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Developing performance-based contracts between agencies and service providers: Results from a Getting To Outcomes support system with social service agencies

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ABSTRACT

This study examines an intervention designed to enhance the ability of social service agencies to implement performance-based contracting using the Getting To Outcomes® (GTO®) accountability framework. The GTO approach to contracting focused specifically on outcomes, provided a comprehensive framework for contracts, and provided multi-component support to agencies. The following results were demonstrated after a nine-month intervention: (1) participants reported being more knowledgeable about 10 areas of outcome accountability; (2) the quality of contracts was rated as improved (especially in regard to measurable outcomes), but still needing improvement; and (3) increased collaboration was reported between funders and providers. Limitations, implications and future directions of the study are discussed.

1. Introduction

Performance-based contracting (PBC) has become an increasingly common technique for holding human service programs accountable for the outcomes they promise. A performance-based contract is a contract that "focuses on the outputs and outcomes of service provision and may tie contractor payment, as well as contract extension, to their achievement" (Martin, 2000, p. 32). Outputs are measures of service volume, while outcomes are measures of improvements in people's lives. Numerous expected benefits of PBC have been identified (FCS Group, 2005), and many state human service agencies that have moved to PBC have seen significant improvements in program performance (for reviews see Martin, 2005; Perrins, 2008; Vinson, 1999). PBC is not without its problems, however. Critics have argued against PBC in the human services because outcomes in this area are too difficult to quantify and measure (Perrins, 2008) and performance measures may influence providers to act in ways that boost numbers without benefiting clients or to select the easiest way to serve clients and neglect more difficult cases (Frumkin, 2001). Despite these difficulties, it is widely expected that the majority of human service contracts will be performance-based in the near future (Martin, 2007).

1.1. PBC in child welfare services

One area in which PBC is becoming increasingly common is child and family services. This is partly due to the realization that traditional fee-for-service contracts may create a financial incentive for providers to keep children in care for long periods of time, conflicting with the goal of finding appropriate permanent placements for children as quickly as possible. A survey by the Child Welfare League of America in the mid-1990s found that about half of all state human service agencies were experimenting with PBC for child welfare services (Eggers, 1997). A number of strategies have been tried to better align provider compensation with the desired outcomes for children including: setting fees per child rather than per service (Unruh & Hodgkin, 2004), paying for the achievement of milestones towards desired outcomes (Martin, 2007; Vinson, 1999), reimbursing based on expected caseload size if placement goals are met regardless of actual caseload size (Martin, 2002), developing weighted point systems based on achievement of multiple desired outcomes (McEwen, 2006), and providing fees for services with bonuses for achieving outcomes (Meezan & McBeath, 2008; Sahonchik, 1999). Another approach has been to keep compensation based on cost reimbursement but to tie contract renewal to performance (Martin, 2005).

The results of these efforts have been mixed. Some states have seen dramatic improvement in placements and permanency rates (FCS Group, 2005; Martin, 2002), whereas others have not (McBeath, & Meezan, 2008; Perrins, 2008). PBC has also had some unintended consequences in some states, including creating severe financial difficulties in some provider organizations (Martin, 2005), increasing placements with kin rather than parents (McBeath & Meezan, 2008),

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and suppressing the provision of service (McBeath & Meezan, 2008). Such problems have led a number of states to revisit their initial implementation of PBC and to create more nuanced compensation schemes in an attempt to avoid these problems (Martin, 2007; McEwen, 2006). These mixed results suggest that PBC has the potential, if done well, to improve outcomes in child and family services. They also suggest that simply tying provider compensation to some performance measure is not sufficient to reach desired outcomes and raises the question of what can be done to support effective PBC.

Following the lead of Florida and Maine, New York State passed legislation (Chapter 57 of the Laws of NYS 2007) that required social service agencies to include performance or outcome-based provisions for preventive services whether purchased or provided directly. In New York, preventive services are services designed to prevent foster care placement or replacement as well as to expedite discharge of children in the foster care system. In January 2007, the New York Office of Child and Family Services (OCFS) began planning how to support effective PBC in county Departments of Social Services (DSS) as required by the new law. OCFS chose to initially advocate for an approach with minimal financial risk to providers in which outcomes would not be tied to provider compensation but potentially could impact contract continuation. OCFS reviewed a number of outcome models to use as a framework for providing training and technical assistance to counties and eventually selected the Getting To Outcomes (GTO)[1] results-based accountability framework (Chinman, Imm, & Wandersman, 2004; Wandersman, Imm, Chinman, & Kaftarian, 2000) for this effort.

