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SCHOOL OF SOCIAL WORK

EXTERNAL ENVIRONMENTAL FORCES AND ORGANIZATIONAL BEHAVIOR:

A STUDY OF MANAGED CARE AND CHILD WELFARE ORGANIZATIONS.

By

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This dissertation is dedicated to the children and youth that reside in residential child caring facilities and the administrators whose task is to meet their basic and therapeutic needs. It is my sincere hope that we continue to seek understanding of the forces that affect service delivery—in the spirit of improvement.

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## ABSTRACT

This study addressed the impact of the external environmental context of individual organizations on their internal structures and service configurations, as they attempted to adapt to a changing political economy, via an examination of a portion of the Georgia child welfare system's response to the introduction of the principles of managed care. Based, in part, on Hasenfeld's (1992) notion that institutional and political economy perspectives are the most important theoretical approaches to understanding external influence on the service delivery systems of human services organizations, the current study presents conceptual and analytical models, which also includes network theory. In 1995, members of the Georgia Association of Homes and Services for Children (GAHSC) began sculpting a strategy for addressing managed care approaches to child welfare service delivery and funding in their state. This phenomenon provided an excellent context for studying the external environmental factors associated with the adoption or rejection of a controversial new methodology.

A survey instrument, based on Dillman's (1978; 1991) Total Design Method, was developed and administered to assess Chief Executive Officers' and Managers' perceptions of the influence of external, political and economic, institutional, and network influences on their organizations' decisions to adopt managed care principles. The sampling frame included all residential child caring agencies licensed by Georgia's Department of Human Resources' Office of Regulatory Services (N=114). The final

response rate for the survey was 33% (n = 37). Survey items were grouped according to theoretical constructs (i.e., perceived political and economic pressure, perceived institutional pressure, perceived network pressure, and perceived adoption of managed care principles) via the creation of index scores based on responses to the survey items. Regression analyses on the index scores for these four variables provided limited support for political economy theory and network theory as significant predictors for the adoption of managed care principles.

Limitations in the design and implementation of this study are discussed to inform the applicability of these findings to human service organizations. Possible implications are also presented for human services organizations, social work practice, and future research in this area.

# CHAPTER 1

## INTRODUCTION

### Statement of the Problem

What is the impact of the external environmental context of individual organizations on their internal structures and service configurations as they attempt to adapt to a changing political economy? This study attempts to address the aforementioned research problem via an examination of a portion of the Georgia child welfare system's response to the introduction of the principles of managed care into its political economy. Chapter 1 of this dissertation provides a contextual description of the historical, contemporary, and future significance of the research problem relevant to social work practice and child welfare. Chapter 2 provides the conceptual, theoretical, and analytical frameworks used to approach the research problem, and presents the research questions and axioms that guided the research. Chapter 3 presents a description of the methodology used to address the research problem. The analytic techniques used to examine the data collected and results of those analyses are presented in Chapter 4. Chapter 5 concludes the dissertation with discussion and conclusions regarding the findings of the study.

## Significance of the Problem

“Managed Care,” it seems, is a term that may elicit a myriad of responses, both spoken and unspoken, among those individuals involved in both the child welfare arena and social work. Among consumers, managed care may cause concern regarding the availability and quality of services. Among service providers, it may evoke concerns about the availability of resources needed to conduct effective treatment. Among policy makers and administrators, managed care may elicit hope for the efficient use of a limited amount of resources aimed at ameliorating many health and welfare social problems. While some may believe that managed care is something that should summon concern, if not outright fear, it is yet to be determined whether the overarching goals of managed care are consistent with social work values and beliefs. Wernet (1999) stated it this way:

Managed care in human services has been described by some people as a tidal surge—catastrophically wiping out everything in its path; some describe it as a sand dune—constantly shifting as it moves forward to claim productive land; others describe it as a phoenix—rising out of the ashes of a devastated system. Rather, managed care in human services is the most recent in a long history of systemic reforms designed to serve the common good with constrained resources.  
(p. 223)

Child welfare organizations are faced with increasing pressure for results in the care and protection of children. Managed care represents the newest effort at overhauling the service delivery, managerial, and administrative components of a system that is badly in need of reform (Courtney, 2000; Embry, Buddenhagen, & Bolles, 2000; Wulczyn, 2000).

The remainder of this chapter will develop a description of the institutional contexts of both child welfare and managed care, as well as outline their importance to social work.

