Arizona’s fifteen counties are divided into six regions, which are referred to as districts, with a total of 64 offices. District I (Maricopa County, including the city of Phoenix and surrounding cities) and District II (Pima County, including the city of Tucson) are the urban districts; Districts III through VI are rural districts. Each district provides:

- Investigation of child protective services (CPS) reports
- Case management
- In-home services
- Out-of-home services
- Contracted support services
- Permanency planning
- Foster home recruitment and training
- Adoptive home recruitment and certification

The Statewide Child Abuse Hotline is centralized for the receiving and screening of incoming communications regarding alleged child abuse and neglect. Incoming communications are centrally screened to determine if the communication meets the definition and criteria of a CPS report. Report information is triaged to determine risk of harm to the child and to establish a response timeframe. Reports are investigated by Child Protective Services Specialists or referred to other jurisdictions (such as tribal jurisdictions) for action.

Central Office functions for the Division and the Administration include:

- Policy and program development
- The Promoting Safe And Stable Families Program
- Finance, budget and payment operations
- Statistical analysis
- Field support
- Interstate Compact On Placement Of Children
- The Child Welfare Training Institute (CWTI) for initial in-service staff training, ongoing/advanced staff training, and out-service and education programs
- New initiatives and statewide programs
- Contracting and procurement
- Continuous quality improvement
- Management information system/automation

According to the DCYF, in fiscal year 2005, there were 1,793 authorized full-time equivalent (FTE) positions, of which 1,023 were CPS specialists and supervisors.
**PART 2: AN ASSESSMENT OF ARIZONA’S READINESS**

**Current Reform Efforts**

As a result of Governor Janet Napolitano’s Child Protective Service (CPS) Reform Initiative and funding support from the Arizona legislature, Arizona has made significant system improvements in recent years, especially in the areas of intake and investigations and case planning. At the same time, the number of children in out-of-home care increased 37% in the two-year period between March 2003 and March 2005. The number of children in out-of-home care increased by an additional 3% between March and June 2005.

Nearly 10,000 children are currently in out-of-home care in Arizona, with approximately 15% placed in group care and 8% in residential treatment centers or shelters. These numbers suggest a system that is overly-reliant on out-of-home care as a service option. The numbers suggest also an under-reliance on community-based services to support and strengthen families and meet the needs of children, youth and families in their own communities.

In response to the challenges that it has identified in effectively serving children, youth and families, DCYF, in partnership with private agencies, is in the process of implementing practice improvements in a number of areas. The following are among the current goals and strategies:

- Keep children safe in their own homes through the implementation of a comprehensive in-home services model that includes intensive and moderate levels of service based upon the needs of the child and family. The model includes collaborative partnerships between CPS In-home Specialist Units, contracted service providers, Behavioral Health Services, and other community organizations. In-home services are being gradually implemented across the state, beginning in Maricopa and Pima Counties.

- Promote reunification through the implementation of a Title IV-E waiver that allows for flexible funding to support reunification efforts through intensive support and wraparound services. DCYF is partnering with contract providers to deliver individualized reunification services in select sites in Maricopa County.

- Build capacity to place children in family-like settings through targeted recruitment in all communities. DCYF currently contracts for foster and adoptive family recruitment from a number of private agencies. An RFP is due to be released that will include expectations for contract agencies to provide resource families on a 24 hour basis for children needing placement.

In addition to the collaborations with private service providers to enhance and expand services, DCYF has a number of other initiatives underway to foster family-centered practices, enhance staff training, and promote integration of services, including the following:

- Enhance family-focused practice through the implementation of “Family to Family.” With support from the Annie E. Casey Foundation, implementation is being phased into various Maricopa County offices with possible expansion to Tucson.
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

DES is implementing three family engagement models: 1) Family Team Decision Making (FTD) for the purpose of making an immediate placement decision; 2) Family Group Decision Making for the development of a plan to safely return the child home or place the child with a relative; and 3) Child and Family teams for the purpose of developing a behavioral health plan.

◊ Foster increased service integration through co-location of DCYF staff with JOBS, TANF, and domestic violence staff support to create Family Connections Teams to address poverty, kinship care support, and family violence. Teams are in place in Maricopa and Pima Counties.

◊ Eliminate the disproportionality and disparate outcomes for children of color through participation in the Casey Family Program "Breakthrough Series Collaborative," an effort being initiated in Maricopa County.

◊ Provide family-centered substance abuse services to parents of children in or at risk of foster care through the Arizona Families F.I.R.S.T (AFF) program.

Some of these reforms have been fully implemented; others are being gradually phased in; and others are in the planning phase.

As noted, DCYF has a history of working collaboratively with private agencies to solve complex problems. In many of the new initiatives private agencies have partnered in planning the initiative and are providing services under contract with DCFY.

2. Listening to Stakeholders: Surveys & Focus Group Findings

Twenty-two focus groups were conducted with stakeholders in District 1 (Phoenix), 2 (Tucson), 3 (Flagstaff), and 5 (Payson and Casa Grande). There were three types of focus groups: (1) internal DCYF staff, (2) private agency service providers, and (3) external stakeholders (non-provider). As indicated in the following tables, there were 205 respondents to the surveys, including 107 DCYF staff (52%), 56 external stakeholders (27%), and 42 providers (21%).

Participants in the DCYF focus groups included CPS Specialists, Supervisors, Assistant Program Managers, and District Program Managers with responsibilities for the Hotline, CPS Investigations, in-home case management, out-of-home case management, adoptions and adoption and guardianship subsidies, and independent living services.

Focus groups with providers included child welfare and behavioral health providers who provide services to children and families in the child welfare system.

Focus groups with external stakeholders who are not private agency providers included parents (birth, kin, foster, and adoptive), CASAs and Foster Care Review Board (FCRB) members, representatives from other State agencies or divisions and the Judiciary, advocates, and Tribal leaders.
Table 2: Types of Non-Provider External Stakeholders Participating in Focus Groups

<table>
<thead>
<tr>
<th>External Stakeholders</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent or Kin Caregiver</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Foster or Adoptive Parent</td>
<td>10</td>
<td>18%</td>
</tr>
<tr>
<td>FCRB or CASA</td>
<td>11</td>
<td>20%</td>
</tr>
<tr>
<td>Judicial</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Other State Agency or Division</td>
<td>17</td>
<td>30%</td>
</tr>
<tr>
<td>Child Advocate</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td>Community Interest</td>
<td>2</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other (4 Tribal, 1 Judge)</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>56</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 3: Types of DES Staff Participating in Focus Groups

<table>
<thead>
<tr>
<th>Position</th>
<th>N</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Service Workers, CPS Specialists, and CPS Program Specialists</td>
<td>70</td>
<td>66%</td>
</tr>
<tr>
<td>Unit Supervisors</td>
<td>30</td>
<td>28%</td>
</tr>
<tr>
<td>Assistant Program Manager/Deputy Program Managers, and District Program</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>Managers</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>106</td>
<td>100%</td>
</tr>
</tbody>
</table>

The provider participants included agencies with large DES contracts (in excess of $10 million annually) and those with contracts of less than $1 million annually. Some of these participating providers were heavily dependent upon DES contracts; others had contracts that represented only a small percent of the agency’s overall budget.

Table 4 breaks out the agencies by contract size and percent of budget. Data from 24 agencies (57%) is included. Eighteen agencies (43%) did not provide budgetary or contract information.

*It is important to note that the survey asked about DES contracts and not specifically about DCYF contracts.*
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

Table 4: DES Contract Amounts of Participants & Percent of Overall Budget (N=24)

<table>
<thead>
<tr>
<th>Contract Tot.</th>
<th>N (% of participants)</th>
<th>N</th>
<th>DES contract as percent of agency budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 million</td>
<td>5 (21%)</td>
<td>3</td>
<td>&lt; 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10-25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>1-2.9 million</td>
<td>7 (29%)</td>
<td>3</td>
<td>&lt;10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>25-50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>52-65%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>3-4.9 million</td>
<td>3 (12.5%)</td>
<td>1</td>
<td>10-25%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>26-50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>51-65%</td>
</tr>
<tr>
<td>5-6.9 million</td>
<td>0</td>
<td>1</td>
<td>26-50%</td>
</tr>
<tr>
<td>7-9.9 million</td>
<td>3 (12.5%)</td>
<td>1</td>
<td>66-80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>&gt; 90%</td>
</tr>
<tr>
<td>10-12.9 million</td>
<td>1 (4%)</td>
<td>1</td>
<td>26-50%</td>
</tr>
<tr>
<td>&gt;13 million</td>
<td>5 (21%)</td>
<td>1</td>
<td>26-50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>51-65%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>66-80%</td>
</tr>
</tbody>
</table>

Most of the focus group participants had a longstanding relationship with DES. Sixty-five percent of external stakeholders have had a relationship with DES for over 5 years; 55% of providers have provided services to DES over 5 years, and 59% of DCYF staff reported being employed with DES for over 5 years. Nearly a quarter of all respondents reported employment, contractual, or other relationship with DES for over 15 years.

Survey Findings

Focus group participants completed a survey prior to the focus group discussion. Slightly different versions of the survey were used with different types of stakeholders but many of the questions were the same, allowing for comparisons within and across stakeholder groups. Survey instruments are included in Appendix 2.

The following findings reflect the information provided by survey respondents. Key issues and themes that emerged in the focus group discussions and individual interviews are summarized at the end of this section.
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

What Does Privatization Mean?

The survey asked respondents to describe what the term privatization means. Fifty-five (27%) of the 205 respondents did not answer the question or indicated they did not know what privatization meant. As evidenced by the examples in the textbox, the majority of stakeholders defined key elements of privatization, with an understanding that it referred to a contractual relationship between DES and a private agency that shifted responsibility for a function or service previously provided by DES to a private contractor.

There were notable differences in the tone of definitions offered by DCYF staff and providers. As the examples illustrate, providers tended to set a neutral or positive tone; no provider addressed the potential loss of public sector jobs. DCYF staff, on the other hand, were far more likely to highlight potential negative consequences, especially the loss of jobs. DCYF staff also mentioned their negative experiences working with for-profit managed behavioral health organizations and under-resourced nonprofit agencies as evidence that privatization would not work for child welfare. External stakeholders that were not providers held a mix of positive and negative opinions about privatization.

What Are the Benefits of Privatization?

Respondents were asked an open-ended question about the possible benefits of privatization. Overall, 122 of the respondents (60%) identified one or more possible benefits of privatization. More than one-half (56%) of DCYF staff and external stakeholders (57%) and close to three-quarters (71%) of providers identified one or more possible benefits.

The identified potential benefits of privatization included: increased flexibility, particularly with respect to "red tape" and personnel matters; greater competition and enhanced consumer participation; better quality and more effective service; enhanced coordination with other local agencies leading to greater continuity of care; increased cost-effectiveness and administrative efficiency; increased professionalism; the promotion of innovation; greater ability to alter or terminate programs; and local investment in the governance process, which results in a better adaptation of the service system to local circumstances and increased local accountability.

As illustrated in the textbox, all types of respondents cited similar types of benefits. Relatively few, however, mentioned the three most widely cited reasons that public administrators (particularly those who move to performance- or results-based contracts) give for privatizing services: improved outcomes for children and families, the introduction of evidence-based...
practices, and increased accountability.

Respondents offered contradictory views about the impact of privatization on costs. Some cited lower salaries in the private sector that would result in cost savings, and others pointed to better salaries and benefits in the private sector that result in increased costs. As noted in the introductory summary of national research, the findings on costs are, in most privatized systems, mixed.

Several respondents noted that families might prefer involvement with a private rather than a public agency and that privatization could provide greater choice and a voice for consumers in the service process. One provider noted that “if contracts are well written, fewer children will be placed in group homes, caseloads will go down, and new practices will strengthen families/ communities.”

What are the Biggest Challenges or Barriers to Privatization?

Research studies have documented many challenges or barriers to privatization, including: decreased public accountability and control; difficulties in establishing, maintaining and monitoring performance standards and contractual obligations; unrealized cost savings; declines in service quality or the "skimming" of clients so that the most difficult and needy clients do not receive services; unreliable or ineffective contractors; and, the subjection of private agencies to public policy shifts and budget cuts that threaten the viability and stability of the agency.25

Surveys asked respondents to describe possible barriers or challenges to privatization. As the examples in the textbox show, 79% of providers, 72% of DCYF staff, and 64% of external stakeholders listed one or more barriers that were consistent with national research findings.

<table>
<thead>
<tr>
<th>Benefits of Privatization</th>
</tr>
</thead>
<tbody>
<tr>
<td>• There could be more resources, less hierarchy and less administrative red tape. (DCYF Supervisor)</td>
</tr>
<tr>
<td>• The private agencies might be able to start with a clean slate. (CPS Specialist)</td>
</tr>
<tr>
<td>• There could be more community support and outside funds from grants. (DES Assistant Program Manager)</td>
</tr>
<tr>
<td>• Most private agencies are accredited, have Masters level supervisors, etc. (DCYF Program Specialist)</td>
</tr>
<tr>
<td>• No benefits of privatization. Studies show no cost savings or improvement in services. (CPS Specialist)</td>
</tr>
<tr>
<td>• More professional employees who have better relationships with foster and adoptive parents. (Foster Parent)</td>
</tr>
<tr>
<td>• More specialized services and better trained staff. (Foster/Adoptive parent)</td>
</tr>
<tr>
<td>• There could be increased accountability. (FCRB/CASA)</td>
</tr>
<tr>
<td>• Families may prefer to work with private agencies as opposed to a state agency. (Other State Agency)</td>
</tr>
<tr>
<td>• There could be more money for Tribes and caseloads could go down. (Tribal leader)</td>
</tr>
<tr>
<td>• Variety in service providers results in innovation and creativity. (Provider)</td>
</tr>
<tr>
<td>• I see a &quot;marriage&quot; of behavioral health/child welfare systems, resulting in a maximization of funding (state and federal dollars) and streamlined processes and access to services. (Provider)</td>
</tr>
<tr>
<td>• Private agencies have TALENT and connections to the community. (Provider)</td>
</tr>
</tbody>
</table>
Both public and private agency respondents frequently noted financial concerns, including the beliefs that the system, as it currently operates, is underfunded (and is likely to remain so) and that private agencies, under privatization, would struggle to attract and retain staff and provide quality services.

All types of stakeholders raised liability issues. Providers were particularly concerned about issues related to investigation functions and legal representation for caseworkers in court proceedings. DCYF staff were most concerned with protecting the State’s interests when they relinquish control over key case management decisions that impact child safety, permanency, and well-being.

Many respondents focused on the difficulty inherent in changing a "bureaucratic" system, including the resistance to change, the need to build better procurement and monitoring capacity, the mechanics of transferring cases while minimizing disruptions to the child and caregivers, and the impact on morale of a stressed public workforce.

Communication and confidentiality issues and the connection to CHILDS were also concerns. Finally, several respondents mentioned challenges posed by the political climate, the need for strong leadership, and the need for a sound privatization plan.

**Which Case Management Services Should Be Privatized?**

The survey asked respondents to indicate their level of agreement or disagreement to the privatization of seven different areas of current DCYF case management if they had to choose.

### Challenges/Barriers

- Small culturally competent providers are unlikely to meet demands of privatization. (External Stakeholder)
- Policies from one agency to another may be inconsistent. (Foster parent)
- How would this work in a rural area where there are no agencies? (Foster parent).
- CPS currently answerable to nobody - will fight to preserve. (Foster/adopt parent)
- Will create overlap and inefficiency. (Judicial)
- Control and management of contract providers. (State agency or other Division)
- How will you gauge success or failure? (External stakeholder)
- Potential for fraud. (Community Advocate)
- Massive change & lack of reliable data to predict the outcomes -- financial and programmatic. (Provider)
- Integration of IT systems with CHILDS. (Provider)
- Training/cross training of private child welfare agency. (Provider)
- Would need current state staff to move to private agencies; how to do this & what would it cost? (Provider)
- Provider’s lack of knowledge and expertise. (DCYF worker)
- Hiring & retaining staff at less $$ and benefits than the State offers. (DCYF supervisor)
- Transitioning to privatization without "losing" kids or letting some “fall through the cracks.” (DCYF Supervisor)
- Having people and families respect and listen to a non-government agency. (CPS Specialist)
- Monitoring compliance. (DCYF Supervisor)
The case management functions to be considered were: 1) hotline staffing, 2) CPS investigations, 3) in-home case management, 4) out-of-home case management, 5) independent living, 6) adoption, and 7) adoption subsidies.

There were five possible forced choice responses to indicate the level of agreement or disagreement each option. Respondents could: 1) Strongly Agree, 2) Agree, 3) Don’t Agree or Disagree, 4) Disagree, or 5) Strongly Disagree. By removing the blank and neutral responses, which represent approximately 27% of all responses, clear agreement and disagreement with each option is more accurately captured. Thoughts of privatizing each case management function evoked both striking differences and subtle commonalities among respondents.

1. I would choose to privatize the Hotline function: Surveys from 57 respondents who either left the item blank or provided a neutral response were excluded from the analysis. Responses from 148 respondents were included, representing over 70% of the total responses. As depicted in Chart 1, the majority (70%) of respondents believed that Hotline function should not be privatized. Providers were most opposed, with 79% disagreeing or strongly disagreeing to privatization. Approximately two-thirds of both external stakeholders and DCYF staff also disagreed or strongly disagreed.

2. I would choose to privatize CPS Investigations: Surveys from 38 respondents who either left the item blank or provided a neutral response were excluded from the analysis. Responses from 167 respondents were included, representing over 82% of the total respondents. As depicted in Chart 2, the vast majority of respondents (89%) disagreed or strongly disagreed with the option of privatizing CPS Investigations. DCYF staff were most opposed to CPS investigation privatization (93%); followed by providers (86%); and then external stakeholders (80%).
3. I would choose to privatize in-home case management: Surveys from 53 respondents were excluded from the analysis. Responses from 152 respondents were included (nearly 75% of the total respondents). As depicted in Chart 3, the privatization of in-home case management elicited very divided responses. Whereas the vast majority of providers (92%) agreed or strongly agreed with privatizing in-home case management, the majority of DCYF staff (58%) disagreed or strongly disagreed with that option. A majority of external stakeholders (63%) agreed or strongly agreed with the privatization of in-home case management.

4. I would choose to privatize out-of-home case management: Surveys from 53 respondents were excluded from the analysis. Responses from 152 respondents were included (nearly 75% of the total respondents). As depicted in Chart 4, the privatization of out-of-home case management elicited almost equal responses at both ends of the spectrum. A slim majority (53%) of all respondents disagreed or strongly disagreed with the privatization of out-of-home case management while slightly less than half (47%) of all respondents agreed or strongly agreed with the option. Clear differences were evident. External stakeholders were somewhat
**PART 2: AN ASSESSMENT OF ARIZONA’S READINESS**

evenly divided in their opinions, with more respondents agreeing (58%) than disagreeing (42%) with privatization. Providers and DCYF staff expressed diametrically opposite opinions, with 89% of providers in agreement with privatization of out-of-home case management and 77% of DCYF staff in disagreement.

5. I would choose to privatize Independent Living Case Management: Surveys from 60 respondents were excluded from the analysis. Responses from 145 respondents were included (70%). As depicted in Chart 5, 78% of respondents agreed or strongly agreed that independent living services should be privatized. Although general consensus existed, provider support (97%) was much higher than that expressed by external stakeholders (76%) and DCYF staff (70%).
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

6. I would choose to privatize adoption case management: Surveys from 55 respondents were excluded from the analysis. Responses from 150 respondents were included (73%). As depicted in Chart 6, 78% agreed or strongly agreed that they would choose adoption case management as a service. Provider support (97%) for this privatizing this function was again much higher than that of external stakeholders (74%) and DCFY staff (72%).

![Chart 6: Privatization of Adoption Case Management](image)

7. I would choose to privatize adoption subsidies: Surveys from 72 respondents were excluded from the analysis. Responses from 133 respondents (65%) were included. As depicted in Chart 7, the vast majority of respondents (83%) agreed or strongly agreed that they would choose to privatize adoption subsidies. Again, there was general consensus among stakeholder groups, with 87% of DCYF workers, 85% of providers, and 76% of external stakeholders agreeing that they would choose adoption subsidies for privatization.

![Chart 7: Privatization of the Adoption Subsidy](image)
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

In summary, as depicted in Chart 8, the three stakeholder groups showed a high level of agreement in several areas. Stakeholders were united in opposition to the privatization of the Hotline function and CPS Investigations. With the exception of the Hotline, CPS Investigation and adoption subsidy functions, providers were far more likely than other respondents to agree or strongly agree to the privatization of all other listed areas. With the exception of the hotline function, DCYF staff respondents were the least likely to agree or strongly agree with any privatization options. However, when forced to choose, DCYF staff were most supportive of Independent Living services, adoption case management, and adoption subsidies being privatized.
**PART 2: AN ASSESSMENT OF ARIZONA’S READINESS**

*How Would You Rate Current Performance in Case Management Areas? (Only DCYF and Stakeholders Surveys)*

The surveys for DCYF staff and external stakeholders asked respondents to rate current DCYF case management performance relative to the Hotline, CPS Investigations, In-Home, Out-of-Home Care, Independent Living, Adoption and Adoption Subsidies. As illustrated in Table 5, the external stakeholders (foster, adoptive, and birth parents, CASAs, FCRB, other state agencies/divisions, Judicial, Advocates, and Tribal Leaders) rated performance less favorably than DCYF staff. For example, over half of DCYF respondents rated the performance of the Hotline as *excellent or very good* as compared to less than one third of external stakeholders (28%).

**Table 5: Current Case Management Performance**

<table>
<thead>
<tr>
<th>Area</th>
<th>Respondent</th>
<th>Excellent N (%)</th>
<th>Very Good N (%)</th>
<th>Fair N (%)</th>
<th>Not Very Good N (%)</th>
<th>Poor N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hotline</strong></td>
<td>DCYF</td>
<td>7 (7)</td>
<td>46 (47)</td>
<td>43 (44)</td>
<td>1 (1)</td>
<td>1 (1)</td>
</tr>
<tr>
<td></td>
<td>Stakeholder</td>
<td>3 (8)</td>
<td>8 (20)</td>
<td>24 (60)</td>
<td>4 (10)</td>
<td>1 (2)</td>
</tr>
<tr>
<td><strong>N=138</strong></td>
<td>Total</td>
<td>10 (7)</td>
<td>54 (39)</td>
<td>67 (49)</td>
<td>5 (4)</td>
<td>2 (1)</td>
</tr>
<tr>
<td><strong>Investigations</strong></td>
<td>DCYF</td>
<td>3 (3)</td>
<td>48 (50)</td>
<td>37 (39)</td>
<td>6 (6)</td>
<td>2 (2)</td>
</tr>
<tr>
<td></td>
<td>Stakeholder</td>
<td>18 (45)</td>
<td>13 (32)</td>
<td>6 (15)</td>
<td>3 (8)</td>
<td></td>
</tr>
<tr>
<td><strong>N=136</strong></td>
<td>Total</td>
<td>3 (2)</td>
<td>66 (48)</td>
<td>50 (37)</td>
<td>12 (9)</td>
<td>5 (4)</td>
</tr>
<tr>
<td><strong>In-Home</strong></td>
<td>DCYF</td>
<td>3 (3)</td>
<td>32 (36)</td>
<td>48 (55)</td>
<td>4 (5)</td>
<td>1 (1)</td>
</tr>
<tr>
<td></td>
<td>Stakeholder</td>
<td>8 (22)</td>
<td>18 (49)</td>
<td>9 (24)</td>
<td>2 (5)</td>
<td></td>
</tr>
<tr>
<td><strong>N=124</strong></td>
<td>Total</td>
<td>3 (2)</td>
<td>40 (32)</td>
<td>66 (53)</td>
<td>13 (11)</td>
<td>2 (2)</td>
</tr>
<tr>
<td><strong>Out-of-Home</strong></td>
<td>DCYF</td>
<td>1 (1)</td>
<td>39 (42)</td>
<td>46 (49)</td>
<td>7 (8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stakeholder</td>
<td>1 (3)</td>
<td>6 (16)</td>
<td>18 (49)</td>
<td>10 (27)</td>
<td>2 (5)</td>
</tr>
<tr>
<td><strong>N=130</strong></td>
<td>Total</td>
<td>2 (1.5)</td>
<td>45 (35)</td>
<td>64 (49)</td>
<td>17 (13)</td>
<td>2 (1.5)</td>
</tr>
<tr>
<td><strong>Independent</strong></td>
<td>DCYF</td>
<td>7 (8)</td>
<td>25 (27)</td>
<td>48 (42)</td>
<td>11 (12)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Living**</td>
<td>Stakeholder</td>
<td>3 (9)</td>
<td>13 (39)</td>
<td>16 (49)</td>
<td>1 (3)</td>
<td></td>
</tr>
<tr>
<td><strong>N=125</strong></td>
<td>Total</td>
<td>7 (6)</td>
<td>28 (22%)</td>
<td>61 (49)</td>
<td>27 (22)</td>
<td>2 (1)</td>
</tr>
<tr>
<td><strong>Adoption</strong></td>
<td>DCYF</td>
<td>7 (8)</td>
<td>39 (42)</td>
<td>40 (43)</td>
<td>6 (7)</td>
<td></td>
</tr>
<tr>
<td><strong>N=127</strong></td>
<td>Stakeholder</td>
<td>2 (6)</td>
<td>5 (14)</td>
<td>13 (37)</td>
<td>11 (31)</td>
<td>4 (11)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>9 (7)</td>
<td>44 (35)</td>
<td>53 (42)</td>
<td>17 (13)</td>
<td>4 (3)</td>
</tr>
<tr>
<td><strong>Adoption</strong></td>
<td>DCYF</td>
<td>5 (6)</td>
<td>25 (30)</td>
<td>45 (54)</td>
<td>7 (8)</td>
<td>1 (1)</td>
</tr>
<tr>
<td><strong>Subsidy</strong></td>
<td>Stakeholder</td>
<td>1 (3)</td>
<td>6 (17)</td>
<td>16 (44)</td>
<td>9 (25)</td>
<td>4 (11)</td>
</tr>
<tr>
<td><strong>N=119</strong></td>
<td>Total</td>
<td>6 (5)</td>
<td>31 (26)</td>
<td>61 (51)</td>
<td>16 (14)</td>
<td>5 (4)</td>
</tr>
</tbody>
</table>
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

How Would You Rate DES On Procurement and Monitoring? (Only DCYF staff and Providers)

The survey asked DCYF staff and provider respondents to rate DES performance on procurement, contract monitoring, and provider relations. As noted in the introductory summary of trends identified through research, these issues are among the areas that have proven problematic for public agencies and their private partners.