1.2. Getting to Outcomes (GTO): a results-based accountability framework

GTO is a method for planning, implementing, and evaluating programs in order to reach desired outcomes. GTO provides a framework of 10 accountability questions which, when answered, help programs achieve results and demonstrate accountability to funders (see Table 1). Interventions involving GTO tools, training, and technical assistance have been found to build individual capacity to plan, implement, and evaluate programs, and to improve program performance (Chinman et al., 2008). OCFS chose GTO because of its user-friendly language, applicability across programmatic areas, and applicability to different system levels. GTO was first customized for use with PBC in the State of Missouri where it was used for developing contracts with local Departments of Public Health and Senior Services. OCFS engaged GTO experts to provide training, tools, materials, and technical assistance to selected counties. It is important to state that the 10 key steps of GTO (needs and resources, goals and desired outcomes, best practices, fit, capacity, plan, implementation/process evaluation, outcome evaluation, continuous quality improvement, and sustainability) are derived from key literatures related to planning, implementation, and/or evaluation; therefore, they have general relevance to practitioners and policy regardless of theoretical or practice perspective. The GTO approach to contracting (GTO contracting) has the following three key characteristics: 1) a specific focus on outcomes, 2) comprehensiveness, and 3) multi-component support.

1.2.1. Key characteristic #1: specific focus on outcomes

GTO contracting is specifically focused on outcomes (rather than outputs). Some have used the term outcome-based contracting to describe this type of approach to distinguish it from performance-based contracting, which may focus on either outputs or outcomes, or both (Honore, Simoes, Moonesinghe, Harold, & Renner, 2004). Martin (2007) has applied a systems framework to human service contracting and pointed out how accountability has shifted over time from focusing on inputs and processes (design specifications), to focusing on processes and outputs, to now focusing on outputs, quality, and outcomes (performance specifications) (Martin, 2007). GTO contracting represents a culmination of this trend with the primary focus on the final component in the systems framework: outcomes. Although short contract timeframes and other practical difficulties may significantly limit how outcome data are collected and used, and require the use of proxy output data, a focus on outcomes is maintained throughout the contracting and monitoring process.

1.2.2. Key characteristic #2: comprehensiveness

A second quality of GTO contracting is comprehensiveness. Martin (2007) noted that most of the states' approaches to PBC have been atheoretical and have lacked an overarching framework, although many specific “best practices” or “lessons learned” appear in the literature. For example, it is recommended that performance-based contracts include a description of the problem that needs to be solved (Office of Federal Procurement Policy., 2004), answers to the questions what, when, where, how many, and how well work is performed (Office of Federal Procurement Policy., 1998), and a plan for monitoring the contract (Behn & Kant, 1999; Eggers, 1997). The importance of being prepared to make changes to programs and contracts based on the results of ongoing evaluation has also been highlighted (Behn & Kant, 1999; Frumkin, 2001; Perrins, 2008). Process evaluation in other approaches to PBC typically is limited to output reporting and resulting contracts usually do not include plans for quality assurance and quality improvement. The GTO model makes quality improvement a priority and specifically addresses it in contracts through Steps 7–9 (implementation and process evaluation, outcome evaluation, and continuous quality improvement).

Although outcomes are the bottom line in GTO contracting, the GTO framework recognizes the importance of all the other elements (other 9 steps) in reaching and sustaining those outcomes. The United Way attempted to move its grantees to be more outcome-based by having grantees specify outcomes in grants but found this was insufficient for moving grantees towards actually achieving these outcomes. Many human service providers lack the background for creating quality plans to reach outcomes. Part of the rationale behind PBC is to encourage innovation among providers by reducing regulations and requirements around process or program design, while maintaining accountability through increased monitoring of outcomes (Frumkin, 2001). The GTO approach to contracting maintains this objective by not dictating program design. Rather, it builds the capacity of providers to create high quality program designs by specifying a general structure that ensures that the key elements of a quality plan are present. This approach also builds the capacity of contract managers to identify program plans less likely to meet intended outcomes, which is particularly important when reviewing the contracts of programs that have not met performance standards.

