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REPORT AUTHORED BY ELEVATE: A POLICY LAB TO ELEVATE MENTAL HEALTH AND DISRUPT POVERTY
Table of Contents

Executive Summary ................................................. 2
Introduction ......................................................... 7
Outcomes-Based Contracting .............................. 9
The OEC Outcomes Rate Card Pilot .................. 11
Evaluation of Stakeholder Impressions and Experiences ... 16
Lessons and Considerations for Future Outcomes Rate Card Initiatives .... 21

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Executive Summary

Introduction
In early 2018, the Connecticut Office of Early Childhood (OEC) launched the year-long Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Outcomes Rate Card Pilot. Through the pilot, the state’s home visiting providers funded by the federal MIECHV program could receive bonus payments up to 3% of their total contract value for the achievement of two-generational outcomes among clients.

In December 2018 and January 2019, Elevate, a policy lab at Yale School of Medicine dedicated to elevating mental health and disrupting poverty, conducted a qualitative evaluation involving semi-structured interviews with 18 individuals, including service provider staff and other key stakeholders involved in the pilot, to explore impressions of the pilot and its effects. This report describes the findings from these interviews and key lessons learned to inform future outcomes rate card initiatives.

Outcomes-Based Contracting
Outcomes rate cards belong to the umbrella of Pay for Success models, which are contracting strategies in which payment is contingent on the achievement of certain measurable outcomes. In the traditional outcomes rate card model, the government determines a set of critical outcomes for a target population and assigns an amount it will pay for each outcome achieved. The government can then contract with multiple providers, for whom payment is contingent on the achievement of each outcome and the number of individuals for whom the outcome is achieved. The payment can be bonus in nature — offered in addition to other “core” payment issued on another basis — or can constitute some or all of the “core” payment to the contracted providers.

The OEC Outcomes Rate Card Pilot
In May 2017, the nonprofit Social Finance awarded OEC 12 months of technical assistance to create one of the first United States-based outcomes rate card projects, with a focus on improving two-generational outcomes for young children and their families. OEC identified the state’s MIECHV-funded home visiting providers as the providers best suited for the pilot initiative.

The MIECHV Program, administered by the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA), provides federal funding for home visiting programs, in which home visitors— typically nurses, social workers, and other maternal and early childhood professionals— provide a number of services, including parenting and health education, aid in navigating available resources, and screening for parent and child safety and well-being. Four of 18 MIECHV-approved home visiting models are offered by providers in the state of Connecticut: Parents as Teachers® (PAT), Early Head Start Home-Based Option (EHS), Nurse-Family Partnership® (NFP), and Child First.
Through the pilot provisions, which were built by the Connecticut Department of Mental Health and Addiction Services Central Contracts Unit (DMHAS CCU) with the assistance of OEC and Social Finance into reauthorizations of the providers’ existing contracts, each provider could earn bonus payments for three different outcomes per client family that were achieved in 2018. All providers were offered bonus payments for achieving outcomes related to (1) safe children and (2) caregiver employment/education. Additionally, the 14 providers of PAT, NFP, and EHS services could receive bonus payments for full-term births. The Child First program in Connecticut has nearly 100% post-natal enrollment, so in place of the full-term birth outcome, the Child First rate card for the remaining 8 providers included bonus payments for achieving an outcome related to family stability. See Table 1 for specific definitions of these outcomes.

Table 1: Outcomes Prompting Bonus Payments

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Children</td>
<td>No substantiated cases of maltreatment and no injury- or ingestion-related ER visits</td>
</tr>
<tr>
<td>Caregiver Employment/Education</td>
<td>Caregiver is employed or enrolled in education or training</td>
</tr>
<tr>
<td>Full-Term Birth (PAT, NFP, and EHS providers only)</td>
<td>Baby is born after 37 weeks of gestation</td>
</tr>
<tr>
<td>Family Stability (Child First providers only)</td>
<td>Identified family need was met in at least one of three areas: child care, health care, housing</td>
</tr>
</tbody>
</table>

For each outcome, the participant family must have first been enrolled with home visiting services for a certain duration to become eligible for achievement and bonus payment. The full-term birth outcome eligibility criterion, enrollment up to 28 weeks of gestation, was created to incentivize and promote early enrollment, thereby increasing the duration of access to resources which could influence the achievement of this and further outcomes.

Evaluation of Stakeholder Impressions and Experiences

Methodology:
Elevate conducted semi-structured telephone interviews with service provider staff and other key pilot stakeholders in December 2018 and January 2019. OEC provided Elevate with names and contact information for potential eligible respondents at all service provider sites. Of the pilot’s 22 service provider sites, 6 were randomly selected by Elevate for interviews with home visitors (6 respondents), and a further 6 were randomly selected by Elevate for interviews with clinical supervisors (4 respondents). An additional 10 key stakeholders were identified by OEC for interviews (8 respondents), making for a total of 22 contacts leading to 18 respondents (81.82% response). Sixty (60) minutes were allotted for each interview, which consisted of 8 open-ended questions concerning stakeholders’ experiences with and views on the pilot’s effects and lessons.
learned. No audio recording or verbatim transcription was used; thematic analysis was conducted manually by the interviewer from interview notes.

