CHILDREN AND FAMILY RESEARCH CENTER

SELECTING OUTCOME MEASURES FOR CHILD WELFARE SETTINGS:

LESSONS FOR USE IN PERFORMANCE MANAGEMENT

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.

Abstract

Child welfare managers and administrators are increasingly concerned with performance-based evaluation of service delivery and incorporation of managed care principles into foster care settings. Evaluating outcomes is seen as a mechanism to identify and reward the most effective programs; inform the public and legislature about the accomplishments and progress of agencies serving children; and identify programs which are ineffective in achieving desired goals. As with most new management tools, using outcome measures to set performance standards is fraught with pitfalls as well as filled with the promise of increased clarity of purpose and goal achievement. The authors summarize briefly the status of measure development in five child welfare arenas and present major considerations in developing outcomes for use in a performance management environment, such as guidance for dimensional deliberation fundamental to identifying and selecting indicators and their measures; development and use of an outcomes framework; and appropriate use of outcome measures in agency management. Steps for selection of domains, indicators and measures are detailed.

Selecting Outcome Measures for Child Welfare Settings: Lessons for Use in Performance Management

Introduction

Managers and administrators in the field of child welfare are moving toward using performance based evaluation of service delivery and incorporating managed care principles in foster care settings. This emphasis on outcomes is seen as a mechanism to identify and reward the most effective programs; inform the public and the legislature about the accomplishments and progress of agencies serving children; and identify programs that are not effectively achieving desired goals,

To this end, the field is working toward the development of universally recognized outcomes. Ideally, this will allow practitioners to begin to link interventions to specified desired outcomes and use information about cases for more effective decision making. Currently, work of researchers, administrators and practitioners has focused on short and long term outcomes for child protective services, family based services, family foster care, and residential care. Several state and nationally targeted efforts are currently underway to identify appropriate outcomes for the field.[1]

To present some guidelines for thinking about and selecting outcome measures, this paper selects information from: (a) current research; (b) work to date in behavioral health care and child welfare on development of outcomes; (e) knowledge of the field including laws, policies, and decision making structures relevant to child welfare practice (e.g., the family or juvenile court); and (d) work with consumers, stakeholders, and collaborative partnerships with other professional groups which have been active in this field. This paper also recognizes the issues of access, appropriateness, and prevention but will focus primarily on the issues for administrators in developing a set of key outcome domains, related indicators and measures.[2]

Background

The study of outcomes in child welfare services has become a major concern for public and private child welfare agencies, child welfare researchers, and the public at large (as embodied by state and federal legislators, child advocates, and the media). These concerns have grown out of several parallel movements, including: public pressure on government agencies to demonstrate observable results; a desire among service providers to improve services in ways that directly impact children

and families; and advances in child welfare evaluation research which have begun to lay the groundwork for further work on development of these measures.

Increased reliance on managed care as a mechanism for child welfare service delivery underscores the need for professionals in the field to proactively participate in the identification and definition of outcome measures (McCullough, 1996). The Child Welfare League of America's (CWLA) national survey on managed care initiatives in child welfare found that 23 of 30 states indicated that their state plan or request for proposal (RFP) identified specific outcomes. The difficulty of operationally defining these outcomes becomes clear upon further reading. Twelve of the 30 states with identified outcomes had determined how to measure them. Yet performance based contracting for service providers was used by 28 of 49 states responding. These responses suggest an essential need to identify and understand what outcomes (complete with operational definitions) are already incorporated into child welfare service delivery. As a first step, the Children and Family Research Center has recently undertaken work with the Children's Bureau to obtain information they have received either through the state plan or self-assessment reports on outcomes in child welfare.

Work on the development of outcome indicators in child welfare has occurred in five arenas which are overlapping in their implementation: (a) federal legislation, rulemaking, funded research and program guidance; (b) foundation initiatives for child welfare reform; (c) state and organizational activities, much of which is not broadly published or disseminated; (d) research in universities and research organizations which has been published in peer review journals or books; and (e) development and adaptation of measures used in other fields such as behavioral health care.