1.2.3. Key characteristic #3: multi-component support system

Finally, the third quality of GTO contracting is that it is implemented with a multi-component support system. Disseminating a contract framework (no matter how well designed or incentivized) is not sufficient for getting funders and providers who are accustomed to fee-for-service, activity-based contracts to implement contracts likely to reach desired outcomes. A support system of tools, training, technical assistance, and quality assurance and quality improvement is also needed (Wandersman, 2009). This system must be responsive to the needs and capacities of the entities implementing PBC and adjust provided support accordingly.

1.3. Need for improved contracting practices

County human service contracts in New York typically have two sections: a legal boilerplate written by county attorneys that is the

[1] The trademark for “GTO” and “Getting To Outcomes” is jointly owned by the University of South Carolina and RAND Corporation.

same for all contracts within a county and a program narrative which describes the service to be provided. Prior to the GTO intervention, program narratives among the counties participating in the intervention were typically written by the executive director or program director in a provider organization in response to a Request for Proposal (RFP) or an informal request—with little input from DSS staff. These program narratives tended to be vague in many important respects, as will be discussed in more detail in the Results section. Most contracts were sole source contracts, were not competitive, and were renewed annually with little or no review. In some cases, contracts were initiated by unsolicited proposals from provider organizations. Mechanisms for monitoring contracts varied widely among the nine counties in the intervention. Informal monitoring through regular phone or face-to-face contact between DSS staff and staff of the provider organization, annual reports, and fiscal audits were most common. Some counties additionally conducted site visits or record audits.

1.4. Study aim

There is a growing trend toward the use of PBC in child and family services. However, empirical studies report inconsistent outcomes associated with PBC. We suggest that PBC can be effective when adequate support is provided. Little is known about the impact of training and technical assistance to enhance PBC, although one study found that providers in health care services who received group and one-on-one training in PBC reported high satisfaction with PBC and also that PBC enhanced collaboration (Honore et al., 2004). In our study, we sought to examine the effectiveness of using a GTO approach to contracting for increasing the capacity of participating county DSS to develop performance-based contracts. GTO contracting: is *outcome-oriented*; *comprehensive* in its elements; and has a *support system* of training, technical assistance. The desired outcome of the intervention was for each participating county to write a GTO contract for at least one preventive service by the end of the project. This article describes an evaluation of the GTO contracting approach.

2. Methods

2.1. Participants

All 57 DSS district offices in New York State were invited to apply to participate in the GTO contracting project. Counties were required to commit a minimum of three staff to participate in the training, technical assistance, and project evaluation in order to be considered. Twenty one of the 57 counties applied, and 10 of the applications were accepted. Counties were selected to provide a mix of counties by geographic region, population, and urban/rural classification. One county dropped out before the start of the project due to concerns over the required commitment of staff time, leaving nine participating counties (three large, three medium, and three small in population density).

2.2. Measures

2.2.1. Participant knowledge

Participants rated their knowledge of activities associated with each of the 10 GTO accountability questions prior to the initial consultation visit and again at the conclusion of the project. For example, for GTO Step 1 participants were asked to rate their knowledge of how to conduct a community needs assessment and a community resource assessment. Ratings were made on a 5-point Likert scale anchored by the ratings "1" for "I know very little about this" and "5" for " I am very knowledgeable about this" with higher scores indicating more knowledge. The mean rating of all GTO questions was used as an overall measure of GTO knowledge.

2.2.2. Contract quality (county rating)

In each county, the team of participants rated the contract for the service that they worked on over the course of the project (the focus service). Ratings were completed at two time points: (1) during a 2-day training that took place at the beginning of the project (pre-intervention), and (2) at the time of the last on-site visit made by assigned technical assistances (post-intervention). Ratings were determined by group consensus of county participants on how well the contract for the focus service addressed each of the 10 GTO accountability questions. In counties with large attendance (>10), at the 2-day trainings participants were broken up into multiple teams and the average ratings of the teams were used as the county rating. Ratings were made on a 5-point Likert scale anchored by "1" for "Not well or incomplete" and "5" for "Very well and complete" with higher scores representing higher quality.

