STATE OF CONNECTICUT
DEPARTMENT OF CHILDREN AND FAMILIES

TO: The Honorable Anthony Musto, Co-Chair, Human Services Committee
The Honorable Peter Tercyak, Co-Chair, Human Services Committee
The Honorable Joe Markley, Ranking Member, Human Services Committee
The Honorable Lile Gibbons, Ranking Member, Human Services Committee

FROM: Joette Katz, Commissioner

DATE: October 1, 2012

SUBJECT: Report on Measurable Outcomes for Contracted DCF Services, 2012

I again am pleased to provide the Department of Children and Families' Annual Report regarding the measurable outcomes for contracted services as required by section 17a-63a of the Connecticut General Statutes:

Section 17a-63a requires the following:

> **Sec. 17a-63a. Private service provider. Contract with Department of Children and Families. Measurable outcomes. Annual report to General Assembly.** The Commissioner of Children and Families shall (1) determine measurable outcomes for each type of service provided by a private provider pursuant to such provider's contract with the Department of Children and Families; (2) incorporate such outcomes into the department's contract with each such provider; and (3) include achievement of such outcomes and other quality indicators in annual evaluations of each such provider. The department shall, annually, submit a report, in accordance with section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the department's progress in implementing such steps, including (A) the number of service types with outcomes, (B) the types of outcomes, (C) the incorporation of such outcomes into contracts, and (D) the application of outcome information into quality improvement.

This report summarizes the department's progress in developing and implementing measurable outcomes as a method of evaluating contracted services. It focuses on the progress achieved by the current administration (January 2011 forward).

The implementation of Results Based Accountability (RBA) throughout the Department of Children and Families (DCF) service system continues to provide the framework for the modification of current contract outcomes, the development of appropriate outcomes for redesigned and/or re-procured services types, as well as new service types. In addition, the department continues to participate in the legislative committee developing the *Annual Results-Based Accountability Report Card Evaluating State Policies and Programs Impacting Children,*

mandated by Public Act (PA)11-109. This report is complementary to the work being conducted in compliance with PA 11- 109.

The **Community-Based Services Outcome Committee (CBSO)**, established in March 2011 to enhance, standardize and monitor client-based outcomes for all purchased services thereby improving system efficiency, accountability, and outcomes for children and families, continues to provide direction and leadership in reaching these goals. The committee, representing all divisions and regional offices, originally reviewed the *then* 76 service types, categorizing them to allow for systematic examination. The committee first addressed the family support, child safety and reunification service category. Over the past year, it has moved forward several initiatives related to these services. This will be described in more detail below but before doing so, it will be helpful to understand how the DCF service delivery system is structured.

The service array is comprised of contracted and fee-for-service providers. Contracted services generally support the agency's community-based service network; fee-for-service providers support the agency's congregate care needs. For contracted services, the area of focus for this report, there are currently seven service categories and 80 service types. Service categories are defined as the broad rubrics which describe and/or are the target of the service type. Service types are defined as the specific program or service, provided by one or more providers, to address particular needs. Approximately 20% of the service types are evidence based models that have embedded fidelity, data and quality management requirements. (As some of the service types are not direct services--and thus not evidence based models--the number of evidence-based models will never reach 100%.) Oversight and evaluation of contracted services are performed by Central Office and Regional staff with expertise in fiscal and programmatic areas. The DCF Commissioner Leadership Team relies on these individual staff and two multi-disciplinary, in-house committees to monitor, evaluate and make improvement recommendations for both community-based and congregate care services.

The goal of the family support, child safety and reunification service category is to strengthen families in order to reduce maltreatment and accompanying DCF involvement. Therefore, a reasonable proxy for determining program effectiveness is the evaluation of changes in family protective factors. A year ago, the committee launched the implementation of the ***Protective Factors Survey*** **(PFS)[1].** The survey was expanded from use with two contracted service types, Family Enrichment Services (FES) and Intensive Family Preservation (IFP), to two additional service types, Family Reunification Services and Community Support for Families, as approved by the DCF Commissioner Leadership Team. The survey will be utilized until any service type adopts an evidence-based model.