Federal Efforts

At the federal level the impetus for this movement is found in the 1980 Adoption Assistance and Child Welfare Services Act, Public Law 96-272, which emphasizes family unity, placement in the least restrictive setting in cases where placement is required, and permanence of living situation for the child. In recent years, the U.S. Department of Health and Human Services' Administration for Children and Families, responsible for administering PL96-272, has developed guidelines for state self assessment that include measuring outcomes pertaining to child safety, permanency of living situation, and child and family well-being. This approach to self-assessment is now being piloted in at least seven states. Illinois, for example, has served as one of these pilot sites with outcomes reports issued since 1995. While the initial reports combine process and outcomes to some extent, the state is progressively moving toward refining their indicators and measures.[3]

Foundation Initiatives

Foundation activities in this area have largely concerned supporting states and localities in the implementation of new systems and programs that will help them fulfill the promise of PL96-272. Two examples of foundations working with multiple states to enhance outcomes (and their measurement) include the work of the Annie E. Casey Foundation and the W.K. Kellogg Foundation. In the Family to Family project, there has been a great deal of emphasis on building the capacity for agency self-evaluation and measuring the outcomes of service delivery. Among other program goals, the Family to Family states (beginning with Alabama, Maryland, New Mexico, Ohio, and Pennsylvania) are seeking to reduce lengths of stay in out-of-home care, reunify children with their families more quickly (where appropriate), and decrease the number of children entering out-of-home care. Similarly, goals of program reform in the Kellogg Foundation sites include outcomes that achieve a permanent home for children within one year and reduce the number of re-placements of children in care to zero.

In order to evaluate these new reforms and ongoing practices, state agencies require the ability to track children longitudinally through the system. In many states the current stage of automation development makes this difficult or impossible. One major goal in Family to Family has been to work with the Family to Family states to convert their current cross-sectional data systems to a longitudinal capacity (Usher, Schneider, and Schorr, 1994).

State and Local organizations

At the same time, several other states and organizations have been working on developing their ability to use administrative data systems to track process and program outcomes for children in out-of-home care. The Administration for Children and Families funded a report, Foster Care Dynamics 1983-1993 (Goerge, Wulczyn, and Harden, 1995), which describes changes over the ten year period in foster care in five states (with respect to time in care and differences by gender, race, age and geographic region). Simultaneously, individual states such as New York, Texas, California, and Illinois are developing their own data systems and reports on a variety of indicators including re-abuse, time to permanent placement, re-entry into foster care, rate of reunification, and adoption.

The design and implementation of outcomes-based systems creates both opportunities and challenges for states. Identifying quality measures and indicators of progress can be time-consuming and expensive because different services require different levels and types of data with varying confidentiality requirements (Weiss, 1997). As most states are in the early stages of planning and implementing outcomes-based systems they are finding a need for avenues to share resources and

experiences, to learn about these new systems, and to obtain information about pioneering states' efforts (Shilder, Brady and Horsch, 1996). In response to this shift to results-based accountability in child welfare American Humane Association (AHA) and the National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Welfare Association, have co-sponsored six annual Roundtables on Outcome Measures in Child Welfare Services, bringing together child welfare professionals, policymakers, and researchers to promote effective outcome-based models of child welfare practice. The Roundtable process has been useful in establishing a common conceptual framework to facilitate discussion of key outcomes and build consensus. Roundtable participants have identified a number of potential indicators relevant for measuring progress in four target outcome categories: child safety; child functioning; family functioning; and family continuity/preservation. The Roundtable indicators are not intended to be an exhaustive or prescriptive list but to serve as a guide for discussion. Table I describes key child safety indicators stemming from the roundtable process followed by recent indicators developed by a selection of states at different stages of the outcome development process. *See Table 1*.

States differ in the design, model of collaboration, and application of outcome measurement systems as each is conceptualized and developed in distinct organizational, technical and political contexts and in response to unique needs. Varied models of collaborating have evolved to address states' needs with sanction for their development stemming from different sources. For example, some state-wide strategic plans (such as Minnesota Milestones and Oregon Shines) have been adopted in response to legislation establishing a performance-based budgeting process that emphasizes accountability beyond the conventional input and output orientation. These plans include state-wide goals and cut across a number of different agencies and programs, requiring agencies to identify achievable results and necessary resources (Schilder, et al., 1996). Federal requirements (such as in family preservation and support) or court decisions (such as in cases brought against child welfare systems by the ACLU) have given rise to other outcome-based plans that enable states to report publicly on agency progress, identify desirable outcomes, and compare performance over time and across systems. In other cases, the development of measurable outcomes began with state agency management or management systems desiring more thorough information about activities and results to improve their services. Approaches may stem from human services management statewide or originate with a specific agency component such as child protective services.