Impressions or Experiences of the Pilot and its Effects:
- Overall perception of the pilot was largely positive across interviews.
- Public and private sector stakeholders outside of direct service provision viewed the model as an innovative paradigm shift for human services contracting.
- Service provider interviewees had a less clear understanding of the reasoning behind the pilot than administrators and external stakeholders, and many saw the bonus payments as acknowledgement for simply doing their jobs.
- Service providers perceived minimal or no change to their day-to-day operations or approach as a result of the pilot and suggested that the aims described by the pilot outcomes have always been part of their work.

Reflections on Pilot Design and Development:
- Stakeholders from Social Finance, OEC, and the Connecticut Department of Mental Health and Addiction Services’ Central Contracting Unit (DMHAS CCU) described the contracting process as efficient, collaborative, and innovative.
- Social Finance found embedding the outcomes-based contract within the reauthorization of an existing contract—rather than drawing up new contracts with providers subsequent to a government request for proposal—to be novel and efficient approach to rate card contracting.
- A number of stakeholders other than service providers suggested that the providers should have been involved earlier in the pilot process in order to help shape the contract language and design.
- Service providers’ experiences with data reporting varied, as OEC finalized and continued to refine a data system it developed for some of the provider models as the pilot began, while other models used their own existing IT infrastructure and reported through Excel spreadsheets.

Challenges with Outcomes:
- Nearly all interviewees whose programs were eligible for the full-term birth outcome believed full-term birth to be largely beyond their control, often a matter of chance and external factors rather than provider effort or quality of care.
- Others found the eligibility criterion for the full-term birth outcome, which required that a participant in home visiting must enroll no later than 28 weeks into pregnancy to qualify, to be a challenge given their perceived lack of control over client recruitment.
- Some providers also noted that certain populations they serve were ineligible or excluded by the outcome criteria for caregiver education and employment by barriers such as immigration status or by the choice to stay at home to care for their children.
Challenges with Implementation:

- While most service provider interviewees described data reporting required by the pilot to create some degree of additional work, perceptions of the burden of data reporting varied widely across pilot sites, as did knowledge of the pilot’s requirements, familiarity with the rate card model, and understanding of the conditions for use of bonus payments.

Lessons and Considerations for Future Outcomes Rate Card Initiatives

For Development of an Outcomes Rate Card:

- Involving service providers in the development of an outcomes rate card from an early stage affords them an opportunity to speak to the needs of the families they serve and their own capacity for implementation, which may be valuable in setting the parameters of the outcomes rate card.

- Contract specialists responsible for the legal framework of an outcomes rate card may not be familiar with the model before pilot design and would benefit from a clear and thorough introduction to the concept.

- Building an outcomes rate card into the reauthorization of existing contracts presents a uniquely efficient approach to enacting the model across multiple provider sites, circumventing the request for proposal process and potentially expediting contract execution.

- Diverse models of client recruitment or referral pathways often exist among providers of the same services. For outcomes payers looking to incentivize changes to participant or client recruitment (such as earlier enrollment), the model of client recruitment or referral may be a key consideration in the selection of service providers best suited for the rate card.

- When choosing the outcomes which qualify for bonus payments, taking into account service providers’ degree of control over client outcomes — as well as providers’ perception of control — may help to maximize provider buy-in. Including an evaluation to help control for other factors and help isolate the causal influence of services on outcomes could achieve this end. If providers believe outcomes to be largely beyond their control, payments are less likely to incentivize efforts towards outcome achievement.

For Implementation of an Outcomes Rate Card

- IT infrastructure for reporting and collecting data was identified by as a critical component of the rate card model and one which posed a challenge for OEC in the early stages of the pilot. Developing, testing, and implementing a unified and minimally burdensome data system for all pilot sites to report outcomes prior to pilot launch may facilitate smooth implementation and decrease the time between reporting and payment.

- Training all levels of service provider staff on the provisions of a pilot initiative, including both clinical supervisors and home visitors, may attenuate the impact of workforce turnover and disparities across program sites on implementation and pilot efficacy.
The timeline of program launch, data reporting, and bonus payments has implications for both providers’ impressions of the work asked of them and the possibility for a feedback loop based on early outcomes data. Short intervals between pilot launch and first reporting period provide the opportunity for early course-correction, and a brief turnaround between reporting and bonus payment receipt may reduce the sense of additional burden on part of service providers.
1. Introduction

Pilot Overview

In early 2018, the Connecticut Office of Early Childhood (OEC) launched the year-long Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Outcomes Rate Card Pilot. With technical assistance from the nonprofit organization Social Finance, supported by a federal Social Innovation Fund grant, OEC piloted the provision of bonus payments up to 3% of total contract value to home visiting service providers for the achievement of two-generational outcomes. The state’s 22 home visiting providers funded by the federal MIECHV Program were able to receive these bonus payments for achieving positive client outcomes in 2018 – 2019 in one or more of three areas: 1) child safety, 2) caregiver employment/education3) full-term birth (for 14 of the 22 providers) or family stability (for the remaining 8 providers), depending on the populations served by different providers. A positive outcome achieved by a higher-risk family triggered a higher bonus payment.