### **The Institutional Context of Child Welfare**

Child welfare is a broad topic that may summon forth a wide range of conceptions, depending on the experiences of the reader. For example, a single mother who is undergoing a child protective services investigation may have a very different perception of child welfare than the administrator of a residential childcare facility. The single mother may view the system as a cruel and interfering entity that threatens her family, while the administrator of a residential child care facility may view the system as trying to accomplish the best interests of all those involved with a limited amount of resources. Therefore, it is necessary to provide a conceptual definition of child welfare and child welfare organizations in order to narrow the discussion. However, a sufficiently wide survey of the domain of child welfare is needed to understand the scope and interrelations of its internal parts. Liederman's (1995) definition of formal child welfare will be utilized as a beginning point for the discussion as it is sanctioned by the National Association of Social Workers (NASW) and appears in the *Encyclopedia of Social Work*. Liederman stated,

Government has organized a formal service delivery system known as child welfare, which is sanctioned by the community and designed to assist children who have been abused or neglected or who are at risk and their families. The government and voluntary agencies that constitute the formal child welfare system are a part of community efforts designed to

- I. protect and promote the well-being of all children

- II. support families and seek to prevent problems that may result in neglect, abuse, and exploitation
  - III. promote family stability by assessing and building on family strengths while addressing needs
  - IV. support the full array of out-of-home care services for children who require them
  - V. take responsibility for addressing social conditions that negatively affect children and families, such as inadequate housing, poverty, chemical dependence, and lack of access to health care
  - VI. support the strengths of families whenever possible
  - VII. intervene when necessary to ensure the safety and well-being of children.
- (p. 424)

Child welfare then is the system of community-sanctioned efforts, which seek to protect children, promote and support family stability and strengths, provide interventions and/or out-of-home care where necessary to ensure the well-being of children.

The following section discusses the growth and development of child welfare services and their related policies. Liederman's (1995) definition noted that formal child welfare has developed from government and community efforts to meet children's needs. Current definitions and conceptualizations that are accepted by child welfare organizations have evolved as a result of the history of those governmental and community efforts. Therefore, a brief overview of the historical development of child welfare services is presented, followed by a discussion of the contemporary context of child welfare services.

**History of Child Welfare Services.** The historical context of child welfare developed here is primarily adapted from the work of Costin (1985), who presented a sufficiently concise overview of historical child welfare development in the United States from a social work point of view. Costin asserted,

Social work's concern for the welfare of children and the development of social services for them and their families reflect a long and often slow evolution of ideas and practices. Each professional generation begins its work with a legacy from the history of child welfare, a legacy rich in commitment to the poor, disadvantaged, and unlucky children of society, and abundant in strategies to advance social justice. That same history reflects controversy, contest, and some decisions that, over time, proved detrimental to children and their families and to the social work profession as well. (1985, p. 34)

Costin developed her summary of the historical development of Child Welfare around four "critical periods" (1985, p. 34) of organized efforts at reform on the behalf of children: the child saving movement, the child rescue movement, the child labor movement, and the century of the child. Each of these movements provides a historical context for the current trends toward a managed care movement within child welfare.

The child-saving movement began in the colonial period of U.S. history and had its roots in the Elizabethan Poor Laws, which were imported from England (Axinn & Levin, 1997; Costin, 1985). The poor law mentality entailed views of "worthy" versus "unworthy" poor based on an ability to work. Those who were deemed "unworthy" were seen as sinners who were slothful or being punished by God and their children needed to

be “saved” before they developed the same characteristics as their parents. According to Costin (1985),

In the early years of this country as an addition to help extended by neighbors to each other, the colonists continued to employ the English poor law system under which individuals who could not maintain themselves or their children were considered to be the responsibility of the township. (p. 35)

The legal basis of intervention on behalf of children in cases where parents were considered poor developed from the doctrine of *parens patriae*. *Parens patriae* was based on the right of the King of England to assume responsibility of children’s estates within his realm. Colonial America extended the notion of *parens patriae* to justify “intervention into the parent-child relationship in an attempt to enforce parental duty or supply substitute care” (Costin, 1985, p. 36).