While much of the work on outcomes in the states has focused on use of administrative data and case status, many local child welfare agencies have long worked with clinical measures to document case progress. As an example, many of the 26 state associations for children's services have begun outcomes projects in which all agencies use and report on common measures (McCullough, personal communication). These agencies are increasingly examining clinical measures for use in evaluating agency or program performance as well. Measures used to indicate progress of a child in care may range from readily available indicators such as school achievement to instruments administered for clinical or research measurement purposes such as the Achenbach Child Behavior Checklist (Achenbach, 1991)

Published Research from Universities and Research Organizations

Many scholars have written extensively about the challenges that must be addressed in the transition to outcomes-based accountability. Most recently Poertner, McDonald and Murray (1997) summarized the status of outcome measures as "standards of success." The authors searched the literature to find not only the measures used but the findings as well. Their questions related to how outcomes such as "recidivism" are measured, as well as the level of performance found in different studies, conducted with different populations. They looked at three types of outcomes: permanency, child well being, and independent living. They hoped to identify consensus where it existed and continue the work begun by McDonald, Lieberman, Poertner, and Hornby (1989) to identify standards for success. They identified less than 20 outcomes associated with safety, permanency, and well-being that had accompanying data for a child welfare population.

This brief summary of the status of measure development in child welfare suggests a great deal of variation among states and agencies in the selection of indicators, identification of measures for each indicator, use of the measures, elaborateness or simplicity of the approach, ability to retrieve case information, and suitability of current practice procedures for collecting information on outcomes.

Selecting Outcomes

Any discussion of outcome measures also raises the question of the many dimensions that are fundamental to identifying and selecting indicators and their measures. Table 2 delineates a number of these different considerations and develops, to some extent, the options available for deliberation in each dimension. In the measure selection process the different dimensions can then be cross-referenced to structure the final identification of the outcome in question. **See Table 2**

The surge of projects and publications on developing mechanisms of performance measurement and, specifically, developing outcomes in child welfare services has provided managers and analysts with valuable guidelines for thinking about constructing an outcomes framework. The problem, as this body of work so eloquently describes, is that actually arriving at measurable child welfare outcomes which are (a) cost and burden conscious; (b) valid, reliable, clinically sensitive; (c) easily available; and (d) reflective of program success is a task which will require ongoing development over several years--and one in which the identification of indicators and measurements is fraught with hazards. With reference to child welfare, English (1994) gives one example with the outcome, "re-referral."

> Do we count any new referral to the agency post case closure or only substantiated re- referrals? If there is a new incident of child abuse or neglect on a different child in the family is that an unsuccessful or successful outcome? How does a new referral that is of less severity or for a different type of abuse get counted? For example, if a child is not reported for a new incident of physical abuse, but is subsequently reported as being left unsupervised? These kinds of distinctions may seem trivial, but can have a significant impact on the interpretation of 'successful' program outcome. Furthermore these distinctions can be drawn for any known outcome measure currently used in child welfare outcome research.

These observations clearly illustrate some of the perplexities of selecting measures, using them to monitor outcomes, and comparing outcomes between programs. Cross and McDonald (1995) set forth six principles for selection of outcome measures in their work on mental health outcomes. While their work referred principally to the use of standardized measures of child and family functioning, their guidance has broad application. Their six principles suggest:

1. Start with program goals.

2. Consider level of program development.

3. Involve stakeholders.

4. Assess resource need and availability.

5. Identify sources of information.

6. Consider the nature of the population.

With respect to program goals, evaluators should consider what outcomes are important to them as well as what outcomes are reasonable to expect from the program at this stage of development. The authors note that "evaluations of human service programs have not demonstrated successful outcomes partly because they used measures that had little relationship to what interventions could be expected to change." The level of program development should also guide the selection of measures. Like programs themselves, the development of appropriate outcome

measures is a process that occurs over time. They suggest beginning with evaluations of client satisfaction and service delivery and gradually moving toward "more sophisticated and convincing measures" of outcomes.