Bonus payments, drawn from a pool of OEC’s MIECHV funds with the approval of the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) and supplemented by philanthropic funds from the Hartford Foundation, varied in value for each outcome based on the likelihood of outcome achievement and the risk status of the family. The pilot began with an enrollment eligibility period starting January 1, 2018, and OEC will continue to make payments for outcomes achieved on a quarterly basis through December 31, 2019. Additionally, while the pilot is ongoing, OEC has further implemented the rate card model for non-pilot providers of state-funded home visiting services.

In the fiscal year 2017, Connecticut MIECHV-funded home visiting programs served 1,270 households including families from pregnancy to children’s kindergarten entry. Of these households, 71% had incomes below 100% of the Federal Poverty Line, and 32% had a history of child abuse or maltreatment.¹

Scope of Report

The purpose of this report is to illuminate the process of the pilot’s development and implementation, as well as the impressions and effects on those involved in the pilot, and to share learnings and recommendations from the year-long pilot in order to guide future outcomes rate card initiatives.

Elevate, a policy lab at Yale School of Medicine dedicated to elevating mental health and disrupting poverty, agreed to conduct an evaluation of the pilot initiative. Though originally intended to provide both qualitative analysis of stakeholder perspectives and quantitative analysis of the pilot’s outcomes and payment distribution, the duration of data collection subsequent to the pilot’s conclusion, in addition to the need for further data cleaning and preparation by OEC in order to verify outcomes and distribute payment, has limited the scope of this report to qualitative evaluation. Elevate conducted semi-structured interviews with 18 individuals, including service provider staff and other key pilot stakeholders, to explore impressions of the pilot and its effects.
This report describes the findings from these interviews and key lessons to inform future outcomes initiatives.

**Elevate**
Publicly launched in May 2019, Elevate works with government partners in the U.S. to advance family mental health as a pathway to economic and social mobility, thereby helping to interrupt the cycle of intergenerational poverty. In carrying out this mission, Elevate develops innovative programs and strategies, helps governments customize and adopt them, and studies how much it helps families and taxpayers. Elevate is housed at Yale School of Medicine (YSM), bridging YSM’s Department of Psychiatry and the Yale Child Study Center. Elevate began working with OEC and other government partners prior to its public launch in May of 2019.

**Structure of the Report**
The remainder of this report is structured as follows:

- **Section 2: Outcomes-Based Contracting**
  - What Is Pay for Success?
  - What Is an Outcomes Rate Card, and How Does It Differ from Other PFS Models?

- **Section 3: The OEC Outcomes Rate Card Pilot**
  - Background and Development
  - The MIECHV Program and Service Models
  - Contract Model and Outcomes
  - Funding Sources
  - Participating Agencies

- **Section 4: Evaluation of Stakeholder Impressions and Experiences**
  - Methodology
  - Impressions of the Pilot and its Effects
  - Reflections on the Pilot Design and Development
  - Challenges with Outcomes
  - Challenges with Implementation

- **Section 5: Lessons and Considerations for Future Outcomes Rate Card Initiatives**
  - Lessons for Development of an Outcomes Rate Card
  - Lessons for Implementation of an Outcomes Rate Card
2. Outcomes-Based Contracting

What is Pay for Success?
Pay for Success (PFS) is a contracting strategy in which payment is contingent on the achievement of certain measurable outcomes. In the traditional PFS model, also called social impact bonds, private or nonprofit investors provide up-front capital for services typically funded by government. Governments agree to repay the investment only if services achieve a set of predetermined outcome metrics as determined by an independent evaluator.

Traditionally, contracts or grants to support social service delivery are based on the volume of services delivered (e.g., number of students taught in a job training program) or short-term outputs (e.g., number of people who graduated from the job training program). An outcome is a longer-term (and hopefully positive) change; for example, a job training participant who finds and keeps a job and experiences an increase in earnings.

Nonprofit Finance Fund

PFS represents a kind of performance-based contracting (PBC), an increasingly popular form of government contract with nonprofit service providers over the last four decades. However, where mainstream PBC performance metrics are service outputs—measures of service delivery activity, such as volume of clients served—PFS concentrates specifically on outcomes for the population served—measures of meaningful differences in or characteristics of a person’s life, like a full-term birth.

What Is an Outcomes Rate Card, and How Does It Differ from Other PFS Models?

An outcomes rate card is a procurement and contracting tool through which government defines a menu of outcomes it seeks to “purchase” for a given issue area and target population, and the amount it is willing to pay each time a given outcome is achieved. For example, if a local government wanted to boost employment among at-risk young adults, it would define the value of relevant outcomes such as industry certification, job placement, job retention, and earnings increases, and use a rate card to procure and pay service providers based on those outcomes and set of associated rates. Thus, outcomes rate cards standardize outcomes-based financing: the tool enables governments to launch multiple PFS projects, using a rate card to procure multiple service providers and reach more people with performance-based services.