Services or interventions were rendered to children who had no parents or whose parents were poor through various means including public outdoor relief, almshouses, indenture, institutions, and foster homes. Public outdoor relief was rendered in the child’s home by local poor law authorities. It was the major form of relief of the time and helped to preserve families; however, it often stigmatized recipients because of the punitive nature of the assistance and because of prevailing attitudes about the evils of pauperism. Almshouses were unsavory alternatives where children were sometimes admitted to live in poor conditions with mentally ill, criminals, the aged, and the ill. The preferred forms of assistance were indentures or apprenticeships, which removed the responsibility from the community and provided career training. Institutions (e.g., orphanages, reform schools) also developed during the Child Saving Movement and provided children with

an education and place to stay but often required termination of parental rights and often involved poor living conditions. The foster home movement began in 1853 with a minister named Charles Loring Brace in New York City who sent immigrant children from the cities to western farms. These foster homes were mainly a way of providing cheap farm labor, removing unwanted immigrant children from the cities, and placing children (who were most often Catholic) in Protestant homes (Costin, 1985). Thus, child saving via foster care became a central concept with regard to children's welfare in the United States.

The next critical period in Child Welfare was the Child Rescue Movement, which developed during the 19<sup>th</sup> and early 20<sup>th</sup> centuries. Costin (1985) stated,

In contrast to the religious motives and charity impulses of the child-saving movement, persons active in child rescue relied more upon legal concepts and efforts to advance the rights of children through the application of the law. Like the child-saving movement, however, child rescue was characterized by social distance from its client group and a considerable degree of coercive reform. (pp. 40-41)

The political and legal climate regarding maltreatment and neglect of children, preceding the Child Rescue Movement, gave great latitude to parents in the discipline and care of their children even to the point of death in some extreme cases (Bremner, 1970; Costin, 1985). Yet, during the late 19<sup>th</sup> century increasing attention was paid to cruelty toward children, as evidenced by the creation of the first Society for the Prevention of Cruelty to Children (SPCC) in 1874 (Axinn & Levin, 1997; Costin, 1985). Societies for the care and protection of animals had been established in the U.S. prior to the first SPCC;

however, once the first SPCC was established in New York, their popularity and number increased dramatically (Costin, 1985).

By the year 1900 there were more than 250 societies in the U. S., which had the prevention of child abuse and neglect as their primary focus (Costin, 1985). The growth of these societies gave rise to differentiation in the motives, methods, and means for provision of child protective services. Although most early SPCCs viewed themselves as morally correct in their coercive actions to reform the poor, lazy, abusive parents of children, the recipient families (often poor immigrants) viewed the protectionists as monsters who would come and tear families apart (Costin). Schisms among SPCCs arose shortly after the turn of the 20<sup>th</sup> century, when according to Costin, “Contests for influence among the SPCCs divided along the lines of the nature of prevention, the proper forms of responding to abuse and neglect, the Societies’ relations to other charitable organizations and to the developing profession of social work” (p. 45). For example, the Massachusetts SPCC developed a philosophy of parental reform with the goal of returning children to their homes (Costin). This reformation philosophy was adopted by other SPCCs but the majority remained with the protectionists’ philosophy which consisted of “. . . investigating reports of serious neglect and cruelty to children, filing complaints against the ‘cruelists,’ and aiding the court in prosecuting them” (Costin, p. 44). Costin highlighted the role of social work in the growing schism of SPCC philosophy when she wrote,

In response to adverse sentiment, Gerry [original founder of the New York SPCC] reiterated the exclusive nature of child rescue work and resisted any kind of collaboration with charitable agencies. He was adamant about any intrusion from

the new social work philosophy and Mary Richmond's principles of social casework. (p. 46)

The era of the SPCCs was all but over with the development of the Child Welfare League of America, which was established in 1921 and had the former head of the Massachusetts society (Carstens) as its first executive (Costin, 1985).

The third critical period in Child Welfare development was the Child Labor Movement, which roughly covered the period from the 1880s to the 1930s in the United States. Prior to the 1880s, the U. S. economy was dependent on as many people as possible contributing to the labor force (especially in agriculture) to meet the country's needs, and this included children (Axinn & Levin, 1997; Costin, 1985). With the rise of industrialization in this nation, children began to move out of the family business (often the family farm) and into manufacturing businesses such as the textile industry because “. . . the prevailing belief was that parents and industry had a right to the profitable fruits of children's labor” (Costin, 1985, p. 49). Costin noted that legislative reform efforts had to be waged on two fronts: child labor and mandatory school legislation, the logic being that children would be better off working than in the streets in the absence of mandatory school attendance requirements. Parents were often against reform because their children's wages supplemented their low wages and employers often opposed reform because child labor could not be unionized and drove adult wages down (Costin, 1985).

