

The Performance Measurement and Outcomes workgroup is tasked with the development of written recommendations for:

1. A set of proposed outcome measures for children and families served by group homes and foster family agencies (FFAs);
2. A process for measuring youth and families' satisfaction with services and program effectiveness; and
3. A set of performance standards and outcome measures for providers.

Following is the first draft deliverable. In it, the PMO group has attempted the following:

- Consideration and inclusion of relevant and ostensibly valuable features of the evaluation systems of several programs, operating both in and outside of California;
- Identification and recommendation of a set of outcome and performance measures by which to evaluate the effectiveness of California group homes and foster family agencies;
- Identification of data sources necessary to inform evaluation on the recommended outcomes and performance measures.

What is not reflected in the current draft of this document at this time is a proposed methodology or plan for development of alternate data sources of data measuring performance quality in group homes and FFAs, for reasons that are hopefully explained on page 5.

Development of Proposed Outcome Measures

The PMO Workgroup has met several times between September 2012 and February 2013; the group represents a variety of stakeholders, including:

- Group Home and FFA Operators
- Child Welfare Advocates
- County Child Welfare Workers, Managers and Executives
- Legislative Staff
- Researchers
- Parent Leaders
- Current and Former Foster and Probation Youth
- CDSS Staff

In the meetings, the group has worked diligently to establish a common understanding of the elements of performance measurement and the tools and resources available to evaluate programs. It has reviewed literature from other states and localities in various stages of implementation of similar reform efforts. It has also engaged in many discussions, brainstorming and evaluating the merits of key outcome and performance measures of importance to youth, their families and support networks.

Moreover, the PMO Workgroup has attempted, in its suggestions for outcome and process measures, to maintain consistency with the CCR Theory of Change, which articulates the overall vision for the effort, and defines strategies, as well as short- and long-term outcomes by which the success of the reform project will be assessed.

CCR Theory of Change

DRAFT for Discussion
v. 01.11.13

Vision

All children live with a committed, permanent, and nurturing family.

Services and supports are tailored to meet the needs of the individual child and family being served with the ultimate goal of maintaining the family or when this isn't possible, transitioning the child or youth to a permanent family and/or preparing the youth for a successful transition into adulthood.

When needed, Congregate Care is a short-term, high quality, intensive intervention that is just one part of a continuum of care available for children, youth and young adults.

Strategies

1. Create a framework for:
 - **Services & Supports** that
 - Engage family & youth & respect voice and choice
 - Coordinate care and services
 - Address trauma
 - Are culturally-sensitive
 - Support aftercare
 - **Assessment & Matching**
 - Evidence-based
 - Appropriate level of care
2. Create a **funding structure** that:
 - Funds needed services and supports
 - Maximizes federal funding across funding streams
 - Flexible to meet individual needs
3. Create a **Quality Assurance System** for providers that is:
 - Performance-based
 - Fiscal accountability
 - Transparent
4. Reassess children who have in group homes one year or longer.
 - **System Capacity & Alignment**
 1. Step-down capacity
 2. Provider & county worker training
 3. Data collection
 4. Licensing

Expected Short-Term System-Level Outcomes

- Reassessment of children who have been in group homes 12 months or longer
- Children and families will receive a core set of culturally-based and trauma-informed services
- Standards for provider performance are identified
- Increased transparency of provider performance
- Funding supports the level and array of needed services

Expected Short-Term Child-Level Outcomes

- Increased family engagement
- Improved family relationships
- Improved family /caregiver supports
- Improved care coordination
- Increased cultural connections
- Increased stabilizing behavior
- Fewer children in congregate care

Expected Long-Term Outcomes

- Fewer children in foster care
- Reduced lengths of stay
- Decreased non-permanent exits
- Decreased re-entry rates
- Increased placement with relative or Tribe
- Increased reunification
- Decreased disparity in achieving all outcomes above

California's current state of reliance on contracted, non-profit providers to administer group home and other congregate placement services within a continuum of care is not unique. As previously stated, the PMO Workgroup's research efforts have confirmed that many other states – some of which share similar geographic and demographic characteristics with California – have embarked on similar reform projects. That said, the State and Counties have limited information upon which to choose and then assess the quality and success of providers. Additionally, (potentially) misaligned fiscal incentives may actually mean that provider activities are at odds with broader child welfare objectives and principles – and therefore hurting, rather than helping, our children and families.

Attempts to use an enhanced accountability structure with altered fiscal structure have been tested both within and outside of California (see attachments for a few reviews of the literature we were able to track down). Although the field is far from having an empirically-based/proven model to draw upon – important lessons have emerged that can (and should) guide our work. Additionally, we have been able to gather a handful of measures used in other jurisdictions to track the success of provider efforts to serve children and families.

Below we have summarized lessons learned by others. These three lessons are then followed by a set preliminary set of measures proposed by the group.