Social Finance

As with the broader PFS model to which it belongs, the outcomes rate card was pioneered in the United Kingdom and later introduced in the U.S. In the rate card model, the government determines a set of critical outcomes for a target population and assigns an amount it will pay for each outcome achieved. The government can then contract with multiple providers, for whom payment is contingent on the achievement of each outcome and the number of individuals for
whom the outcome is achieved. The payment can be bonus in nature — that is, in addition to other “core” payment issued on another basis — or can constitute some or all of the “core” payment to the contracted providers. In the first-ever outcomes rate card project in the United Kingdom, for example, a set of outcomes reflecting improved employability among at-risk youth were valued between £700 (“Improved attitude towards school”) and £5100 (“National Vocational Qualification level 3 or equivalent”) per participant.6
3. The OEC Outcomes Rate Card Pilot

Background & Development

OEC was established in 2013 to coordinate and improve the delivery of early childhood services for Connecticut children and families; the agency’s four divisions include Early Care and Education, Licensing, Early Intervention, and Family Support Services. OEC is not the first agency in the state to launch a PFS initiative in partnership with Social Finance: the Connecticut Family Stability Pay for Success Project, launched in 2016, is an ongoing, 4.5-year initiative of the State of Connecticut, specifically the Connecticut Department of Children and Families (DCF), to scale the Yale Child Study Center-coordinated Family-Based Recovery program, with Social Finance serving as the intermediary for investment and repayment. The state will repay the investment funding on the condition of outcomes achievement, subject to a randomized control trial evaluation to be conducted by the University of Connecticut Health Center.

The two-generational OEC Outcomes Rate Card Pilot emerged as a result of the state’s two-generational interagency framework, created in 2016 with the passage of legislation establishing a two-generational school readiness and workforce pilot program (“Two-Generation Initiative”). The Two-Generation Initiative served to fund the implementation and evaluation of programming and partnerships to support both caregivers and children in low-income families. The legislative report on the initiative’s first year, authored by the Two-Generational Interagency Working Group, offered among other learnings the following lessons from the two-generational pilot:

> Accountability and indicators are based on funding requirements and not on systems or coordinated outcomes. These need to be incentivized.

> The two-generational model does not seek to create something new and costly. In truth, if the model works, it prunes unnecessary practices and braids together resources with intentional impact.

OEC’s engagement with PFS initiatives was furthered by the April 2017 appointment of David Wilkinson, who had previously served as Director of the White House Office of Social Innovation and Civic Participation — which spearheaded the incorporation of PFS into the federal government and led the charge to support state and local PFS initiatives on behalf of the Obama Administration in the United States — as OEC Commissioner.

The development of the Outcomes Rate Card Pilot was ultimately brought about in May 2017, Social Finance awarded OEC 12 months of technical assistance to create one of the first US outcomes rate card projects, with a focus on improving two-generational outcomes for young children and their families. Social Finance worked with OEC to analyze the state’s Early Childhood Information System (ECIS) and identify a set of outcomes for the pilot based on analysis of statewide data. Selection of the services for which to introduce the outcomes rate card took into consideration the target population and issue area, outcomes possibilities, funding and resources, legal and procurement authority, provider capacity, and data infrastructure. Ultimately, OEC and Social Finance identified the state’s MIECHV home visiting program as the service best suited for
the pilot initiative. In lieu of a request for proposals and subsequent award of contracts, the provisions of the outcomes rate card were built into the reauthorization of existing contracts with service providers, prepared by the CT Department of Mental Health and Addiction Services Central Contracts Unit, between OEC and 22 MIECHV home visiting providers. The first quarterly period during which outcomes would qualify for payments began on January 1, 2018, and OEC formally announced the pilot on February 1.8

The MIECHV Program and Service Models

The MIECHV Program, administered by HRSA, “supports voluntary, evidence-based home visiting for at-risk pregnant women and parents with children up to kindergarten entry.”9 In these voluntary programs, home visitors—typically nurses, social workers, and other maternal and early childhood professionals—provide a number of services, including parenting and health education, aid in navigating available resources, and screening for parent and child safety and well-being.

MIECHV currently funds 18 home-visiting program models which have met the HHS criteria for evidence of effectiveness.10 Four of these models are offered by MIECHV home visiting providers in the state of Connecticut. Table 2 below describes these models.