There was very little protection for children from labor exploitation prior to the American Civil War, as evidenced by the fact that only a few states passed any child labor legislation and the policies that were passed were often not enforced (Costin, 1985). Efforts at reform progressed however, and by the beginning of the 20<sup>th</sup> century state

legislation seemed to be addressing the problem with age and hour restrictions in word if not in deeds (i.e., legislation was passed in most progressive states but enforcement was resisted by competing employers [Costin]). It took ten years for the first federal child labor law to be enacted, which limited the interstate sale of products that used child labor. Child labor reformists supported an amendment to the Constitution in 1924, which would authorize Congress to enact child labor legislation; it was not ratified by the states. It was not until the late 1930s that child labor reform made any significant progress. Costin (1985) noted, "When the time came that it met the interests of industry and labor, and when citizens in general had been convinced of the atrocities committed upon children by exploitive labor conditions, children and young people were given protection in New Deal reform legislation as part of the Fair Labor Standards Act of 1938" (p. 52). Costin recognized that often, issues surrounding the exploitation of child labor in the U. S. were defined by economic concerns.

The latest critical period for child welfare development, according to Costin (1985), began early in the 20<sup>th</sup> century and was heralded as "the Century of the Child". The Century of the Child brought many accomplishments and advancements to the child welfare field. One of the major accomplishments was the development of the Juvenile Court. It was first created in Illinois in 1899 largely due to the efforts of Julia Lathrop and other pioneering social workers associated with Jane Addams and Hull House. The purpose of the Juvenile Court was to protect children from the severity and punishing nature of the adult justice system and included an ideology of rehabilitation and individualized justice. Although the Juvenile Court and subsequent system enhancements

over the last 100 years have been important steps in achieving social justice for children, we seem to remain far from that ideal.

Another important development was the initiation of the White House Conferences on Children. President Theodore Roosevelt started these decennial conferences in 1909. Costin (1985) argued that the first conference probably yielded the most impact on public policy for children because many of its recommendations led to the development of a federal children's bureau, the Child Welfare League of America, regulation of child-care facilities, and a move from congregate living to cottage living in child-caring agencies. Subsequent conferences yielded important ideas and directions for the child welfare movement but none as pivotal as the first. The conferences received increasing scrutiny about their necessity as they grew larger and more expensive each decade. Costin's critique of the White House conferences suggests that while having significant impact on the direction and scope of child welfare in the United States, they have not achieved their potential for directing the path of child welfare.

The mother's pension movement also developed early during this century. Mothers' pensions were developed to assist single mothers and their children in an attempt to preserve their home (Costin, 1985). Costin noted,

Nevertheless support for the concept of public responsibility for dependent children from their own homes for the sole reason of poverty resulted in the 1911 enactment, in Illinois, of the first statewide mothers' pension law. Ten years after the Illinois act, forty states had enacted such legislation. (p. 56)

The Century of the Child ended with the turn of the new millennium. What have we learned over the past century? Lindsey (1994) provided an excellent review of the

research literature in the area of child welfare, ranging from the first effectiveness studies of Charles Loring Brace's foster care movement to research on family preservation services. Lindsey's most salient point is that we have not overcome the challenges posed by poverty.

**Current child welfare issues and trends.** The National Committee to Prevent Child Abuse estimated in 1996 that there were 3,126,000 children reported as abused or neglected – an increase of 45% from 1987 (NCPCA, 1997). It was also estimated that the rate of child fatalities due to abuse and neglect increased 25% from 1985 to 1996 (NCPCA). While the causes of these dramatic increases are arguable, child abuse continues its rate of increase despite current efforts. This increase should inspire child welfare advocates from all disciplines to question efforts aimed at ameliorating current social problems of children. The problem is exacerbated by current trends, such as decreased funding in all human services, devolution by the federal government, and increased competition among service providers (Besharov, 1994; Edwards, Cooke, & Reid, 1996; Videka-Sherman & Viggiani, 1996). Children are disproportionately affected by these trends because policy revisions are aimed at the poor and children make up a majority of the poor population (Videka-Sherman & Viggiani, 1996). For example, it has been estimated that approximately one in five children in the United States is affected by poverty (Lamison-White, 1997). The Center on Budget and Policy Priorities (1996) estimated that two out of every three people that would be affected by welfare reform would be children. It has also been noted that, when compared with children with higher financial resources, children living in poor families tend to have higher risks of problems such as depression (Dornfield & Kruttschnit, 1992), lower initiative and sociability

(Hanson, McLanahan, & Thomson, 1997), and problems with peer relations and classroom behavior (Patterson, Kupersmidt, & Vaden, 1990).