As depicted in Table 6, providers rated procurement and monitoring performance higher than DCYF staff in two areas. Twenty-six percent (26%) of providers rated performance in procurement and contract negotiation as excellent or very good as compared to 15% of DCYF staff. Nearly half of providers (48%) rated DES as excellent or very good in relation to establishing a level of mutual trust and respect as compared to 24% of DCYF staff.

The majority of both types of respondents, however, gave DES fair or not good ratings in all areas. The lowest ratings by both providers and DCYF respondents were given to quality monitoring and compliance. Fifty-nine percent of DCYF staff and 35% of providers rated DES performance in this area as not good or poor. If provider and DCYF ratings are accurate reflections of current performance, these findings indicate that improvements are needed in all areas if DCYF is going to effectively manage current and future privatized contracts.

Table 6: Ratings on Procurement, Monitoring, and Provider Relations

<table>
<thead>
<tr>
<th>Area</th>
<th>Respondent</th>
<th>Excellent N (%)</th>
<th>Very Good N (%)</th>
<th>Fair N (%)</th>
<th>Not Good N (%)</th>
<th>Poor N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procurement &amp; contract negotiation. N=98</td>
<td>DCYF</td>
<td>0</td>
<td>11 (15)</td>
<td>31 (41)</td>
<td>26 (35)</td>
<td>7 (9)</td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>1 (4)</td>
<td>5 (22)</td>
<td>12 (52)</td>
<td>5 (22)</td>
<td></td>
</tr>
<tr>
<td>Quality &amp; compliance monitoring. N=103</td>
<td>DCYF</td>
<td>2 (3)</td>
<td>10 (12)</td>
<td>21 (26)</td>
<td>28 (35)</td>
<td>19 (24)</td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>1 (4)</td>
<td>2 (9)</td>
<td>12 (52)</td>
<td>6 (26)</td>
<td>2 (9)</td>
</tr>
<tr>
<td>Establishing trust &amp; respect. N=105</td>
<td>DCYF</td>
<td>3 (4)</td>
<td>16 (20)</td>
<td>38 (46)</td>
<td>23 (28)</td>
<td>2 (2)</td>
</tr>
<tr>
<td></td>
<td>Provider</td>
<td>1 (4)</td>
<td>10 (44)</td>
<td>6 (26)</td>
<td>6 (26)</td>
<td></td>
</tr>
</tbody>
</table>

The survey asked providers to rate DES in other contract management areas. As Table 7 shows, providers gave the highest rating to timely reimbursement. The lowest ratings were given for rewarding providers for good performance and holding providers accountable for poor results—both critically important under performance based contracting options.
Table 7: Ratings on Key Contract Management Areas

<table>
<thead>
<tr>
<th>Area</th>
<th>Excellent N (%)</th>
<th>Very Good N (%)</th>
<th>Fair N (%)</th>
<th>Not Good N (%)</th>
<th>Poor N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to make timely reimbursement</td>
<td>1 (4)</td>
<td>7 (32)</td>
<td>11 (50)</td>
<td>2 (10)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>The level of reimbursement</td>
<td>0</td>
<td>0</td>
<td>9 (41)</td>
<td>10 (45)</td>
<td>3 (14)</td>
</tr>
<tr>
<td>The flow of information &amp; communication</td>
<td>0</td>
<td>3 (13)</td>
<td>17 (74)</td>
<td>3 (13)</td>
<td></td>
</tr>
<tr>
<td>The training provided</td>
<td>0</td>
<td>0</td>
<td>11 (50)</td>
<td>9 (41)</td>
<td>2 (9)</td>
</tr>
<tr>
<td>The level of collaboration</td>
<td>0</td>
<td>6 (26)</td>
<td>11 (48)</td>
<td>6 (26)</td>
<td></td>
</tr>
<tr>
<td>Rewarding providers for good results</td>
<td>0</td>
<td>0</td>
<td>3 (13)</td>
<td>17 (71)</td>
<td>4 (16)</td>
</tr>
<tr>
<td>Holding providers accountable for poor performance</td>
<td>0</td>
<td>1 (5)</td>
<td>6 (27)</td>
<td>11 (50)</td>
<td>4 (18)</td>
</tr>
</tbody>
</table>

The survey asked providers, “What is one thing DES could do to improve current procurement, negotiation or monitoring performance?” The providers offered many suggestions, as illustrated in the textbox.

The majority of comments focused on the need for greater flexibility in procurement, improved communications, onsite monitoring, improved negotiations based on true costs, problem-solving mechanisms, accountability for poor performance, and rewards for good results. Several providers also indicated the need for greater local control in procurement.

**Improving Procurement & Monitoring**

- There is no "negotiation." Let the market drive this!
- There is no monitoring and no resources for it. Devote some resources.
- Better communication before a huge issue arises.
- Monitoring should include visiting the agency.
- Provide more time, more answers & fewer amendments on RFPs. STREAMLINE!
- Don’t renew contracts of agencies providing poor service just because they already had a contract.
- Pay rates that allow an agency to do better than just survive.
- There are no consequences for bad performance and no rewards for good results.

**Can Private Agencies Provide Higher Quality Case Management At A Lower Cost?**

The survey asked all respondents whether their level of agreement or disagreement with the statement: "In general, private agencies can provide higher quality case management services than the current system.” Ninety-six percent of all respondents answered this question (N=198). Of this group, one-third (34%) disagreed or strongly disagreed with the statement, and just under one-third (30%) agreed or strongly agreed.

There were significant (striking) differences among stakeholders. Close to three-quarters (71%) of providers agreed or strongly agreed and only 2% disagreed or strongly disagreed, slightly more than one-third (36%) of external stakeholders agreed or strongly agreed and one-quarter
(24%) disagreed or strongly disagreed, and only 10% of DCYF staff agreed or strongly agreed with one-half (50%) disagreeing or strongly disagreeing.

The survey asked whether respondents agreed or disagreed with the statement: "Privatized case management will cost less than the current system." Ninety-two percent of respondents answered this question (N=188). Of this group, close to one-third (30%) disagreed or strongly disagreed with the statement and about one-fifth (22%) agreed or strongly agreed. Nearly half indicated they did not know. Providers were more likely to agree or strongly agree: 41% of providers agreed or strongly agreed. By contrast, one quarter (24%) of external stakeholders agreed or strongly agreed and one-third (32%) disagreed or strongly disagreed. Only 15% of DCYF staff agreed or strongly agreed that privatized case management will cost less and more than one-third (36%) disagreed or strongly disagreed.

Were You Aware of the Legislative Language? (DCYF staff and Providers)

The survey asked DCYF staff and providers to indicate the degree to which they agreed or disagreed with the statement: "I was aware of the legislative requirement to examine privatization options before this meeting." The findings revealed significant differences in the two groups. Only 40% of the DCYF staff that responded to the question (N=95) indicated they agreed or strongly agreed with the statement. By contrast, 84% of the providers that responded to the question (N=26) agreed or strongly agreed that they were aware of the privatization language in the legislative bill.

This disparity in awareness was also evident in the focus group discussions where it appeared that providers were familiar with national privatization trends, had considered options for privatization, and were well aware of legislative actions whereas DCYF workers did not seem as well informed.

Is the Work That You Do Valued By DES and the Legislature? (DCYF staff and Providers)

The DCYF survey asked respondents to indicate their level of agreement with the statement: "DES values the work that I do." The provider survey asked for responses to a similar statement: "DES values the services that my agency provides."

Forty-one percent (41%) of the DCYF staff (N=96) agreed or strongly agreed that DES values their work. By contrast, 80% of providers (N=25) agreed or strongly agreed that DES values the services that they provide.

The DCYF staff survey asked respondents to indicate their level of agreement with the statement: "The Legislature values the work that I do." The provider survey asked for responses to a similar statement: "The Legislature values the services that my agency provides."

Only 15% of the DCYF staff that responded (N=95) agreed or strongly agreed that the legislature values their work. By contrast, 60% of providers that responded (N=25) agreed or strongly agreed that the Legislature values the services provided by their agencies.
How Ready Is Your Agency For Privatization? (For Providers Only)

The survey instrument for providers asked respondents to rate their level of knowledge, experience and capacity in key areas related to readiness for privatization and the quality of the agency’s relationship with DES. Not all providers responded to all questions.

The vast majority of providers (84%) rated their relationship with DES as either excellent or very good. One third (32%) said that the relationship was excellent, and more than one-half (52%) said that it was very good.

Providers also were asked about specific readiness areas in relation to privatization, as listed in Table 8. When the responses were analyzed by the size of the agency’s contract with DES, some interesting findings emerged. Agencies with DES contracts under $5 million were significantly more likely to rate their understanding or experience as excellent or very good when compared with agencies with contracts over $10 million. Agencies with contracts with DES over $10 million were more likely to rate current knowledge and experience as fair. For example:

- 70% of the agencies with smaller contracts felt they had an excellent or very good understanding of privatized case management models, compared to 50% of the agencies with larger contracts.
- 72% of the agencies with smaller contracts believed they had an excellent or very good understanding of the roles of DES staff throughout the life of a case, compared to 25% of agencies with larger contracts.
- 77% of agencies with smaller contracts rated their understanding of risk and liability issues as excellent or very good, compared to 50% of the agencies with larger contracts.
- 77% of agencies with smaller contracts rated their capacity to track and report outcomes and fiscal data as excellent or very good, compared to 25% of the agencies with larger contracts.

The only area in which agencies with larger contracts gave higher self-ratings than agencies with smaller contracts was the current relationship with DES. All of the agencies with contracts over $10 million described the relationship as excellent or very good, compared to 76% of the agencies with smaller contracts.

There may be a number of explanations for these findings. Providers with contracts under $5 million may be overestimating their capacity in many of the readiness areas because they have less familiarity with how DES operates and less understanding of system challenges. Agencies with larger contracts seem to have a greater understanding of what they do not know and a more realistic judgment of their current capacity. Table 8 presents the results of the self-assessments of provider readiness.
Table 8: Provider Self-Ratings of Readiness

<table>
<thead>
<tr>
<th>Area</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Fair</th>
<th>Not Very Good</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of privatized case management models (N=24)</td>
<td>6 (25%)</td>
<td>11 (46%)</td>
<td>7 (29%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of risk-or-results-based payment options (N=25)</td>
<td>9 (36%)</td>
<td>9 (36%)</td>
<td>5 (20%)</td>
<td>2 (8%)</td>
<td></td>
</tr>
<tr>
<td>Knowledge of the roles of DES workers (N=26)</td>
<td>10 (39%)</td>
<td>4 (15%)</td>
<td>11 (42%)</td>
<td>1 (4%)</td>
<td></td>
</tr>
<tr>
<td>Knowledge of risk and liability (N=25)</td>
<td>12 (48%)</td>
<td>6 (24%)</td>
<td>6 (24%)</td>
<td>1 (4%)</td>
<td></td>
</tr>
<tr>
<td>Experience providing case management (N=25)</td>
<td>11 (44%)</td>
<td>13 (52%)</td>
<td>1 (4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience handling court-related processes for DES children (N=26)</td>
<td>6 (23%)</td>
<td>5 (19%)</td>
<td>11 (42%)</td>
<td>3 (12%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Your relationship with DES (N=25)</td>
<td>8 (32%)</td>
<td>13 (52%)</td>
<td>3 (12%)</td>
<td>1 (4%)</td>
<td></td>
</tr>
<tr>
<td>Your capacity to track and report outcomes, and fiscal data. (N=25)</td>
<td>9 (36%)</td>
<td>6 (24%)</td>
<td>10 (40%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The survey included a list of areas that have proven difficult for private agencies in other privatization initiatives. Providers were asked to rank the top three areas in which their agency needs help to prepare for privatization. Very few respondents followed the directions and ranked areas but twenty-five respondents did check up to three areas. As Table 9 shows, court related procedures and the recruitment and retention of case managers and supervisors were the two areas that received the greatest response. QA/QI and best practices in case management were the two areas that received the fewest responses.

Table 9: Areas in Which Providers Need Help (N=25)*

<table>
<thead>
<tr>
<th>Area</th>
<th>N</th>
<th>Percent of providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court related process</td>
<td>18</td>
<td>42.9%</td>
</tr>
<tr>
<td>Recruitment, training, retention of case managers/supervisors</td>
<td>11</td>
<td>26.2%</td>
</tr>
<tr>
<td>IT &amp; Data tracking, reporting systems</td>
<td>8</td>
<td>19%</td>
</tr>
<tr>
<td>Financial &amp; Risk Management</td>
<td>7</td>
<td>16.7%</td>
</tr>
<tr>
<td>Integration of CM w/ utilization management</td>
<td>7</td>
<td>16.7%</td>
</tr>
<tr>
<td>QA/QI with a focus on contract compliance and results</td>
<td>6</td>
<td>14.3%</td>
</tr>
<tr>
<td>Intro of best practices in CM</td>
<td>2</td>
<td>4.8%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Total does not equal 100% as respondents could rank up to three concerns.
What Is The Impact of Privatization on Current Relationships With DES?

The survey asked external stakeholders how they thought privatization might affect their current relationship with DES. Twenty-nine stakeholders (52%) responded to the question and provided one or more comments about the impact of privatization on their current relationship with DES.

As illustrated by the sample of comments in the textbox, responses were mixed. Nine respondents (31%) anticipated little or no change in their relationship with DES; 4 respondents (14%) mentioned potentially negative consequences; and 4 respondents saw potential for an improved relationship with DES. The remainder of respondents highlighted both potential benefits and potential problems in relating to DES with the privatization of services.

The DCYF survey asked staff to indicate the degree to which they agreed or disagreed with the statement: "Implementation of privatization would make me concerned about my job security." Respondents were also asked about possible employment opportunities within the private sector. As indicated in Table 10, the majority (58%) of the 96 respondents who answered the question about potential job loss were concerned that privatization would pose a threat to jobs. There were subtle differences when the respondent’s experience and current position were considered but these differences were not statistically significant.

Table 10: Perceived Impact of Privatization on DCYF Staff (N=96)

<table>
<thead>
<tr>
<th>Indicate how you feel about each statement.</th>
<th>Strongly agree N (%)</th>
<th>Agree N (%)</th>
<th>Not Sure N (%)</th>
<th>Disagree N (%)</th>
<th>Strongly Disagree N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of privatization would make me concerned about my job.</td>
<td>27 (28)</td>
<td>29 (30)</td>
<td>22 (23)</td>
<td>12 (13)</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Implementation of privatization would be viewed by me as an employment opportunity</td>
<td>5 (5)</td>
<td>12 (13)</td>
<td>39 (40)</td>
<td>17 (18)</td>
<td>23 (24)</td>
</tr>
<tr>
<td>I would never want to work for a private agency.</td>
<td>9 (10)</td>
<td>6 (6)</td>
<td>48 (50)</td>
<td>23 (24)</td>
<td>10 (10)</td>
</tr>
</tbody>
</table>
While not necessarily viewing privatization as an opportunity, the vast majority of DCYF staff appeared open to considering employment with a private agency.

Twenty-six of the respondents provided comments to add to or clarify their ratings on these issues. The examples in the textbox are typical of the comments about employment with private agencies—both pro and con. It was noteworthy that many DCYF staff said that they were nearing retirement in the State system and could not afford to leave unless they could retain their benefits.

Views on Working for A Private Agency

- Been there, done that. Felt insecure at the private agency.
- I feel that there would be less room for growth in a private agency & that benefits would not be as good. (I’m also close to retirement)
- I’ve experienced overwhelming inadequacy in private agencies.
- Not so much red tape with a private agency.
- If it was the right opportunity and I could help families, I would be interested.

What Is the Most Important Thing for DES to Consider When Making Decisions About Privatization?

The survey asked all respondents to list the top three things that DES should consider in weighing privatization issues. The written comments are consistent with issues raised by participants in the focus groups (described in the next section) and with comments provided in other responses to survey questions. Twenty-nine of the 42 providers (69%) offered 58 suggestions for DES’ consideration. Thirty-four of the 56 external stakeholders (61%) offered 69 suggestions for consideration. Seventy-two of the 107 DCYF respondents (67%) offered 90 suggestions for consideration. There was consistency in the suggestions across respondent groups. Table 11 highlights frequently cited suggestions organized under seven broad topic areas and by the type of respondent.

Table 11: Most Important Things DES Should Consider in Making Privatization Decisions

<table>
<thead>
<tr>
<th>Providers</th>
<th>Other Stakeholders</th>
<th>DCYF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals/Purpose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clearly define goals, objectives, roles and responsibilities as a first step.</td>
<td>Is the key issue $ savings or doing a better job?</td>
<td>The primary focus has to be on families and children - not employees.</td>
</tr>
<tr>
<td>Who will decide why, when, and how to privatize -- Central or local DES?</td>
<td>What are our flaws and how can privatization cure them?</td>
<td>Why privatization? Should be clear and concise answer.</td>
</tr>
<tr>
<td></td>
<td>To the public, will it look like DES is trying to shift responsibility &amp; &quot;blame&quot; to private sector?</td>
<td>What benefit are you looking for?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What do you want to achieve?</td>
</tr>
</tbody>
</table>
## Part 2: An Assessment of Arizona’s Readiness

<table>
<thead>
<tr>
<th>Providers</th>
<th>Other Stakeholders</th>
<th>DCYF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Populations/Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider unique needs of metro Phoenix versus rural areas.</td>
<td>Consider the effect on foster parents when things are always changing</td>
<td>Where is the safety net? What if it doesn’t work and the system has been dismantled?</td>
</tr>
<tr>
<td>If there is not adequate service capacity will providers have authority to increase it?</td>
<td>How does it affect Tribes in regards to CPS and other services?</td>
<td>Prioritize areas for privatization that can be measured for achievement of safety &amp; permanency outcomes.</td>
</tr>
<tr>
<td>Keep investigations w/ State, and services with providers -- we will be able to work more closely and collaboratively with families.</td>
<td>How will you ensure cultural and religious sensitivity in services?</td>
<td>For profit organizations, number one concern is the profit! What about the kids and what they need?</td>
</tr>
<tr>
<td><strong>Funding/Costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will overdone (or badly done) oversight and hidden costs defeat any efficiency we achieve?</td>
<td>Won’t administrative costs be higher?</td>
<td>Is this about money or quality?</td>
</tr>
<tr>
<td>Will the rates support the expectations?</td>
<td>Money may not be saved.</td>
<td>No qualified social worker would work at a private agency for the $ they could offer.</td>
</tr>
<tr>
<td>Will there be flexibility?</td>
<td></td>
<td>Put enough money in to hire and keep qualified workers.</td>
</tr>
<tr>
<td><strong>Procurement/Monitoring/Quality/Accountability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clearly define standards of care and quality and results expectations.</td>
<td>DES needs better contracts.</td>
<td>Many functions are currently done by private agencies. There appears to be little to no oversight.</td>
</tr>
<tr>
<td>Look at private agency capacity, experience, and past performance in selection.</td>
<td>Will this really improve services? How will DES know?</td>
<td>If we do privatize, need to ensure we choose qualified agencies.</td>
</tr>
<tr>
<td>DES has significant deficiencies in the contracting/procurement areas that need to be remedied.</td>
<td>Overseeing cases would be important and difficult.</td>
<td>We need fair competition in bidding (not low ball bids).</td>
</tr>
<tr>
<td>Use this transition to improve the level of protections and the quality of care for children.</td>
<td>Allow for customer feedback to evaluate the quality of services</td>
<td>How will we accurately track performance?</td>
</tr>
<tr>
<td></td>
<td>CPS implements new ways of making services better and more efficient. But, there is no follow-up.</td>
<td>How will state deal with non-conformance to contracts?</td>
</tr>
<tr>
<td><strong>Legal/ Ethical/Court</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will we understand and be able to meet legal mandates?</td>
<td>Relationship that DES has with juvenile court &amp; the effect privatization would have on the court system</td>
<td>I am not sure if privatized agencies can take positions in court as strongly as state employees. How would liability be handled? There is a conflict of interest—decision-making &amp; money making.</td>
</tr>
<tr>
<td>Providers will need training and support in legal/liability readiness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there buy-in from court systems?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

<table>
<thead>
<tr>
<th>Providers</th>
<th>Other Stakeholders</th>
<th>DCYF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DES &amp; Provider Issues</strong></td>
<td>DES does not have an infrastructure for oversight.</td>
<td>How will private agencies monitor success/failure/neglect/malpractice?</td>
</tr>
<tr>
<td>This should not be an outside entity &quot;managing&quot; the funding &amp; contracting for services.</td>
<td>There is a lack of accountability already with contract providers.</td>
<td>Will this be nonprofit versus for profit agencies?</td>
</tr>
<tr>
<td>Agencies chosen should have adequate resources to expand quickly.</td>
<td>Phase-In/Pilot the approach to work out kinks</td>
<td>Religious based agencies may have bias in attitude/approach to CPS work in general.</td>
</tr>
<tr>
<td>DES manages change poorly and this would be massive change!</td>
<td>Will this benefit/improve ICWA notification to the Tribes? Would RBHA services improve/accept</td>
<td>DES is a large &amp; cumbersome agency where decisions are usually politically driven.</td>
</tr>
<tr>
<td>How does this fit with the new contracts they just signed for family preservation services?</td>
<td>Tribal referrals to services? Will the Tribe have to compete for Title IV-E/B funds and would they lose out based on rural location of Tribes population?</td>
<td>How will you solve the staffing problem that currently exists?</td>
</tr>
</tbody>
</table>

### Miscellaneous Words Of Wisdom

**GO SLOW** Pilot first.  
With increased responsibility there should also be increased authority!  
Don't view this as a way to save money.  
You get what you pay for! Patience -- this won't be overnight results!  
Keep dialogue open while planning  
Streamline communication after implementation.  
Rural areas see the focus as always being on the “state of Maricopa.” Recognize that all districts have their own needs and polices & they are often very different from each other.  
Engage the faith community.  
Stay focused on the now, not past wrongdoing. Be more respectful to each other.  
Just Say NO!  
Fix the issues don't just rename the agency.  
Understand privatized CPS isn't a “magic bullet.” Legislators need to understand the problem before throwing the solution at us.  
Is leadership, at all levels, committed to privatization?  
Too much change too fast will overburden/stress the system.  
Do the opposite of the [name deleted] RBHA contract!  

### Findings from Focus Groups & Interviews

**The Focus Groups**

In September 2005, at the start of the project, the DES staff and the consultants identified the various types of stakeholders who would be invited to participate in focus groups. Decisions were made to hold focus groups with DCYF staff, providers, and external (non-provider) stakeholders. It was also decided that focus groups would be held in four of Arizona’s six Districts. DES project staff identified local contacts in each of the four Districts. In advance of each of the focus group meetings, they emailed information about the project, the agenda for
focus groups, and the survey instrument that focus group participants would be asked to complete.

To ensure a broad-based mix of DCYF staff, local District Program Managers issued focus group notices and encouraged staff participation in meetings. To reach the provider community, it was determined that the Arizona Council of Human Service Providers would convene agencies from across the state at a meeting in Phoenix. With regard to the external (non-provider) stakeholders, Central Office DES staff initially identified individuals from the other stakeholder groups and then scheduled and arranged meeting logistics with CASAs, FCRBs, the Arizona Intertribal Council, the Arizona Foster and Adoptive Parent Association, the interagency Community Network Steering Committee in Tucson, and the Durango Court Dually Adjudicated Work Group.

Most focus groups lasted between 1.5 and 2 hours. Given the size of the provider group (over 40 participants), the focus group was extended to a three-hour time period. Following introductions, participants were told the purpose of the focus group and the ground rules for the discussion. Assurances were given that confidentiality would be maintained regarding all observations made in the surveys or revealed in discussions.

The same general format was used for all focus groups. First, instructions were provided for completing the surveys. Participants completed the surveys and then were asked if they had any questions about privatization or about the issues in the survey that they would like to raise for discussion. Typically, groups asked facilitators for information about privatization in other parts of the United States. When this occurred, brief information was provided on successes and challenges (as described in Part 1 of this report). For the remainder of the time, the discussion was free-flowing with participants encouraged to voice concerns or raise issues that they wanted to have addressed in any future privatization planning.