Lesson 1: Outcome measures should emphasize quality and the achievement of desired results - not what work is performed.

A fundamental aspect of economic (and management) theory is that “it makes more sense to set goals and measure results than to specify methods and try to enforce them” (Porter & Teisberg, 2006, p. 234). In other words, it is better to create agency incentives and accountability structures that focus on results than it is to mandate process compliance by setting standards. If the maintenance or expansion of an agency's contract hinges largely upon process compliance (e.g., day to day or month to month protocols that must be adhered to), the incentive structure is such that agencies will be motivated to improve their compliance, rather than their results.

Emphasizing standard-compliance (by paying for its delivery) can thwart advancements in practice. If tight standards are in place, and compliance is the only measure of performance that matters, then creativity is not encouraged, new practices are not advanced, and a lack of innovation weighs down the field as a whole. This is not to say that input/process and quality/performance don't matter or should not be measured. *Rather, it is simply to say that ultimately it is outcomes that capture the intangible aspects of good practices with children and families and if there are fiscal incentives in a contract - these should be tied to outcomes.*

Compliance measures were once the only readily available means of tracking child welfare performance. The technology simply did not exist to compile, analyze, or disseminate data capturing more complex outcome measures (Brady, 1990). While certainly holding agencies accountable for something was better than nothing, and it is not unreasonable to assume that compliance with a standard was (and still is) correlated with competence in outcome domains, that doesn't change the fact that it is an outdated method of evaluation. Standards create a level of conformity. Knowing that every child in out-of-home care has been visited by a social worker every month is reassuring; it is comforting to know that each case is reviewed for the achievement of permanency every six months.

But meeting standards does not imply that a high level of care has been or is being provided. Different agencies can follow the same guidelines and meet the same standards, but good social work practice is far more nuanced. Process measures capture very narrow bands of service and indicate only that some minimum level of care has been provided. As such, they offer limited information with which to determine provider performance. This manifests in inefficiencies as resources are wasted on ineffective services offered by low-quality providers.

Lesson 2: The OVERWHELMING message from the literature and from other jurisdictions is that we should limit the number of performance measures we are tracking.

Measuring results or outcomes is much more difficult than measuring process compliance. The additional value a client gains through a specific service provided by a given agency cannot be assessed from a single good outcome at a single point in time. Unfortunately, outcomes are, by necessity, measured discretely. Efforts to create more complicated measures are increasingly common and are useful at some level, but the composite metrics can also be very difficult to understand.

While there is a tendency to want to measure outcomes for everything that matters (as well as all the processes we lead to those outcomes - think of the full list of measures our group came up with), one of the most common themes to emerge from the literature was that we must restrict our work to a small number of formal outcome measures. We should attempt to find (or develop) measures that are concise, but, comprehensive, and we should limit the number of measures and the degree of complexity such that they can be understood to reflect a meaningful assessment of performance.

As an example to prove this point: Tennessee uses a total of THREE outcomes in its Performance Based Contracts. These measures include:

1. Reduction in the number of care days.
2. Increase in the number of permanent exits (reunification, adoption, guardianship).
3. Reduction in the number of reentries.

Again, this is not to say that we should not propose input/process or quality/performance measures; but the primary focus should be on a measurable outcome when the state can achieve a consensus that it is a reasonable outcome to hold providers accountable for, where it has the data to measure it, and where it can incentivize agencies to improve practice in order to achieve the outcome.

The approach proposed by the PMO Workgroup at this time, is to establish and monitor a relatively small number of very clear outcome measures, but a more comprehensive list of process (input) and performance (quality) measures that we would recommend for inclusion as other items that are tracked and or outlined in contracts – yet without standards or fiscal incentives attached. Additionally, the outcomes may vary somewhat based on the service objectives outlined for different providers (per email exchange with someone from Iowa – who will send us a list of their congregate care outcome measures, but indicated there are different performance based outcomes for different provider types).

Lesson 3: We MUST take into consideration the availability and reliability of the data, as well as the administrative barriers created by paper data collection/analysis and qualitative indicators.

Another theme that emerged in the literature we reviewed is that it will be completely meaningless to establish outcomes based on data we hope to have in 5 or 10 years. The continuum of care cannot hold providers accountable for what it does not have the capacity to measure or track. If, even at the outset, measures are established for which there exists no method for progress monitoring, the effort will fall short of the meaningful, ground-level changes that are envisioned.

Additionally, although qualitative measures provide useful input and performance information, they are unlikely to yield the outcomes we have been charged to develop. Given how labor-intensive qualitative data collection efforts generally are, we should be mindful of the costs and benefits of these types of measures.