The current atmosphere in the child welfare field seems to be -- do more with less and be able to prove to funding sources that it was worth the effort. The traditional responses of child welfare professionals to problems facing children and their families seem to have been to jump on the bandwagon of the most popular interventive fad.

According to Maluccio and Whittaker (1997),

. . . the preferred solution or alternative has been determined by prevailing values and biases more than validated theories and empirically-based knowledge. The history of child welfare suggests a persistent pattern of uncritical adoption of -- and perhaps, overly high expectations for -- one response or another to the needs and problems of vulnerable children and their families” (pp. 5-6).

Furthermore, Karger and Stoesz (1997) stated, “In the 1990s, data on child abuse, neglect and child homicide dispels the myth that the current approach to child welfare is a solution for child abuse and neglect” (p. 119-120). Similarly, Rycraft (1999) asserted, “Unquestionably, the current child welfare system is in crisis, unable to fully meet service demands, societal expectations, and its mandates of child protection and family preservation” (p. 28).

The preceding discussion points to the importance of critical evaluation of the current child welfare system. Human services organizations involved in child welfare are prime targets for evaluation and possible change. Various organizations, from adoption agencies to child advocacy organizations, determine the nature of the services that are delivered to consumers. Those organizations are faced with the daunting expectations of

a political economy that demands ever-increasing effective results with ever-decreasing resources. The pressures of a failing system, coupled with the demands for effective results with fewer resources may exacerbate tendencies to adopt policies and practices based on less than conclusive evidence of effectiveness. Therefore, the importance of human service organizations to Child Welfare must not be overlooked. This dissertation will now discuss one of the latest phenomena to impact child welfare—Managed Care.

### **The Institutional Context of Managed Care**

Managed care may be considered the latest systemic fad to be adopted by some parts of the child welfare field. Managed care assumes the promise of increased effectiveness of treatment with a minimal input of resources. However, many have raised serious concerns about its ability to accomplish either effectiveness or efficiency within the field of child welfare (Embry, Buddenhagen, & Bolles, 2000; Heflinger & Northrup, 2000; Mordock, 1999; Rycraft, 1999; Wulczyn, 2000). The following discussion will begin with a general overview of managed care as a system and proceed to its application to the field of child welfare. The discussion will also present critical issues and possible impairments to the implementation of managed care within the child welfare system.

**Overview of managed care.** Managed care was conceived out of the private medical industry's desire to contain health care costs (Broskowski, 1991; Finkelstein & Frissel, 1990; Root, 1991; Wernet, 1999). Wernet (1999) asserted, "Managed care has two overarching goals. They are to control costs while maintaining the quality of services" (p. 1). Yet, many professionals see these two goals as competing or even as being diametrically opposed to one another (Sederer & Bennett, 1996; Sederer & St. Clair, 1990; Webb, 1987; Wernet, 1999). The vehicle (i.e., managed care system) for

achieving these overarching goals consists of three basic levels (Wernet, 1999). The levels include policy making, system design and implementation, and the service provider network.

The policy making level is responsible for establishing guidelines intended to achieve cost containment and high quality services. The system design and implementation level involves developing the service system, establishing protocols for treatment, implementing and maintaining gatekeeping mechanisms, and implementing and maintaining utilization reviews and quality assurance processes. The service provider network level is responsible for selecting and maintaining qualified providers within the network. According to Wernet (1999), “When implemented, a managed care system has five essential elements. These include capitation and performance contracting, deflection from substitute care, preauthorization, utilization review, and case management of higher-volume users” (p. 7).

Capitation and performance contracting are the first essential elements of a managed care system (Broskowski, 1991; Christianson & Gray, 1994; Cole, Reed, Babigian, Brown, & Fray, 1994; Frank, McGuire, & Newhouse, 1995; Freeborn & Pope, 1994; Schinnar, Rothbard, & Hadley, 1989; Wernet, 1999). Capitation refers to a formula-based rate of payment, established primarily from historic usage, for the services that are to be rendered (Wernet, 1999). Performance contracting involves reimbursement that is predicated on the impact on consumers of the services that are provided. Both capitation and performance contracting involve risk assumption on the part of the service provider (i.e., providers are paid a set amount regardless of the costs involved). For example, under managed care if a child is placed in a system of care, that system is paid a

single agreed upon amount for the care and/or treatment of the child until the goals of the treatment or care are met regardless of the cost to the system. If the cost to the system is less than the contracted amount the system is allowed to keep the surplus and if the cost is more, the system has to absorb the additional costs.