Schorr et al. recommends that communities, states, and collaboratives can best begin the process of identifying outcomes by asking the question, "What do we want for our children?" These deliberations are likely to produce consensus around what people desire most for their children before they get into the question of what is to be measured (Schorr, Farrow, Hornbeck, and Watson, 1994).

The issue of stakeholder involvement is one that is often mentioned but not always understood in its fullest sense. With stakeholders ranging from the clients served to the director of the agency, and in child welfare, the public at large, simply identifying a finite number of measurable outcomes acceptable to all "players" may be a daunting project. Clearly it is not possible to satisfy all of everyone's needs or even to accurately measure those items on which all agree. The involvement of stakeholders is a painstaking process but one that can yield great dividends in public acceptance of program work when done thoroughly and consistently.

The resources available for measuring outcomes are the fourth consideration. Cross and McDonald caution that there are penalties for economizing at the expense of accuracy as well as for selecting measures that are too resource intensive to gather effectively. Some suggestions they offer include (a) balancing the specificity and rigor of the measure with the expense of data collection; (b) ensuring that the usefulness of the data is not sacrificed to false economy; (d) ensuring sufficient funds for data management and analysis; and (d) considering measures that are already being used for clinical or management purposes. Questions about resources should include:

1. Need for special staff for data collection, data management and analysis.
2. Requirements for training in all aspects of data collection and use.
3. The amount of staff and client time required for data collection.
4. The amount of time, money, equipment and staff that must be devoted to storing cleaning integrating and analyzing data.
5. The costs of purchasing copies of copyrighted instruments and related materials or reproducing other measures.

Ideally, evaluators seek multiple sources of information on outcomes regarding the same case. One notable example is the difference in results on the Achenbach Child Behavior Checklist (Achenbach, 1991) between teachers and parents when the form is completed for the same child.

The authors suggest that one approach to developing a comprehensive data set is to add selected measures to already existing data. In cases where existing data are not already retrievable for this purpose it may be possible to use data management techniques and newly available technology to create more useful systems (see, e.g., Goerge, Wulczyn, and Fanshel, 1994; Usher et al., 1994).

Finally, the nature of the population will affect the accuracy of outcome measures. Measures developed for one group cannot easily be transferred to another. Factors impacting validity and reliability include race, gender, culture, values, language, socioeconomic status, and day-to-day experience (see, e. g., Barth, Courtney, Needell, and Jonson-Reid, 1994). This is another area where the input of stakeholders is invaluable.

Schorr et al. (1994) would add that any "start-up" effort in identifying outcome measures should focus first on measures that are the least ambiguous and clearly differentiated from process, that already exist and are easy to obtain, and that are not easily subject to misuse.

Issues in Development and Use of an Outcomes Framework

Schorr et al.'s (1994) guidance in selecting outcome measures suggests that there are several major issues to consider in framework development. One example is the very real tension between holding service providers accountable for both outcome and process. To illustrate, the provision of a timely, sensitive, thorough, and accurate investigation in child protection services is a goal in and of itself. In addition, one of the outcomes for protective services might be to have no substantiated abuse or neglect reports on the same child and alleged perpetrator within the next six months. Both the process and the outcome are important to those who are investigated as well as the children who are subjects of these reports.

Barth et al. (1994) did an excellent job of identifying some of the struggles in appropriately using outcome measures in child welfare services. The Child Welfare Research Center examined the potential linkages between fiscal incentives and service outcomes. The authors concluded that reliance on case outcomes, to the exclusion of structure and process, can result in an inaccurate picture of system functioning. They assert that "child welfare services, in general, are individualized, require a shared responsibility for cases with complex histories and include considerable uncertainty about the best outcome for individual cases."