The discussions in all the focus groups revealed attitudes and perceptions about privatization that are consistent with information provided in the written surveys. DCYF staff were outspoken in their opposition to privatization. They used the focus group as an opportunity to share anecdotal negative experiences (particularly in relation to the RBHAs) to demonstrate that privatization of DCYF case management would not work. In contrast, the providers, while cautious, were much more enthusiastic about potential opportunities. The providers reported having considered various privatized case management options. They saw the opportunity for improved results in the creation of an integrated case management approach that would target children and youth with complex or therapeutic needs. They believed that they could create an effective partnership with the RBHAs to test a system of care model that would offer individualized wraparound services and more timely access to therapeutic and non-therapeutic care and supports to children and their families.

Alternately, providers also indicated that they would consider a random assignment pilot of all types of cases in which they would receive a set number (or percent) of randomly assigned referrals each month in a designated region and would have responsibility for case management until permanency was achieved. They stated that under either the integrated system of care or mixed caseload model, results could be compared between the publicly and privately managed cases to assess whether there was any advantage in terms of outcomes, quality, efficiency, and child and family satisfaction with services.
Although most providers appeared excited by the prospect of privatized case management, many also expressed concern about the potential challenges that their agencies would face in preparing for the change. As a group, they were united in their opinion that DES should proceed with caution and allow providers time (and resources) to support preparation. The level of awareness of potential barriers and difficulties was more apparent in the focus group discussions with providers than in the providers' written responses to the survey.

In the dialogue with external stakeholders, both positive and negative opinions were expressed about whether privatization could be an additional strategy that might help DES reach its goals. As a group, external stakeholders were more open to the idea of privatization than DCYF staff, but they were less optimistic than providers that privatization would make a significant difference. In general, they were quite supportive of current DES improvement efforts and the vision of DES leadership. On other issues, however, there was less unanimity. Many external stakeholders pointed to "entrenched" problems in moving a bureaucracy to accept change, and many questioned whether current reform efforts or privatization would be successful.

Within some external stakeholder groups, there was praise for the hardworking DCYF staff, and in other groups, participants stated that they held DCYF staff in low regard. Some groups expressed positive experiences with private agency staff while others questioned their motives and competencies. There was dissatisfaction expressed with current contracts with RBHAs, a widespread belief that the needs of children and families are not being met, and more than a little concern was expressed that a privatized child welfare case management system might have the same deficiencies.

**Interviews**

Central Office project staff arranged for individual interviews with the DES Director, DES administrative staff and Legislative staff and a meeting with the Children’s Action Alliance. All interviews were helpful in providing a context for consideration of privatization and in gaining insights into current areas of strength and weakness. For example, DES administrative staff members stated that DCYF’s greatest weakness in moving forward with a case management privatization initiative was the lack of current contract monitoring capacity. The interview with the DES Director, held mid-way through the focus groups, provided an opportunity to explore his thoughts about opportunities and challenges. He made clear that his key concern was that privatization efforts complement current DES goals and strategies.

**3. Summary of Readiness Review Themes & Findings**

In the first section of this report, a number of challenges to and key elements for successful implementation of privatization were described. Using those characteristics as a yardstick to measure readiness, the profile that emerged from the review is one of a system with significant strengths and equally significant challenges.
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

Areas of Strength

There are strengths in the current system’s business practices indicating readiness to plan and implement a future privatization initiative. Strengths include:

- **Clear Goals**: DES is committed to reform and DCYF is in the midst of major improvement efforts, with clearly defined objectives and strategies for meeting goals. Privatized case management could be incorporated into one or more of the current initiatives.

- **Positive Relationships**: DES has extensive experience collaborating with private agencies and community leaders to find solutions to complex problems.

- **Previous Experience**: While procurement is not without problems, privatization is also not a new concept for Arizona. DES is familiar with how contracts can be structured and financing aligned to achieve improved results.

- **Technology**: CHILDS, the IT system, though imperfect, has been improved and is able to support many contract and payment functions.

- **A Focus on Results**: DES is able to generate a variety of performance reports that are being used currently to support planning and quality improvement efforts. For example, the recently launched data Dashboard is tracking key indicators related to the Blueprint. This capacity would be essential as one component of a monitoring system that would ensure the quality of any privatized case management system.

Areas That Require Attention

It was clear from the interviews, surveys and focus groups that a consensus about the privatization of case management does not currently exist. Among DCFY staff, providers and external stakeholders, views are divergent regarding privatization itself as well as the specific case management functions that lend themselves most effectively to privatization. Both DCYF and the providers will need to continue the dialogue to reach any true consensus on potential privatization efforts, a dialogue that will need to include other external stakeholders as well.

Given current assessments regarding the state of readiness on the part of both DCFY and the providers if case management were privatized, both DCYF and the private agencies would need to invest significant time and money to prepare for the change. The Framework in Part 3 of this report is intended to help guide continuing discussions. The following are among the barriers that DCYF must remedy before implementing privatized case management:

- **Procurement, Negotiation & Monitoring for Compliance**: Every group, including providers, voiced concerns about the manner in which contracts are negotiated and about the absence of effective contract monitoring on the part of DCYF. The inability to hold providers accountable for contract compliance and the failure to develop and ensure corrective actions even when problems have been clearly identified are areas that DCYF will need to address either within Contracts & Procurement or as part of an overall approach to QA/QI. In addition, DCYF must reassess its overall approach to procurement to ensure that providers
who have met or exceeded performance expectations are rewarded in evaluation criteria used in future procurements.

Although these challenges were identified by all stakeholders (contracted providers, external stakeholders, and by DCYF staff) who participated in focus groups, it is important to note that over the last year DCYF has implemented several procurement improvement processes that include the following: (1) DCYF now conducts statewide Requests for Information (RFI) meetings to obtain potential provider comments and ideas about a proposed Scope of Work for a service prior to the official release of the Request for Proposals; and, (2) new or renewed requests for contracted services include performance-based contracting components. To the extent possible with existing resources, DCYF does monitor contracts and attempts to hold providers accountable for contract compliance. However, DCYF acknowledges that this is an area that could be improved with additional staff capacity.

Within the past several months in response to issues raised by the Protecting Arizona’s Family Coalition (PAFCO) whose membership includes the Arizona Council of Human Service Providers, DES began a process to improve internal procurement and contract monitoring. The DES Office of Procurement and the Director’s Office met with PAFCO and a number of providers, including DCYF providers, to discuss issues and provide education about the procurement process. This meeting resulted in implementation of a plan of Procurement Reform and Education, including further education of providers and DES staff. Planned DES Procurement improvements include the semi-centralization of the procurement solicitation process. By moving the solicitation responsibilities out of the program areas and into the centralized procurement office, some of the needed resources may be freed up to refocus the programmatic efforts on contract administration.

- **Access To A Full Array of Quality Services and Placement Options, Including Behavioral Health Services:** In the wake of the Jason K. Settlement Agreement, DES has worked diligently with the REBHAs to improve therapeutic services for children in the child welfare system. In spite of these ongoing efforts many stakeholders attributed DCYF’s performance difficulties in the areas of safety, well-being, and permanency goal attainment to the caseworkers’ inability to access needed therapeutic services or appropriate placements that the RBHAs manage. In addition, most DCYF staff described planning processes that were disjointed, duplicative, time-consuming, achieving few meaningful results, and, at times, operating at cross-purposes with DCYF mandates. As one caseworker put it, “I am always attending one meeting or another—often with the same people at the table, but the discussion is not focused on the case plan goals or what needs to happen to get the child home. It is like child welfare has become a stepchild of mental health.”

As noted in the previous section, the provider group, while acknowledging challenges, also saw an opportunity for an integrated system of care privatization project (pilot). They proposed bringing the RBHAs and providers together in a coordinated case management system that would result in a single case plan (the child’s legal plan) that addresses not only safety, permanency, and well-being but also the child’s education, health and behavioral health needs. Privatization of child welfare case management cannot fix inadequate service capacity. It will be difficult for private case managers to achieve improved results if the current access and capacity barriers are not addressed as part of the privatization plan. What is required is a willingness on the part of the RBHAs to go outside the parameters of their current contracts in support of a privatized DCYF case management initiative.
PART 2: AN ASSESSMENT OF ARIZONA’S READINESS

• The Current Work Environment: Caseworkers and other stakeholders noted the plethora of new initiatives that have been launched as part of the Governor’s reform plan. Although most seemed supportive of the intent, many DCYF respondents also cited the difficulty in implementing so many reforms in such a short period of time. In addition, staffing shortages and high caseloads have contributed to low morale and increased caseworker stress. One caseworker’s comments summed up sentiments heard at each DCYF focus group: "I know we are trying to improve but too many new programs are being started. We don’t want to see what’s working before starting something new. It is taking a toll on workers."

• Improved Communication: By far, the greatest resistance to privatized case management is internal to DCYF, a reality that will be exacerbated by ineffective communication. If the discussion about privatization continues, it will be critical to engage staff in planning and to develop and implement an internal communications plan to ensure that staff is informed as decisions are made. Providers and external stakeholders also raised communication issues, noting the many DES improvements that are underway but also the lack of ongoing communication to the field. As one stakeholder put it, "DES is doing a lot of innovative things but nobody seems to be connecting the dots or if they are, we don’t know about it.” When an issue is as politically charged as privatization, managing communication will become increasingly important.

• Ensuring Provider Readiness: DCYF will have a willing partner in the private sector if a decision is made to proceed with one or more case management privatization pilots. Because the private agencies will be partners in any case management privatization initiative, it is essential that providers be ready to assume new responsibilities. The assessment revealed some wide differences in private agencies’ self-assessments of their readiness for privatization of child welfare case management. Of importance to any privatization effort will be the development of readiness criteria, systematic evaluations of providers’ readiness, and the provision of adequate time and technical assistance, as needed, to ensure that providers have the infrastructure, personnel and competencies to proceed before cases are assigned. Given current DCYF staff capacity this type of support and technical assistance would be difficult if not impossible for DCYF to provide.

Limitations of the Assessment

The assessment was conducted in response to the Legislative requirement to review options for the privatization of some or all portions of case management currently provided by DCYF. In order to be most responsive to the request a determination was made to assess interest and capacity in each of the areas currently managed by DCYF. Stakeholders were therefore asked to consider privatization in the context of how the current case management system is organized (i.e., by the type of service the child is receiving). DCYF respondents were familiar with how things are currently done and were able to respond easily to the questions. However, some providers and external stakeholders recognized that the organization of the survey did not allow for alternative approaches to be proposed. As one stakeholder noted, "If privatization were to occur shouldn’t it be done to test a new approach that can possibly result in a more coordinated system rather than replicating current practice?" In hindsight the observation made by that stakeholder (as well as similar sentiments voiced by others) is correct. A clear finding from research studies is that simply changing from a public worker to a private one and holding all else constant will not result in improved outcomes for children and families. Should DCYF decide to continue the dialogue about the possible merits of privatization it will be important to pursue all options.
PART 3: RECOMMENDATIONS & A FRAMEWORK FOR DECISION MAKERS

This section includes recommendations for next steps and provides a framework that is intended to be a technical assistance resource for Arizona policymakers, administrators, and stakeholders to use in weighing any future child welfare case management privatization options.

Recommendations for Next Steps

This assessment occurred as a result of a legislative request and not as an outgrowth of DES’ current reform efforts. The dialogue that occurred with stakeholders was beneficial not only in gauging perceptions about privatization but also identifying many areas of strengths and areas needing improvement in the current system.

As evident throughout this report there are hurdles to overcome and no clear consensus on the best course of action. However, there is also strong support from the provider community and from some external stakeholders to plan and implement a pilot project that is designed to complement current reform efforts and test innovative practices in order to enhance current performance. Based upon the level of interest and the overall assessment, the following recommendations are made:

• Make this report widely available to internal and external stakeholders for comment, including those who participated in focus groups and completed surveys.

• Regardless of whether or not the State moves to privatize any case management duties, it is strongly recommended that a DCYF Public/Private Partnership Work Group be formed to build upon the previously described Procurement Reform and Education effort. The focus of the newly created Work Group would not only be to address the barriers identified in this report but also to improve current business practices. It is recommended that if a Work Group is created it be comprised of internal and external stakeholders, including providers, and that the work be organized through the creation of subgroups charged with responsibility for examining and crafting approaches to address the identified issues outlined in the report and in the following framework. Both DCYF and any potential future privatized case management system can benefit from such an effort.

• It is recommended that DES expand its current internal procurement and monitoring improvement efforts to specifically address DCYF challenges. Given the amount of funds that currently support DCFY contracts and the number of children and families already served by private agencies, it is imperative that resources be allocated and plans implemented to address identified quality assurance and monitoring weaknesses. It would be ill advised to expand contracting efforts to include case management until capacity is adequate to monitor and enforce compliance of current and future contracts. Resources may be needed to support needed improvements, which may necessitate Legislative support.

• It is recommended that DES explore any potential legal, financial and risk impacts of privatizing any portion of case management services. Other states have privatized child welfare services, including case management, and have not encountered difficulties regarding their claims for reimbursement for foster care expenses under the federal Title IV-E program. Nonetheless, given the lack of explicit guidance from the U.S. Department
of Health and Human Services regarding the impact of privatization on states’ claims for reimbursement under Title IV-E, it would be prudent to seek clarification of federal policy in this area. There is also a lack of clarity in state law and court rules that may preclude the private agencies from presenting the "State's" recommendations to the courts as agents of the state. If DES is required to have a state employee present to represent the department in all court appearances, this would result in considerable duplication of effort and expense. It is not clear if the Office of the Assistant Attorney General's attorneys would be able to represent the private agency case manager in these court proceedings as this Office does for CPS staff.

A Framework for Decision Makers

If privatization is to move forward and if the intent of any future privatization of case management is improved results and cost efficiency, significant energy will need to be devoted to planning the effort and to overcoming the previously described challenges. This framework is provided as a technical assistance resource for decision makers and the recommended Public/Private Partnership Work Group to use in improving current practices and weighing privatization options. The following principles provide guidance and raise issues in ten areas that would need to be addressed:

1. View Privatization As A Method to Improve Current Case Management

In far too many States, fiscal and contract reforms are treated as discrete, isolated efforts and not as an integral part of the State’s overall approach to system improvement. Often, inadequate staff resources are committed to the planning phase. Planning for best practice takes time and the process needs to acknowledge - and expect - that DCYF staff and providers will need time to plan and prepare for any potential privatization of case management.

As Arizona examines options for privatization, it will be important to ensure that improvement efforts described in the previous section are the foundation for future privatization efforts. Any privatization plans that emerge should be supportive of and consistent with other State reform goals, strategies and initiatives.

DCYF will need to identify key Central Office staff to guide the effort and develop the infrastructure to support an inclusive planning process that engages external stakeholders throughout the planning and implementation, including District Office staff, providers, and other external stakeholders. Mechanisms will need to be created to link discussions with the ongoing work to implement the strategies set forth in the Blueprint For Realigning Arizona’s Child Welfare Program.
2. Define Success

Stakeholders will want to know whether the privatization effort worked to improve performance. That should be a straightforward question with a clear-cut answer. In many initiatives across the country, it isn’t. For example, in a comparison of contracts with four of the Florida community based care agencies: one contract had 47 outcome measures, two contracts had seven, and one contract had nine. No contract directly stated what the overall measure of success would be. From the outset of planning, it would be important for DCYF, provider agencies, and external stakeholders to agree on the overall purpose and what constitutes success; define common performance requirements and child and family outcomes that will be used as indicators of success; and report performance on the same indicators over time. Unless this occurs the State will never be able to say conclusively whether privatization of case management was a success.

In weighing options for privatization and establishing broad goals, planners would need to rely upon current performance data and information gathered through the focus groups, surveys, and interviews to identify potential avenues where privatization could enhance strengths or remedy deficits. In setting performance targets and desired outcomes, it is important to start with a realistic assessment of current performance. DES has the capacity to generate performance reports on core permanency, safety, and well-being outcomes. The data in these reports will be critical as planners establish a baseline on which to build.

3. Have a Clear Rationale for Selecting the Target Population and the Case Management Model

There are seven areas where DCYF currently provides case management services for children and their families. Each of these broad areas was assessed for possible privatization benefits. As noted previously, no State has chosen to privatize the Hotline or CPS initial investigation functions, and it seems unlikely from the responses to the survey and focus group discussions that these areas would be viable options for privatization in Arizona.

Based upon national trends over the past decade, the more likely opportunities lie in the areas of out-of-home care, in-home services, independent living, adoption, and adoption subsidies. Although some of

| What does Arizona hope to achieve through privatization of case management? |
| What are the overarching goals and how will success be defined and measured? |
| How will results be communicated? |
| Which children and families should be included? |
| Children in foster care or only those in therapeutic levels of care? |
| Children under age 6 in group care? |
| Dually adjudicated youth? |
| Youth in transition? |
| Children served in-home? |
| Children at risk of entering care? |
| Children with adoption as a permanency goal? |
| Children in the care of relatives? |
| A portion of some or all children in the current caseload or only new referrals? |
| Will the initiative be statewide or limited to a geographic region? |
| Will it be phased in over time, or all at once? |
| Is a pilot the right way to go? |
these areas were attractive to some survey respondents, few were overwhelmingly endorsed by all. Furthermore, the choice of target population and the focus of privatization must be based not only on stakeholders' views but also on a host of other factors. While adoption and adoption subsidies or independent living appeared to have the greatest level of stakeholder support, offering the path of least resistance, those areas, if privatized, might not result in the greatest benefit for the children and families.

Arizona planners should weigh privatization in relation to current initiatives, asking: Is there a role for privatized case management that would add value to the initiative and to the broader system improvement effort? It was beyond the scope of this project to fully evaluate DES performance in case management areas to identify places where a new approach could perhaps produce better results. That assessment should be done before final decisions are made.

There are many privatized case management options that merit consideration. The integrated system of care option raised by providers is worthy of consideration because it not only would strengthen case management for a difficult to serve population but would also provide an opportunity to test a new approach to the integration of child welfare with behavioral health case management. There is no one "right" choice. Importantly, however, the decisions that are made about the target population for privatized case management should drive decisions about the services beyond case management that need to be included in the initiative.

Once the target population and focus are clear, the State will still need to decide the size of the population to be served and the geographic area(s) for the initiative. The initiative could be Statewide, with some level of flexibility for regional differences, and could be implemented through a gradual statewide phase-in or through a single pilot in one or more regions of the State. Stakeholders urged a cautious implementation approach, suggesting one (or more) pilots in several regions to demonstrate effectiveness over time with services provided to children and families residing in both urban and rural areas.

**4. Define Roles**

Role clarity has been a prevailing concern for both public agencies and their contract providers in privatization efforts across the country. Some States have chosen a "dual" case management model in which public agency staff retain responsibility for certain functions while delegating responsibility for other decisions to the private agency.

Other initiatives provide contract oversight but delegate total control over key decisions to private agencies. Some initiatives start with

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will develop and revise the case plan?</td>
</tr>
<tr>
<td>Who will handle court-related petitions and</td>
</tr>
<tr>
<td>hearings?</td>
</tr>
<tr>
<td>At what point will the referral be made to</td>
</tr>
<tr>
<td>the private agency?</td>
</tr>
<tr>
<td>Will it be a &quot;no reject, no eject&quot; system?</td>
</tr>
<tr>
<td>Who makes decisions about placement, level</td>
</tr>
<tr>
<td>of care, permanency goals, and case closure?</td>
</tr>
<tr>
<td>At what point will the provider’s responsibility for the case end -- at the time of permanency or for some period of time thereafter?</td>
</tr>
<tr>
<td>If the child returns to care, will the same agency pick up the case?</td>
</tr>
<tr>
<td>In cases of disagreement, who has ultimate authority?</td>
</tr>
<tr>
<td>What problem-solving mechanisms and dispute resolution processes will be needed?</td>
</tr>
</tbody>
</table>
one model and evolve over time into something different. Some States define the case management approach, including specific caseload standards. Others have allowed private agencies the flexibility to define their approach, with the understanding that State and federal requirements and a limited number of performance standards will be met.

5. **Ensure Service Capacity**

When broad goals, target population(s), and roles are defined, it will be important to specify which services and supports will be available to the private case management agency, including the responsibility or authority they will have for filling gaps in service availability prior to assuming case management duties.

One of the reported benefits of the lead agency model has been the expansion of both traditional and non-traditional services. If service expansion is to occur, flexible funds will be required and adequate time will be needed by the private agency to create a provider network or merge new services into the RBHA network.

Some initiatives have included limited funds and time as *start-up* to allow either the public agency or private contractor to expand services prior to the start of the privatized case management system. When funding and time for *start-up* are not built into the implementation, initiatives have encountered serious fiscal and programmatic challenges.

Service capacity was of particular concern to the rural stakeholders who questioned how a privatized case management approach could work in the absence of an array of services that children and families need.

As noted in the assessment, many stakeholders were also concerned that the funding/services that are controlled and managed by the RBHA’s would need to be integrated with any child welfare case management privatization effort. DCYF will need to work with stakeholders and build into any privatization plan a recognition of and plans for meeting gaps in service capacity and eliminating access barriers.
6. Design and Implement a QA/QI and Contract Monitoring System

As noted in Part 1 of this report, numerous research studies have revealed an inconsistent, inadequate or inappropriate approach to monitoring across privatization initiatives.

In this assessment, all stakeholder types identified the need for an improved monitoring system. There was strong agreement that private providers are not currently held accountable for the results that they are expected to achieve nor are they rewarded for good performance.

When initiatives across the country have worked to establish an effective monitoring system, disagreement commonly has arisen around the definition of results and the means of ensuring the validity of data that indicate whether results were or were not achieved.

In the early days of CBC implementation in Florida, for example, CBC agencies voiced concern in some sites that frequent reporting of data was required on too many and not always meaningful indicators. The lead agencies were subject to periodic (and at times, too frequent) onsite quality assurance reviews by state or local Department staff. Some CBC contracts required quarterly quality assurance reviews by the local Department office, four internal quality assurance reports, at least one administrative review, a minimum of six licensing reviews, an annual evaluation, an independent audit, preparation for national accreditation, daily entry of data, monthly reports including reconciliation of all expenditures.26

Over time, many Florida sites and other privatization initiatives have found a balance that allows the public purchaser to monitor for results while also granting the provider the flexibility to innovate. Many performance-based contract initiatives now combine monthly or quarterly Desk Reviews that are focused on results rather than process with a limited number of onsite visits that look in-depth at a random sample of cases, following a methodology similar to the federal review process for States (data analysis, record reviews, and interviews). Finally, an increasing number of initiatives are requiring national accreditation for providers as added insurance that the provider has the capacity to ensure a consistent quality of care. Meeting nationally accepted standards is one of the most effective means of ensuring overall quality of a system.

Planners need to carefully think through the monitoring process, drawing on the "lessons learned" from other communities that have struggled with finding the right balance and developing standards and quality assurance processes that promote contract compliance and the private agencies' achievement of defined results without stifling the provider's ability to innovate.
7. Assess Data Technology Needs

Most researchers have noted that privatized initiatives have placed a premium on access to real time information to guide case-level decisions and system planning. However, there is abundant evidence that many initiatives have lacked the technology or staff resources to collect or manage data.

Both public agencies and providers need data for operational decisions and successful contract management. The MIS must be able to track performance from a variety of different perspectives—client status, service utilization, service/episode costs linked with case plan goals, treatment, and outcomes. The system must be need-driven, flexible, user-friendly, and capable of generating useful reports for all users.

Additionally, at the case level, when private agencies assume case management responsibilities they are often allowed or required to enter data directly into the State’s SACWIS. When private agencies have this requirement, they have often had to develop complex and dual entry mechanisms—running their own management information systems to manage their business processes and separately entering data into State systems to meet contract requirements—hardly an ideal or cost-effective solution.

The necessity for dual data systems arises in part because few State systems are equipped for utilization management, provider network management, or claims/billing/reconciliation and payments—all core functions required in some private agency contracts.

During the focus groups, many of the providers and external stakeholders identified data technology as an area that might be problematic for implementation of a privatized case management system in Arizona. Planners of any privatized case management contract will need to assess the current IT capacity of DES and identify enhancements that may be required. They will need to ensure that contract agencies have the technological and human resource capacity to meet specified data collection and reporting requirements.
8. Identify Funding Sources and Financing Options

According to the most recent CWLA 50-state survey of child welfare financing trends, half of the states are now testing new methods of financing child welfare contracts. In the best-case scenario, these new reforms have increased flexibility and more closely aligned fiscal incentives with programmatic goals, resulting in better outcomes for children and families. Best-case scenarios, however, do not happen automatically.

Most child welfare privatization efforts are supported primarily by child welfare funds, but States are increasingly using funds outside of child welfare to better address the complex needs of the children and families served. Planners will need to identify funding sources and establish linkages with other child serving systems (such as mental health, substance abuse and Medicaid) for the provision of services that will not be reimbursed directly to the provider.

As the previous section indicated, one challenge that was frequently mentioned by focus group participants and described in survey responses was the manner in which current funding for therapeutic services is managed by RBHAs. If the child welfare system does not have a set aside pool of Medicaid funds to pay for therapeutic placements and services, it is essential that mechanisms be in place to ensure that child and family needs are being met through the RBHA plan.

Most privatized initiatives introduce some elements of financial risk. DES has some experience in risk-based contracting, although many providers indicated that the current mechanisms have not always been effective in stimulating the results desired. Risk-based contracts require providers to have the infrastructure, knowledge, and skills to consistently assess and meet the needs of the children and families they serve while managing resources to achieve fiscal goals.