The second essential element is deflection from substitute care (Abbott, Jordan, & Murtaza, 1995; Dorwart & Schlesinger, 1988; Mechanic, Schlesinger, & McAlpine, 1995; Wernet, 1999). According to Wernet (1999), “Deflection from substitute care is the operationalization of the concept of substitutability. Substitutability is built on three different ideas: comparability of services, least restrictive environment, and cost efficiency” (p. 9). Comparability of services suggests that there are some services that can be used in the place of others more efficiently with similar results (e.g., the use of family preservation services in child welfare instead of out-of-home placements). Least restrictive environment suggests that a consumer should receive treatment in a setting that is as close as possible to a natural environment. Cost efficiency dictates that consumers use the least expensive method of treatment available that will elicit the desired outcome goals.

Preauthorization is the third essential element of a managed care system (Broskowski, 1991; Hoge, Davidson, Griffith, Sledge, & Howenstine, 1994; Winegar, 1993; Wernet, 1999). Preauthorization (i.e., precertification or gatekeeping) has two goals: 1) to ensure that a consumer is linked with the appropriate services given her/his presenting problem(s); and 2) cost containment via limiting access to costly services and substituting less costly services with less expensive ones where outcomes are similar or at least acceptable (Wernet, 1999). Medical/clinical necessity and clinical

appropriateness are presumably considered when performing gatekeeping functions. Medical/clinical necessity dictates that the least expensive of a variety of techniques be used, while clinical appropriateness calls for the best treatment for a consumer regardless of its costs. This is a potential point of contention between managed care administrators and providers.

The fourth essential element is utilization review (Allen, 1993; Hoge, et al., 1994; Mechanic, et al., 1995; Sederer & St. Clair, 1990; Wernet, 1999). According to Wernet (1999), utilization review “. . . is the process by which treatment effectiveness and service outcome is assessed by the managed care system. It is concerned with the efficacy of treatment and treatment protocol” (p. 11). The final element of a managed care system is case management of high volume users (Goldstein, Bassuk, Holland, & Zimmer, 1988; Sederer & Bennett, 1996; Wernet, 1999). This refers to the evaluation of systems that have consumers who utilize a high amount of goods and services (beyond reasonable and customary amounts), in an attempt to move those clients out of the treatment system by offering combinations of services and resources.

Managed care, in summary, generally has five elements that address its two overarching goals of cost containment and quality service utilization. Capitation and performance contracting provide formula-based approaches for spreading both costs and risks based on historical data and actual performance. Deflection from substitute care calls for the use of alternative treatments where appropriate to control costs and service utilization. Preauthorization functions as a gatekeeping device to ensure that consumers are matched with appropriate services and/or treatments. Utilization reviews control costs by keeping track of the effectiveness of services and service configurations. Finally, case

management of high volume users seeks to ensure appropriate service utilization by consumers to reduce costs.

What are the implications of managed care for the fields of child welfare and social work? Do the goals, values, and objectives of managed care align with those in the child welfare and social work fields? Do special considerations exist within child welfare that precludes the use of managed care techniques and tactics? What is the role of social work with regards to the implementation of managed care principles? The following sections further highlight some of the current debate and concerns between both the child welfare and social work realms—beginning with child welfare.

**Managed care and child welfare.** Rycraft (1999) noted,

Child welfare is a vast nationwide system made up of a continuum of services that encompasses investigation of child abuse and neglect reports, intensive services to prevent placement and preserve families, placement and maintenance of children in various levels of substitute care, preparation of adolescents for adult living, family reunification services, and adoption. It has developed into one of the largest, most complex social service systems in the nation. (p. 28)

The child welfare system is currently funded through a myriad of complex funding mechanisms that vary almost as much as the services and providers themselves. The bulk of the responsibility rests with individual states: however, the federal government shoulders a significant amount of the burden as well (Rycraft, 1999). A recent study reported a conservative national estimate of \$14.4 billion in total federal, state, and local spending on child welfare services (Geen, Boots, & Tumlin, 1999). The primary vehicle for funding support of child welfare comes from various titles of the Social Security Act

(1935). Even with federal and state spending in the billions and increasing every year the demand for services continues to rise in all areas of the child welfare arena with no relief in sight (Mordock, 1999; Rycraft, 1999).