Barth, el al. recommend instead the use of "performance indicators" that include program structural characteristics, program process and case outcomes (case status, client status, and client

satisfaction) including risk adjusted case status outcomes. The findings of their study supported the notion that child age, ethnicity, foster care type (kin or non-kin), and reason for referral had a discernible impact on case status outcomes and should be adjusted for in examining child welfare outcomes,

There are also potential risks in misusing outcomes for guiding management, budget and policy decisions, as noted by Schorr et al., Barth et al., and others. Figure I lists concerns cited by Schorr and her colleagues in making the shift to results based accountability . *See Figure 1*

In addition to the issues of accounting for process, selecting the measurements chosen, developing consistency across field offices and different programs in using measurement, ensuring that measures are risk adjusted, and guarding against misuse of outcomes as performance standards are just a few of the major factors to be considered in developing outcomes in child welfare.

Thinking About Outcomes in Child Welfare

There has been more work on outcomes in child welfare than can easily be reviewed here. It is important, however, to highlight the most salient points about the types of outcomes used in child welfare and other human service delivery models and to illustrate their complimentary nature for use in evaluating programs and developing performance expectations. Because there has been a great deal of activity in outcome development for mental health and substance abuse treatment agencies, it would be helpful to begin with a look at one or two approaches. In Mental Health and Chemical Dependency services, the Science Applications International Corporation (1996) identified the following outcome domains *(see Table 3)*. These domains emphasize client well-being measures including both status of illness and ability to function in the community. In addition, service utilization and client satisfaction are seen as an integral part of understanding the results of intervention. Service utilization includes amount and type of services used per "episode" of treatment. Other sources of outcome plans include re-entry into care, recidivism and other markers of progress. In child welfare, Magura and Moses (1986) translated these concerns into case, client status and client satisfaction; that is, what is happening with the case progress, how is the client faring, and was the service perceived as satisfactory. Barth et al. (1994) speaks cogently to many of the major concerns in identification of these performance measures.

To date, child welfare studies have most often focused on case status such as readmission to foster care or reports of reabuse, because, in many states, the child welfare system systematically collects such data. It is often not easy to analyze due to the structure of the management

information systems used to collect it, but the data itself can be remarkably rich. Clinical and social data on child well-being can also be extremely difficult to navigate. Case records or information systems may routinely have data about school attendance and immunizations, but only maintain information on social performance if it is highly unacceptable. Family data and service delivery information has also not been customarily followed closely. In some localities, it may consist of whether or not the parent(s) have gone to parent training.

Developing Outcomes for Use in a Performance Management Environment

As noted above, applying managed care concepts to child welfare is not a straightforward endeavor. Some of the major considerations (Feild, 1996) are that much of child welfare services are involuntary and not "selected" by the consumer; in most cases the transcendent goal is to protect the child and achieve a permanent living situation for that child; the state may be the guardian of the child, changing radically the relationship between client and service provider; the degree of control the provider has over many of the conditions contributing the problems of the child and family; and the role of the court in impacting on child welfare service decisions and outcomes (added from McHugh, 1996). Nevertheless, if adapted appropriately, managed care outcomes may be developed to aid agencies with more effective service utilization, more accurate identification of service needs that makes public the actual level of need, and increased contribution to the overall effectiveness and efficiency of the child welfare service system.

One of the most commonly cited examples of developing an outcomes framework for managed care is the Mental Health Statistics Improvement Program's Consumer Oriented Report Card (MHSIP, 1996). The consumer-oriented report card has many advantages in the Mental Health field. One is the degree to which it is designed to report on consumer experience in a way that is helpful to future or potential consumers. A second advantage lies in the systematic way that concerns, indicators, and measures are described for the identified outcomes. It is obviously not possible to use the consumer-oriented report card in this precise way in an involuntary service provided by the state. Yet the format and the selection of the domains of access, appropriateness, result (or outcome), and prevention are instructive. New York City, in its contract monitoring procedures, historically relied on an internal (not public) "report card" that reported on process, adherence to regulation, consumer complaints, acceptance of referrals, and outcomes based on available management information system data. These reports were issued periodically to the Board

which granted the City's foster care and service contracts and, privately, to each of the private provider agencies. While NYC's approach had some clear differences from the MHSIP report card approach, it demonstrates that such approaches are possible in child welfare and suggests that they can have great impact on provider accountability. Any outcomes framework to be developed in child welfare will have to include, after the behavioral health model, domains, indicators, measures and recommendations for use and further development.