2.2.3. Contract quality (independent rating)

The focus service contracts, collected at the beginning and end of the intervention, were also rated by an external rater in order to obtain objective data. The external rater was not involved in providing technical assistance to any of the counties and was "blind" to whether contracts were "pre" or "post" contracts. The ratings were completed using a measure, developed by the GTO team, which assesses the quality of items associated with each of the GTO accountability questions. For example, items for *GTO Question 1: needs* and *resources* included:

> "A problem statement describing the community needs to be addressed by the contract;""A description of the population(s) to be served;""A description of the geographic area(s) to be served;""A statement that identifies gaps, if any, in the existing services and how the service provided under this contract will fill those gaps."

Ratings were made on a 5-point Likert scale anchored by "1" for "Not addressed" and "5" for "Addressed exceptionally well" with higher scores representing higher quality. The mean of the ratings for the items associated with each GTO question was used as a measure of the quality with which the contract addressed that GTO question.

2.2.4. Qualitative data

In addition to the quantitative measures, the authors reviewed the pre and post contracts to identify descriptively how contracts had changed over the course of the intervention. The study evaluators also interviewed the technical assistance providers from the project to identify formal or informal changes in county contracting and monitoring processes that were not reflected in the written documents.

2.3. Design

The nine-month intervention consisted of four activities which included the following: 1) an initial consultation visits; 2) a 2-day training on GTO and PBC; 3) ongoing technical assistance; and 4) a 1-day mid-project booster session.

2.3.1. Initial consultation visit

One initial consultation visit was made to each participating county by a technical assistance provider assigned to the county. The purpose of the initial visit was for the technical assistance provider assigned to the county to make contact and begin establishing relationships with participating staff, to gather information about county needs, issues, and goals, and to help counties select a preventive service contract to be rewritten as a performance-based contract. The selected contract became the focus service on which they worked throughout the project. Counties were advised to select a

contract for a service where there was potential for performance improvement, but which was not overly complex.

2.3.2. Two-day training on GTO and PBC

Within six weeks after the initial consultation visit, a 2-day training was conducted in each county. The training included an overview of GTO and the 10 GTO accountability questions, an overview of performance-based contracting, and hands-on exercises. The hands-on exercises began with participants reading through a fictional example of the development of an outcome-oriented service contract described by each GTO question.

During the training, participants also reviewed their own contracts for the service in their county that they would be working on over the course of the project (the focus service). In teams, participants were then asked to discuss and rate the process used in their county to develop the contract for the focus service based on each GTO question. This was followed by team report-outs and discussion. The purpose of the exercise was to deepen participants' understanding of GTO and PBC by having them apply the newly learned material to a task relevant to their county. The exercise was also designed to enhance the motivation of county staff to engage in the project by highlighting the discrepancy between county participants' perception of how contracting ought to be conducted and how it was currently being conducted in their county.

2.3.3. Ongoing technical assistance

The 2-day training was followed by technical assistance provided by a member of the GTO team. The technical assistance consisted of approximately three on-site visits as well as phone and email contact on an as-needed basis. Counties primarily used their technical assistance to provide additional training to DSS staff. For example, technical assistance providers implemented staff with training on how to respond to the new state requirements of performance-based contracts, how to conduct county needs assessments, how to review county contracting forms and instructions modified to be consistent with performance-based contracts, and how to structure county planning documents to be consistent with the GTO framework. They also assisted staff members with setting appropriate goals and objectives in contracts. The technical assistance provided to each site was customized to the needs of the particular county.

2.3.4. One-day project booster session

A 1-day booster session was conducted five months into the project. The booster session brought participants together from eight of the nine counties to share progress and challenges, and to renew energy. Participants from one county did not attend in light of a child service emergency in their county. Breakout sessions were held in which each county was able to present their work. The GTO team gave a presentation on contract monitoring. They also facilitated discussions on applying GTO to services provided directly by DSS and on the resources needed by counties from OCFS to continue moving their services to be more performance-based.

