Children and Youth Services Review 38 (2014) 101–112

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

An empirical typology of private child and family serving agencies

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ARTICLE INFO

Available online 31 January 2014

Keywords:
Child welfare
Management
Strategy
Private agencies

ABSTRACT

Differences in how services are organized and delivered can contribute significantly to variation in outcomes experienced by children and families. However, few comparative studies identify the strengths and limitations of alternative delivery system configurations. The current study provides the first empirical typology of private agencies involved with the formal child welfare system. Data collected in 2011 from a national sample of private agencies were used to classify agencies into five distinct groups based on internal management capacity, service diversification, integration, and policy advocacy. Findings reveal considerable heterogeneity in the population of private child and family serving agencies. Cross-group comparisons suggest that differences in agencies' strategic and structural characteristics correlated with agency directors' perceptions of different pressures in their external environment. Future research can use this typology to better understand local service systems and the extent to which different agency strategies affect performance and other outcomes. Such information has implications for public agency contracting decisions and could inform system-level assessment and planning of services for children and families.

1. Introduction

The context in which child welfare services are delivered in the U.S. has changed dramatically over the last two decades. The role of Medicaid and other federal programs in funding services such as child welfare, mental health, and residential foster care has expanded (Geen, Sommers, & Cohen, 2005; Mark, Levit, Buck, Coffey, & Vandivort-Warren, 2007; Smith, 2012), resulting in increased fiscal centralization even as the movement towards New Public Management means that responsibility for service decisions are increasingly devolved to the state and local level (Conlan, 1998; Scarcella, Bess, Zielewski, & Geen, 2006; Terry, 1998). State and local agencies have, in turn, responded to changing institutional demands by experimenting with new, privatized service arrangements (Auger, 1999; Dilger, Moffett, & Struyk, 1997; McCullough & Schmitt, 2000).

Federal, state, and local governments have long subcontracted with private agencies to deliver services to families (Flaherty, Collins-Camargo, & Lee, 2008; Salamon, 1995). However, the amount and scope of contracting occurring at all levels of government are a relatively new development (Gronbjerg, 2009). In child welfare, particularly notable is the extent to which core, mandated services once maintained exclusively within the public agency domain have now been privatized (Collins-Camargo, Ensign, & Flaherty, 2008). One example of this is the shifting of frontline case management functions (e.g., working with families to set case goals, decide how and when services will be accessed and delivered, and monitoring progress towards case goals) to the private sector; as of 2008, public child welfare administrators in over a fifth of states (23%) reported having some privatized case management, although only 13% reported doing so on a large-scale basis (Collins-Camargo, McBeath, & Ensign, 2011).

The inclusion of more market-based and outcome-oriented control mechanisms within these contracts is also a relatively recent phenomenon with significant implications for how child and family services are delivered (Smith, 2009). Currently, public child welfare administrators in at least 27 states report use of performance-based contracts that specify levels of performance expected of subcontractors and link at least a portion of contract reimbursement and/or prospects for future contracts to achievement of performance milestones (Collins-Camargo et al., 2011). These changes affect the administrative infrastructure and competencies required of agencies, e.g., to successfully complete required reporting activities (Austin, 2003; Gooden, 1998) and have also made the contracting process significantly more competitive, particularly given reduced overall funding availability due to the Great Recession of 2008 (McCullough, 2004; McCullough, Pindus, & Lee, 2008; Smith, 2012).

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http://dx.doi.org/10.1016/j.childyouth.2014.01.016

Changing client needs and increased emphasis on evidence-based practice have also affected the types, cost, and quality of services being contracted. For example, in many states, efforts to promote safety and permanency through early intervention have resulted in the development of alternative response or differential response systems that allow for the provision of voluntary case management and other, community-based services to low- and moderate-risk families (Children's Bureau, 2005; Conley & Berrick, 2010). Increases in prevention and other early intervention services (e.g., family support and home visiting programs) have been offset by reduced placement of children in congregate care (Kids Count., 2011); however, need for physical health, behavioral health, and associated wraparound services has grown (Blome & Steib, 2004; Oberg, 2011; Scarcella, Bess, Zielewski, Warner, & Geen, 2004). Many public and private funding sources also either encourage or mandate service coordination (Alter, 2000; Sowa, 2009), placing pressure on agencies to either offer a comprehensive array of services in-house or form inter-organizational relationships to ensure safety, permanency, and well-being outcomes are met.

While these trends are well-documented, less well understood are the strategies and structures that private child and family serving agencies have employed to adapt to these shifting environmental demands. In the general social services sector, focus groups conducted with social service agencies in one county in the 1990s suggest that agencies may respond by building administrative capacity, developing new inter-organizational relationships, and strategically expanding programs and client bases to capture new revenue (Alexander, 2000). More recent evidence drawn from 2007 data on 501(c)(3) organizations maintained by the Urban Institute indicate that while some private, non-profit organizations have evolved into large, multi-service organizations with high administrative capacity and extensive ties within the community, many remain small and relatively isolated from other social service organizations (Smith, 2012). Specific agency responses to environmental pressures are likely to be influenced by local context as well as internal factors such as mission, current capacity, and leadership style (Battilana & Casciaro, 2012; Crilly, Zollo, & Hansen, 2012; Fiss & Zajac, 2006), resulting in considerable heterogeneity in organizational adaptations and service structures.