Selecting Domains, Indicators, and Measures

The process of selecting outcomes in child welfare services is a parallel one, with individual provider agencies (e.g., private providers and local public agencies) and larger public agencies, such as states, selecting their own measures. At the same time, all agencies are working in a broader context such as adaptation to recommended standards or conforming with the requirements of the U.S. Department of Health and Human Services, the National Child Abuse and Neglect Data System and the Adoption and Foster Care Analysis and Reporting System. In order to aid agency administrators and managers in selecting outcomes, this section will provide guidelines for walking through the process.

<u>Steps for Selection of Domains, Indicators and Measures</u>[4]

1. Involve constituents in discussion of what domains and outcomes should be, from clients to the legislature (for public agencies).

2. Review program goals to determine the desired outcomes of your service. Sources should include program mission statement, stakeholders and any existing or immediately forthcoming mandates concerning reporting. Focus should be on the domains to be included and the indicators within each domain.

Reports from the American Humane Association/American Public Welfare Association's National Roundtables on Outcome Measures in Child Welfare Services are excellent references to aid in selecting or defining outcome domains and indicators (this comprehensive approach outlines a broad range of possibilities, but is not necessarily a prescription for wholesale application).

3. If you are in the early stages of this process, look first at your current data collection system. Examine currently available data to determine whether any are used for reporting on end results of your service delivery. If any of these items are in line with program goals and objectives (Step 1), begin by using this data for tracking, reporting and performance monitoring.

4. Add additional indicators systematically, selecting them based on urgency or importance of the outcome (e.g., re-abuse or return to care after reunification), the target to be measured,

and on what it is possible to realistically collect. These items should be separated into those which may be made part of an ongoing information system, for example, school achievement information from case records, and those which must be measured and collected at the client level. This might include, for example, levels of child and family functioning. Each type of effort requires quite a different investment from managers, workers and clients, which will be detailed below

5. For every outcome selected, examine carefully how setting performance standards may cause unintended consequences, and create checks and balances as necessary

For example, do not hold programs responsible for length of time to reunification without the ability to also measure return to foster care within a specified period of time. Do not reward numbers of adoption placements without also tracking adoption disruptions. The same caution holds true for setting numbers for performance indicators. In many cases, norms have not been established to tell us what is to be expected; or the expected may differ radically from place to place due to definitions of terms. What is considered a report (or re-report) in Phoenix, Arizona will be different from what is considered a report in Richmond, Virginia. One may be more inclusive in their definition of reports, resulting in a higher re-reporting rate. Or one state (or locality) may have different rules or practices for recording re-reports.

This may also true for different localities within a state. In county administered states, differences in definition and policy almost certainly differ radically from county to county. Even in state administered child welfare systems, urban and more rural areas will differ. This may be due to something as simple as the number and kinds of resources available in the community. With few resources, the child welfare agency may become the principal provider of services simply because there is no alternative. This situation would have an effect on working definitions of client populations, type of services provided, how services are recorded (or not), etc. In some cases, systematic review of case data may be required. Often, other reviews or quality assurance practices may be used to provide needed information.

6. Examine, to the extent fiscally possible, the characteristics (e.g., validity and reliability) of the indicators and measures selected. This is true for administrative measures - due to the issues about definition raised above as well as for more clinical instruments.

An invalid measure could result in laudatory changes in the measure with little actual effect on that which is being measured. Without reliability it will not be possible to measure accurately, without error. An absence of information about what are expectable (or normative) results prohibits making comparisons using new program findings.

In addition to the above characteristics a measure of outcome must be sensitive to change. For example, if a psychiatric measure indicates the presence of a problem but does not measure the degree to which it causes difficulty for the client, or an increase or decrease in problems in functioning or symptomatology it will not be possible to observe change. The measures used must also be appropriate to the population being measured. Differences in race, gender, culture, values, language and day- to- day experience can impact the appropriateness and validity of the measure in many ways. Therefore it is always important to consider these issues in any selection of measurement.