Prior to determining whether risk-based options are desirable or which risk-based financing option Arizona might use, it is important for planners to assess current provider capacity and to...
carefully explore the pros and cons of different models with that capacity and interest in mind. It is equally important to assess DCYF's comfort level in relinquishing control over some decisions in return for the introduction of financial risk. It is unrealistic to embrace a full or partial risk contract and assume that current roles and responsibilities will remain intact.

9. Consider Staffing and Training Issues

In the past several years, the nationwide staffing crisis for both public and private child welfare agencies has become a well-documented and difficult to remedy reality. For that reason alone, it is important to acknowledge that any move towards privatization of case management may negatively impact the ability of DES to recruit and retain workers.

The degree of anxiety and frustration expressed by DCYF staff in every focus group was striking and disturbing. As one staff member pointed out, "It is naive to assume that discussions about privatization will not negatively affect staff morale at a time when we are already overworked, underpaid, and under-valued."

It is essential for planners to recognize that the discussions about privatization, regardless of the outcome, are likely to increase anxiety of the public agency staff. It is imperative that staff be engaged in any planning effort and that the State have a communications plan in place to ensure that timely and accurate information is disseminated as decisions are made.

Concerns about staffing issues were not confined to DES staff. Providers were concerned that they would not be able to attract and retain qualified case managers and supervisors and questioned whether DES staff would be interested in transitioning to the private sector.

As noted in the readiness review, issues related to salaries, benefits, pensions, staff qualifications, and training will need to be addressed by planners as they weigh various privatization options.
10. Chart A Course From Planning to Implementation

Finally, if a decision is made to launch a privatization initiative, DCYF will need to finalize design elements and determine the best course for translating the vision into a solid procurement and implementation plan.

Throughout the planning, DCYF will need to determine the best means of engaging local District Offices, providers, and community stakeholders in the planning, without jeopardizing the integrity of a competitive procurement.

It will be important for the Request for Proposal (RFP) to describe in detail the purpose of the contract; the expected outcomes and deliverables; performance standards; methods for payment, including provisions for any bonuses or penalties; the responsibilities of the contractor, DCYF, and any other partnering agencies; and the mechanisms that will be used to monitor contract compliance and attainment of goals.

DCYF will need to develop a clear plan for implementation, evaluation, and continual refinement as changes are proposed and made. The detailed transition plan would need to address the impact on current DES operations (including DCYF staff recruitment and retention), and the additional supports, if any, that might be needed in the short term to support implementation.

If national studies are an indication, it is likely that approaches to financial risk, performance standards, and outcomes may evolve over time with increased knowledge and experience. Under the best-case scenario, these changes will occur as part of a continuous quality review and improvement process.

What are the pros and cons of performance-based single agency contracts versus lead agencies?

Are there other hybrid models that could be developed?

What are the capacities, limitations, and interests of current providers in different structural and fiscal models?

If DES issues an RFP, who will be allowed to bid -- nonprofit firms or proprietary agencies as well? Existing individual provider agencies or newly created corporations comprised of multiple partners?

Are there sufficient DES staff resources to prepare the RFP?

How will the solicitation and review process be managed?

How will proposals be evaluated and best value be determined?

What role will District Offices have in shaping the design and the RFP?
Endnotes


3. There have been several major research projects in recent years that have focused on management, finance and privatization changes occurring in state child welfare agencies across the nation. Studies include those conducted by the U.S. Government Accounting Office, the Child Welfare League of America (CWLA), George Washington University’s study of contracting practices, a decade of reports of the Health Care Reform Tracking Project (HCRTP), which is a collaborative effort of the Research and Training Center for Children’s Mental Health at the University of South Florida, the Human Service Collaborative of Washington, D.C. and the National Technical Assistance Center for Children’s Mental Health at the Georgetown University Center for Child and Human Development, and the previously cited Children’s Rights study. All reports of the HCRTP are available from the Research and Training Center for Children’s Mental Health, University of South Florida (813) 974-6271. Special analyses related to the child welfare population are available from the National Technical Assistance Center for Children’s Mental Health at Georgetown University (202) 687-5000, deaconm@georgetown.edu. Information in this section draws from each of these efforts.


March 2005, Texas Senate Bill 6, the Adult and Child Protective Services (APS/CPS) reform bill.


Florida Coalition for Children (2003). Implementing Community Based Care: Critical Issues and Sensible Solutions. A white paper developed by the Florida Coalition.
ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Children, Youth, and Families

Child Welfare Privatization

APPENDIX 1:
CASE EXAMPLES & INTERVIEWS WITH PRIVATE EXECUTIVES

A report prepared by McCullough & Associates, Inc.

December 2005
APPENDIX 1:  
CASE EXAMPLES & INTERVIEWS WITH PRIVATE AGENCY EXECUTIVES

Overview
Arizona must weigh options for privatizing some or all portions of case management services in five overlapping areas: (1) Hotline functions, (2) Investigations, (3) In-home Services, (4) Out-of-Home Services, (5) Adoption/Adoption Subsidy.

Areas Covered in the Case Studies
The authors are aware of no State in which Hotline functions have been privatized so no case study is offered for that area. Similarly, the initial protective service investigation function also remains clearly in the hands of public child welfare workers or, in a few states, resides with the Sheriff’s departments. As a result, no case studies are provided. However, as many States reassess their approach to investigations and create differential response systems, some are turning to private agencies to provide services to low-risk children and families who do not require an open child protective service case but do need access to community services, similar to Arizona’s former Family Builders. Should Arizona decide that is an area worthy of further study, case examples will be provided for the Iowa Community Diversion program (launched in 2005).

What this section clearly demonstrates is that no two case management initiatives are alike. It includes:

- A newly awarded Family Network Lead Agency contract in Massachusetts in which case management responsibilities are shared between the public and private agency, with no-financial risk or incentives to the provider.
- A performance-based contract for children in the foster care system in Missouri in which the contractor has total responsibility for case management (but no responsibility for room and board costs in the first year).
- A foster care case rate pilot project in Cuyahoga County (Cleveland), Ohio. This is typical of the most common form of privatization in child welfare.
- A comprehensive case management Lead Agency contract in Florida’s Community-Based Care System where the Lead agency is responsible for all services from referral at the time of investigation to permanency, including accessing health and behavioral health care for the enrolled children.
- A recently awarded reunification and family preservation contract in Kansas.
- Two approaches to adoption contracting—a Massachusetts model and the Kansas case rate adoption contract (Note: The design of the Kansas adoption contract in the most recent 2005 procurement differs from the model presented.)
Massachusetts- A No-Risk, Dual Case Management Model

Background

Massachusetts has a long history of contracting for an array of child welfare services, including in-home and out-of-home care services and adoption. At one point in the 1980s, the State also contracted for Protective Investigations for some cases through one private nonprofit agency (MSPCC). The MSPCC contract granted full case management responsibility to the provider. Several years after it was launched, the MSPCC contract was terminated after sustained pressure from critics, notably the Labor Union. The only private agencies that have had full case management responsibility since that time are those that serve a limited number of the Department’s adoption cases. In all other instances, case management services are either solely the responsibility of the Department staff or a shared responsibility—with private contractors providing care management in collaboration with Department social workers.

The State was one of the early pioneers in implementing a risk-based contract with lead agencies to provide services to youth in need of therapeutic levels of out-of-home care. The Commonworks program was in place from 1996 to September 2005. At present, the Department is in the process of dismantling Commonworks and a similar lead agency contract for Family-based services and integrating both of those services and others under a new Family Network Initiative.

The following pages provide an overview of the still evolving new initiative in which private Area Lead Agencies will share responsibilities for case management services for children referred by the Department.

Family Network Area Lead Agencies

Through its Family Network Initiative, DSS is engaging providers in the work of creating an integrated, values-based service system for children and families. The Department has noted that the scope and scale of Family Networks—a statewide initiative, integrating $300M in placement and family-based purchased services, is the largest undertaking for the department in over a decade. The Request for Responses (RFR) for Area Lead Agencies was issued in February 2005.

On July 1, 2005, DSS began its partnership with provider agencies serving as Family Networks Area Lead Agencies. There are 29 Lead Agencies in 6 regions with a total of about $12 M contracts. This represents an $8 M increase over the administrative costs of the previous Commonworks and Family-based contracts. The State has released a purchased services RFI that describes the proposed critical services that will be provided through the Family Networks.

The first phase of implementation will focus on decreasing the use of residential services by supporting families whose children are at risk of or already in long-term residential placement in caring for their children at home.

DSS expects that over time, resources previously spent on managing and purchasing long-term residential placement will be redeployed and used to support an increasing capacity of family and community based services. This effort, in turn, will support more families in caring for their children without the need for long-term residential placement.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

The total anticipated duration of these contracts is July 1, 2005 through June 30, 2014. Duration of all contracts awarded is dependent upon appropriation funding and performance.

A Dual Case Management Model

DSS retains the following areas of decision-making authority.

- **DSS Service Plans:** DSS social workers are responsible for establishing and making changes to the service plan goal, outcomes, and tasks. Lead Agencies are key contributors to recognizing in a timely way that a service plan needs to be revised to address new issues or lack of progress. DSS social workers will participate in the family team meetings convened by the Lead Agency.

- **Placement Services:** DSS retains decisions for placement related services for most children. When DSS determines that a child is best cared for through placement outside their home, DSS will select the service provider, the level of care, and the location for initial and any subsequent placements. DSS will make determinations regarding the type, level, and scope of advocacy on behalf of the child’s educational and medical needs. The exception to this role is the group of children and families with whom the Area Lead Agency works to avoid or shorten residential placement through care management (see below).

- **Permanency Plans:** DSS retains responsibility for establishing permanency plans and approving a permanent caretaker resource. To support effective permanency planning, the Lead Agency will work with parents and DSS to gather information on factors leading to permanency, including recommendations on kinship placement. DSS is responsible for decisions regarding case closure.

- **Legal Decisions and Proceedings:** DSS staff attorneys remain responsible for representing the Department in all legal proceedings and Court appearances. DSS attorneys work with DSS and Lead Agency staff to develop court petitions and recommendations to the Court regarding changes in children’s custody and termination of parental rights. DSS remains responsible for all legal decisions, including the following:
  - Change in custody or care of child
  - Return custody of child to his/ her family
  - Recommending to the Court termination of parental rights

The Lead Agency Responsibilities

- **Convening Family Teams:** The Lead Agency is responsible for convening family team meetings. The DSS social worker who established the original service plan with the family will be an important member of these family teams.

- **Service Coordination:** For children and families in need of family-based services, the role of the Lead Agency is to identify and coordinate the services necessary to achieve the goal and outcomes identified in the DSS service plan. The Lead Agency staff will do this by bridging the DSS service plan with the treatment plans established by each provider working with the family.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

- **Access and Referral:** DSS will establish criteria and a process for identifying which families to refer to the Lead Agency for coordination services. The referral could come at any point in the family’s involvement with DSS – at initial engagement, after DSS completes an assessment, after the service plan is established, or after months of involvement in response to changing circumstances. The Lead Agency will have no right to refuse a referral because of the type of case and intensity of need. Lead Agency contracts will identify a projected number of children and families to be served annually.

- **Emergency Access and Response:** The Lead Agency will be responsible for responding to emergency placement and crisis response service needs that arise during regular business hours as well as after-hours.

- **Utilization Review:** Lead Agencies are responsible for reconvening family team meetings in order to review progress towards the goals identified at the initial team meeting. Utilization review meetings occur no less than quarterly. In between formal meetings, the Lead Agency is responsible for monitoring progress and communicating to the DSS social worker any updates or modifications made to the service plan.

- **Care Management:** DSS will determine which children in or at risk of residential placement will be referred to the Lead Agency for Care Management. Care management is a different, more intensive role than service coordination. There are two key distinctions. First, care managers will be empowered to make a wider range of decisions (as described below) than service coordinators. This broader authority aligns with the greater responsibility for achieving the result of helping families whose children are at risk of or in long-term residential placement to care for them at home. The second distinction is the anticipated lower caseload for care managers. Care managers would work more intensively with fewer families (e.g., 20) than service coordinators (e.g. 60). As with the service coordination role, care managers are responsible for linking the DSS service plan and provider treatment plans.

- **Referrals:** DSS will be the source of referral to this level of care management. The Lead Agency will conduct and lead the assessment of alternative services that it could arrange through its network to support families whose children are at risk of or in long-term residential care but could be cared for in permanent family settings. In conducting its review of children and families, the Lead Agency must consult with and build consensus with the DSS social worker and family.

- **Care Management Decision-Making Authority:** As with all service coordination decisions, the Lead Agency is expected to build consensus with the family and DSS social worker regarding the opportunity to avoid or return from residential placement. When there is disagreement about a referral to this level of care management, DSS holds final decision-making authority. However, once a child and family are referred, the Lead Agency has the decision-making authority to decide what services are necessary and to work with network providers to develop and manage appropriate treatment plans. The Lead Agency is granted authority to make the some decisions in addition to those listed under its service coordination role.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Lead Agency Decisions under Service Coordination role
1. Selection of specific family based service models, providers, and community resources to work with a family / family member.
2. For each family based service, the intensity and frequency of service receipt.
3. Changes in service providers working with a family / family member.
4. For children in their home, short term respite in out of home settings.
5. For each family based service, duration and termination, whether because of success or ineffectiveness.

Lead Agency Decisions under Care Management role
1. The frequency and location of visitation. (DSS decides whether it must be supervised.)
2. Short-term trial visit for purpose of transitioning to permanent family.
3. The placement provider, the level of care, and the location (initial and subsequent changes)
4. Determination of type, level, and scope of educational advocacy on behalf of the child.

• Level of Service Decisions: The Lead Agency must use a Level of Service decision support tool to guide the service decisions it makes with the family teams (MA has decided to use CANS for this purpose). The first application will be to identify children currently in or at risk of long-term residential placement who might be equally well served at home with the proper services. Ultimately, the guide will be used for identifying the level of a family or community based service for families even when placement is not being considered.

• Legal Proceedings: Lead Agency staff must be available for and participate in any legal family-related discussions, hearings, and trials determined necessary by DSS. Lead Agency staff is required to participate in trainings regarding the legal framework for the Department’s work.

Administrative Management Role and Responsibilities

DSS will provide administrative management to support Family Networks including:

- Automated Information System: Lead Agencies will be required to use the information system(s) provided by DSS to manage their work with families and service networks. When using DSS office space, they will have access through dedicated desktop computers. In order to connect from their own offices, Lead Agencies must have equipment that meets specifications set by DSS.

- Financial Management Systems: DSS will manage contracting, payment, and service budgets through its FamilyNet system. In the first phase of this system (at least), Network Provider contracts will be held directly with and paid by the Department, not by the Lead Agency. Lead Agencies are not expected to build their own financial management systems.

- Performance Reports: As FamilyNet will serve as the case management and financial system of record, it will also be the source of reports on performance and quality.

- Office Space Co-location: DSS Area Offices will support their partner Lead Agencies and Regional Resource Centers by providing office space to use on a “hoteling basis”.

4
Financing & Rate Specifications

The total estimated expenditure to be made during the life of this procurement is $135M. Estimated expenditures under the initial contract duration are anticipated to be $45M (July 1, 2005 – June 30, 2008).

The Department is using a cost reimbursement compensation structure for these contracts for the first year (at a minimum), with the option to negotiate a different structure at a future date.

The RFR provided a Price Range of $450,000 to $550,000 per Area. Lead Agencies bid within the range.

Start Up & Phased Implementation: The first quarter of implementation for Area Lead Agencies overlaps with the phasing down of current service coordination contracts. The new Area Lead Agencies must take over the relevant responsibilities of the current Family Based Services Lead Agencies, Commonworks Lead Agencies, and Boston’s FRN Lead Agency at the end of a 3-month transition period (July 1 to September 30, 2005).

Phased Implementation: The first phase of implementation focuses on the residential system. Lead Agencies will provide service coordination or care management to the children and families receiving services through the residential system beginning October 1, 2005. Demonstrated success in this first phase will be the basis for proceeding to the next phase of incorporating the additional groups of programs (e.g., therapeutic foster care, shelter). The timing of these subsequent phases may vary across the state.

Future Year Adjustments: The RFR noted that changes may be made in scope, budgets and reimbursement arrangements in future years.

Flex Funds: Lead Agencies have some flexible funding available to catalyze family involvement. The amount of flex funds allocated per Area Lead may change over time.

Building the Service Network

DHS will secure contracts for services that will be accessed by the Lead Agency. An RFI has been issued to refine what services will be available. Lead Agencies may also be service providers. A cap, however, is imposed. DSS’ review of network referral patterns will trigger intervention when the Lead Agencies’ share exceeds 15% of the Area Office’s total network service budget.

Performance Management & Measurement

Although DSS will not implement financial risk / reward sharing in the first year, it will use a case flow model as a framework for tracking performance. First year performance will be measured against FY05 baseline data. Implementing the performance measurement system will allow DSS to determine the specific measures and the appropriate data sources, assess the impact of performance measurement on practice, and establish goals to which each party will be accountable in the following year. In conjunction with performance reporting and accountability, program standards will be established for Area Lead Agencies, Regional Resource Centers, and Network providers. The specific process measures and outcomes are still under development. However, the RFR included draft outcome indicators related to safety, permanency, and child well-being for children not in placement and for those requiring placement.
Contract Monitoring

DSS holds contract monitoring responsibility since it will hold the Lead Agency and Network Provider contracts. DSS will coordinate a process to identify the Area or Region to “host” the contract and will then have lead responsibility for monitoring the Lead Agency contract. They will assemble monitoring teams, which will include the DSS Area Resource Coordinators and Planning & Program Development Division staff. DSS expects that all partners will take a continuous quality improvement and learning approach to any program improvement plan that results from monitoring efforts.

Lead Agencies hold the responsibility and have an incentive for monitoring the performance of providers in their networks. One of the tools they have to influence and incentivize improved performance is referrals. As the main referral source, the Lead Agency must be satisfied with a provider’s performance in order continue or increase referrals to them. Preferred provider status is intended for providers whose performance is in the top tier of their peer group.

Interview With a Family Network Area Lead Agency

The interview is with Joe Leavey, the Executive Director of Communities for People, Inc., one of the largest child welfare agencies in Massachusetts and a recipient of one of the Area Lead Agency contracts.

What are your main concerns about the new initiative?

Mr. Leavey’s comments focused on five principal areas:

1. **Outcomes and Expectations**: “While the goal is clearly to move towards a greater focus on family involvement and permanency, with an immediate reduction in the use of residential care, the State has not yet finalized the performance standards or specified the outcomes or results. We have started implementation without a full understanding of expectations.”

2. **Data Capacity**: “In order to implement this Initiative, the State dismantled two contracts with agencies that were previously responsible for data collection, performance monitoring, and reporting for the previous Commonworks and Family-based contracts. Instead of outsourcing data collection and reporting, under this initiative, DSS intends to collect and monitor data by building capacity in the State’s SACWIS (FamilyNet). There is a great deal of skepticism about how long it will take to build adequate capacity to generate the types of reports that were most useful under prior contracts. While the Lead Agency contracts did include data specialist positions for each Area, it is not clear what data will be collected and tracked.”

3. **Service Capacity**: “The primary goal in the first year is to reduce reliance on residential and group care. Even though the Lead Agency is not at financial risk, the Lead Agency is expected to help DSS achieve that goal. The difficulty is the lack of alternative foster care and community options to support the complex needs of children currently in the more restrictive placement settings. The recently released RFI sets out a plan for beginning to build alternatives to residential and group care through the creation or expansion of intensive foster home care ($180/day with $80 to Foster Parent and $100 for services/supports provided by the foster care agency); and stabilization beds (Residential) for short-term, crisis stabilization/respite or...
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

assessment. Over time, it is clear that children may be able to be diverted from intensive placements but in the short-term, there are limited alternatives available.”

4. **No Incentives**: The lead agency has no risk but there are also no incentives to achieve desired results. CFP was formerly a Commonworks Lead Agency. That contract was initially no-risk but after 18 months, the lead agencies were given a case rate, with a monthly payment per child served (the payment was approximately $180/day). They had wide latitude in the use of the funds and were able to tailor services to individual needs. If their efforts resulted in savings, the lead agency was allowed to retain savings and enhance services. In addition, by attaining specified goals, agencies were able to earn bonuses. On its surface, the current contract seems like a giant step backwards, at least in the first year when it is a straight cost reimbursement of approximately $400,000 per Lead Agency solely for care coordination or care management. While the Lead Agencies may make referrals, they will not pay for services or hold contracts with providers or reimburse for services provided. DSS currently spends about $250 million in RTC and $27 million in non-purchase of service contracts, but the lead agencies will not have the authority or financial flexibility to stimulate needed capacity unless DSS agrees that a service is needed and contracts with a provider to deliver it.

5. **Service Coordinators, Care Managers and DSS workers**. While the current contract is far clearer than the earlier Commonworks contracts were, there are still a lot of day-to-day gray areas in terms of who has authority to do what. The lead agencies would much prefer to have full case management responsibility to eliminate duplication and redundancy in the current dual approach. However, that has proven to be an elusive goal. The labor contracts for DSS staff are in place for at least another year. The Union will oppose any attempt to delegate or change any of the work of their staff. The opposition at times makes it difficult to operate. For example, Lead Agencies wanted to get together to develop common forms for Intake and Referral and were told that no such work could happen without Labor’s approval since new forms might impact the work of DSS workers.

**What was the impetus for the Initiative?**

There was a perfect alignment of two forces. Critics who argued persuasively that a disproportionate share of the resources were being consumed by residential services were joined by those who have long advocated for more family-centered approaches to practice. The State has over 2500 kids in long-term residential care (at about $380/day). It became clear to all that the number needed to be reduced.

**What should public agencies consider in contracting for case management?**

1. Make sure there is clarity in public and private roles/responsibilities.
2. Make certain that the public agency retains the responsibility for legal services.
3. Include fiscal incentives aligned with results—but make sure you have IT and quality assurance capacity to monitor both costs and outcomes.
What should private agencies consider in developing the capacity to provide case management services?

1. Look at this as an opportunity but also recognize what you don’t know and hire the people who know case management from the public agency perspective.
2. Look at staffing—recruitment, training, and then build capacity to respond to the public agency’s need for immediate responses.
3. Have an attorney on board to review liability issues and prepare the Agency’s Board.

If you had it to do over again, what would you do differently?

I would have fought harder to eliminate the dual system of case managers and DSS workers. This approach works well in some cases and not so well in others. Too often it comes down to personality or the culture of one Area office versus another. In the absence of clear terms about respective responsibilities, you end up with role confusion—not just for the DSS and private agency staff but also for the children and families.

What were your greatest “success” and your greatest difficulty with the previous Commonworks and Family Based Contracts?

1. CFP met expectations. In hindsight maybe they weren’t all the right expectations (there was not enough focus on family involvement or permanency) but still we succeeded. I think I am most proud that we expanded service options in the network and increased cultural diversity by recruiting new agencies.
2. The greatest difficulty has been managing an ambiguous relationship with DSS. The public agency does not structure our relationship to build on inherent private agency strengths. Private agencies could (if allowed) innovate, bring in more community support, advocate for more resources for both DSS and the system as a whole, and operate differently from the Department.”

For Further Information, Contact:

Joe Leavey
Executive Director
Communities for People, Inc
Boston, MA 02215
jleavey@communities-for-people.org
2. Missouri-Performance-based Contracts for Case Management Services

Background
The Department of Social Services, Children’s Division released an RFP in April 2005 to procure performance based case management contracts to meet the needs of the foster care population in targeted areas of the state.

Prior to the release, DSS contracted with Mercer Government Human Services Consulting (hereinafter referred to as Mercer) to analyze potential monthly case rates for alternative care case management services for selected counties in the next year and for future years with consideration for foster care room/board and residential treatment services. Mercer provided what they consider an actuarially sound rate range for each Geographic Area for the provision of case management services. The information was included in the RFP as a guide for bidder’s to propose their rates.

Geographic Coverage
Case management services will be provided in three regions:

- Geographic Area 1 includes St. Louis City, and St. Charles, St. Louis, and Jefferson Counties.
- Geographic Area 2 includes Andrew, Buchanan, Clay, and Jackson Counties.
- Geographic Area 3 includes Greene County.

Target Populations
Children eligible to be referred include:

- Abused and neglected children under the jurisdiction of the Juvenile Court who have been placed in out-of-home care,
- Children of youth under the jurisdiction of the Juvenile Court who have been placed in out-of-home care,
- The families and siblings of the children placed in out-of-home care under the jurisdiction of the Juvenile Court, and
- Out-of-home care providers.

Scope of Case Management Services
The contractor will provide case management services for referred cases including, but not be limited to, the following services:

- Assessment - the consideration of social, psychological, medical, and educational factors to determine diagnostic data to be used as a basis for the treatment plan.
- Treatment planning - an agreement designed through a mutual process of negotiation between the family case manager, parents or guardian from whom the child was removed, and the juvenile court (if required by the court), setting out those activities necessary for achievement of reunification of the child.
- Placement services - selection of the most appropriate placement resource for children based on the assessment of the child’s unique needs and personality and the out-of-home care provider’s capacity and skills in meeting those needs.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

- **Service planning** - the provision of any services indicated and needed as identified through an assessment and treatment plan or ordered by the Juvenile Court.
- **Permanency planning** - determining the permanent plan which best meets the needs of the child.
- **Concurrent planning** - working towards family reunification while, at the same time, developing an alternative permanent plan such as guardianship or adoption.
- **Community resource development** - recruitment, assessment, and training of placement resources. It also includes the development of services to best meet the needs of the child and family when they are not readily available.