In December 2011, an ad hoc workgroup of the committee reviewed three of the largest family support, child safety and reunification service types and found that there was significant overlap in the outlined service provision and outcomes. In addition, none of the service types were evidence-based. It was decided by the committee, with support from the Leadership Team, that the three services should be redesigned, moved to evidence-based models (EBMs), with the potential for merging services to improve service clarity, reduce any duplication, and improve capacity to monitor outcomes. Two committees were established in March 2012 to redesign FES

[1] The PFS was developed by the Administration for Children and Families-funded National Resource Center and the University of Kansas. It is a pre-post evaluation tool for use with caregivers receiving child maltreatment prevention services, and measures protective factors in five areas: family functioning/resilience; social support; concrete support, nurturing and attachment, and knowledge of parenting/child development.

and to redesign and combine IFP and Family Reunification Services (FRS), moving all to evidence-based models. The committees included DCF regional representatives, provider representatives, and parents. The FES committee has selected the Positive Parenting Program (Triple P) as its evidence-based model which will be augmented by some additional case management services that are currently in the service type. It is anticipated that the initial training of all provider staff in Triple P will occur during spring 2013 with implementation starting July 2013.

Embedded in the use of the Triple P model are established outcomes that can be monitored through prescribed processes. This will allow markedly enhanced ability by the department to ensure that there is fidelity to this widely used model and, concurrently and more importantly, that parent-related outcomes are achieved that will reduce maltreatment.

The IFP/FRS service type redesign committee has a similar make-up (DCF, providers, and parents). The committee determined that two evidence-based models may have the capacity to provide the core services in the present service types: Triple P and Homebuilders. The original (and current) intent of the existing service type is to provide short-term, intensive services to families at imminent risk of child removal *and* provide short-term, intensive support to children being reunified where the family setting is high risk and/or the child has complex issues that place challenges on the return process. Additional information is being gathered to better understand the needs of the target population to assure any change in service delivery does not negatively affect children in the care of the department.

The CBSO is moving its attention to the next category, committed delinquent aftercare services, through the redesign and re-procurement. This effort includes reconfiguring the services through combining services and redesign. This will allow for more equitable distribution of services throughout the six regions based on parole caseload data, refining services to meet the most current needs of parole youth (often related to vocational and social development), and to address the *Raise the Age* impact on the parole community support structure. This process will be occurring throughout State Fiscal year (SFY) 2013.

Data Collection, Monitoring, and Outcomes

Concurrent to the above-described redesign and reprocurement processes, the committee has focused on data collection efforts and strategies to support the measurement of outcomes. A number of the established evidence-based models have systems in place to ensure quality data, performance improvement, model compliance, and outcome achievement, often through outside fidelity, data and quality management contracts. The CBSO and Leadership Team are considering how best to ensure similar processes are in place for all contracted services. Performance improvement centers (PICs) exist, and others are being established for some of the larger, although not necessarily evidence-based, models. Those services that shift to EBMs either will utilize the developer's quality assurance/performance monitoring agency or will need to contract for monitoring and quality assurance as outlined by the model.

The department's Office for Research and Evaluation (ORE) continues to support the monitoring of contract outcomes through a variety of means, primarily using the Programs & Services Data Collection & Reporting System **(**PSDCRS). Both demographic and outcome domains are tracked for 30 service types through this system and data may be accessed by both providers and DCF staff. During summer 2012, ORE provided training on PSDCRS and dashboard

development to a number of DCF stake-holders. During the current SFY, ORE will work with stakeholders to develop dashboard reports within PSDCRS to support enhanced services and ensure quality improvement in coordination with program leads, regional staff and providers. In addition, training to Area Office staff to allow them aggregate level data access to PSDCRS will be occurring in October 2012. Some service types not in PSDCRS are monitored through other formal mechanisms. The remaining few service types are either cued up to be added to PSDCRS or are developing other quality measurement systems.