3. Results

Of the nine counties, six completed a performance-based contract for their focus service by the end of the project, two decided to work on a "request for program narratives" based on the GTO questions rather than an individual contract, and one county did not meaningfully participate in the project due to competing demands on staff resources brought about by various crises within the county. The requests for program narratives were planned to be sent out to all of the providers of preventive services in the two counties that chose this approach. The responses to these requests would then be attached to contracts as they were renewed. Several counties completed more than one performance-based contract by the end of the project period. Nine contracts were completed altogether, and most of these were signed and implemented prior to the end of the project. A number of counties were in the process of creating additional performance-based contracts at the time the project ended.

3.1. Participant knowledge

A total of 52 respondents from the nine county teams completed the participant knowledge measure. Of these respondents, only 15 participants successfully completed both the pre and post measure as a result of changes in project staffing over the nine-month duration of the project. Comparing all respondents' self-report of knowledge, data analyses showed that knowledge was higher at the conclusion of the project ($M = 2.98$, $SD = 0.88$, $n = 31$) than at the beginning ($M = 2.35$, $SD = 1.02$, $n = 36$). When only participants who completed both the pre and post measure were examined, the increase in self-report of knowledge was even greater from the beginning of the project ($M = 2.00$, $SD = 0.93$, $n = 15$) to the conclusion ($M = 3.11$, $SD = 0.93$, $n = 15$).

3.2. Contract quality ratings

The quality ratings for each GTO question by both the counties and by the independent rater for each county that completed a contract appear in Table 2. Both the counties and the independent rater rated the contracts as improved on all of the GTO Questions. However, the counties rated their contracts higher than the independent rater.

3.3. Qualitative data

The GTO team reviewed the pre and post contracts to identify the nature of changes made to the contracts over the course of the intervention (see Table 3). Overall, post-intervention contracts were more consistent in addressing the 10 GTO accountability questions, as would be expected. The most evident pre-to-post contract change related to statements of goals and objectives (GTO Question 2). In GTO lexicon, goals are broad statements that describe desired long-term impact on the target population, and objectives are specific, measurable changes that indicate desired outcomes to show achievement of or progress towards a goal. Prior to the intervention, three of the six contracts contained goal statements, although all were vague (e.g. "Prevention of out-of-home placements"), and only one contained measurable objectives. After the intervention, all of the contracts contained both goals and measurable objectives. Moreover, the contracts tended to be more specific in addressing the capacities required to implement the program (GTO Question 5), the plan for implementing the program (GTO Question 6), and the plan for evaluating the program (GTO Questions 7 and 8). Despite this increased specificity, most of the contracts still contained sections that were too vague in the judgment of the GTO team, particularly when describing the need for the contracted service (GTO Question 1), the rationale or justification for using the chosen program or model (GTO Question 3), how the contracted service fit into the community context (GTO Question 4), and how the program would be sustained over time with adequate capacity and quality (GTO Question 10).

The technical assistance providers for the project reported that in addition to the changes made to the contracts, a number of counties made formal or informal changes to contracting and monitoring processes. The most notable change was the increase in collaboration between DSS staff and staff from the provider organizations in all aspects of the contracting process. Previously, providers typically wrote the program narrative portion of the contract with little input from DSS staff. As a result of this project, most counties created teams consisting of both DSS staff and provider staff who worked together on all aspects of the program narrative. Consequently, DSS staff

became more knowledgeable about the programs that they were working with and/or monitoring.

The project also led to greater clarity and better alignment among the funded intent of contracts, the goals of provided services, and expectations of both the DSS and provider staff. In addition, a number of counties increased the number of staff involved in the contracting process, and included line staff and caseworkers rather than just administrative staff. The increase in staff involvement and representation made it possible for the language used in the program narratives to more accurately reflect the activities occurring within the provider organizations. Two of the counties were also planning to increase their use of RFPs rather than relying exclusively on sole source contracts. And two of the counties created a Request for Program Narrative structured using the GTO questions and began requiring all renewed contracts to include narratives in this format.

As the result of the project, counties also became more specific in their reporting requirements for process and outcome data. For example, two counties adopted the practice of requesting more frequent updates rather than only receiving updates through annual or quarterly reports. Several counties began requiring data on client and/or staff satisfaction. And one county began requiring providers to follow-up with clients three and six months after termination from the service to assess whether gains in functioning were sustained.