Under each of these areas, the contract provides detailed specifications and outlines consequences for failing to meet requirements, including Corrective Actions, loss of referrals, and potential loss of the contract.

**Goals**

- A safe environment and well-being for all children served;
- Timely permanency;
- Reunification of children in out-of-home placements with their family when possible;
- Continuity for the child in out-of-home care;
- Preservation of a child’s connection to the family of origin when possible;
- Continuity of the contractor’s family case managers assigned to the case until permanency is achieved;
- A child’s right to belong to a family; and
- The child’s and family’s satisfaction with services.

**Qualifications & Staffing Standards for Contract Agencies**

**Licensing Requirements** – The contractor and/or the contractor’s subcontractors must be licensed as a child placing agency.

**Accreditation Requirements** - The contractor must either (1) be accredited by one or more national accrediting bodies or (2) be a licensed child placing agency that must submit an application for accreditation with one or more national accrediting bodies within three months of the effective date of the contract and must become accredited by a national accrediting bodies within two (2) years of the effective date of the contract.

The contractor must be a public or private not-for-profit or limited liability corporation owned exclusively by not-for-profit children’s services providers.

The RFP also detailed qualifications, credentials, training, and staff development plans required for all case management staff and senior managers, including the specific training topics.

**Access**—The contractor’s professional staff must be available to the state agency and out-of-home care providers 24 hours a day, seven days a week.

**Supervisory Ratios** – The contractor’s supervisors must not supervise more than seven (7) staff.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Caseloads – The contractor must provide a minimum of one case manager for every:

- Twenty (20) children in out-of-home care
- Thirty-five (35) children under post-placement supervision
- Thirty (30) active adoptive or birth families; or
- A reasonable combination of the above.

Outcomes

The contractor is required to meet the outcomes listed below for the original contract period. The outcomes for the renewal options periods will be determined through negotiations with the state agency making the final decision.

A percentage of children in out-of-home care must achieve permanency.

- 32% or more children in out-of-home care under the jurisdiction of one the juvenile courts located in geographic area 1 must achieve permanency.
- 30% or more children in out-of-home care under the jurisdiction of one of the juvenile courts located in geographic area 2 must achieve permanency.
- 24% or more children in out-of-home care under the jurisdiction of one of the juvenile court(s) located in geographic area 3 must achieve permanency.
- 99.43% or more of children in out-of-home care must not have substantiated child abuse/neglect reports with the alternative caregiver listed as the perpetrator.
- 91.4% or more children in the custody of the state agency or under the supervision of the state agency must not re-enter state agency custody or supervision within twelve (12) months of previous exit.
- 82% or more of children in out-of-home care will experience two (2) or less placement settings starting with the contract effective date for the first year or the referral date if the case was referred after the contract effective date during the first year of the contract.
- 82% or more of children in out-of-home care will experience two (2) or less placement settings subsequent to referral in the second year of the contract and thereafter unless the referral was received prior to the effective date of the contract in which case the contract effective date is used.

Reduce the average utilization days for residential treatment placements by 2%.

The current average utilization days by geographic area are:

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>Average Utilization Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geographic Area 1</td>
<td>169</td>
</tr>
<tr>
<td>Geographic Area 2</td>
<td>183</td>
</tr>
<tr>
<td>Geographic Area 3</td>
<td>170</td>
</tr>
</tbody>
</table>
Appendix 1: Case Examples & Interviews

Referral Process

The contractor must accept any referral. The state agency reserves the right to make no referrals. The state agency has the final authority on which cases will be referred to the contractor. The state agency will refer additional cases throughout the contract period with the intention of replacing cases which are expected to move to permanency until the contractor has met the maximum number of cases stated in the Notice of Award combined with the number which are expected to move to permanency throughout the year.

Random rotation process – The state will refer additional cases meant to replace those moving to permanency in accordance with a random rotation process. Exceptions to the random process include placement of siblings with the same contractor, cases in which the contractor has a past relationship, and re-entries of children within 12 months of permanency who will be reassigned to the same contractor.

Approximately the same number of referrals each month will be made to each provider to replace the children expected to move to permanency. This process will be accomplished through a rotational process whereby contractors will receive a predetermined number of cases each month with the remainder of the cases being assigned monthly to the state agency.

Disenrollment

The contractor provides case management services to all referred cases until or/unless the following occur:

• The court orders the case to be reassigned.
• The court has terminated jurisdiction over the child in out-of-home care and there has been three (3) months of post-permanency services for those achieving permanency.
• A case has been accepted for enrollment in the specialized case management contract.
• A child or family has filed a grievance against the contractor and requests their case be reassigned.
• Contractor’s staff has been involved with an unacceptable incident and the state agency determines it is not in the best interest of the child/family to reassign the case to another of the contractor’s family case managers. In such circumstances, the case will not be replaced and the monthly payment will be reduced by the number of cases disenrolled. In addition, the contractor may be placed on referral hold, or the contract may be cancelled at the discretion of the state agency.
• The state agency determines it is in the best interest of the child/family to reassign the case to state agency staff. These situations may include, but are not limited to, those situations when a child in out-of-home care is not moved to a permanent home within a reasonable timeframe.
• In the event the child/family moves out of a county, the case will not be disenrolled and the contractor must continue providing services.
• When a contractor loses referrals due to egregious situations during the first year of the contract, the number of referrals made during any subsequent years of the contract will be reduced by the same amount.

Automated Systems
Missouri does not have a SACWIS. However, the contractor will have access to the state agency’s Children’s Division information system (PROD) through Virtual Private Networking (VPN). The State provides the software and the Contractor is responsible for internet service provider and associated costs. (If the State moves to a SACWIS, the Contractor will have the ability to update as requested by the State). The Contractor updates the client record including information regarding, but not limited to, placements, court hearings, and Family Support Team meetings.

Legal/Court Responsibilities
The contractor cooperates with the state agency and the Division of Legal Services (DLS) in the preparation for and handling of any legal matter that may arise regarding any child or family receiving services under the terms of the contract. The contractor's family case managers attend court hearings involving the child(ren) for whom they have case management responsibility.

Financial Arrangements
Start-Up Funds — The contract includes one-time firm, fixed start-up price of no more than $126,000.

Case Management Invoicing — The contractor submits a monthly invoice at the beginning of the month for the number of cases stated in the Notice of Award and additional referral(s) made by the state agency in excess of the number of cases stated in the Notice of Award to keep siblings in out-of-home care with the same contractor. The contractor does not invoice for additional cases assigned through the contract period which are meant to replace the cases of children moving to permanency.

• The contractor reduces the monthly invoice by the number of cases which are to be referred monthly while the contractor is placed on referral hold.

• The contractor does not invoice for re-entries into care within 12 months of permanency.

• For the renewal options periods, the contractor invoices for the room and board and residential treatment in accordance with the fixed price stated in the contract plus any percentage of increase(s) throughout the contract period specified by the state agency due to percentage increases in state agency maintenance or residential payments.

Reimbursements for Services — The state agency will reimburse the direct provider of service in the initial year. Room and Board costs will be incorporated into the renewal contracts with Lead Agencies.
Interview With a Performance-Based Case Management Agency

The interview is with Dick Matt, the Executive Director of the Missouri Alliance, a limited liability corporation with nine equity partners, that holds multiple case management contracts under different Missouri initiatives.

Can you describe the Missouri Alliance case management model?

"Before describing the current PBC contracts, it is important to recognize that there are multiple different case management contracts in Missouri, beginning with the Interdepartmental Initiative for Children that the Missouri Alliance has held since October of 1998. It has been extended six times (it has never been re-bid). The contract is expiring in December 2005, and it is not yet clear what the State will choose to do with that contract. In addition to the Interdepartmental Initiative that targets children with serious and complex needs, the State also has a limited number of case management contracts that are not risk-based. And, most recently, the State has launched Performance-based Contracts (PBC). These came about after the designers of the Illinois model spent time working with the State to understand and adapt the Illinois model.

Under the specialized case management contracts that preceded the current PBC contracts, the case managers operated just like the Department staff and the contracts were closely monitored—micro-managed. Those contracts paid about $22.00/day/per case. Those agencies came together with original Missouri Alliance agencies to bid on the new PBC contracts. They were already serving over 150 of the 525 cases that were to be included in this region.

There are currently three PBC contractors, one for each region. The Missouri Alliance has the region that includes the St Louis area.

In each of the Missouri privatized case management models, the RFPs and resulting contracts prescribe the case management system and all contracts contain language about outcomes. The bidder simply follows the path laid out by the RFP. In the PBC the focus is on family involvement and best practice in conducting Family Support Teams, focusing on permanency and using concurrent planning. Each contract specifies the staffing and caseload requirements.

In all cases, the legal services are provided by the States Legal Service Staff but with the case management agency preparing the documents and attending the hearings with legal staff.

The PBC is clear on the roles and responsibilities of the Contract agency. That was not always the case in the Interdepartmental Initiative where there was some role confusion. In the PBC, it is clear that the Contractor’s case managers are fully responsible for the specified outcomes. The Department does not have social workers for the cases referred to the PBC Contractor and the Contractor does not have to get prior approval to make placement changes or to change the case plan. The contractor is totally responsible for working with the child and family to achieve timely and safe permanency.

What was the process for receiving initial referrals?

In the new PBC contracts the State included start-up funds and allowed the Contractors three months to build the capacity before transferring cases. Then in the first month of
implementation, the agencies received all the cases they had bid. In the case of the
Missouri Alliance, we bid 525 cases which are being divided among the partner agencies.

This is brand new. The cases are just now being transferred. The initial group was
matched with the caseload that is kept by Department in terms of age, sex, length of
stay, prior experience, etc. The match was done to help with the evaluation which will
be conducted by the University of Missouri. About 60% of the foster care caseload stays
with the Department social workers.

After the initial matching, the state will use random assignment. The case transfer has
varied depending on the county—some hold formal case transfer staffings, others have
private workers and public social workers meet informally to review cases, still others
just send the files. Once accepted, the Contractor is responsible from the time of
referral until the child achieves permanency and the case is closed. We are also
responsible for ensuring that the permanency is stable. If the child returns within 12
months, we get the case but not additional funds.

**How many cases are you currently managing?**

In the Interdepartmental Initiative, we have between 390 and 400. For the PBC, it is
525. The PBC RFP called for caseload of 1:18 but the Alliance is hoping to keep it at
1:15. The supervisor: case manager ratio is 1:7.

**Is there a direct link between outcomes and payment?**

The Interdepartmental Initiative was a case rate with both bonuses and penalties linked
to outcomes. The PBC contracts specify outcomes that are implicit in financing but
there are no direct bonuses or penalties.

**What are the funding sources and reimbursement mechanisms?**

In original Interdepartmental Initiative, there were blended funds from Mental Health,
Youth Services, Medicaid and Child Welfare. After Mental Health and Youth Services
pulled their funding out in 2003, Medicaid continued to provide about 17% of the rate
(based on cost of care in 1996). The rate has changed over time with periodic increases.
Currently it is about $3800/month per child, with about $475 of that designated for case
management which was added midway through the contract. The contract also has
performance penalties and bonuses that have remained the same since inception.

The PBC is a staggered implementation. In Year 1, all funds are child welfare; in future
years when the Contractors assume responsibility for placement costs, Medicaid (rehab
funds) will be used for therapeutic levels of care. Contractors are expected in Year 1 to
bill Medicaid for non-placement services that are not included in the rate but the State
pays placement providers for placement costs. The PBC does not have explicit bonuses
or penalties. But, the risk is clear. The providers continue to receive referrals but the
income is fixed at the price specified in the contract. If the provider does not move
children to permanency, the caseload increases but the funds don’t. To stay in
compliance with caseload standards, the contractor would have to hire additional staff
with no funds to cover.

In the first year, our rate is about $816/month per case. We are projecting that about
half of the costs will go to services for the child and family and the remainder will cover
case management and administrative costs. The State was spending about $33 month
per case for services so we plan to significantly increase that amount. Each Alliance
agency with case management responsibilities will have a budget and authorization will occur through the Alliance.

**How were the rates determined?**

For the first year of PBC, agencies are paid for case management and non-placement services. In future years, the state will roll in room and board costs. The agencies said how many kids they wanted to serve and the RFP provided a price range based upon a projection of what the state paid for case management and treatment services.

If awarded the contract, the agency gets 1/12 of the payment the first day of the month. If the agency meets the target expectations then they still get the same funds and cases drop. If they do not reach goals, they get more cases but no more money.

There is no mechanism in either the Interdepartmental Initiative or the current PBC to mitigate risk. In both, however, there is front-end funding flexibility and agencies can retain and reinvest any savings.

**Is case management just one of the services you provide in your contract with the Department? If yes, what other services do you provide?**

In the PBC, the Missouri Alliance has some therapeutic foster homes but all case management is divided among the partner agencies. This is the reverse of the model we used for the Interdepartmental Initiative where the Alliance provided almost all case management services (there are about 50 case managers and the Alliance has all but about 6 who are employees of Alliance partner agencies).

**What is the process for authorizing and paying for services needed by the child/family?**

The process to authorize services is fairly straightforward:

1. The Care Manager with the Family Support Team designs a Plan of Care including Goals, Objectives and Services necessary to accomplish the goals.

2. The Care Manager goes to the computer and pulls up “Service Authorization” screens. They begin to enter each service individually. They select the provider from a drop down box which currently lists all the providers under contract for a particular service.

3. They authorize a specific number of units of the service (8 units of Individual Counseling, for example) for the coming month (authorizations only cover a one month time frame). The service must be directly related and identified in the system toward one of the goals.

4. The computer generates a “turnaround” document which functions as the billing invoice.

5. The document is mailed or faxed to the provider.

6. The provider returns the document after the close of the month with accompanying progress notes.

7. The document is then processed within the computer system for payment.

Of course, the actual mechanics are much more detailed but this gives you a good idea of the process.
Does your organization maintain a network of service providers? If so what services are represented?

For the Interdepartmental Initiative, over time the Missouri Alliance expanded services and built capacity in needed areas. In the PBC, some of the kids being referred are already being served by agencies outside the Missouri Alliance so they are being added to the Missouri Alliance network.

Do you have contracts where providers are assured referrals or do you have lists of services and rates paid but with no guarantee of referral? Are rates the same for all your providers?

Actually, we use both methods. We primarily have contracts with providers which are open ended and guarantee no specific number of referrals. They are very “service” specific rather than “program” contracts with the exception of residential treatment. We have probably 400 such contracts.

However, we have instituted a few “guaranteed” contracts for residential care. These were specifically with our equity partners. We redefined what we wanted from a residential placement. We wanted: (1) staff trained in wraparound theory, (2) short term stays, and (3) primary concentration on getting information about necessary treatment to put the child in the community. In other words, it was not a typical “program” as usually conceived by the residential providers. We then guaranteed a certain number of beds that we would pay for even if vacant. We have 2 such programs going now.

We have rates which we view as a maximum. However, they have become the “standard”. We will, however, negotiate rates for individual services such as mentioned in the guarantee program, or inpatient psych placement.”

Is there any formal application/credentialing process for your providers?

Yes, all providers go through a formal application and credentialing process. We are sometimes, however, forced to pay some providers prior to the completion of the process due to the necessity of obtaining immediate services.

What is your responsibility for monitoring provider performance versus that of the Department?

The Department has no responsibility for monitoring our providers. We provide all monitoring of their performance and report those to the Department.

Are you required to go outside your equity partners for services?

No, we are not required to go outside. However, it becomes a necessity. For the Interdepartmental Initiative, we are currently running at about $18 million a year and the 9 owners cannot produce all of the services which we require because it is such a vast array. In the beginning, the state attempted to push us away from our owners into other providers but there was no contractual requirement. We have significantly increased the use of the partners during the last 3 years. The Missouri Alliance will monitor for PBC outcomes and service provider contracts contain specific requirements.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

What was the impetus for the public agency to contract for case management services?
The Legislature has increasingly called for expanded privatized contracts. Sweeping mandates have not passed but the PBC contracts appear to be an incremental step. The PBC will undergo an evaluation that should help to answer what works and what doesn't.

What are the top three issues that public agencies should consider in developing a plan for contracting for case management?
1. Build a real partnership with the private sector to get the political clout needed for hard times.
2. Make sure the financing option gives flexibility in funding and specifies the outcomes/results desired.
3. Require accreditation as an added protection for quality. (Both the contract agencies and the Missouri Department are required to go through accreditation)

What are the top three things that private agencies should consider in developing the capacity to provide case management services?
1. First, they need to build the expertise—start by hiring experts to guide them through all they don’t know about the system’s obstacles.
2. Get a handle on costs and if the money isn’t there—don’t bid.
3. Philosophy of care— Many providers will need to embrace family-centered practices, build child/family strengths that will help to achieve permanency, while also acquiring new business tools and skills.

If you had it to do over again, what is at the top of the list of things that you would do differently?
1. With the Interdepartmental Initiative, the Alliance should have immediately expanded services to include traditional and TFC to reduce reliance on RTC.
2. Hire seasoned child welfare workers— Initially, the Alliance relied too heavily on mental health folks who did not understand child welfare and who did not bring family-strengths perspective.

Describe your greatest "success” and your greatest difficulty.
1. With the Interdepartmental Initiative, the greatest success has been meeting the outcomes of moving kids to lower levels of care. But, one of less successful parts has been not doing that quickly enough.
2. The greatest difficulty has been and continues to be the financing. Take an under-funded state system, increase expectations but not money, and you have problems.

FOR MORE INFORMATION, CONTACT:
Dick Matt
The Missouri Alliance, Inc.
Jefferson City, MO
DMatt@MA-CF.org
3. Cuyahoga County, Ohio-A Case Rate Lead Agency Pilot for Foster Care

Background
In 2000, the county launched a case rate lead agency pilot. Notification to awardees and contract negotiations began in December and extended through January 2001. Implementation began in the Spring of 2001. The primary difference between the current system and the pilot is that contracted lead agencies will be expected to:

- Adhere to no eject/no reject policy with a response within 90 minutes of the initial call and placement within 4 hours,
- Provide a foster family within the child’s community,
- Work with the birth family when reunification is the goal,
- Concurrently plan for adoption,
- Provide all services needed to achieve permanency,
- Be evaluated on specific performance measures, and
- Take some level of financial risk for each child.

Goals
The primary goals are to ensure permanency decisions are made within 12 months and have permanency stability with no reentry for 9 months, reduce lengths of stay, improve outcomes and accountability for children and families, improve cultural relevance of services provided, and improve community support by encouraging pilot contractors to link with community-based organizations. (Lead agencies will connect to existing collaboratives created under the Casey Family-to-Family initiative.)

Population Served
The initiative targets a portion of the county’s caseload from birth to age 14 who are in specialized foster care. Only children who have behavioral or health care needs (Levels 2 and 3) and their siblings are included in the pilot population. Each contractor will serve 100 children and families per year in the region of the county they specified in their proposal. It is projected that 168 children will be served in the first 12 months. When fully implemented, each of the three contract providers will serve up to 100 children and families annually.

Services
- Coordination with CPS intake and investigation
- Assessment, diagnosis, and case management
- Crisis services and emergency shelter
- Home-based family preservation and support services
- Permanency planning with families
- Family and treatment foster care
- Group and kinship care
- Residential care and day treatment
• Inpatient psychiatric hospitalization
• Adoption recruitment and post-adoption subsidies and support
• Outpatient mental health services and substance abuse treatment
• Respite care
• Independent living

Quality and Outcomes
The contracts with lead agencies include performance standards and explicit outcome indicators in the following areas:
• Access to services
• Use of standard protocols to ensure appropriateness of care
• Accreditation for lead agencies
• Grievance and appeals
• Safety and permanency
• Continuity/stability of placement
• Child and family functioning
• Recidivism/reentry

The contracts require that lead agencies ensure family involvement, including specifying the frequency of contact between the child and family and between the care manager and the family. The RFP also requested documentation of cultural competency, including prior experience with diverse populations, outreach strategies, inclusion of diverse providers in the network, and recruitment of and support for diverse caregivers.

Reports from providers, assessments, and data will be used to monitor system performance and outcomes. In addition, the department is matching the children referred to a control group and will compare outcomes over time.

Lead Agencies
DCF is contracting with three nonprofit lead agencies. The lead agencies are responsible for contracting with network providers; providing ongoing use management, including prospective, concurrent, and retrospective reviews; handling all case management related to treatment and permanency planning; and collecting data to meet state and federal requirements.

The current lead agencies are Beech Brook, with a case rate of $56,000 for children aged 14 and younger; Catholic Charities Services/Parmadale, with a case rate of $53,000 for children aged 12 and younger; and NBA Cleveland Christian Home, with a case rate of $54,000 for children aged 14 and younger.

Financial Arrangements
The budget for the initiative in the next first year was $3.48 million. The department estimates the total cost of the 5-year pilot project will be between $13.6 and $17.1 million. The project is fully funded with child welfare funds.
DCF is using an episode of care case rate. The episode begins at the point of referral and ends 9 months after permanency plan, or up to 36 months, whichever is sooner. The payment schedule for contractors calls for 18 equal monthly payments for each client. It is possible that a front-end payment or other prospective payment may be negotiated in the future. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the pilot contractor must take responsibility for the child’s care and services from the original case rate.

The contract does not have bonuses attached to performance but there are penalties associated with failing to achieve permanency. The lead agencies serving children aged 14 and younger must achieve permanency within 36 months for 80% of the children served. The lead agency serving children 12 and younger must achieve permanency within 36 months for 87% of children served. For every child over the allowable standard who has not achieved permanency, the provider will be fined $3,600. The case rate for those children will end and the child will be removed from the pilot project but will remain in his or her current placement.

The case rate amount was established through the RFP process. The department offered a range based on current costs for a cohort of similar children, and the bidders specified the rate within the acceptable range. The department estimated case rate costs at approximately $45,000 per child for projects serving children aged 12 and younger and approximately $47,500 per child for projects serving children through age 14. The case rate is designed to cover the period of custody to permanency, plus 9 months (12 months for adoption cases), and assumes that at least 50% of children achieve permanency within 12 months. The actual rates paid under the contract are significantly higher than the department had projected.

Included in the case rate are per diem costs, case management costs, all social services, emergency cash, therapeutic costs not billable to Medicaid, all clothing costs, and administrative costs. The rate is not intended to cover psychiatric hospitalizations or any Medicaid services. Pilot providers may have access to home-based services provided through the department on a limited basis. Medicaid, general revenue funds, and TANF will be used to pay for services outside the case rate.

**Limits on Risks and Savings**

One contractor has accepted full risk; the remaining two contractors have a 10% risk corridor. There are limits on the potential retained savings. The contractors may request that as much as 30% of retained earnings be used for documented, department-approved start-up costs. The remainder must be used based on a joint neighborhood planning process to benefit the community in which the pilot is located and the department must approve the plan.
Interview With a Lead Agency Operating Under A Case Rate

This interview was conducted with Patricia Varanese, Director of Family Connections at Beech Brook in Cleveland, OH.

*What is the scope of work of your case managers?*
Our Family Connections’ case managers do everything the public caseworker would do for similar cases. We receive the case from County Intake. It is our responsibility to place the child or sibling group in a foster home or another relative’s home and supervise that placement. We develop the case plan along with the family and present it to the court and county for input. We work on reunification, TPR or adoption, based on the case plan. We also input data into the public IS system, and we are responsible to apply utilization management to all case plans and services. Family Connections has Family Life Specialists who manage aftercare cases and other supportive activities to aid the case managers.

*Describe your case planning process.*
The case manager completes the strength and needs assessment tool and presents this at the first family team meeting to identify necessary services for the case plan. The team gets buy in from the family, DCFS, and others important to the child. The case plan provides direction for working with the family. All case plans are highly individualized, and due to the flexibility of funding, services are tailored to child and family needs.

*Who is the identified client (the child or the family)? How are cases identified in SACWIS?*
The SACWIS system is called FACTS and cases are identified by the family, but Family Connections is paid a case rate per child.

*How is the family involved?*
The family is involved from the first family team meeting. A three level concurrent permanency plan is developed. Plan A is for placement with the parent, Plan B is for custody to go to a kinship family, and plan C is for adoption.

*If the family is actively involved in case planning, describe that process. Does the family “sign-off” on the case plan?*
Parents are involved in case planning and decision making and do sign off at family team meetings.

*What is the case plan review process? What is the role of the court in that process?*
We review progress with the family at monthly team meetings. The court signs off on the initial plan and semi-annual reviews thereafter. We need court approval for all case plans.

*Who represents the family in the legal process?*
Most parents get a court assigned attorney, GALs are assigned for the child, and a public defender or assigned counsel for the families.

*Does the family’s legal representative become involved in the case planning?*
The family’s legal representative has very little involvement. He or she is more involved in the initial complaint.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

What is the interface with Protective Investigations pre-disposition?

We get referrals from the Intake worker/PI who has 30-45 days to complete the investigation. Once the transfer to CRPP occurs, the PI is out of the case and an “ongoing” Department Case Manager oversees the case, but has very little to no involvement with the child or family.

Does the Department also have case managers/service workers? If yes, what is your relationship with those public agency workers? Are the respective roles clearly defined?

The assigned Department Case Manager oversees the case and sometimes, there are control issues. We continually have to review the roles between Family Connections and the public agency workers, especially with turnover and with new supervisors and caseworkers.

Does the (state) Department have sign-off on individual case plan decisions, and if so, how does that process work?