PMO Workgroup Summary 01.17.13: Combination of process, performance, and outcomes for 8 domains

Measure #	Domain & Description	Basis & Timeframe	Source & Method of Monitoring
Domain 1. Safety			
Safety Performance/Outcome: No substantiated cases of abuse or neglect involving the residential contractor during the service period. (Measures the effectiveness of provider efforts to care for children in a safe environment.)		CFSR	CWS/CMS
(input) Safety.1	Foster parents and staff have cleared criminal background checks		
(input) Safety.2	No complaints against caregiver/staff (or a reduction in complaints over time)		
Domain 2. Stable and Permanent Connections			
Stable and Permanent Connections Performance/Outcome 1: Percentage of total residential spells resulting in sustained and favorable discharges. Favorable is defined as a positive step-down to a less restrictive setting (including reunification); sustained indicates that the child remained stable in the discharge placement for 180 days. (Measures the effectiveness of provider efforts to provide services and promote connections that allow children to make stable transitions to lower levels of care / return to family.)		Illinois	CWS/CMS
Stable and Permanent Connections Performance/Outcome 2: The percentage of time a child spends actively in treatment during a residential placement stay. Thought of as “Treatment Opportunity Days”, calculated as the number of active days in care (numerator) divided by the number of active days plus interruption days (denominator). Interruptions days occur when a child is AWOL, hospitalized, or in a detention center. (Measures the effectiveness of provider efforts to provide a stable treatment environment which the child/youth is actively engaged and receiving the appropriate services – assumption is that this outcome is tied to all sorts of good inputs and other good outcomes.)		Illinois	CWS/CMS w/ provider IDs
Stability.1	Case record reflect that child/youth has identified important stable adults/caregivers/peers/family		Qualitative Case Review
Stability.2	Child/youth visits with related or nonrelated family members and visits are sufficient in frequency and quality		Qualitative Case Review
Domain 3. Health			
Health Performance/Outcome: (Possible inclusion of modified version of Safety Outcome 2 in the Iowa documentation...)			

Health.1	Health and dental needs are addressed and demonstrate improvement. a. Initial health screening completed before or upon placement. b. Necessary Well-Child Visits completed timely with a primary care provider and documented in HEP CWS/CMS. c. Timely dental exams on recommended schedule based on age and needs documented in case plan and HEP CWS/CMS. d. Current HEP records reflect identification and ongoing management of chronic health issues.		HEP
Health.2	Mental health needs are addressed and demonstrate improvement. a. Baseline MH screening/assessment provided and documented before or upon placement. b. MH appropriate services provided or offered. c. Psychotropic medication is tracked/timely; Case record shows justifications and proper authorization for medication changes.		HEP
Domain 4. Educational Achievement			
Educational Achievement Performance/Outcome: None at this time, perhaps rely on process measures.			
Education.1	Education rights holder is identified and performs duties to ensure progress in achieving educational goals.		
	a. If/when child changes schools, provider requests and follows-up on transcripts as documented in the case.		
	b. Caregiver tracks school attendance, and ensures child attends 95% of scheduled school sessions.		
	c. If there is an IEP, there is ongoing IEP progress toward meeting identified benchmarks and goals.		
Domain 5. Life Skills			
Life Skills Performance/Outcome: None at this time, perhaps rely on input/process measures that will be tracked for contractual compliance.			
Life Skills Prep.1	Case record documents engagement with ILP or other preparatory services within 60 days of 14th birthday as documented in CWS/CMS.		
Life Skills Prep.2	Youth is screened for SSI eligibility and other appropriate services after age 16.		
Life Skills Prep.3	Case plan reflects instruction provided in: *Household management *Time & money management *Transportation, Secondary Education *Job Readiness		
Domain 6. Engagement and Satisfaction			
Engagement and Satisfaction Performance/Outcome: None at this time, perhaps rely on input/process measures that will be tracked for contractual compliance.			
Engagement.1	Positive responses to youth satisfaction survey(s).		YSS & YSS-F
Engagement.2	Participatory case planning utilized for decisions regarding education, health/MH, IEP, visits, extracurricular activities, etc.		Qualitative Case Review
Engagement.3	Provider engages with child and demonstrates quality engagement (discusses case planning/service delivery and goal attainment).		Qualitative Case Review

There currently exists a series of data reports that will augment the proposed outcome measures. These additional data can be used to measure outcomes (e.g., median time to adoption) and processes (e.g., caseworker visits with children) to inform progress toward achieving the CCR outcome goals. Some of the additional data include:

- Recurrence of Child Maltreatment Allegation after Exiting Foster Care
- Entries into Foster Care by Removal Reason
- Reentry Following Reunification
- Exit Outcomes for Youth Aging Out of Foster Care
- Days in Care by Placement Type
- Foster Children with an Individualized Education Plan
- Foster Children Authorized for Psychotropic Medication
- Distance from Home of Removal to Placement
- Placement of Sibling Groups

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