At the conclusion of the intervention most counties had not yet considered how they might change the way that they monitor contracts. One county that had not previously conducted site visits was considering it, and one county added regular conferences between DSS caseworkers and provider staff.

4. Discussion

This article examines the application of a results-based accountability approach to contracting across nine geographically-dispersed counties in New York. The study findings showed that the intervention was successful at increasing the capacity of county DSSs to develop performance-based contracts using GTO, but that achieved outcomes were partially limited by resource constraints within participating counties. The results revealed an increase in knowledge among county staff about activities associated with each of the 10 GTO accountability questions. Moreover, contract quality ratings completed by both county staff and an independent, blind rater showed that contracts were of higher quality and more comprehensive at the end of the intervention when compared to pre-intervention contract ratings. At the project's conclusion, most of the counties were expanding their use of GTO beyond the single contract that they worked on initially, reinforcing the idea that counties saw the utility of the approach in reaching outcomes and improving accountability.

4.1. Project challenges

The ratings of the independent rater and the review of contracts by the GTO team suggest that although the contracts improved over the course of the intervention, there remained much room for further improvement in addressing all 10 of the GTO accountability questions. Responses to two of the GTO accountability questions that received particularly low scores in the post-intervention contracts deserve some explanation. Most of the counties involved in this intervention had access to very limited needs assessment data in their communities prior to the intervention. While the counties recognized the importance of acquiring better data on their communities, none of the counties were able to conduct a needs assessment during the course of the intervention. This limited their ability to adequately address the needs assessment accountability question (GTO Question 1) in their contracts, although lack of experience and understanding of formal needs assessment was also clearly a factor.

GTO was originally designed to help plan, implement, and evaluate grant-funded programs. Sustaining grant-funded programs past the life of the grant is an issue of much concern to both funders and grantees and was the rationale behind GTO accountability Question 10 (sustainability). Initially, the GTO project team was uncertain how this concept would translate to the legally mandated services in this project, which typically were able to rely on state funding "indefinitely." Over the course of the project, it became clear that sustainability in child and family services was more an issue of maintaining the capacity and quality of programs over time in the face of threats (e.g., frequent staff turnover) rather than an issue of funding. The lack of clarity on the application of this question to the services in this project from the outset likely explains why most contracts did not address this issue and those that did, did so only superficially.

4.1.1. Resource constraints

The fact that the contracts resulting from this project still had much room for improvement is consistent with the results of preliminary attempts to move to PBC in other states (Chapin & Fetter, 2002). The process of moving to PBC requires considerable time and resources that are typically not in place at the beginning of the process, which negatively impacts the quality of initial attempts. Acquiring these resources is a challenge for organizations that are often strapped for resources to begin with. Fifty-five percent of United Way grantees responding to a survey reported that new requirements to identify and measure outcomes overloaded their record keeping capacity and 46% reported that these activities diverted resources away from existing activities (United Way, 2000).

One resource needed to implement PBC was a significant investment of both county and provider staff time. DSS staff tended to be under considerable time constraints prior to the beginning of this project due to budget pressures, recent staff cuts, demands of meeting state requirements, and the considerable needs of their clients. Investing the time needed to implement performance-based contracts was frequently a considerable challenge for DSS staff and has been identified as a major barrier to implementing PBC in the literature (FCS Group, 2005). Larger county DSS were able to dedicate significant portions of specific staff's time to the project, which facilitated their move to PBC.

PBC also requires skill and knowledge in areas in which county provider staff have traditionally not been trained, such as participatory planning, setting measurable outcomes, and collecting valid and reliable data (Frumkin, 2001). Setting and measuring good outcomes for programs was particularly difficult for participants in this project, and has been cited as one of the biggest implementation issues with PBC (Behn & Kant, 1999; Chapin & Fetter, 2002; FCS Group, 2005). Since these skills are typically lacking, providers are likely to need considerable, ongoing outside assistance to acquire these skills (Perrins, 2008). Inadequate staff training has been a frequent problem in moves toward performance-based contracting (FCS Group, 2005). PBC also requires a fundamental shift in perspective on service delivery from a process orientation to a true outcome orientation that is not easy for staff to make (FCS Group, 2005; Frumkin, 2001; Perrins, 2008). The experience from this project suggests that it takes months of training and technical assistance grounded in current, local examples to make this shift. The level of training and technical assistance provided in this intervention, although sufficient to meet the limited goal of helping each county produce one performance-based contract, would not be sufficient to fully move the counties to PBC across all their contracts, particularly in light of the high staff turnover encountered among county staff.