7. Determine the costs of collecting information on the outcome measure.

Reisinger and Burlingame (1997) detail a number of questions to be considered: who will provide information, client or worker; is a computer scanner necessary to process the result; how often will outcome information be collected and by whom; who will tabulate the data, interpret it, and analyze it in the aggregate. For standardized measures you should also know if you have to pay a fee for every use. What are the monthly and annual costs? The costs are not only in payments but also in staff time. The authors suggest that, as a rule of thumb data collection should take no more than 10 minutes. This is very difficult standard to meet given the number and variety of outcomes that are important in child welfare. A further cost consideration follows from determining whether the information collected (that is not already part of the data collection system) should be collected on a sample of clients or on the whole population. If the information could also be important in planning interventions and is not too difficult or expensive to collect, the whole population may be preferable. If the purpose is solely for measurement purposes, a sample would seem preferable (assuming that it is identified in a rigorous fashion).

8. Develop systems of feedback for all interested constituents as well as managers. These systems must be relevant to the user and contain information they can use to improve performance or goal setting. In addition, they should be integrated into the agency in such a fashion that it is possible to get periodic reports.

Conclusion

As with most new management tools, the use of outcome measures to set performance standards is fraught with pitfalls as well as promises of increased clarity of purpose and goal achievement. Cautions that are often ignored are several; for example, determining whether the measure really can do what is hoped for and whether focusing on a particular measure will help inform users about what changes should be made in the system.

As child welfare agencies increasingly move into this era, the frustrations in the beginning will be many and the rewards few. The major challenge in the beginning will be to think small enough in terms of indicators and measures so that some success in measurement will be realized; while holding on to the larger picture and investing sufficient resources in developing an ongoing system that is able to use information that may be harder to develop but richer in its yield. Finally, in a performance environment it is essential to remember to measure the checks and balances so that, for example, reunification rates are balanced by returns to foster care or evidence of maltreatment at home.

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TABLE 1

Child Safety Indicators: AHA/NAPCWA[a] and Selected States

AHA/NAPCWA ROUNDTABLE[bc]	Los Angeles County [d]	Colorado[e]	Illinois[f]	Oregon Benchmarks[g]
% of child welfare cases with a subsequent substantiated report of CA/N for any child in the home (a) within a given time frame following the initial substantiated report (b) while open for services (c) for families involved in prior unsubstantiated cases of CA/N (d) within a specified period of time following case closure	Repeat neglect or abuse in the home for (a) open cases, (b) closed cases or (c) for siblings of children known to the system	Abuse and neglect of children who are served in their own home	% of children (a) living with family caregiver in which there is an indicated report subsequent to case opening (b) with an indicated report whose cases are not opened and for whom there is another indicated report (c) whose cases are closed and for whom there is a subsequent indicated report within 6 months.	% of families with a founded report of child buse who did not experience a founded report in the previous 12 months
	Neglect or abuse in placement (including the home of a relative)	# of children who are abused/neglected while in out-of-home care	% of children living in (a) adoptive homes (b) family/specialized foster care (c) group homes (e) institutions who have an indicated report during the fiscal year	Abuse by caretakers of a child in the State's custody who is placed in a foster home, including related and unrelated, paid and unpaid foster parents
		# of children entering out-of-home care or remaining in care beyond 60 days		# of children who enter foster care from their own home
Incidence of preventable serious injuries or fatalities resulting from CA/N	Child deaths as a result CA/N for children (a) while in the system (b) not known to the system			
		% of children who once returned home, are subsequently referred for a new report of CA/N within 12 months	% of children returned home from substitute care in which there is a subsequent indicated report	
Incidence of domestic violence in families receiving services	Domestic violence			
Parents' knowledge of children's physical and developmental needs				
Child's sense of safety and security				
Community risk factors				

[a] American Human Association /National Association of Public Welfare Administration

[b] McDaniel, N., & Thielman, B. (1997). Matrices of indicators, Fourth National Roundable on Outcome Measures in Child Welfare Services: Summary of Proceedings (pp. 108-121) Englewood, Co: American Humane Association.

[c] Child safety indicators addressing youth delinquency are not included here. For a full listing contact the American Humane Association.

[d] McCroskey, J (1991) Monitoring the well-being of children at risk of abuse or neglect: Outcome indicators for child protective services in Los Angeles County. Unpublished

[e] Colorado Division of Child Welfare (1997) Child Welfare managed care initiative concept paper [on-line] Available http://www.state.co.us/gov

[f] Children and Family Research Center (1998).