Table 2: MIECHV-FUNDED HOME VISITING MODELS IN CONNECTICUT

<table>
<thead>
<tr>
<th>Home Visiting Model</th>
<th>Eligibility by Child Age</th>
<th>Description</th>
<th>Number of Providers in Pilot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents as Teachers® (PAT)</td>
<td>Prenatal - kindergarten</td>
<td>One-on-one home visits, monthly group meetings, developmental screenings, and connections to resources</td>
<td>12</td>
</tr>
<tr>
<td>Early Head Start Home-Based Option (EHS)</td>
<td>Birth – age 3</td>
<td>Weekly 90-minute home visits and two group socialization activities per month for parents and their children</td>
<td>1</td>
</tr>
<tr>
<td>Nurse-Family Partnership® (NFP)</td>
<td>Prenatal (enrollment no later than 28 weeks) – age 2</td>
<td>One-on-one home visits by a trained registered professional nurse</td>
<td>1</td>
</tr>
<tr>
<td>Child First</td>
<td>Prenatal – age 5</td>
<td>A mental health/developmental clinician and care coordinator conduct joint home visits twice per week for first month, and thereafter visits occur either separately or jointly and at least weekly</td>
<td>8</td>
</tr>
</tbody>
</table>
Contract Model and Outcomes

OEC and Social Finance worked with DMHAS CCU, which oversees all OEC contracting with service providers, to build the provisions of the outcomes rate card into the reauthorization of service contracts for each of Connecticut’s 22 federally-funded MIECHV home visiting providers. The contracts built the rate card pilot as a supplement to, rather than replacement for, service typical financing, whereby providers could earn bonus payments beyond basic service funding.

Each provider could earn bonus payments for three different outcomes per client family. All providers were offered bonus payments for achieving outcomes related to (1) safe children and (2) caregiver employment/education. Additionally, the 14 providers of PAT, NFP, and EHS services could receive bonus payments for full-term births. The Child First program in Connecticut has nearly 100% post-natal enrollment, so in place of the full-term birth outcome, the Child First rate card for the remaining 8 providers included bonus payments for achieving an outcome related to family stability. Outcome definitions and eligibility requirements are given in Table 3.

Table 3: OUTCOMES PROMPTING BONUS PAYMENTS AND CLIENT ELIGIBILITY REQUIREMENTS

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Definition</th>
<th>Client Eligibility for Outcome PAT, NFP, EHS</th>
<th>Child First</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Children</td>
<td>No substantiated cases of maltreatment and no injury- or ingested-related ER visits</td>
<td>Family enrolled at least 12 months</td>
<td>Family enrolled at least 6 months</td>
</tr>
<tr>
<td>Caregiver Employment/ Education</td>
<td>Caregiver is employed or enrolled in education or training</td>
<td>Caregiver enrolled at least 12 months</td>
<td>Caregiver enrolled at least 6 months</td>
</tr>
<tr>
<td>Full-Term Birth</td>
<td>Baby is born after 37 weeks of gestation</td>
<td>Caregiver enrolled prenatally before 28th completed week of gestation</td>
<td>Not eligible</td>
</tr>
<tr>
<td>Family Stability</td>
<td>Identified family need was met in at least one of three areas: child care, health care, housing</td>
<td>Not eligible</td>
<td>Caregiver/child enrolled at least 6 months; need was identified on the Service Needs Inventory for Families (SNIFF) at program entry</td>
</tr>
</tbody>
</table>

The full-term birth outcome eligibility criterion, enrollment up to 28 weeks of gestation, was created to incentivize and promote early enrollment. OEC sought to promote early enrollment as a factor that could help to increase the opportunity for providers to influence the full-term birth outcome through connection to quality care and health education, and which also maximized the period of the client’s eligibility for service receipt following enrollment—increasing the duration of access to resources which could result in further outcome achievement.
The value of outcomes payments varied according to level of “difficulty” of achievement of that outcome for providers, a determination made based on OEC data on previous home visiting measures. Payment values were further differentiated according to the determined risk level of the client family to reflect the greater service needs of high-risk families. Risk was assessed using both the Revised Early Identification instrument (REID)—a screening tool used regularly in Connecticut home visiting services—and the Kempe Family Stress Inventory. Outcomes payments were capped at approximately 3% of total contract value (the sum of basic service payments for January 1 – December 31, 2018) per provider. Table 4 indicates the bonus payment values for each outcome.

Table 4: BONUS PAYMENT VALUES FOR OUTCOMES

<table>
<thead>
<tr>
<th>Validated Outcome (per family)</th>
<th>PAT, NFP, EHS</th>
<th>Child First</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low-Risk</td>
<td>High-Risk</td>
</tr>
<tr>
<td>Safe Children</td>
<td>$90</td>
<td>$115</td>
</tr>
<tr>
<td>Caregiver Employment</td>
<td>$180</td>
<td>$225</td>
</tr>
<tr>
<td>Full-Term Birth</td>
<td>$135</td>
<td>$170</td>
</tr>
<tr>
<td>Family Stability</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Providers of PAT and EHS services reported quarterly outcomes data through ECIS; NFP and Child First providers reported outcomes directly to the OEC through Excel spreadsheets.

**Funding Sources**

Twelve months of technical assistance from Social Finance to support OEC’s development of the pilot was funded by a grant from the Social Innovation Fund, a program of the federal Corporation for National and Community Service.