Progress on Outcome Development and Enhancement

The Commissioner of the Department of Children and Families delegates the responsibility for the design and implementation of contracted services to the Administrators of Clinical and Community Consultation and Support *and* Age-Appropriate Child and Adolescent Services as well as to the Regional Office Administrators and their staff. These are the senior managers who oversee the seven primary service areas for which the department contracts. Managers within these areas assess children's service needs, identify or develop appropriate services to respond to those needs, and assist the contract division in developing the scopes of service that specify the expected services and its outcomes.

The 80 different services that the department funds through Purchase of Service (POS) contracts with private community service providers are specified in the contracts in a *Scope of Services*. Beginning in 2008, contract unit staff began reviewing for accuracy the language in the Scopes of Services with managers in the central and regional offices in describing the service the department wishes to purchase and the outcomes expected from that service. Service types were prioritized according to size (number of providers and/or total funding) with a focus on those services that were not part of an ongoing outside evaluation. Service types were rated from one to three relative to their inclusion of outcome measures. Those contracts that had only data collection requirements and no outcomes listed were ranked "1"; those with only process outcomes were ranked "2"; and those with service or client based outcomes were ranked "3". The term *process outcomes* refers to results that arise from the delivery of any service, such as the number of clients to be seen, number of days of service or the number of sessions or home visits. That term corresponds to the RBA question "How much did we do?" The term *service or client outcomes* encompasses both the RBA question "How well did we do it?" and "Is anybody better off?" and includes such measures such as improvements in standardized testing, stability in living situations, reduction in truancy. From 2010 to 2011, the number of service types with no outcomes was reduced by more than 50% and the number of process-only outcomes was reduced by almost 80%, leaving 77% of the service types now having appropriate contract outcomes.

From 2011 to 2012, the percentage of service types with client-based outcomes moved from 77% to 97.5%; only two service types lack these outcomes. One of these is being re-procured fall 2012 and outcomes are being included; the second is a small LINK funded service, specific to one area office. While this is a significant step forward, the CBSO and Leadership Team recognize the continuing enhancements that remain in refining the extant outcomes. For example, the outcomes need to: support Results Based Accountability; require data that are collectable; inform questions that are salient to the department's mission, values, and goals; be of reasonable breadth and, whenever possible, non-duplicative; and be utilized to inform change. Accordingly, the CBSO initiated a pilot project in July 2012 toward enhancing current outcomes in Scopes of Service. The committee selected four service types (Multi-dimensional Family Therapy; Outpatient Psychiatric Clinics; Supportive Housing; Therapeutic Foster Care) for initial review. The department's program leads, staff responsible for monitoring contracted operations

and evaluating outcomes, with the guidance of CBSO representatives most familiar with RBA concepts, are working with the regional office and providers to redevelop the outcomes along the RBA and related parameters. The goal is to have the revised Scopes of Service included in the contract amendments scheduled for January 2013. It is anticipated that all service types will be reviewed and improved following a similar process.

In addition, as contracts are re-negotiated, renewed or amended for other reasons, the RBA framework informs the development and/or revision of outcomes and indicators. As with the pilot project above, this task is shared among contract, program and regional staff in partnership with the specific providers. In addition, the specific indicators for programs within the child welfare system that are included in PA11-109 will be integrated into the relevant programs' contracts and will be added to the annual report cards employing the results-based format.

As noted previously, contracts are negotiated for three years and performance information is reviewed prior to renewal, including input from the Area Office staff as well as the managers in the responsible service areas. Data collection and reporting for both process and client outcomes continue to improve with the increased use of the PSDCRS (discussed above) and additional service types having come on-line. Also, those services that have external quality assurance systems (PICs) have additional monitors that assist the department in assessing program performance; the Multi-Systemic Therapy models are examples of this. The department recognizes that a number of service types still need more attention to ensure that performance measures are meaningful and is working aggressively toward this goal. ORE continues to improve the means for translating the information the department receives from providers into meaningful feedback that can be used to monitor and improve service quality.

Summary of Progress
Outcome Status for Service Types

	2010	2011	2012
No outcomes	17	8	2
Outcomes	67	68	78
Total Service Types[2]	84	76	80

C: Members of the Human Services Committee
Human Services Committee, Clerk
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[2] The variance in service type totals from year to year is due to elimination of service types, combining of service types, and initiation of new service types.