[g] Oregon State Office for Services to Children and Families (1997). Quarterly report for January-March, 1996. Contact George Boyles, Senior Research Analyst

TABLE 2

Ways of Organizing or Thinking About Outcome Data

Services to be Evaluated[a]	Preventive services Child protective services Family based services Family foster care Residential care and residential treatment		Source and Method of Data Collection	Management information system Case record review Interview with, or written responses from (a) children (b) family (c) allied informants
Service Goals[b]	Child Safety Permanency Child well-being Family well-being		Use of measure	Program improvement Monitoring agency performance Clinical evaluation of child Clinical evaluation of family Research to inform practice and policy
Type of Outcome	Case status Client status Client satisfaction		Expected Performance[c]	Prevention of harm (added) Prevention of deterioration of functioning Slowing a progressively deteriorating condition Maintenance of functioning Increase in functioning
Unit of Measure	Event (e.g. abuse report) Child Family Program Agency			

Note: Prepared by Susan J. Wells © Children and Family Research Center, School of Social Work, UIUC, 199

[a] Administration for Children and Families, U.S.D.H.H.S. State self-assessment reporting form.

[b] Magura, S. & Moses, B. (1986.)

[c] Pecora, P. (1996). Reporting on an outcome measures discussion group at the Behavioral Healthcare Quality and Accountability Summit, Oak Brook, IL, June 14, 1996. In "Improving Family-Based Services Programs and Research: A Call for Action", a paper presented at the Children's Institute Conference, Anaheim, CA From the Casey Family Program, Seattle, WA., September 1996

TABLE 3

Outcome Domains in Mental Health Services

Health Related Quality of Life	Satisfaction Resource use Treatment utilization
Clinical Status	Survival Symptomatology Acute clinical stability Severity of disorder
Functional Status	Physical Social and interpersonal Work

Note: Science Applications International Corporation (1996).

Figure 1. Risks in Making the Shift to Results Based Accountability, (Schorr et al., 1994).

1. Funders, the public, and program people may be <u>dissatisfied with the length of time required to achieve change in outcomes</u>. The (single most frequently cited lesson from major current reform efforts: is that implementation and achieving change takes much longer than expected.

2. The requirement for documentation of <u>results may result in "creaming" of the target population,</u> seeking those most likely to improve as first choice for intervention -- or in concentration on "countable" outcomes to the detriment of less easily measured goals.

3. The public may misinterpret the meaning of goal achievement, and <u>abandon strategies with long range results</u> to emphasize with more immediate results.

4. Some measures are more useful on an aggregate basis, such as school readiness, than to describe individual functioning. Care is necessary to avoid <u>labeling families or children</u> in ways that will make their future lives more difficult.

5. The current paucity of information on the link between interventions and outcomes, information about outcomes alone <u>will not identify needed and missing element of a program.</u>

6. The increasing emphasis on outcomes and results "<u>cannot be allowed to substitute for rock-bottom safeguards</u> against fraud, abuse, poor services, and inequities or discrimination based on race, gender, disability or ethnic background."

[1]See for example, Annie E. Casey, Casey Family Services and Casey Family Program RFP's to Develop an Outcomes Framework and Decision making Protocols for Child Welfare Services (10/28/96); work from Chapin Hall, University of Chicago, Chicago, Illinois; and Earth, et al. (January 1994) Performance Indicators for Child Welfare Services in California.

[2]Key definitions will be taken from the Annie E. Casey, Casey Family Services and Casey Family Program RFP's to Develop an Outcomes Framework and Decisionmaking Protocols for Child Welfare Services (10/28/96). These definitions were adapted for the RFP from the work of the Center for the Study of Social Policy in 1994 on results based decisionmaking and budgeting

[3]Outcome domain or result is a condition of well-being for families, children or communities. Indicator is a measure, for which data are available, which helps quantify the achievement of outcomes. Performance measurement methods are how the outcomes or outcome indicators are assessed (e.g. records of child abuse reports).

[4]This list is derived from the resources listed in the references with special acknowledgement to Cross and McDonald (1995)