A total of up to $250,000 was available for outcomes payments. Payments drew primarily from OEC’s available MIECHV funds; the Hartford Foundation for Public Giving (“Hartford Foundation”) committed up to $34,000 for payments towards the total $250,000. MIECHV funding is administered by HRSA; for Fiscal Year 2018, Connecticut received approximately $9.8M for the MIECHV program. In November 2017, HRSA approved OEC’s use of a portion of these funds for the Outcomes Rate Card pilot. If all possible outcomes were achieved and the maximum bonus amounts paid to each provider, bonus payments would use approximately $226,000 of the state’s MIECHV funds, 2.3% of the total award to Connecticut in FY 2018.

**Participating Agencies**

The following 22 agencies and organizations provide federally-funded MIECHV services in Connecticut and participated in the Outcomes Rate Card Pilot, referenced as “providers” and “service providers” throughout this report:
• Bridgeport Hospital (Bridgeport)
• Charlotte Hungerford Hospital (Torrington)
• Child and Family Guidance Center (Fairfield)
• Child Guidance Clinic for Central Connecticut (Meriden)
• Bridgeport Public Schools (Bridgeport)
• Community Health Center (Middletown)
• East Shore District Health Department (Branford)
• EdAdvance (Torrington)
• Family and Children's Aid (Danbury)
• First Choice Health Centers (East Hartford)
• Generations Family Health Center (Willimantic)
• Hospital of Central Connecticut (New Britain)
• Intercommunity (East Hartford)
• Lower Naugatuck Valley Parent Child Resource Center (Derby)
• Madonna Place (Norwich)
• Prospect Manchester Memorial Hospital (Manchester)
• TEAM, Inc. (Derby)
• United Community and Family Services (Norwich)
• The Village for Families and Children (Hartford)
• Visiting Nurse Association of Southeastern Connecticut (Waterford)
• Wheeler Clinic (Plainville)
4. Evaluation of Stakeholder Impressions and Experiences

Methodology
Elevate conducted interviews with service provider staff and other key pilot stakeholders in December 2018 and January 2019. OEC provided Elevate with names and contact information for potential eligible respondents at all service provider sites. Of the pilot’s 22 service provider sites, 6 were randomly selected by Elevate for interviews with home visitors (6 respondents), and a further 6 were randomly selected by Elevate for interviews with clinical supervisors (4 respondents). An additional 10 key stakeholders were identified by OEC for interviews (8 respondents), making for a total of 22 contacts leading to 18 respondents (81.82% response).

Semi-structured telephone interviews were conducted by a member of the Center’s research team. Sixty (60) minutes were allotted for each interview, which consisted of 8 open-ended questions concerning stakeholders’ experiences with and views on the pilot’s effects and lessons learned. Interview duration ranged from 18 to 43 minutes, with an average of 31 minutes ($SD = 8.04$). No audio recording or verbatim transcription was used. Thematic analysis was conducted manually from interview notes by the interviewer.

Beyond service providers, the additional 8 responding stakeholders included the following individuals:

- OEC Home Visiting Data Manager
- Two Directors at Social Finance
- Two Contract Managers at DHMAS Central Contracts Unit (CCU)
- Director of Early Childhood Investments at Hartford Foundation
- Executive Director of the Connecticut Early Childhood Alliance
- HRSA Project Officer

Impressions or Experiences of the Pilot and its Effects
Overall perception of the pilot was largely positive across interviews but markedly different between 1) service providers and 2) other key stakeholders. Public and private sector stakeholders outside of direct service provision shared a common vision of the model as an innovative paradigm shift for human services contracting which they hope will lead to improved outcomes for families. Those outside of OEC commended the agency as impressively, if unexpectedly, pioneering.

“State government is not known for innovation. It’s so easy for state governments to do things the way we’ve always done them, just because it’s the way we’ve always done them.”
— Executive Director, Early Childhood Alliance
Service provider interviewees, on the other hand, had a less clear understanding of the reasoning behind the pilot. Many were surprised by the pilot, particularly because they saw the bonus payments as acknowledgement for simply doing their jobs—not as incentives for improvement of their families’ outcomes, but as recognition of the work of home visitors. Others believed the incentives to be aimed at increased workforce retention in home visiting or simply expressed a desire to know more about the motivations for the pilot. Few service providers were familiar with the PFS concept or had heard of Social Finance.

Where other stakeholders saw the rate card as a significant departure from convention, service providers perceived minimal or no change to their day-to-day operations or approach. Many acknowledged that the implementation of the pilot focused their attention on these specific goals but that these aims have always been part of their work:

“It’s made us more aware of concentrating on goals and outcomes for our clients. We’re paying more attention to making sure we’re successful. The outcomes are very similar to goals we had anyway—full term birth and prenatal care are big for us, as well as employment and education.”
— Home Visitor, TEAM, Inc.