Continuing trends toward privatization in all areas of human services, including child welfare, demand a workable system of reimbursement that is amenable to both service providers and funding agencies. Some laud managed care as a workable solution. For example, Rycraft (1999) stated,

Seeking a more efficient and effective service delivery system, child welfare is entering another era of reform. The most widely used and increasingly lauded method of service provision is managed care. Managed care had been promoted as an administratively sound system of quality assessment and cost containment in the appropriate distribution of social services. Following the footsteps of other social service delivery systems, child welfare is preparing for its entrance in the arena of managed care. (p. 37)

Currently, more than 80% of all states have implemented or are considering implementation of managed care and/or managed care techniques in some fashion (Rycraft, 1999). In a 1999 survey, 29 of 49 states and the District of Columbia reported one or more initiatives that included managed care systems or principles consistent with managed care (McCullough & Schmitt, 2000).

Courtney (2000) has commented on recent adoptions of managed care principles stating, “Curiously, these developments are taking place without any significant empirical basis for assuming that managed care will either improve outcomes for children or families or lower the costs of child welfare services” (p. 88). In addition to the paucity

of empirical support for the effectiveness of managed care with child welfare outcomes and costs, some barriers to adoption of managed care systems have been identified. For example, Embry, Buddenhagen, and Bolles (2000) identified “. . . a lack of understanding of the essential features of managed care by public sector administrators, limited child welfare risk assessment capabilities, the pervasive role of the courts regarding placement decisions, very limited child welfare management information system capabilities, and the coercive nature of child welfare services” as significant barriers to the appropriate adoption of a managed child welfare system (p. 93). Despite its probable limitations, managed care has and will continue to impact child welfare in America. The nature of the impact is yet to be determined and offers great opportunity for social workers to be involved in its study and development.

**Managed care and social work.** Managed care has encountered much resistance within the field of social work. While some of the resistance may be viewed as difficulties with change (Elias & Navon, 1996; Shapiro 1999; Wilson & Kallmann, 1999), there are feasible arguments for the existence of ethical dilemmas between the demands of a managed care system and core social work values (Elias & Navon, 1996; Wilson & Kallmann, 1999). Schools of social work are being called to address the impact of managed care on their curricula (Berger & Ai, 2000) and on the field instruction of their students in the following areas: inability of agencies to get reimbursed for student’s supervision and activities; decreased placements; and curricula that are not adequate to prepare students for working in a changing environment (Raskin & Blome, 1998). Clinical social workers have to deal with changes in the client-practitioner relationship resulting from external oversight and decreased practitioner autonomy (Strom-Gottfried

& Corcoran, 1998) as well as the questions regarding the quality of services that can be provided within prescribed cost limitations (Heflinger & Northrup, 2000). Yet, as Wernet (1999) has noted, “Although there are many problems and challenges, the impact of managed care on the field of social work and human services is not all bad. As one CEO of a human service organization reflected, ‘Change was inevitable. Its name happened to be managed care’” (p. 19).

Social workers who manage human service organizations must weigh the potential conflicts associated with managed care against societal demands for increasingly efficient results. Yet little is known about the impact of managed care at the client level and even less is known at the organizational or societal levels. What are the costs (economic and service) of a managed care philosophy to the provision of services that an organization may offer? What are the costs to society if managed care techniques are implemented improperly or contrary to its intended implementation? What are the costs to agencies when their practitioners are limited with regard to the help that they can offer? The role of social work seems clear. Evaluation and research into the effects of managed care philosophy at all levels is needed to fully ascertain and guide its impact on the helping relationship.

### **Summary and Conclusions Regarding Context**

The current turbulent context of human services in general, and child welfare specifically, demands attention. Child welfare agencies and organizations are under increasing pressure to produce results while enduring the pressures of devolution of responsibility, privatization of service delivery systems, increasing demand for services, increasing fiscal restraint, and stiffer accountability. Managed care is a proposed reform

to a system in need of repair. It has yet to be determined whether managed care will do what it purports to do, however. Social work has the unique opportunity to guide the implementation of managed care by providing research and evaluation regarding its impact. Research in all areas (e.g., client level, organizational level, and societal level) is needed to determine the effects of implementation of managed care. Although the efficacy of a managed care system is not the focus of this dissertation, it was discussed briefly here to describe the controversial mechanism of funding that has been introduced into the political economy of the child welfare system. The remaining chapters present a study that explores one section of the child welfare system's response to managed care.

## CHAPTER 2

### CONCEPTUAL/THEORETICAL AND ANALYTICAL MODELS

#### **Introduction**

This chapter develops a conceptual model for understanding external environmental influence on human service organizations. An analytic model is derived from the conceptual model to inform a testable set of research questions regarding the influence of external environmental factors on human service organizations, within the child welfare system, in response to the advent of managed care. The chapter will conclude with a discussion of the axioms and research questions that guided the course of study.