4.2. Leveraging a collaborative approach

Fostering collaborative relationships between providers and funders has been seen as crucial for effective PBC (FCS Group, 2005; Frumkin, 2001). A collaborative approach helps allay providers' fears,

overcome resistance, and increase buy-in to changing practices (Perrins, 2008). Providers are often in a better position than funders to recognize the complexities involved in measuring outcomes within the context of their services, so their input is crucial (Else, Groze, Hornby, Mirr, & Wheelock, 1992). If providers are involved in the establishment of performance standards, they are also more likely to feel ownership of these standards, which may lead to better performance (Martin, 2005). Collaboration is also important for effective continuous quality improvement (Behn & Kant, 1999).

The increased collaboration between DSS staff and provider staff reported by the technical assistance providers in this study appeared to contribute significantly to the improvement in contracting processes. One of the threats to effective contracting described in the literature stems from information asymmetry, or the greater access that providers have to information about the actual implementation of contracted services than their funders (Martin, 2003). Information asymmetry can lead to providers pursuing their own interests rather than the goals of the funder. Such tendencies are traditionally guarded against through providing incentives that align provider financial interests with the goals of the funder and through program monitoring. The collaborative process resulting from the intervention appeared to heighten focus for both the providers and funders on the overarching goal of helping children and families, thereby, decreasing the tendency of providers to engage in activities inconsistent with the goals of the contracts. The personal relationships formed across organizations also appeared to decrease the threat of information asymmetry because providers were more likely to share relevant information with funders.

4.3. Study limitations and suggestions for future research

Several limitations should be considered along with the study findings. First, only one outcomes-oriented framework to contracting was examined in the current study. This precludes any conclusions being drawn about how the GTO accountability-based approach might compare to other existing approaches. Since no previous studies have examined the effectiveness of the GTO approach to contracting, we believed it valuable to conduct a focused study on the GTO method. Future research should build on this study by investigating how the GTO approach to contracting compares with other methods. Second, the reliability of the contract quality rating completed by the independent rater cannot be determined in light of the absence of additional independent raters. Constraints in study resources did not allow for additional independent raters. However, the fact that county contract ratings showed changes in the same direction as reported by the independent rater increases our confidence that contracts did improve. Third, staff turnover resulted in a high percentage of missing data on pre and post tests of participant knowledge such that statistical inference testing was not useful and only trends could be described. Lastly, and perhaps most importantly, the current study was unable report on the degree to which the practices fostered by the intervention were sustained and disseminated beyond the intervention period. At the time of the project's conclusion, several counties were known to be actively applying the GTO approach to other contracts. The project did not continue due to very severe state budget cuts. Additional research is needed to assess the extent to which improvements made to county contracts subsequently benefit child and family services.

4.4. Study conclusions

The use of performance-based contracting is becoming increasingly common in child and family services. However, previous studies suggest that merely linking provider compensation to performance measures is not sufficient for reaching desired outcomes. The current study examined a systematic accountability-based approach to developing, planning, and writing contracts for social services that involved addressing 10 accountability questions, training, and ongoing technical assistance. The inclusion of responses to the 10 accountability questions in contracts encouraged careful attention to implementation, outcomes, and continuous quality improvement by both providers and funders. This systematic approach resulted in: 1) improved contracts in terms of comprehensiveness and quality, suggesting that the GTO approach to contracting effectively enhances the ability of social service agencies to develop performance-based contracts, and 2) increased collaboration between funders and providers – a feature known to be important for effective execution of performance-based contracts – indicating that the approach examined in this study can also benefit PBC implementation. Identifying effective approaches to supporting quality PBCs is a critical step to improving the quality of child and family services. However, the project challenges identified in this study suggest that doing so may require working with participating entities to build their organizational capacities *prior* to engaging in contract-related activities. Further research on the GTO approach to contracting is needed to determine whether the observed improvements in contract quality subsequently result in improved outcomes for children and families.