“These outcomes are ones we’d be looking for anyway. Because we’re reporting quarterly, it probably has made my team more homed in on these specific things. It put a spotlight on the care coordination piece of the program.”
— Clinical Supervisor, United Community and Family Services

Some service providers described the bonus payments as fostering a sense of motivation towards extra effort or even promoting a climate of friendly competition among staff. Those who reported specific changes to their work mentioned engaging in new or more frequent brainstorming sessions focused on resources and strategies to help families achieve the pilot outcomes, as well as posing more questions to families about their goals and barriers to them.

Across the board, stakeholders were optimistic about the future of the outcomes rate card. Service providers felt that the pilot signaled recognition of the value of home visiting and offered a financial opportunity that could benefit their work, and stakeholders in both the public and private sector viewed the pilot as an innovative but low-risk initiative to effect positive change for Connecticut families.

Reflections on Pilot Design and Development

Stakeholders involved in the early stages of designing and developing the pilot—including interviewees from Social Finance, OEC, and the Connecticut Department of Mental Health and Addiction Services’ Central Contracting Unit (DMHAS CCU) -- generally described the process as efficient, collaborative, and innovative.

Interviewees from DMHAS CCU had been unfamiliar with the rate card model prior to the pilot’s development and suggested that they would have benefited from a clearer introduction to the concept from the outset of their involvement and described the restricted time frame for contracting
as a challenge. Additionally, both found surprising the degree to which Social Finance, rather than OEC, led the process; remarks from an OEC interviewee, expressing appreciation for the breadth of Social Finance’s assistance and expertise, similarly suggested that the nonprofit was heavily involved in leading these early stages of the pilot’s development. Still, both CCU interviewees believed the process to be successful and held a positive view of the pilot. For Social Finance, embedding the outcomes-based contract within the reauthorization of an existing contract—rather than drawing up new contracts with providers subsequent to a government request for proposal—represented a novel approach to developing a outcomes rate card model that would be implemented at several provider sites within this pilot. Interviewees from the organization saw this contract integration as an efficient and atypically smooth approach to the implementation of a multi-site pilot.

A number of stakeholders outside of direct service providers suggested that the providers should have been involved earlier in the pilot process. Interviewees from DMHAS CCU believed that contributions from providers should help shape the contract language and design, as did an interviewee from the Hartford Foundation, who suggested that engagement of service providers may shape whether they ultimately experience a rate card model as form of innovation that furthers their goals or as a burden which punishes “insufficient” work. Service providers shared similar views and advocated for a better understanding of their experiences on the part of government leaders.

“People in charge of making change don’t have a realistic view of what’s going on. Spend more time in the trenches. Spend a day in the shoes of the workers.”
— Home Visitor, TEAM, Inc.

Service providers also spoke to the value of a system for recording outcomes data which minimized the burden of reporting, an area of the pilot where they saw a need for improvement. Providers’ experiences with data reporting varied: OEC finalized and continued to refine a data system it developed for some of the provider models as the pilot began, while providers of Child First and NFP home visiting continued to track outcomes in databases used exclusively by their models’ national organizations, to be reported subsequently to OEC. Stakeholders from both OEC and Social Finance also identified these challenges, noting the technological demands of the rate card model and expressing hopes for a unified data system in the future.

Challenges with Outcomes

Describing limitations of the outcomes rate card model, a data manager at OEC noted that outcomes-based contracts run into the problem of “paying service providers for outcomes over which they don’t have 100% control,” a challenge mentioned explicitly by many service provider interviewees. Nearly all interviewees whose programs were eligible for the full-term birth outcome believed full-term birth to be largely beyond their control, such that achievement of the outcome was often a matter of chance and external factors rather than a reflection of home visitors’ effort or quality of care.
“Depending on when you get a young lady in her pregnancy [enrolled], if it’s not early on, it’s harder. The closer to 28 weeks they are, the less change we can make.”
— Home Visitor, City of Bridgeport

“We had a pregnant mom who was very high risk but had a baby full term; a low-risk mom who had a baby born early last week… you wonder if there’s something else you could have done.”
— Clinical Supervisor, EdAdvance

Several home visitors described feeling “penalized” for failing to achieve—and thus not receiving payment for—outcomes that were perceived to be beyond their control. This feeling was expressed even though the nature of the pilot was such that outcomes payments were received as bonuses.

Others perceived logistical challenges related to the eligibility criteria for bonus payments for full-term births meant to incentivize early enrollment, which required that a participant in home visiting must enroll no later than 28 weeks into pregnancy to qualify for the group where full-term births could trigger bonus payments. A home visitor from East Shore District Health Department, a Parents as Teachers (PAT) program, reported that limitations on the number of clients might mean the program would have no capacity to enroll eligible prenatal caregivers for the duration of the pilot. The home visitor suggested that the program does not have direct control over recruitment but rather accepts participant referrals from a medical center—rendering the pilot’s strategy to motivate early enrollment inapplicable for this site; while some sites accept referrals as a primary source of participants, all sites are still able to recruit outside of the referred participant pool. In contrast, a clinical supervisor from EdAdvance, also a PAT program, reported that her team has taken concrete action to recruit participants earlier in pregnancy with efforts including careful screening for enrollment and redirection of ineligible would-be participants to other programs. The supervisor expressed concern about these consequences of the eligibility requirements.