Evidence in the human services literature suggests that differences in how services are organized and delivered can contribute significantly to variation in outcomes experienced by children and families (Keiser & Soss, 1998; McBeath & Meezan, 2009; Sandfort, 2000; Yoo & Brooks, 2005). However, few comparative studies identifying the strengths and limitations of alternative delivery system configurations exist. As a result, public child welfare policymakers and administrators currently have little empirical information on which to base decisions about the organization of responsibilities and the allocation of resources via subcontract to private child and family serving agencies. A better understanding of how private child and family serving agencies are configured, and the extent to which these configurations developed in response to specific environmental pressures, represents a critical first step towards subsequent comparative effectiveness research on strategies for improving agency performance and client-level outcomes.

In other areas such as health services and public health, researchers and policy analysts often rely on typologies to classify heterogeneous organizations and delivery systems, including health insurance plans (Brach et al., 2000; Grembowski et al., 2000), health care networks and systems (Bazzoli, Shortell, Dubbs, Chan, & Kralovec, 1999; Dubbs, Bazzoli, Shortell, & Kralovec, 2004), public health delivery systems (Mays, Scutchfield, Bhandari, & Smith, 2010), and community health partnerships (Mitchell & Shortell, 2000). These typologies are used for the purpose of comparing identified groups or classes of organizations and systems on selected performance and outcome indicators, and ultimately, identifying strategies for improvement. In health care, typologies have informed policy and administrative approaches to improving hospital quality and efficiency (Bazzoli et al., 1999; Dubbs et al., 2004; Shortell, Bazzoli, Dubbs, & Kralovec, 2000). In public health, typologies of public health systems have allowed for the identification of new governance and inter-organizational arrangements resulting in improved population health (Mays et al., 2010; Rodriguez, Chen, Owusu-Edusei, Suh, & Bekemeier, 2012).

The current study utilizes a similar approach to develop a theoretically grounded typology of private child and family serving agencies. Data collected in 2011 from a national sample of private child and family serving agencies are used to classify agencies into distinct groups based on four identified structural and strategic characteristics (e.g., internal management capacity, diversification, integration, and policy advocacy). We then explore the extent to which these characteristics were associated with different pressures within agencies' external environment. Since many private agencies serving child welfare client populations do not consider themselves “child welfare” agencies, private child and family serving agencies are defined as any private non-profit and for-profit agencies providing services to children and families involved with child welfare, i.e., investigated or assessed for maltreatment by Child Protective Services. These services could include traditional child welfare services as well as preventive, behavioral health, and social services.

1.1. Environmental forces influencing agency behavior

Agency structure and strategy, represented by the unique mix of activities and values each puts into practice, are heavily influenced by factors in the external environment. The current study focuses on four elements in agencies' external environment known to influence the ways in which private child and family serving agencies develop new programs, deliver long-standing ones, and form inter-organizational relationships. These environmental factors include available funding sources, laws and regulations, local population needs, and use of performance management systems at the federal and state level.

Services provided by state child welfare agencies are supported by government funds. However, specific funding sources, total per capita spending on child welfare, and types of services contracted vary significantly across states and counties (Geen, Boots, & Tumlin, 1999; Scarcella et al., 2006). Intentionally or not, financial incentives and pressures within agencies' external environment may also influence agency behavior in ways that affect both specific populations served and services provided (e.g., Jang & Feiock, 2007). For example, families involved with child welfare also frequently access services such as mental health treatment through systems other than child welfare. Increased privatization and de-institutionalization of such services have affected the types of revenue opportunities available to private agencies and may also have implications for the types of services they provide. Although the Great Recession of 2008 resulted in cutbacks, overall public spending on public social welfare programs has more than quadrupled since the 1960s, much of it driven by growth of Medicaid and other federal programs (Gronbjerg & Salamon, 2012; Smith & Lipsky, 1993). The expanded role of federal programs such as Medicaid in funding services for vulnerable populations means that funds are increasingly linked to client eligibility rather than through provided as block grants or cost-reimbursement contracts (Scarcella et al., 2006; Smith, 2012). In theory, this trend should result in increased competition for clients. In practice, federal and state efforts to control costs, either via managed care arrangements or by setting reimbursement at pre-determined amounts rather than at cost, mean that funds for certain categories of services may be insufficient to cover costs of employing professional staff to provide them. In these situations, agencies providing such services may limit the number of Medicaid clients they are willing to take, strategically compensate for losses in one service area via fundraising and/or profits in another, or stop providing that service altogether (Decker, 2012; Gronbjerg, 2009; Raghavan, Inkelas, Franke, & Halfon, 2007).