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Appendix A

Table 1
The 10 GTO Questions and how to answer them.

Accountability	Relevant literature
1. What are the *needs* and *resources* in your organization/school/ community/state?	1. Needs assessment; resource assessment
2. What are the *goals*, *target population*, and *desired outcomes* (objectives) for your school/ community/state?	2. Goal setting
3. How does the intervention incorporate knowledge of science and *best practice* in this area?	3. Science and best practices
4. How does the intervention *fit* with other programs already being offered?	4. Collaboration; cultural competence
5. What *capacities* do you need to put this intervention into place with quality?	5. Capacity building
6. How will this intervention be carried out (*plan*)?	6. Planning
7. How will the quality of *implementation* be assessed?	7. Process evaluation
8. How well did the intervention work (*outcomes*)?	8. Outcome and impact evaluation
9. How will *continuous quality improvement* strategies be incorporated?	9. Total quality management; continuous quality improvement
10. If the intervention (or components) is successful, how will the intervention be *sustained*?	10. Sustainability and institutionalization

Appendix B

Table 2
Changes in contract quality.

GTO question	County rating			Independent rating		
	Pre	Post	Δ	Pre	Post	Δ
1. Needs and resources	2.67	3.79	1.13	1.38	2.60	1.21
2. Goals and objectives	1.96	4.00	2.04	1.75	4.21	2.46
3. Best practices	1.63	4.17	2.54	1.33	2.61	1.28
4. Fit	2.92	4.17	1.25	1.22	2.00	0.78
5. Capacities	3.27	4.50	1.23	1.33	3.07	1.74
6. Plan	2.85	4.42	1.56	2.50	3.41	0.91
7. Process evaluation	1.86	4.50	2.64	1.06	2.93	1.87
8. Outcome evaluation	2.04	3.83	1.79	2.17	2.95	0.79
9. CQI	1.63	4.17	2.54	1.13	2.83	1.71
10. Sustainability	1.58	4.42	2.83	1.00	2.17	1.17
Grand Mean	2.24	4.20	1.96	1.49	2.88	1.39

Note: N = 6.

Appendix C

Table 3
Description of contracts before and after GTO intervention.

GTO Question	Pre-intervention (6 contracts)	Post-intervention (6 contracts)
1. Needs and resources	Three have vague references to community needs; two also defined target population; three do not reference needs or resources.	All define a target population and made some attempt to define community needs although in vague terms; four mention past or projected referral numbers.
2. Goals and objectives	Three contained goal statements, although they were vague, and only one contained measurable objectives.	All contained both goals and objectives, although in four the objectives either lacked specificity or were not clearly linked to the stated goals.
3. Best practices	One provided a rationale for why the contracted service was likely to be effective.	All either described the rationale behind the model to be used or identified it as a "best practice". Only one provided evidence of effectiveness.
4. Fit	None mentioned how the program would fit within the context of the community or target population, although four reference interface with existing services.	Two described fit within the community and target population. Three others reference this issue (apparently to adhere to the GTO framework), but were either vague or conceptually confused.
5. Capacities	Five mentioned staffing requirements for the service and three additionally described staff qualifications or experience.	All addressed staffing and staff qualifications and additionally discussed other technical or material requirements for implementing the service.
6. Plan	All described the basic activities involved in delivering the service.	Two contained brief implementation plans and four descriptions of program activities (two detailed).
7. Implementation/ process evaluation	One required client satisfaction data; three required data on numbers served; all required access to documentation (e.g. case plans, progress notes).	Four required client satisfaction data and two additionally required staff satisfaction data. One included a detailed process evaluation plan. Two required only minimal data on numbers served.
8. Outcome evaluation	One had detailed outcome evaluation plan; two tracked client progress; three mentioned tracking outcomes but not specific.	All mention intent to track objectives from Question 2; three contained fairly detailed outcome evaluation plans and three contained vague plans.
9. CQI	Four specified regular meetings between the provider and DSS to review the service.	All contracts contained some plan for CQI although in two cases these plans were vague.
10. Sustainability	No contracts mentioned sustainability.	Four contained superficial references to sustainability.

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