“I don’t want a situation where we decide not to enroll someone who would benefit because they’re past 30 weeks or not working, and not as likely to succeed on these outcomes, but most in need of our program.”
— Clinical Supervisor, EdAdvance

Some providers also noted specific concerns related to the definition of education and employment outcomes, citing that some of populations they serve were ineligible or excluded by the outcome criteria. Several interviewees referred to the significant number of undocumented parents their programs serve. Immigration status may be a barrier to education and employment for participants, one over which home visitors have no control; undocumented participants who work as unreported employees cannot be recorded as achieving the pilot’s employment outcomes. Additionally, several interviewees also expressed frustration with the education and employment outcome’s failure to recognize as work the unpaid labor of mothers who stay at home to care for their children. Many expressed a desire for additional metrics for bonus payments but tended to suggest outputs, rather
than outcomes, as they believed these outputs better reflected the efforts of home visitors. Despite limitations in outcome measurement, however, the majority of providers expressed that outcomes chosen for the pilot were well aligned with the core work and aims of home visiting.

Challenges with Implementation

While most service provider interviewees described the data reporting required by the pilot to create some degree of additional work, perceptions of the burden of this reporting varied widely across pilot sites. Those who saw the additional reporting as a minimal burden often described a pre-existing structure or schedule for data entry, such as days each month set aside for reporting. Interviewees who felt more frustrated by additional reporting tended to associate the burden of data reporting with the scheduled delay in bonus payments, and the resulting sentiment among staff that they were performing more work without seeing any reward. Stakeholders from Social Finance and DMHAS CCU pointed to the delay between pilot launch, data reporting, and payment as an obstacle to providing a feedback loop for providers or course correction based on early findings.

Notably, knowledge of the pilot’s requirements, familiarity with the rate card model, and understanding of the conditions for use of bonus payments also varied widely across home visitors at different sites, despite the resources and training provided to clinical supervisors. Some home visitors voiced detailed understanding of the criteria for achieving each outcome, while others expressed a lack of familiarity. One home visitor asked in the interview whether a pregnant participant’s attendance of all prenatal doctor’s appointments would count for a full-term birth outcome, even if the birth was pre-term (the pilot does not allow this); another said she would have liked for OEC to have distributed an explicit outline of the outcomes and criteria for achieving them, though materials including such an outline were in fact distributed to each site. Several home visitors commented on the ambiguity surrounding how bonus payments could and would be used by their sites, whether payments would support the home visiting programs or the sites’ other activities, and whether home visitors would personally receive bonus income from the payments.
5. Lessons and Considerations for Future Outcomes Rate Card Initiatives

For Development of an Outcomes Rate Card

- Involving service providers in the development of an outcomes rate card from an early stage affords them an opportunity to speak to the needs of the families they serve and their own capacity for implementation, which may be valuable to the government agency in setting the parameters of the outcomes rate card.

- Contract specialists responsible for the legal framework of an outcomes rate card may not be familiar with the model before pilot design and would benefit from a clear and thorough introduction to the concept early on in the pilot design.

- Building an outcomes rate card into the reauthorization of existing contracts presents a uniquely efficient approach to enacting the model across multiple provider sites, circumventing the request for proposal process and potentially expediting contract execution.

- Diverse models of client recruitment or referral pathways often exist among providers of the same services. For outcomes payers looking to incentivize changes to participant or client recruitment (such as earlier enrollment), the model of client recruitment or referral may be a key consideration in the selection of service providers best suited for the rate card.

- When choosing the outcomes which qualify for bonus payments, taking into account service providers’ degree of control over client outcomes — as well as providers’ perception of control — may help to maximize provider buy-in. Including an evaluation to help control for other factors and help isolate the causal influence of services on outcomes could achieve this end. If providers believe outcomes to be largely beyond their control, payments are less likely to incentivize efforts towards outcome achievement.

For Implementation of an Outcomes Rate Card

- IT infrastructure for reporting and collecting data was identified by as a critical component of the rate card model and one which posed a challenge for OEC in the early stages of the pilot. Developing, testing, and implementing a unified and minimally burdensome data system for all pilot sites to report outcomes prior to pilot launch may facilitate smooth implementation and decrease the time between reporting and payment.

- Training all levels of service provider staff — including clinical supervisors, home visitors, and administrators — on the rationale and provisions of a pilot initiative may attenuate the impact of workforce turnover and disparities across program sites on implementation and pilot efficacy, as well as generate buy-in and improved understanding that may increase job satisfaction and performance.

- The timeline of program launch, data reporting, and bonus payments has implications for both providers’ impressions of the work asked of them and the possibility for a feedback loop based on early outcomes data. Short intervals between pilot launch and first reporting
period provide the opportunity for early course-correction, and a brief turnaround between reporting and bonus payment receipt may reduce the sense of additional burden on part of service providers.
References