The Department Case Managers do have final sign off, and they receive a monthly packet with reports of case-level activity to keep them informed. The Department Case Manager is invited to family team meetings, but few come.

Are you responsible for court-related processes?

We provide input to the Department for the court report. Their lawyers represent CRPP staff [not clear: must be in agreement.]

Was there a phase in process for referrals?

Yes, we started with 20 “transition” cases of children who were already in the system at a Level 2 or 3 and then gradually went to intakes of new children to the system.

Describe the case transfer process.

Materials were copied and transferred by staff to the CRPP

At what point in the life of a case do you accept cases? At what point does your responsibility end?

Our responsibility ends once a permanency placement has been reached plus 9 month of legal aftercare or 12 months for finalized adoption cases. During that time, we keep track of the family and the progress they are making, but the families are not considered active cases for case management.

What are the caseloads for case managers? What is the ratio for supervision?

12-15 children for each case manager and a ratio of 4 to 1 for supervision.

What are the quality assurance/improvement and contract monitoring requirements?

The contract describes the scope of work, service array, and neighborhood and community linkages. Team meetings need to be held within 7 days and within 30 days, the case plan needs to be developed for approval by the county. There are financial penalties for not reaching permanency within 24 months. If a child comes back into care while still in aftercare, CRPP is still responsible financially.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

The Department monitors our contract through outcomes on a quarterly basis and financially on a monthly basis. We have debriefing meetings to review the results with Department staff and their consultant.

**Does the contract set caseload standards?**
The contract does not set caseload standards.

**Is there a direct link between outcomes and payment?**
Payment is capitated and CRPP is at risk. CRPP gets a $5,000 bonus for achieving a finalized adoption.

**What are the outcomes or performance indicators in your contract?**
We are compared to the control group at the county. So far, we have the same or better outcomes. Outcome indicators include: out of home length of stay, length of stay in high levels of care, placing children within their neighborhoods, placing sibling together, non disruptions in foster care, recidivism, and no additional incidents of abuse and neglect. The outcomes and performance standards have stayed the same over time.

**Are there ongoing mechanisms for you and the Department to review performance and problem-solve difficulties?**
We had monthly meetings at the startup and for the first year, then we went to quarterly meetings.

**What are your data collection and reporting requirements?**
Our case managers enter data into FACTS.

**Is case management just one of the services you provide?**
Family Connections covers case management of the child and family and that includes all financial risk for out of home services. We purchase a variety of out of home services on behalf of our clients. Therefore, we have a network to provide services outside of the intensive case management that our case managers deliver.

**Can you determine what the costs and reimbursement are for the case management component of your contract?**
We have a case rate but we are able to determine, through the use of Activity Based Accounting, the true costs of our case management.

**What funding source does the Department use to pay for case management?**
Foster Care funds, IV-E

**Is your payment schedule linked to performance?**
Payment is fully capitated in the form of a case rate. We accept full risk for all the costs of service delivery, including needed foster care, residential care, and family preservation services. Invoices are not paid until all our reports are received by the county.

**How was the rate for case management determined?**
The county proposed a ceiling for the case rate and then in a competitive procurement process, each potential bidder had to develop their own case rate based on utilization data and expenditure data from the county for the previous 3 years.
**APPENDIX 1: CASE EXAMPLES & INTERVIEWS**

*Are there any mechanisms in place to protect you against financial risk?*

The only mechanism is that CRPP can ask to have a child reevaluated for appropriateness for the program within 30 days. This step has only been taken twice. With those two children, there were medical issues and one of the children in the family did not fit the criteria. The case was transferred back to the county.

*Are there mechanisms to allow you to retain savings and carry over to next FY?*

Yes, we can retain savings, but we are required to share the savings with the county for anything over 10% (minus startup costs) of the final savings. We have been able to carry our share of the retained savings over to the next FY.

*Have the rates or payment mechanisms changed contract?

Yes the case rate has been reduced from $56,251.00 to $52,500 due to county financial short falls.

*Does the Department have any contingencies on the funding contract?*

Yes, specific to adoptions, the money that the county has to provide bonuses to us for finalizing adoptions is dependent on the Adopt Ohio Act and funding.

*What is the process for authorizing and paying for services needed by the child/family?*

The case managers recommend services and the Director authorizes payment for the services. The Director knows the utilization targets and is able to measure performance against the targets.

*How do the case managers know what services are available?*

We have a network of providers and all case managers have a list of the network providers and can decide which providers offer the appropriate services.

*How do your case managers get feedback from the service providers?*

Through monthly updates, written and phone calls, or meetings.

*Do you have a formal process for disputes?*

Our provider manual and provider contract defines a resolution process to discuss case differences.

*How was the network developed?*

Initially, the network was developed for inclusion into the RFP process, based on what we thought we would need to provide case management services, and out of home services, including foster homes, residential treatment, family preservation, mentoring, and emergency placements. Once we became operational, we tended to use the more successful providers.

*Does your organization have contracts with the service providers?*

Yes we have written contracts which were patterned around a combination of managed care provider contracts and the current county contracts with providers.
How are service providers held accountable for the services they deliver?

If we have a problem in the delivery of service from a provider, we meet with them and make suggestions for better services. If the provider does not make the necessary changes, we may not use them in the future.

Were there any restriction on the amount or types of other services you could provide?

This has not been an issue. We purchase service from a broad provider network and if our sponsoring agency does not always offer the most effective service, we use other providers.

What was the impetus for the public agency to contract for case management services and what have the results been?

The previous Director of the Department of Children and Family Services and the Alliance (provider group) promoted the idea of capitated child welfare through joint meetings, CWLA training, and outside consultants. This process was more provider-driven than public agency-driven.

Has the initiative undergone any independent evaluation? If yes, by whom and is there a written report?

Tracy Fields of the Human Services Institute did a concurrent review and evaluation for the Department. We would meet quarterly to review our progress and outcomes. However, a final written report has not been completed.

If no independent evaluation has been conducted, what other methods are used to track and report "success?"

The consulting firm of Human Services Research Incorporated has been the consultant for the county in the development of this project and monitors the results on a quarterly basis.

What are the top three issues that public agencies should consider in developing a plan for contracting for case management?

- Getting “buy in” from all levels of the public agency staff. The public and private agencies need to have a mutual understanding and agreement of the goals and direction of the project.
- Clearly defined roles and responsibilities between the county staff and the case management organization need to be communicated and understood by all.
- Have to have mechanisms to avoid and manage the risk of abuse and neglect of children while in the system.

What are the top three things that private agencies should consider in developing the capacity to provide case management services?

- Make sure that they have enough referrals that fit the project criteria—Is the target population big enough?
- Understand risk. Risk can be created by actions outside of the control of the case manager (ie: court, school).
- Make sure they have the services that will meet the needs of the population that will be included in the project, including enough appropriate foster homes.
If you had it to do over again, what is at the top of the list of things that you would do differently?

- Build a stronger relationship with the public agency and consider co-location.
- Have regular meetings on a monthly basis with top and mid level managers to work through all the issues.

Describe your greatest "success" and your greatest difficulty.

- Our greatest outcome is the results for the children and families (i.e.: siblings placed together, length of stay is shorter, lack of disruptions, and recidivism and lack of re-abuse and neglect).
- Our greatest difficulty has been contracting problems and ensuring a smooth relationship and quality services from the sponsoring agency.

FOR FURTHER INFORMATION, CONTACT

Patricia Varanese
Director of Family Connections
Beech Brook, Cleveland, Ohio
Patricia_varanese@beechbrook.org
4. Florida-Statewide Privatization of All Child Welfare Services (Global Budget)

Privatization of child welfare services in Florida began in 1996 when the state legislature required the Department of Children and Families (DCF) to establish pilot programs in which community-based agencies would provide child welfare services through contracts with DCF. Four privatization pilots subsequently were established. Following the implementation of these pilot programs, the state legislature, in 1998, mandated statewide privatization of child welfare services. An extensive planning process ensured and the transition to a privatized system began in 2000. In recent months, the final service contract was awarded to the lead agency in District 11 (Miami-Dade County). The statewide implementation is now complete.

Over time, the term “privatization” came to be replaced with the term “community-based care (CBC).” CBC refers to the development and implementation of a system of care in which private providers, acting in collaboration with community stakeholders, provide all child welfare services post investigation; there is flexibility in how those services are provided; and efficiency is expected in all aspects of service provision, particularly in relation to fiscal management. Included within the concept of community-based care are a “child-centered” orientation and the delivery of individualized services to meet families’ needs through a “wraparound” approach.

The State has service contracts with twenty lead Community Based Care (CBC) agencies, covering all regions of the State. Some CBCs have been operational for almost four years while a few are just beginning the incremental phase-in of all cases. A few CBC agencies were previously single agency service providers (such as the YMCA in Sarasota), but most are newly formed entities created solely for the purpose of bidding on the CBC Invitations to Negotiate. Many CBCs were formed by 4-5 (or more) community service providers who had a vested interest in making certain that the CBC agency would meet the needs of local children and families and fully engage the agencies that serve them. Typically, the founding partners had a seat on the Board of the CBC and also became service providers. More recently, the State has required that the equity partners step off the Board after the contract is awarded to eliminate conflict of interest or perceived conflict.

The CBC transformation has undergone a series of evaluations at every stage of implementation. The Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida, has been under contract with the Department of Children and Families since September 2002, and has conducted an annual statewide evaluation of CBC. The most recent report includes data from 11 lead agencies (28 counties) implementing CBC in FY2003-04.

The following description of the implementation of community-based care in District 14, Heartland for Children (HFC) is illustrative of the implementation of community-based care; however, it is important to recognize that CBC agencies have had highly varied experiences in planning for and implementing community-based care across different counties and Districts. As a result of the variability, it is not possible to present a uniform picture of the implementation of privatization statewide. The experience of HFC is not intended to reflect the Florida’s initiative overall, but it is illustrative of the complexity of the task. HFC is also widely recognized for its approach to quality assurance/monitoring and its prevention focus.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Interview With a Florida Community-Based Care Lead Agency

For consistency, should these names appear here? Marcie Biddleman, President of HFC or Kathleen Cowen, Vice President of HFC
The responses to these questions are based on interviews with Heartland for Children (District 14- Lead Agency Community Based Care) as a system administrator. HFC contracts case management to four separate non-profit organizations.

Describe your case management model.

Heartland for Children offers flexibility in allowing each case management organization (CMO) an opportunity to design a unique approach to case management while accomplishing the same desired outcomes and results. Heartland requires each case management organization to embrace a wraparound approach to case planning and service delivery. Case management models include the Family Team Conferencing Approach and a “team” approach to case management (both case managers familiar with the client).

The role of the case manager replaces the public agency case manager. The HFC case manager’s specific role is to gather and assess information about the family. This assessment includes identification of the family’s problems, strengths, available resources, service needs (case plan) and treatment strategies. The case manager has to continually assess the results of interventions ensuring that appropriate decisions are made regarding child safety, the risk of future abuse, and the family’s accessibility to existing resources to meet current and future needs (prevention).

The case manager is required to have regular contact with all family members to include a minimum of a monthly face to face visit with the child receiving services in the child’s home environment. The case managers are required to document all case related activities, provide required information to the court (if applicable), consult with other treatment professionals, supervise visitations, provide transportation services and meet other outcome measures that drive timely permanency (reunification within 12 months of initial removal).

The Family Support Worker supports the case manager by providing some clerical support and assisting in transportation of children to scheduled visits and appointments. The Family Support Worker can also be involved in tracking certain outcome measures (i.e., timely submission of court reports) and other duties that would assist the case manager, including taking photographs of children and supervising visitations if determined appropriate.

Describe your case planning process.

The case planning process involves meeting with the client and jointly identifying safety concerns and creating a plan to assure child safety. The case manager plays a very important role in determining both the formal and informal services and resources available to and needed by the family, addressing the changes that need to occur to ensure child safety and arranging for service provision. This case planning process includes negotiating specific goals with the family, negotiating specific dates and prioritizing needs in an effort to develop a realistic case plan.

Who is the identified client (the child or the family)? Both. How are cases identified in SACWIS?
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

By the mother’s name (Last Name, First Name)

How is the family involved?

The family is involved in the assessment process to help identify family problems, assess family strengths (including external supports). The family participates in the service planning and service provision process. This can be done informally in the family’s home residence, utilizing a family team conferencing approach or through a judicial mediation.

If the family is actively involved in case planning, describe that process. Does the family “sign-off” on the case plan?

The family is encouraged to sign the case plan after it is completed. Although signing the case plan is not an admission to the allegations identified in a dependency petition, some parents are encouraged by defense counsel not to sign the case plan until after the Adjudicatory Hearing (Trial). The case plan must be developed within 60 days of removal or by case disposition (whichever comes first). If the parent does not sign the initial case plan, the case manager is encouraged to file the case plan in an effort to meet the judiciary timeframes without an actual signature. As additional information is gathered on the family through the assessment and case planning process, the case manager is required to amend the case plan as determined appropriate.

What is the case plan review process?

The case manager has to make every effort to provide defense counsel with a copy of the case plan prior to submission of the document to the Court. During the judicial proceeding, the Court will review the information contained in the Case Plan and will remove and/or add information as determined appropriate. If no revisions are necessary, the Court will approve and accept the case plan.

Who represents the family in the legal process?

If a child is removed from the custody of a parent, the parent has a right to legal representation. If a parent can not afford legal representation, an attorney is appointed by the Court. The appointed attorney is required to represent the parent during the legal process. The family’s legal representative becomes involved in the case planning.

What is the interface with Protective Investigations pre-disposition?

Completion of the Pre-Disposition report is a joint responsibility between the child protective investigator (CPI) and the case manager. The CPI completes the initial three sections of the pre-disposition report which captures information on the family’s response to the child abuse allegations, prior abuse history and efforts to prevent removal. The case manager completes the remaining sections of the pre-disposition report which involves the social history data and recommendations for disposition.

Does the Department also have case managers/service workers? If yes, what is your relationship with those public agency workers?

The Department has child protective investigators. The role of the case manager has been totally privatized.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Does the Department have sign-off on individual case plan decisions? If so how does that process work? If not, how do you keep public agency informed?

No, the CBC has total responsibility. The Department monitors through outcome measures. The State requires that children are safe, their well-being needs are met and they achieve timely permanency. Outcomes are measured through quality assurance monitoring.

Are you responsible for court-related processes?

Yes, as the lead agency, Heartland provides oversight regarding the timely submission of court documents and appropriate representation of clients during the judicial process. Heartland is also involved in assisting with judicial barriers that may delay the dependency process (role of Court Liaison) and addressing systemic issues to include implementation of best practices to improve efficiencies. The Department employs all of the Child Welfare Legal Service attorneys that represent case managers during the dependency process.

Was there a phase-in process for referrals?

Yes. HFC phased-in case management services over a six month period by case management organizations. Prior to the transfer of files and cases, the organization conducted a 100% review of case files.

At what point in the life of a case do you accept cases?

When a CPI makes a determination that a family is in need of case management supervision, the case is scheduled for an early service intervention staffing. It is at this staffing that a case is officially accepted. The case managers remain involved with a case until the goals and objectives of the case plan are achieved or there is some other acceptable reason for termination of supervision (i.e. dismissal of the case in Court, family refused services, the family relocates). A case cannot be closed until the case manager evaluates the family’s progress and makes a determination that the risks that led to the initial involvement have been sufficiently reduced to ensure child safety. When custody of a child is returned to a parent, the case manager must remain involved for a minimum of six months before a recommendation can be made to the Court to terminate services.

How many cases are you managing at any one time?

Caseloads are calculated by the number of children receiving services. On average, Heartland provides services to approximately 3400 children.

What are the caseloads for case managers?

Approximately 26 kids.

What is the ratio for supervision (supervisors: case managers)?

Approximately 1:6.

Did the RFP/contract include performance standards?

Yes, the contract has 16 performance standards. Many directly reflect [CFSR Outcome items that cannot be negotiated. The standards are as follows:
1) At least 95% of the children served shall be protected from child abuse and neglect. (Source: CFSR, Safety Outcome)

2) No more than 1% of children served in out-of-home care shall experience maltreatment during services. (Sources: CFSR national standard, Permanency)

3) At least 95% of children served shall be safely maintained in their own homes whenever possible and appropriate. (Source: CFSR, Safety Outcome)

4) The percentage of children entering out-of-home care who are re-entering care within 12 months of a prior reunification or release to relatives shall not exceed 8.6%. (Source: CFSR national standard, Permanency)

5) The percentage of children reunified who were reunified within 12 months of the latest removal shall be at least 76.2%. (Source: CFSR national standard, Permanency)

6) The percentage of children with finalized adoptions whose adoptions were finalized within 24 months of the latest removal shall be at least 32% (Source: CFSR national standard, Permanency)

7) At least 95% of children served shall have permanency and stability in their living situations (Source: CFSR, Permanency)

8) No more than 49.52% percent of children in out-of-home care on June 30, 2005 shall have been in out-of-home care 12 months or more. (Source: Department Priority)

9) The continuity of family relations and connections shall be preserved for at least 95% of the children served. (Source: CFSR Permanency Outcome)

10) At least 200 adoptions shall be finalized during state fiscal year 2004-05. (Source: Department Priority) -- The number of adoptions in this measure varies from CBC to CBC.

11) a) At least 65% of children in non-TANF out-of-home care will be eligible for Title IV-E; b) At least 80% of children receiving TANF out-of-home and in-home supports will be eligible for TANF. (Source: Department Priority)

12) At least 95% of families shall have enhanced capacity to provide for their children’s needs. (Source: CFSR, Well-Being Outcome)

13) At least 55% of adults whose child welfare case plans require substance abuse treatment shall have documentation in the case file that the adult completed treatment or was actively receiving treatment at the time of the review. (Source: Department Priority)

14) At least 95% of children served shall receive appropriate services to meet their educational needs. (Source: CFSR, Well-Being Outcome)

15) At least 95% of children served shall receive adequate services to meet their physical and mental health needs. (Source: CFSR, Well-Being Outcome)

16) 100% of children under supervision who are required to be seen each month shall be seen each month. (Department Priority; also CFSR Well-being Outcome)

How does the Dept. monitor your contract?

HFC’s first DCF monitoring performed by the district contract performance unit was held in May 2004 and was a desk review. The second review performed by the department’s
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Contract oversight unit is scheduled for November 2005 and will have an on-site component. HFC provides several reports in accordance to the terms of the contract with the department. On a monthly basis, reports include a Child Protection Staff Roster. On a quarterly basis, HFC provides a Training Report and a Locale Improvement Plan report. Annually, HFC provides an Adoptions Incentive Funding Report. A summary of required reports are listed below by frequency and process.

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Frequency of Report</th>
<th>Submit to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tangible Personal Property Inventory</td>
<td>Must be completed for initial transfer of equipment, and annually thereafter.</td>
<td>Contract manager</td>
</tr>
<tr>
<td>CBC Personnel Report</td>
<td>Monthly; 10th calendar day of the month for prior month</td>
<td>Contract manager</td>
</tr>
<tr>
<td>Child and Family Services Report Tool</td>
<td>Monthly; 5th calendar day of the second month in which services were delivered</td>
<td>Contract manager and <a href="http://www.teamfla.org/databases.html">www.teamfla.org/databases.html</a></td>
</tr>
<tr>
<td>Family Support Matching Report Tool</td>
<td>Monthly; 5th calendar day of the second month in which services were delivered</td>
<td>Contract manager and <a href="mailto:DSFSM@DCF.state.fl.us">DSFSM@DCF.state.fl.us</a></td>
</tr>
<tr>
<td>PSSF Activity Log</td>
<td>Monthly, 5th calendar day of the second month in which services were delivered</td>
<td>Contract manager and Central Office Pr. <a href="mailto:Mngr.-Maria_L_del_Riesgo@dcf.state.fl.us">Mngr.-Maria_L_del_Riesgo@dcf.state.fl.us</a></td>
</tr>
<tr>
<td>Adult-Adolescent Parenting Inventory</td>
<td>Web based instructions</td>
<td>Contract Manager</td>
</tr>
<tr>
<td>PSSF Match Funds Reports</td>
<td>Monthly; 5th calendar day of the second month in which services were delivered</td>
<td>Contract manager and Central Office Pr. <a href="mailto:Mngr.-Maria_L_del_Riesgo@dcf.state.fl.us">Mngr.-Maria_L_del_Riesgo@dcf.state.fl.us</a></td>
</tr>
<tr>
<td>Child &amp; Family Services Plan</td>
<td>May 15, 2009 and every 5 years thereafter</td>
<td>Contract manager and <a href="http://www.teamfla.org/databases.html">www.teamfla.org/databases.html</a></td>
</tr>
<tr>
<td>State Child Access Program Survey</td>
<td>Quarterly, 10th calendar day after the end of each quarter.</td>
<td>Contract manager</td>
</tr>
<tr>
<td>Local Program Improvement Plan Report</td>
<td>Quarterly, 10th calendar day after the end of each quarter</td>
<td>Contract manager</td>
</tr>
<tr>
<td>Report of Trust Fund Totals by Client</td>
<td>Quarterly</td>
<td>Contract Manager</td>
</tr>
<tr>
<td>Independent Living Spending Plan Report</td>
<td>Monthly; 20th calendar day of the month for prior month.</td>
<td>Contract Manager</td>
</tr>
</tbody>
</table>
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Frequency of Report</th>
<th>Submit to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection Staff Roster</td>
<td>1. Initial List of Staff 2. Monthly updates Staff List</td>
<td>Contract Manager and Child Welfare Training Unit Administrator –</td>
</tr>
<tr>
<td>Prevention Expenditures</td>
<td>Quarterly, 10th calendar day after the end of each quarter</td>
<td>Contract Manager</td>
</tr>
</tbody>
</table>

Does the contract set caseload standards? If so, what are they and on what were they based (i.e., national COA standards, or others)?

No, the contract does not set caseload standards. The contract specifies that there is a no-eject or no-reject policy and the provider shall deliver a comprehensive array of foster care and related services to all eligible children and families in the following county or counties: Polk, Highlands and Hardee. Services include, but are not limited to: family preservation, independent living, emergency shelter, residential group care, foster care, therapeutic foster care, intensive residential treatment, foster care supervision, case management, post-placement supervision, permanent foster care, family reunification and adoption services.

Is there a direct link between outcomes and payment?

No, there is not a direct link between outcomes and payments between the Department and HFC. HFC has entered into a cost reimbursement contract with the department. The department reimburses allowable expenditures incurred in the delivery of services that are provided in accordance with the terms and conditions of this contract under the global budget. HFC contracts with four case management organizations. The current method of payment for case management agencies is a fixed price contract. Plans are in place to change the method to a unit rate contract.

Have any of the performance standards or outcomes changed since the contract was first signed?

Yes, the performance standards have changed since the contract was signed. All changes were formally negotiated. The first set of measures relied very heavily on the Child Welfare Integrated Quality Assurance (CWIQA) reviews. Measures were removed and replaced with measures that more specifically addressed the underlying elements that would have comprised “substantial conformity” in the specified CWIQA domains.

It must be noted that the current performance measures are currently being renegotiated for the current fiscal year’s contract. There is a statewide initiative to re-engineer the quality monitoring process, including a dramatic revision of contract performance measures. The new measures have not yet been approved. The list of proposed measures is as follows:

- Percent of children not abused or neglected during services
- Percent of child investigations commenced within 24 hours.
- Percent of foster children who were subjects of reports of verified or indicated maltreatment.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Percent of victims of verified or indicated maltreatment who were subjects of subsequent reports with verified or indicated maltreatment within 6 months.

Percent of children reunified who were reunified within 12 months of the latest removal

Percent adoptions finalized within 24 months of the latest removal.

Percent of child investigations from an entry cohort completed within 60 days.

Percent of child victims seen within the first 24 hours.

Percent of initial Child Safety Assessments (CSA) submitted within 48 hours

Percent of adults in child welfare protective supervision who have case plans requiring substance-abuse treatment who are receiving treatment

Percent of children in non-TANF out of home who are eligible for Title IV-E

Percent of adoption goal met

Percent of children who age out of foster care with high school diploma or G.E.D.

Percent of children who age out of foster care who are working or in post-secondary education.

Rate of children who are missing per 1,000 of children in home or out of home care.

Percent of school days attended.

Percent of children placed within same school zone after removal

Percent of children removed within 12 months of a prior reunification.

Percent of children who achieved alternate permanent placement 15 of 22 months when reunification is not an option.

Percent of children with more than 2 placements within 12 months removal.

Percent of in-state children in active cases (both in-home and out of home) seen monthly

The algorithm by which compliance on these measures is to be calculated has also been at the root of the re-engineering process. There has been a deliberate shift away from point-in-time and exit cohort measurements toward entry cohorts with longitudinal analysis. There has also been much discussion regarding measures with built-in disincentives, such as the measure requiring a certain percentage of completed adoptions to be completed within 24 months.

It is not anticipated that all of the measures listed above would become part of the CBC contract as many of them relate to the Protective Investigations function. Additional information regarding current and potential future measures may be found at the Florida DCF Performance Dashboard at http://dcfdashboard.dcf.state.fl.us/.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Are there ongoing mechanisms for you and the Department to review performance and problem-solve difficulties? If so, what are they?

Yes, HFC has a strong QA/QI Plan that involves both quantitative and qualitative measurement instruments to assess quality in an ongoing basis. Ongoing processes include:

The DCF Zone reviews HFC twice annually using the Child Welfare Integrated Welfare Assessment (CWIQA) case review instrument.

To complement the Zone’s reviews, HFC requires each CMO to use a statistically abridged version of that same instrument to review at least two cases per month. CMOs use these reviews as supervisory reviews for those cases. HFC then validates two of those reviews for each CMO on a monthly basis. These validations are intended to assure that a) the reviews are being conducted as required, and b) the CMOs are appropriately applying the review instrument at the supervisory level. This helps to enhance understanding of performance expectations among front-line managers and provides HFC staff with a first-hand view of the quality of case management. The statistically abridged version of the CWIQA, originally developed by D14, has been acknowledged as a valuable asset and has been redesigned by a statewide workgroup for implementation at the state level.

HFC conducts 10 Home Visit Follow-up Surveys each month. Those surveys are conducted telephonically with caregivers after Home Safenet reflects that a monthly visit has been conducted. The follow-up survey addresses the regularity and purposefulness of visits, and provides caregivers with an opportunity to voice any concerns with case management or lead agency oversight. The fact that surveys are regularly conducted by the lead agency reinforces to Case Managers the requirement for effective home visits. This survey instrument and process has been acknowledged at the state level as a “best practice.”

HFC conducts 10 Foster Parent Satisfaction Surveys each month. These surveys are conducted telephonically. The purpose is to provide an ongoing assessment of foster parent satisfaction with case management and lead agency oversight, as well as to provide foster parents with an opportunity to voice any concerns.

HFC requires customer satisfaction surveys from its subcontractors. This helps to assure that services being offered are meeting the needs of the clients and that they meet quality standards.

Quarterly, the HFC Executive Director meets with the Executive Director of each CMO to review an Executive Management Report. This report reflects each CMO’s performance on key performance measures. This assures consistent attention on critical performance factors at the highest levels of management within the partner agencies.

Every Monday morning, the Lead Agency conducts a conference call with Program Managers, any CMO staff or supervisors invited by their Program Managers, DCF management team members, the HomeSafenet representative, a Protective Investigations representative, CWLS, Coordinated Child Care representative, to discuss key performance measures for the preceding week. These key measures include number of children seen, adoptions finalized, cases closed, children reunified, and caseload census. In that meeting, emergent issues that impact on those data elements
**APPENDIX 1: CASE EXAMPLES & INTERVIEWS**

are discussed. This allows for the immediate application of interventions before small issues become significant performance problems.

Operations Workgroup Meeting: Every other Wednesday, Heartland’s Management team meets with managers from DCF and Case Management organizations as well as representatives from Economic Self Sufficiency, Child Welfare Legal Services, Protective Investigations, Coordinated Child Care, Agency for Persons with Disabilities, Substance Abuse and Mental Health and key providers. In those meetings, issues that affect the network as a whole are surfaced. These meetings also allow for an exchange of information among entities whose scope of responsibility impacts upon the same group of children and families.

CMO Workgroup Meetings: On alternate Wednesdays, the Program Directors and HFC management team meet to discuss issues that impact only at the CMO level. These meetings are truly working meetings wherein problems are addressed and resolutions are achieved through a cooperative and synergistic effort.

Budget Meetings: On a monthly basis, the senior management team from HFC meets with the contracts and budgets staff from DCF to review performance from a fiscal perspective.

*Do your case managers enter data directly into the SACWIS?*

Yes, Case Managers currently enter directly into HomeSafenet, which is the state’s SACWIS system. As the system evolves, Case Managers will be responsible only for entering Chronological Notes (Case Notes). Other data entry functions will be completed by a Data Services department comprised of data entry specialists.

*Is case management just one of the services you provide?*

No, the organization is contracted to provide a total array of services to include but not limited to: independent living services, emergency shelter, residential group care, foster care, relative care giver assistance, therapeutic foster care, intensive residential treatment, foster care supervision, case management, post placement supervision, permanent foster care, family reunification, prevention and adoption services.

*Can you determine what the costs and reimbursement are for the case management component of your contract?*

No, the contract does not specifically breakout the cost of case management.

*What funding source does the Department use to pay for case management?*

A variety of funding sources are used to cover the cost of case management. The funding sources include: state funds, Temporary Assistance to Needy Families (TANF), SSBG, Title V-E, Title V-E Foster Care, Title V-E Adoptions, Title XIX Medicaid, CAPTA, Independent Living, and Safe and Stable Families.

*Is your payment schedule linked to performance? If yes, how?*

No, payment is based on a cost reimbursement contract. The department agrees to reimburse the provider for allowable expenditures incurred in the delivery of services that are provided in accordance with the terms and conditions of this contract. Payment is linked to the proper expenditures by budget entity.
**APPENDIX 1: CASE EXAMPLES & INTERVIEWS**

*How was the rate for case management determined?*

The contract award was based on the selected recipient of providers submitting proposals for the Initiation to Bid (ITN). The department utilized the services of experts within the department and community for the evaluation and selection of the lead agency. The proposed cost of service was not included in the decision of the Community Based Care provider selection. The rate was determined after the selection of the lead agency through the submission of a proposed budget with supporting information which was negotiated between the Department and the organization.

*Are there any mechanisms in place to protect you against financial risk?*

Yes, the contract stipulates various mechanisms to protect against financial risk, including:

**Unanticipated Increase of Individuals Served** - In the event there is a 10% increase in either the number of new in-home services clients or new out-of-home services clients, the department/provider will initiate a review to assess performance utilization level. The performance contract utilization review will determine the number of children to be served based upon a projection of clients served both in-home and out-of-home. In certain cases, providers may serve more cases than has been projected. In circumstances where factors outside the provider’s control and the provider is able to document that the provider has used all funds appropriated by the legislature, the provider may be eligible for additional funds.

**Dispute Resolution** – Contract terms define a mechanism to resolve disputes at the lowest level. In the event the representatives’ good faith efforts to resolve the dispute fail, other levels of resolution are defined.

**Fidelity Bond** - The organization maintains a fidelity bond from a surety company licensed to do business within the State of Florida issued by a Florida licensed agent to ensure against any losses or mismanagement.

**Fiscal Monitor** – The Department is in the process of contracting out the services of a fiscal monitor. The fiscal monitor will provide financial oversight and ensure integrity regarding the CBC Lead Agency’s fiscal operations. This includes monitoring adherence to generally accepted accounting principles, but also federal and state regulations regarding the appropriate use of the various funding streams included in CBC contracts.

*Are there mechanisms to allow you to retain savings and carry over to next FY?*

No. All funds earned are based on cost reimbursement.

*Have the rates or payment mechanisms changed since you first signed the contract?*

HFC has been awarded equity funds which has increased the value of the contract.

*Do your case managers authorize services for payment or just refer for services?*

Case managers are not responsible for the approval or authorization of services. Case managers are responsible for making service referrals. Authorization of service payment is provided by Heartland for Children’s Utilization Management Unit.
If someone else authorizes service payment, what process is used?

Authorization of service payment is provided by Heartland for Children’s Utilization Management Unit (hereafter referred to as UM). The goal of the UM unit is to promote child safety and ensure the least restrictive, most appropriate array of services while moving the child and family towards the goal of permanency. UM specialists possess the authority to approve (not deny) services. They ensure triage and referral decisions that require clinical judgment are made by a qualified professional. The use of service dollars is closely reviewed by UM specialists in an effort to ensure both the child and family receive the right services, at the right time and in the right amount. The UM specialists oversee the screening process to determine the necessity of requested services. They evaluate the rationale for services, assessments of current placement, case plans and need for additional evaluations through the consideration of the child/family’s circumstance and the provider’s ability to meet the service need or provide alternate settings. They collect data for preauthorization and concurrent review. UM specialists routinely analyze all data collected to detect under- and over-utilization of services and recommend appropriate interventions. Case management has access to many services providers through the web site www.heartlandforchildren.org.

How do the case managers know what services are available?

Many of the available services are identified at each staffing process (Child Protection, Early Services Intervention, Permanency, Multidisciplinary, and Community Resource Staffings). At the Early Service Intervention Staffing, there is an expert panel of treatment professionals who utilize their clinical expertise and knowledge of the child welfare system to review and assess the service intervention needs of the child and family. Treatment professionals are also available during the other staffing processes outlined above. In addition to the staffing process, the UM Specialist works directly with the case manager to assist in the identification of needed services and appropriate interventions. The UM staff utilize an internal Service Inventory database (stores information on services and providers in the community) as a guide to identifying necessary services in the tri-county area. During the triaging process with the case manager, the UM Specialist will approve and authorize the appropriate service so that the case manager can make the necessary referrals.

How do your case managers get feedback from the service providers?

The service providers are required to provide written progress reports to the case manager regarding the family’s receptiveness to services and their progress towards completion of the treatment goals.

Do you have a formal process for disputes?

Heartland for Children designed Policy 1300-06 to resolve conflicts related to the level of service intervention identified for the child and family. It is the policy of Heartland for Children to participate fully with the Department, contracted providers and others to evaluate children and families, assess risk, identify strengths and needs of the child and family and create an appropriate array of services to expedite permanency. HFC strives to expeditiously resolve any and all conflicts that may arise as a result of the identification and/or authorization of services.

When the conflict resolution policy has been initiated, it is the intention of HFC to err on the side of child safety, rendering an immediate temporary resolution until a thorough
review can be completed and a less restrictive or more intense array of service intervention is recommended. This procedure is applied whenever a HFC contracted provider, DCF representative or other party involved with a case identifies a concern or disagrees with the service intervention recommended for a child and/or family. If a service authorization is denied by Utilization Management, the CPI and/or CMO counselor (hereafter referred to as complainant) will re-staff the case with their supervisor. If the supervisor agrees that the service is necessary, the UM specialist will be contacted via phone or in writing regarding the concern. The UM specialist and CMO supervisor will attempt to resolve the concern through case discussion. If after a thorough review of the presenting concerns the parties are unable to reach a consensus, the case will be referred to the next level of review.

The next level of review will be conducted by the Assistant Director of Operations (who oversees programmatic functions) and CMO Director. Within 48 hours of the noted concern, the Assistant Director of Operations and CMO director will conduct a joint review and/or informal staffing to discuss case dynamics. The Assistant Director of Operations will chair the Level 2 review process and may include other parties as deemed necessary. If after a thorough review of the facts the parties are unable to reach a consensus, the case will be referred to the next level of review. The complainant will have five business days from receipt of the committee’s recommendation to outline any additional concerns and/or comments during Level 3 of the review process. All concerns must be addressed to the attention of the HFC Assistant Director of Operations. Upon receipt of the complainant’s additional concerns, the HFC Assistant Director of Operations will forward information to the Executive Director of HFC who will render a final decision/recommendation within one business day of receipt of the compliant. The final recommendation must be documented in HSN and included in the hard copy record.

How was the HFC network developed?

Initially the network was developed though existing contract arrangements the Department had in place with area providers. Since the transition, the network has been developed to secure the services of new providers. Techniques used to develop the provider network include: community meetings, news articles, commercials on local stations, development of the website www.heartlandforchildren.org which allows for prospective providers to enroll, expansion of new services with existing providers, word of mouth, hosting of an annual conference and trade show, open bi-weekly operations meetings, provider visits, networking with other community based care agencies, formal request for proposal initiatives and word of mouth.

Does HFC have contracts with the service providers? If so, please describe.

The organization currently has two documents templates for purchase of services: sub-contracts and rate agreements. Documents are individualized to the provider providing the service and the service to be purchased. Terms of the sub-contracts include: services to be provided, provision of services, deliverables/performance standards, method of payment and special provisions.

How are service providers held accountable for the services they deliver?

It is the responsibility of the Network Development department to monitor the effectiveness of each of the service contracts executed. Monitoring consist of on-site
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Review of fiscal, personnel, services delivery and compliance with performance measures. The review process includes: preparation of the monitoring tools, scheduling of the review, entrance interview, on-site monitoring of records, interviews with staff and consumers, analysis of findings, exit review with the provider and completing a monitoring report with findings. Plans of corrective actions are required for items found to be out of compliance. Technical assistance is provided by the contract team and organization program specialists.

How do you prevent a perceived or actual conflict of interest if you are both a case manager and provider?

To avoid perceived or actual conflict of interest, HFC conducts business in the open. Case Management organizations are not excluded from providing any services (foster home, in-home supports, supervised visitation, residential care etc.). HFC secures the best possible provider for the services identified. Utilization management is the responsibility of HFC as the lead agency. Case managers do not have the authority to purchase services. Service authorizations are approved through the utilization management unit of HFC, thus avoiding possible conflict of interest.

What was the impetus for the public agency to contract for case management services and what have the results been?

After a series of highly publicized cases in which children in the child welfare system were abused, neglected, or even died, numerous approaches were taken to address issues related to lack of funding, low morale, and poor collaboration among agencies. In 1996, Florida legislatively mandated transition to CBC.

Has the initiative undergone any independent evaluation?

Yes. In order to determine the cost-effectiveness and quality of services, the Florida Department has contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) to evaluate the CBC agencies. Copies of these reports are available at: http://www.dcf.state.fl.us/publications/pubs.shtml#cbc

What are the top three issues that public agencies should consider?

1. The importance of data accuracy, accessibility, and integrity.
2. The complexity of financial reporting (merging governmental accounting into traditional non-profit accounting systems).
3. The importance of strong leadership and the requirement of critical, analytical thinking to ensure viability of the lead agency.

What are the top three things that private agencies should consider?

1. Prevention Capacity. Prevention is an investment strategy. When properly administered, it will realize cost avoidance. Community engagement through education is an intentional process that increases the effectiveness of primary prevention in the system of care. Agencies need to consider expanding the capacity at the front end of the system of care to manage flow further into the system. Specifically, community awareness and education programs can enhance the collective awareness of citizens regarding their individual responsibility for child safety before harm comes to a child. Establishing and strengthening connections with community service agencies can provide resources for families who simply need help rather than protective services. By diverting those families from moving deeper into the system of care, protective services
resources can be more appropriately allocated toward those families who need them. To increase prevention capacity, Heartland capitalized on the existing prevention awareness infrastructure already in place through the Devereux Kids organization. To further connect resources, Heartland founded a Prevention Awareness Workgroup to keep attention on the ever-expanding network or resources and on the fundamental principle of providing help before harm.

2. Services Capacity. Utilization Management is a core business strategy in the system of care to manage resources, increase choice and promote cost efficiency. When developing the range of services in a region, it is critical to consider the unique characteristics of the region and its people. Heartland is located in the methamphetamine capital of the United States. As such, it has been essential that Heartland focus on developing partnerships with substance abuse agencies and providers. Similarly, issues of culture, language, and socio-economics will drive the direction of service and resource development.

3. System Capacity. A true “system” of care includes the best characteristics of structure, process, subsystems, information, growth and integration. Heartland has maintained a strong commitment to assure that demand for protective services does not outpace the capacity of the system of care. Not only is there a strong emphasis on the front end through prevention programs and diversion processes, there is an equally strong emphasis on permanency and case closure. Heartland has an aggressive permanency staffing program that assesses children at 5, 8, and 11 months for permanency options. When a case can be closed, Heartland’s system of care is designed to link those children and families back into the community for wrap-around aftercare services to help minimize recidivism. By maintaining focus on both the front end and the back end of the system of care, Heartland has been successful in managing the demands on the resources of the system.

If you had it to do over again, what would you do differently?

1. Retain the management and delivery of foster care recruitment, re-licensing, and retention.
2. Increase the planning timeline before transition of services.
3. Secure the resources and expertise of specialty areas i.e., financial accounting in the public sector as it relates to the non-profit sector.
4. Allow for planning time before transition of any service, i.e. revenue maximization.
5. Wait until the CBC contract is signed before finalizing performance measures in case management contracts.

Describe your greatest “success” and your greatest difficulty.

Greatest Success: Collaboration...collaboration... collaboration.

Difficulty: Development of a successful foster care program, to include: foster parent satisfaction, retention of quality homes, and adequate capacity to offer choice in every placement made.

FOR FURTHER INFORMATION, CONTACT:
Marcie Biddleman, President of HFC or Kathleen Cowen, Vice President of HFC
Heartland for Children
Bartow, FL
mbiddlem@heartlandforchildren.org
5. Kansas: Privatization of Family Preservation, Foster Care and Adoption

Background

In Kansas, the privatization of child welfare services was initiated by the Governor of the state in response to a range of systemic problems that had been identified by the Kansas Department of Social and Rehabilitative Services (SRS). Between July 1996 and February 1997, Kansas utilized a competitive bidding process to select not-for-profit contractors to serve as the lead agencies for the provision of family preservation services, adoption services, and foster care and group home care services. Five contracts for the delivery of family preservation and three contracts for the provision of foster care services were awarded in pre-defined geographical areas of the state; one contract was awarded for the delivery of adoption services throughout the entire state. Each contract contained a case rate and a payment structure based on the achievement of certain milestones. In each contract, there were defined performance goals and requirements that contractors accept all referrals that SRS made to them.

As a result of the contracting out process, not-for-profit agencies undertook responsibility for service delivery (and the necessary day-to-day decision-making). SRS remained the funding source and continued to set and manage policies on the type and quality of services to be provided. In most cases, SRS retained legal custody of the children and continued its role of advising the court of disposition recommendations for children in foster care, including recommendations regarding children’s return to the custody of their parents or their being freed for adoption. SRS also retained responsibility for child protective services, thereby continuing to be the “gatekeeper” controlled the number of children who entered and remained in the system.

The experiences of the contractors and SRS varied in each of the service areas that were privatized - family preservation, foster care and adoption.

As noted in a previous section when the contracts were re-bid in 2000, a number of changes were made in the financing, outcomes and performance measures, and in the lead agencies selected to manage the three types of contracts. The re-bid process changed family preservation providers in three of the state’s five service regions, foster care providers changed in two regions, and the prime statewide adoption provider changed. The 2000 contracts also included standards for maximum caseloads for all three program areas. Prior to July 1, 2000, maximum caseloads only applied to family preservation (maximum of 10 families). Similar requirements are now specified for foster care/reintegration (maximum of 25 families) and adoption (maximum of 25 children). The independent evaluation looked at findings in each of the three program areas.

In addition to changing from case rates to a monthly fixed rate for foster care and adoption, the state eliminated the provision in previous contracts that allowed the contractors to carve out some children to be served under fee-for-service arrangements. Foster care contractors were still at risk for managing the cost of care and ensuring the child remains home following permanency (12 months for foster care and 18 months for adoption) without additional state reimbursement. The Family Preservation provider continued to receive a case rate.
The 2000 contracts provided the following rates:

- The per child/per month foster care rates are: Region 1 = $1,958; Region 2 = $2,200; Region 3 = $2,174; Region 4 = $1,997; Region 5 = $2,177. The payments are based on the number of children in out-of-home placement the first of each month.
- The adoption per child per month rate is $1,426. Payments cease when the adoptions are finalized.
- After the 2000 procurement, case rates for family preservation services varied by region and ranged from $3,412 to $4,481. One-third of the case rate is paid at the time of referral, and the lead agency is allowed to retain this sum even if the family does not use the services. The remainder of the case rate is paid in two installments, at 45 and 60 days, and is paid in full if the family signs the case plan, regardless of whether they complete the plan.

In January 2005, SRS announced it has awarded new contracts for adoption, reintegration/foster care and family preservation effective July 1, 2005. The State awarded the new contracts to:

- **Family Preservation:** DCCCA, The FARM, and St. Francis.
- **Reintegration/Foster Care:** The Farm, KVC Behavioral Health, St Francis and United Methodist
- **Adoption:** (one Statewide contract): KCSL

There are some changes in the 2005 contracts:

- The need to transition children between Family Preservation, Reintegration/Foster Care and Adoption contractors has been eliminated.
- The responsibility for the child/family’s case management and services will remain, throughout the life of the case, with the contractor who originally receives the referral.
- The statewide adoption contractor will be responsible for recruiting and training a pool of families willing to adopt, providing matching services to the Family Preservation and Reintegration/Foster Care contractors when needed, and providing post adoption support to the family.

In announcing the awards, SRS pointed to successes of the privatization effort:

- Before privatization, family preservation services were available on a limited basis in only 45 counties. Today, family preservation services and community early intervention and family support services are available to at-risk families statewide.
- Prior to privatization, SRS could not ensure an adequate number of stable, family settings for children placed out of home. Today, it is likely that children will be placed in family foster homes, experience stability while in care and stay connected to their family and community.
- Approximately 300 adoptions were finalized each year prior to contracting for adoption services. Today, the average is closer to 500 adoptions per year.
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

Interview with A Kansas Lead Agency

The interview was with Mike Patrick, EVP and CEO for the FARM, a lead agency in Kansas since the inception of privatization in 1997.

Tell me about the Kansas Privatization and how it has evolved.

Case Management has been privatized for 10 years. The State is divided into 5 service regions.

Case management is divided into the following process: Re-integration case management includes all foster care (Foster homes, groups homes, residential treatment, day care, transportation) and adoption.

Family preservation and all in-home supervision is a separated contract. The need to transition children between Family Preservation, Reintegration/Foster Care and Adoption contractors has been eliminated.

The responsibility for the child/family's case management and services will remain, throughout the life of the case, with the contractor who originally receives the referral.

The FARM has been a case management provider for most of this time and currently has 2 large programs (?): Family Preservation in NE Kansas and Reintegration in the SE region.

Describe your case management model.

The FARM's case manager basically does the same activities that the public caseworker did in the past: all supervision of the child and family, case plan development, foster placement and supervision.

How is the family involved?

The award of new Family Preservation, Reintegration/Foster Care, and Adoption Resource Recruitment services contracts culminates the implementation of family centered practice initiated in 2004. Beginning July 1, 2005, families and children will have continuity of case-management providers for the life of the case regardless of the services needed. [note: this answer does not really address family involvement]

What is the case plan review process? What is the role of the court in that process?

The FARM is in the process of validating a 14 point assessment tool that will be administered during the first 20-day evaluation and intake period. This tool predicts the length of out of home care and expectation as to how long it will take for reunification within a 3 month range. The case plan will be developed accordingly and monitored by the FARM's Utilization managers for compliance. Recommendations will be made for the
case plan according to what is needed to meet the needs of the family. [this answer
does not address the role of the court – should the question be deleted?]

*What is the interface with Protective Investigations pre-disposition?*

The PI does the investigation, removes the child, places the child for safety and within 72 hours, makes a determination to transfer the case to the FARM. The PI completes a one page referral form and makes the transfer. The FARM Case Manager must hold the first meeting with the family within 24 hours of transfer, the initial assessment must be completed with in 7 days, and the case plan must be developed and agreed to by the Family Team within 20 days.

*Does the Department also have case managers/service workers?*

The Department still has case workers who currently sign off on the case plan and present the case in court. The state is in the process of a pilot project in which the private case manager signs off on the case plan and takes the case to court. The plan is to use this system statewide over the next year. The public case managers are being absorbed into either the private agency or into another department within SRS.

*Are you responsible for court-related processes? What role, if any, does the Department retain in legal processes?*

At the current time, the FARM case workers provide input to the public case manager. That will change over the next year. [not clear how this answer addresses the questions]

*Was there a phase-in process for referrals?*

With this re-bid, the Farm already had the foster care cases. As a result, no phase-in was necessary. (?)

*At what point in the life of a case do you accept cases? At what point does your responsibility end?*

We accept the case from the PI at the point when he/she decides to transfer the child for out of come care or family preservation. We are funded on a capitated case rate basis and our responsibility ends once we return the child home or have a permanency placement or adoption.

*Did the RFP/contract include performance standards—ie, frequency of contact with child, with family or timeframes for case plan development? If so, please describe the performance standards.*

The RFP contains the standards (Coming under separate mailing – please note that information is needed here)

*Is there a direct link between outcomes and payment? If yes, what was the process used to determine which outcomes and measures would be used?*

Payment is based on a capitated case rate that was negotiated. The link with outcomes is through the payment schedule (see below).
Is case management just one of the services you provide in your contract with the Dept? What other services do you provide?

The FARM currently provides case management called Reintegration and has a separate contract for family preservation services. Our case management contract includes adoptions and foster care recruitment, training and retention.

Can you determine what the costs and reimbursement are for the case management component of your contract?

Yes, as we use an activity-based accounting process.

What funding source does the Department use to pay for case management?

Foster care funds IV-E.

Is your payment schedule linked to performance?

Payment to Reintegration/Foster Care contractors for services for children in out-of-home care is based on a tiered, incentive system. The tiered system is designed to achieve a more rapid reintegration or alternative permanency by providing higher rates for the first twelve months of service.

The Farm receives payment on a monthly basis, with an average annual case rate of $3,500 per year. That sum is paid out on a monthly basis as follows: 100% per month is paid for the first 6 months, 66% for months 7-12, and 33% for anything over 12 months.

Do your case managers authorize services for payment or just refer for services? If someone else authorizes service payment, please describe that process.

Case Managers make recommendations for service and the Utilization Managers make referrals and authorize payment.

How do the case managers know what services are available?

They know what services are available from the provider network and based on input from the Utilization Managers.

What was the principal driving force for the privatization of child welfare services in Kansas?

SRS contracted for community-based child welfare services in 1996 and is recognized as the first state in the nation to privatize child welfare services. The decision to contract for family preservation, reintegration/foster care and adoption services was driven by the belief that community based child welfare services would yield improved outcomes for children and families. Ten years ago, the privatization was a result of a statewide consent decree. Since SRS dismantled their full case management system, the privatization process continues.

What are the top three issues that public agencies should consider in developing a plan for contracting for case management?

1. Make sure the public agency understands what impacts the case management system changes will have on the federal requirements for documentation and regulation. If possible, get the appropriate IV-E and Medicaid waivers. At the current time, Kansas is unable to draw down between $20-45 million due to a mismatch in encounter data.
Kansas did not require the privatized case management agencies to collect all the correct data.

2. The public agency needs to have an idea of the actual expenses to deliver case management (including all direct and indirect costs). Develop a formula to determine the real costs instead of just cost estimates.

3. The public agency needs to have a comprehensive plan to develop “buy-in” from all stakeholders affected by the privatization of case management. Stakeholders include all providers and the legislative and executive branches. The case management organization has to waste a lot of time re-educating the stakeholders...even after 10 years in Kansas.

What are the top three things that private agencies should consider in developing the capacity to provide case management services?

1. The private agency needs to have an MIS system that will capture the type of data that is needed to track cases, provide reports to the public agency, develop management reports and capture encounter data and both support the case management system and a utilization management system.

2. Develop a utilization management system which will provide for authorizations of all out of home placement and services. The system should include both preauthorization and concurrent authorizations. At the Farm, the case managers only make case plan recommendations for services; the UM/Care Managers do all the authorizations for payment.

3. The private agency needs to develop a budget and be prepared to pay their mid-level managers higher than average salaries. This is hard work and the staff needs to be compensated accordingly to avoid turnover and make a commitment to making the systems work. The private agency needs to hire skilled social workers for the mid-level management who understand business and the child welfare system and combine both in a philosophical way to produce outcomes.

If you had it to do over again, what is at the top of the list of things that you would do differently?

1. Put more resources upfront to handle the transition and implementation process. The first 6 months are chaotic and this is the time to staff up and not cut short on the resources. After this time, turnover can take care of the “extra staff” that you have hired to handle the transition process.

2. Be more careful about developing the proposal and pricing for the procurement process. The Farm submitted 8 contracts and was only awarded 2. The state was concerned that their low bids in some areas would result in poor quality. Achieve a better balance between quality and the proposed budget.

Describe your greatest “success” and your greatest difficulty.

Our outcomes have been our greatest success:

Just to identify a few, when we first got our contract, 24% of the total foster care population or 187 kids were in Residential Treatment. We now have 2% or 20 kids in RT. In fact, for the first time since we got the contract, we are seeing few kids placed
APPENDIX 1: CASE EXAMPLES & INTERVIEWS

in shelter or emergency placement and this past month had 3 days when no kids were in these placements.

Expansion of foster homes from 350, when we first got the contract, to 615 at the current time. We recruit about 200 homes per year due to foster home turnover. Turnover is caused by adoptions, kids aging out, and foster parents retiring or quitting.

Relative placements has increased from 17% to 36% over the course of our contact. We believe that kids return quicker to their homes if they stay, or come back to the community as soon as possible. First by placement in a foster home and then into the birth home.

Our greatest difficulty has been working with the mental health providers. The FARM case management is based on the family treatment and decision making model, but the mental health providers are more individual client based and do not treat the family as a whole and do not want to go into the families home. It is a split system of care with competing treatment models.

FOR FURTHER INFORMATION, CONTACT

Mike Patrick  
COO  
The FARM  
EMPORIA KS  
Email: Mikep@the-farm.org
Adoption- Privatization In Kansas and Massachusetts

1. Kansas

Unlike the regionally based contracts for family preservation and foster care, Kansas entered into a statewide adoption contract. Lutheran Social Services (LSS), the sole bidder, was awarded the first contract in October 1996. LSS, as required by its contract, subsequently established subcontracts with 12 adoption service providers across the state. An adoption case rate was established that encompassed all placement services, mental health services, and other services such as day care. LSS and its subcontractors assumed responsibility for recruitment and training of adoptive families, matching children and families, and providing post-adoption supportive services for 18 months following placement. The contract estimated that SRS would initially transfer 1,000 children with adoption as their permanency plan to LSS and that an additional 325 to 425 children would be referred to LSS during the first year.

### Kansas Adoption Outcomes and Performance Standards

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Performance Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children permanently placed within 180 days (reunification, placement with relative, adoption)</td>
<td>55% – Year I&lt;br&gt;70% - Year II to 2000</td>
</tr>
<tr>
<td>Children permanently placed within 365 days (reunification, placement with relative, adoption)</td>
<td>70%&lt;br&gt;(new standard added in Year II)</td>
</tr>
<tr>
<td>Placements finalized within 12 months</td>
<td>90%</td>
</tr>
<tr>
<td>Adoptive placements intact for 18 months following finalization</td>
<td>90%</td>
</tr>
<tr>
<td>Client satisfaction</td>
<td>90%</td>
</tr>
<tr>
<td>Children placed with siblings</td>
<td>65%</td>
</tr>
<tr>
<td>Children with fewer than three moves since referral</td>
<td>90%</td>
</tr>
<tr>
<td>Children not experiencing abuse or neglect prior to finalization</td>
<td>95%&lt;br&gt;(new standard added in Year II)</td>
</tr>
</tbody>
</table>

(State of Kansas, Division of Children and Policy, June 2000)

As with foster care contractors, LSS faced significant problems with the contracted adoption case rate, including a degree of instability in the program. The contracted case rate was set initially at $13,556 for each child for whom adoption planning and services were needed (although SRS had estimated a slightly higher average case rate of $13,756 per child)vi. Ten percent of the children were placed outside the case rate because of their medically fragile status or extraordinary medical needs. Under the terms of the first year contract, LSS was paid one-half the case rate when the child was referred to the agency; 25% when the agency placed the child with an adoptive family; and 25% when the adoption was legally finalized.vii It soon became clear, however, that
the case rate was inadequate, particularly for children with significant special needs. Subsequently, the state revised the case rate upward (to $16,168 for each child in the agency’s care), but financial problems continued to plague LSS. In the summer of 2000, LSS declared itself on the verge of bankruptcy as it faced $9.2 million in debt and only $7.3 million in revenue\textsuperscript{vi}. Only after an additional infusion of state funds in September 2000 was LSS able to repay its creditors (74 cents on the dollar) and rescind its plans to file for bankruptcy.\textsuperscript{vii}

In 2000, the adoption contract was re-bid and was awarded to Kansas Children’s Service League (KCSL). Under the earlier contract with LSS, this contract required KCSL to provide independent living and post-adoption services. As occurred with the foster care contracts, SRS changed the adoption reimbursement methodology to a monthly payment for each child in KCSL’s care ($1,426 monthly for each child). KCSL, as lead agency, remains financially responsible for children who return to adoption services within 18 months following their adoption. Maximum caseloads have been established at 25 children, a caseload level far larger than recommended by the Child Welfare League of America (2000) when children are older or have special needs (the recommendation is 10-12 children).

Upon assuming the contract, however, KCSL faced a host of challenges in meeting its obligations under the contract. Social workers left their positions more quickly than they could be replaced; the number of children referred for adoption services continued to increase; and the number of agencies willing to subcontract with KCSL to provide adoption services dwindled. The James Bell Associates report (2000) highlighted the growing pressures within the privatized adoption program as increases in the number of children with special needs were freed for adoption (and, therefore, who were more challenging to place with adoptive families). The Legislative Division of Post Audit report (Legislature of Kansas 2001) also verified that although the number of finalized adoptions had increased since privatization, the number of children freed for adoption had outpaced the number of children whose adoptions had been finalized.

In the most recent rebid in 2005, KCSL was again awarded the Statewide contract but with some changes in both reimbursement and scope of responsibilities. Most notably, when a child is referred for adoption support (when there is no identified adoption resource), the case manager assigned to the case at the time of original referral stays the same. KCSL merely provides the required assistance identifying and preparing an adoption resource family and supporting the assigned case manager in working with the child and family to prepare for the adoption. (Information on the rates not available at the time of the report but it appears that the contractor will be paid for accomplishing certain tasks and not a monthly rate).

2. Massachusetts-Case Management Contracts for Adoption Cases

Massachusetts procured its most recent adoption case management contracts in July 2005. The Interview was with Joe Leavey, Executive Director of Communities for People.

\textbf{Interview with An Adoption Agency}

Communities for People, Inc (CFP) has been providing adoption case management services for the Department since 2000 and was awarded a new 5-year contract as a result of the new procurement in 2005. The contract grants full case management responsibility for adoption cases referred to the provider.
APPENDIX 1: CASE EXAMPLES: DIFFERENT APPROACHES TO PRIVATIZATION

What is the scope of the adoption contract?

The Department reimburses providers for six categories of adoption case management services:

1) Consultation provided to area offices for:
   - Adoption assessment of a child
   - Adoption assessment/homestudy of relatives who wish to adopt
   - Assessment/homestudy of foster parents who wish to adopt
   - Provision of MAPP

2) Adoption Placement case management services for a child referred by the Department, including assessing the child, preparation for adoption, identification/matching with a pre-adopt family, disclosure to pre-adopt family, preparation of both child and family, post-placement support services, legalization in court, and limited post-legalization support services.

3) Adoption Family Development Services, which includes recruitment and pre-qualification of adults interested in adoption.

4) Time limited recruitment activities for an identified child previously assessed as appropriate/read for adoptive placement (particularly focused on older youth who may have a goal of either adoption or guardianship at the time of referral).

5) Intervention Case Services which include the provision of consultation on adoption cases requiring a high level of clinical intervention and at times court involvement.

6) Interstate case services provided for children placed in Massachusetts from other states who have adoption as the goal.

Bidders were allowed to specify some or all of the six case management areas and to indicate the number of referrals of each type that they would receive. Agencies were allowed to limit the geographic area (MA has six service areas) or propose to accept referrals from all Service Area offices.

Were the outcomes specified?

The overarching goal is to provide casework to promote the realization of adoption for Special Needs Children. The indicators include:

1. An increase in the families recruited, trained, and approved for special needs children.

2. The number of adoptive placements achieved each year.

3. The number of legalized adoptions achieved each year.

Performance outcome measures focus on the operation of the adoption process and include:

- The length of time required to complete the adoption process
- Pre-adoptive placement disruptions
- Sibling group placements
APPENDIX 1: CASE EXAMPLES: DIFFERENT APPROACHES TO PRIVATIZATION

What are your case management responsibilities?

All new referrals are received by the provider’s Director of Adoption, who reviews the information included in the referral packet, contacts the referring Area Office to discuss the case in further detail, and reviews the case on FamilyNet (SACWIS). Once the referral is accepted, the Director notifies the Area Central Office, assigns the case to a social worker, and participates in a case transfer meeting with the referring Area Office. From that point forward, the provider ensures that all requested adoption services are provided in an appropriate and timely manner. When clinically appropriate, the provider applies for an adoption subsidy for the child and completes all paperwork necessary to petition the court for the child’s adoption. The agency provides post-legalization support to the new adoptive family for a period of three months, then closes the case and returns the case record to the referring Area Office.

Legal services are provided by the Department’s legal staff but the contractor prepares all the papers and accompanies legal staff to court hearings.

How is the Reimbursement Structured?

With the adoption contract the private contractor does the casework and payment is incremental and attached to completion of various tasks for the six different types of referrals. If at any time the case does not move forward, the provider does not receive additional funds but still provides the case management services. If the case progresses and all payments are made, the rate totals approximately $17,000 per case.

<table>
<thead>
<tr>
<th>Service</th>
<th>Product</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adoption Consultation</td>
<td>Written Assessment entered into FamilyNet (SACWIS)</td>
<td>$1590 per child</td>
</tr>
<tr>
<td></td>
<td>Written assessment of foster/relative family entered into FamilyNet</td>
<td>$1590 per family</td>
</tr>
<tr>
<td></td>
<td>(child in the home)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Homestudy of relative (child not in the home)</td>
<td>$2000 per family</td>
</tr>
<tr>
<td></td>
<td>MAPP certification and written homestudy</td>
<td>$2000 per family</td>
</tr>
<tr>
<td></td>
<td>Appearance fee 9copy of dictation)</td>
<td>$240 per activity</td>
</tr>
<tr>
<td></td>
<td>MAPP training only</td>
<td>$425 per family</td>
</tr>
<tr>
<td>Adoption Placement</td>
<td>Family Net SW assigned</td>
<td>$425 per case</td>
</tr>
<tr>
<td></td>
<td>Adoption assessment of the child entered into FamilyNet</td>
<td>$1590</td>
</tr>
<tr>
<td></td>
<td>Placement of a child</td>
<td>$3300, $5310, $8025</td>
</tr>
<tr>
<td></td>
<td>Family Development (service referral)</td>
<td>$2650, $4250, $6375</td>
</tr>
<tr>
<td></td>
<td>Re-evaluations</td>
<td>$650, $160, $1590</td>
</tr>
<tr>
<td></td>
<td>Legalization</td>
<td>$3300, $5310, $8025</td>
</tr>
<tr>
<td></td>
<td>Adjustment for cases held 3 years but less than 5 years</td>
<td>$500 per child</td>
</tr>
</tbody>
</table>
**APPENDIX 1: CASE EXAMPLES: DIFFERENT APPROACHES TO PRIVATIZATION**

<table>
<thead>
<tr>
<th>Sibling bonus/legalization</th>
<th>2= $940, 3= $2000, 4= $3700, 5+= $1180 X # of sibs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family bonus at time of finalization</td>
<td>$415 per child (minimum of 2)</td>
</tr>
<tr>
<td>Closure</td>
<td>$1060</td>
</tr>
<tr>
<td>Delayed adoption (copy of dictation)</td>
<td>$360</td>
</tr>
<tr>
<td>Transfer of case (no activity for 6 months)</td>
<td>$940</td>
</tr>
<tr>
<td><strong>3. Family Development</strong></td>
<td></td>
</tr>
<tr>
<td>Presentation of Family Net Service referral</td>
<td>$4000</td>
</tr>
<tr>
<td>Re-utilization of a closed home-updated study</td>
<td>$1415</td>
</tr>
<tr>
<td><strong>4. Recruitment</strong></td>
<td></td>
</tr>
<tr>
<td>Child-specific recruitment</td>
<td>$1415 for 6 months</td>
</tr>
<tr>
<td>Child Specific recruitment renewal</td>
<td>$1415 for an additional 6 mos</td>
</tr>
<tr>
<td><strong>5. Intervention</strong></td>
<td></td>
</tr>
<tr>
<td>Separate negotiated rate for services</td>
<td></td>
</tr>
<tr>
<td><strong>6. Interstate</strong></td>
<td></td>
</tr>
<tr>
<td>Homestudy</td>
<td>$1590</td>
</tr>
<tr>
<td>SW assigned</td>
<td>$415</td>
</tr>
<tr>
<td>Case supervision</td>
<td>$3300</td>
</tr>
</tbody>
</table>
ENDNOTES

1 DSS is has decided to use the *Child & Adolescent Needs and Strengths (CANS)* tool. The Child Welfare Institute will provide training on the final selected tool to Lead Agency and Regional Resource Center team members.


iv Craig, 1998 as cited in Freundlich

v Belsie, 2000 as cited in Freundlich

vi Ranney, 2000a; Miles, 2000 as cited in Freundlich

vii Ranney 2000a As cited in Freundlich
ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Children, Youth, and Families

Child Welfare Privatization

APPENDIX 2:
Survey Instruments for DCYF Workers, Providers &
External Stakeholders

A report prepared by McCullough & Associates, Inc.

December 2005
# Child Welfare Privatization Survey: DCYF Staff

## Tell US About Yourself

<table>
<thead>
<tr>
<th>What is your current position within DCYF?</th>
<th>Human Service Worker</th>
<th>CPS Specialist</th>
<th>CPS Program Specialist</th>
<th>CPS Unit Supervisor</th>
<th>Assistant Program Manager/Deputy Program Manager</th>
<th>District Program Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check one answer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 2. How long have you been with DCYF?

<table>
<thead>
<tr>
<th>Less than 1 year</th>
<th>1-2 years</th>
<th>3-4 Years</th>
<th>5-10 years</th>
<th>11-15 years</th>
<th>Over 15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check one answer.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## 3. What is your major area of responsibility?

<table>
<thead>
<tr>
<th>CPS Hotline</th>
<th>CPS Investigations</th>
<th>In-Home CM*</th>
<th>Out-of-Home CM</th>
<th>Independent Living CM</th>
<th>Adoptions CM</th>
<th>Adoption Subsidy CM</th>
<th>Management or Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check one that best applies to you at this time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*CM = Case Management

## 4. What does the term privatization mean to you?

## Read the statements and circle the number that best describes how you feel about the statement. If you want to, also tell us why you feel that way.

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>I don’t agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

5. If I had to choose an area to privatize, I would privatize the CPS Hotline function.

Why?

6. If I had to choose an area to privatize, I would privatize CPS Investigations.

Why?

7. If I had to choose an area to privatize, I would privatize In-Home Case Management.

Why?

8. If I had to choose an area to privatize, I would privatize Out-of-Home Case Management.

Why?

9. If I had to choose an area to privatize, I would privatize Independent Living Case Management.

Why?

10. If I had to choose an area to privatize, I would privatize Adoptions Case Management.
### Child Welfare Privatization Survey: DCYF Staff

<table>
<thead>
<tr>
<th>Why?</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. If I had to choose an area to privatize, I would privatize Adoption Subsidy Case Management.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Implementation of privatization would make me concerned about my job security.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Implementation of privatization would be viewed by me as an employment opportunity.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I would never want to work for a private agency.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I was aware of the legislative requirement before this meeting.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. DES values the work that I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The Legislature values the work that I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. In general, private agencies can provide higher quality case management services than the current system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Privatized case management will cost less than the current DES system.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. What are some of the possible benefits of privatization (list up to 3)?

21. What are some of the biggest challenges (or barriers) to privatization (list up to 3)?

22. What are the most important things for DES to consider when making a decision about privatization?
Rate Current Performance

<table>
<thead>
<tr>
<th>23. Please check the box that best describes how you would rate DCYF performance.</th>
<th>Excellent</th>
<th>Very good</th>
<th>Fair</th>
<th>Not very good</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The CPS Hotline function.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CPS Investigations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In-Home Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Out-of-Home Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Independent Living Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Adoptions Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Adoption Subsidy Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Procurement and contract negotiation with service providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Establishing a level of mutual trust and respect with service providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Monitoring contracts to ensure quality and compliance with contract terms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What Did We Fail to Ask...

Please provide any other comments that you think are important for DES to know.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
## Child Welfare Privatization Survey: Providers

### Tell Us About Your Agency

Please check one answer.

<table>
<thead>
<tr>
<th></th>
<th>Less than 1 year</th>
<th>1-2 years</th>
<th>3-4 years</th>
<th>5-10 years</th>
<th>11-15 years</th>
<th>Over 15 years</th>
</tr>
</thead>
</table>
1. How long has your agency provided services to DES children and/or their families? |
2. How long have you been in your current position? |

Check all that apply

<table>
<thead>
<tr>
<th></th>
<th>In-Home services</th>
<th>Foster/Adoptive Home Recruitment Study &amp; Supervision</th>
<th>Group/Residential Care</th>
<th>Adoptions</th>
<th>Independent Living Skills</th>
<th>Other (Describe)</th>
</tr>
</thead>
</table>
3. Which services do you currently provide under contract with DES? |

Check one.

<table>
<thead>
<tr>
<th></th>
<th>&lt; I Million</th>
<th>1-2.9</th>
<th>3-4.9</th>
<th>5-6.9</th>
<th>7-9.9</th>
<th>10-12.9</th>
<th>&gt; 13 Million</th>
</tr>
</thead>
</table>
4. My DES contracts total: |

Check one.

<table>
<thead>
<tr>
<th></th>
<th>&lt; 10%</th>
<th>10-25%</th>
<th>26-50%</th>
<th>51-65%</th>
<th>66-80%</th>
<th>81-90%</th>
<th>&gt; 90%</th>
</tr>
</thead>
</table>
5. My DES contracts represent this % of my total budget. |

### Tell Us What You Think

What you think the term *privatization* means?

**Read the statements and circle the number that best describes how you feel about the statement. If you want to, also tell us why you feel that way.**

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>I don’t agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
</table>
1. If I got to choose an area for DES to privatize, I would choose the CPS Hotline function. | 5 | 4 | 3 | 2 | 1 |
Why? |
2. If I got to choose an area for DES to privatize, I would choose CPS Investigations. | 5 | 4 | 3 | 2 | 1 |
Why? |
### Child Welfare Privatization Survey: Providers

Read the statements and circle the number that best describes how you feel about the statement. If you want to, also tell us why you feel that way.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>I don’t agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. If I got to choose an area to privatize, I would choose In-Home Case Management services.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>4. If I got to choose an area to privatize, I would choose Out-of-Home Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>5. If I got to choose an area to privatize, I would choose Independent Living Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6. If I got to choose an area to privatize, I would choose Adoptions Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7. If I got to choose an area to privatize, I would choose Adoption Subsidy Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>8. If case management was privatized my agency would be interested in providing the service.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>9. Privatizing case management would not affect how my agency delivers its current services.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>10. If I did not get a case management contract, I would rather have DES retain case management than to have another private agency have case management for the children I serve.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>11. I was aware of the Legislative requirement before this meeting.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>12. DES values the services that my agency provides</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>13. The Legislature values the services that my agency provides.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>14. In general, private agencies can provide higher quality case management services than the current DES system.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>15. Privatized case management will cost less than the current system.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
16. What are some of the possible benefits of privatization (list up to 3)?

17. What are some of the biggest challenges (or barriers) to privatization (list up to 3)?

18. What are the most important things for DES to consider when making a decision about privatization? (list up to 3)

Rate DES’ Current Procurement & Monitoring Performance

<table>
<thead>
<tr>
<th>Please check the box that best describes how you would rate DES’ performance</th>
<th>Excellent</th>
<th>Very good</th>
<th>Fair</th>
<th>Not very good</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Procurement and contract negotiation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Monitoring contracts to ensure quality and compliance with contract terms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ability to make timely reimbursement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The level of reimbursement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. The flow of information and communication between DES and providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. The training provided.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The level of collaboration between DES and providers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The level of mutual trust and respect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Rewarding providers for good results.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. What is one thing DES could do to improve procurement, contract negotiation, and monitoring?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Child Welfare Privatization Survey: Providers

Rate Your Agency’s Readiness

<table>
<thead>
<tr>
<th>Please check the box that best describes your current readiness.</th>
<th>Excellent</th>
<th>Very good</th>
<th>Fair</th>
<th>Not very good</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Knowledge and full understanding of privatized case management models.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Knowledge and full understanding of risk-or results-based payment options.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Full understanding of the roles of DES workers during all stages in the life of a case.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Understanding of risk and liability.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Current or past experience providing case management for DES or other public sector clients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Current or past experience handling court-related processes for DES children.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Your agency’s current relationship with DES.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The capacity to track and report outcomes, system indicators, fiscal data.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. What are the three greatest challenges your agency will face if you assume responsibility for results- or risk-based contract opportunities for case management?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. Rank the areas in which your agency is most likely to need help (Rank the top 3):
- Recruitment, training, retention of case managers/supervisors
- Introduction of best practices in case management-(family team, concurrent planning, etc)
- Court-related processes/documentation
- Financial & Risk Management
- IT and Data tracking, reporting systems
- Integration of case management with utilization management
- QA/QI, with a focus on contract compliance and results
- Other (Describe)

What Did We Fail to Ask...

Please provide any other comments that you think are important for DES to know.

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
# Child Welfare Privatization Survey: Other External Stakeholders (Non-Providers)

## Tell Us About Yourself

<table>
<thead>
<tr>
<th>1. What is your current relationship with DCYF?</th>
<th>Parent or Kin Provider</th>
<th>Foster or Adoptive Parent</th>
<th>FCRB or CASA</th>
<th>Judicial</th>
<th>Other State Agency or Division</th>
<th>Tribal Council</th>
<th>Community Interest</th>
<th>Other (Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please check one answer.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. How long have you had a relationship with DCYF?</th>
<th>Less than 1 year</th>
<th>1-2 years</th>
<th>3-4 Years</th>
<th>5-10 years</th>
<th>11-15 years</th>
<th>Over 15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please check one answer.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. What does the term <em>privatization</em> mean to you?</th>
</tr>
</thead>
</table>

---

## Read the statements and circle the number that best describes how you feel about the statement. If you want to, also tell us why you feel that way.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>I don’t agree or disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. If I had to choose an area to privatize, I would privatize the CPS Hotline function.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If I had to choose an area to privatize, I would privatize CPS Investigations.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. If I had to choose an area to privatize, I would privatize In-Home Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. If I had to choose an area to privatize, I would privatize Out-of-Home Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. If I had to choose an area to privatize, I would privatize Independent Living Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. If I had to choose an area to privatize, I would privatize Adoptions Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. If I had to choose an area to privatize, I would privatize Adoption Subsidy Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. If I had to choose an area to privatize, I would privatize In-Home Case Management.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. In general, private agencies can provide higher quality case management services than the current system.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Why?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Privatized case management will cost less than the current DES system.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
14. What are some of the possible benefits of privatization (list up to 3)?

15. What are some of the biggest challenges (or barriers) to privatization (list up to 3)?

16. What are the most important things for DES to consider when making a decision about privatization? (list up to 3)

17. What affect do you think privatizing certain case management functions may have upon your current relationship with DES?

Rate Current Performance

18. Please check the box that best describes how you would rate DCYF’s performance.

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Fair</th>
<th>Not very good</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The CPS Hotline function.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CPS Investigations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In-Home Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Out-of-Home Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Independent Living Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Adoptions Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Adoption Subsidy Case Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What Did We Fail to Ask...

Please provide any other comments that you think are important for DES to know.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________