#### Theoretical Model of External Determinates

The following model is based largely on the work of Yeheskel Hasenfeld (1983; 1992; 2000) who asserted that the most important questions involving human services organizations' behaviors are those regarding the delivery of services. He also posited that a combination of political economy and institutional theories provide a theoretical model best suited to understanding how and why human services organizations structure their service delivery systems in the ways that they do. Hasenfeld's work, though relatively undeveloped and for the most part untested (i.e., specifically his assertions that human service organizations are different from other forms of organization), guides the

conceptual design of this dissertation. The approach presented by Hasenfeld draws on a critique of several approaches to the study of organizations to develop a combination of theories (i.e., political economy and institutional theories), which in his opinion best explains the service configurations of human services organizations. The importance of Hasenfeld's approach is in the combination of these theories. It provides the heart of the conceptual model for this dissertation and is described in the following section.

### **Hasenfeld's Approach**

Hasenfeld (1982) provided a review and critique of several theories and perspectives that he considered germane to the study of human services organizations. He included bureaucracy, scientific management, the human relations perspective, decision-making theory, contingency theory, the natural system perspective, and the Neo-Marxian perspective. He concluded with an endorsement of the political economy perspective as a theory that could address some of the shortcomings of the aforementioned theories. Later, Hasenfeld (1992) further developed his perspective based on an eclectic compilation of theories that he claimed addressed different components of an organization's behavior. According to Hasenfeld,

Considering the complexities of human services as a class of organizations, what theoretical approaches are best suited for their study? Morgan (1986) suggests that theories on organizations arise from the images or metaphors we have about them. Yet, these metaphors produce a limited and partial picture of the organization. As a result, the theories themselves, while claiming to be encompassing, only provide a partial, if not biased, understanding of the organization. Such images range from viewing the organization as a rational

instrument designed to achieve specific goals to a system determined and driven by powerful environmental forces. (1992, p. 24)

Hasenfeld believed that organizational theories were for the most part disjointed and inapplicable to human service organizations and offered a combination of theories for addressing what he considered the most important questions regarding human service organizations.

Hasenfeld's (1992) review and critique of organizational theory included the rational-legal model, the human relations approach, contingency theory, negotiated order, political economy, Marxist theory, institutional theory, and population ecology. His review led him to believe that no single theory could adequately explain the processes and structure of organizations, let alone human service organizations. Hasenfeld argued that the efficacy of the theory was dependent on the nature of the organizational phenomena under study.

Hasenfeld (1992) concluded,

Yet, to me the most fundamental question to be asked about human service organizations is what determines the nature of their service delivery system. By service delivery system I include such issues as who are the clients to be served, the services to be provided, the manner in which the services will be provided, and, most importantly, the patterns of client-staff relations. I would propose that to address this set of questions, an integration of the political economy and the institutional theories would be most appropriate. I follow DiMaggio's (1988) lead in suggesting such integration. Because I assume that institutional rules arise from

political processes, I also refer to the approach articulated by Moe (1990) on the politics of structural choices in public bureaucracies. (Hasenfeld, 1992, p. 49)

Hasenfeld presented a model for understanding what he considered the most important aspect of human service organizations--their service delivery systems.

Hasenfeld's (2000) most recent work did not modify his original ideas, but instead highlighted the importance of organizational theory to the practice of social welfare administration. For example, Hasenfeld tied the administrative task of goal attainment to rational-legal organizational theory and the task of personnel management to human relations and feminist theories of organizations. However, the most significant part of this most recent work was his strong critique of practicing without theory and using theory without empirical testing, noting,

. . . models of practice are often rationalized based on organizational theories that have questionable validity, especially when applied to human service organizations. . . . important theoretical developments and empirical research that could inform social welfare administration remain neglected. With a few important exceptions, when models of practice refer to organizational theories, the use of such theories to inform practice principles is superficial and uncritical. Equally serious is the tendency to emulate popular management models that lack empirical validity or sensitivity to the attributes of human service organizations. For the field to flourish, it must be grounded in theory and research . . . Therefore, social welfare administration should embrace and adapt organizational theories that most effectively address its particular administrative issues within the social welfare context. (p. 108)

The following section presents an extension of Hasenfeld's model, which takes into account the interaction of organizations within networks, in addition to the institutional and political/economic aspects of their external environments.

### **Review of the Literature Relevant to Hasenfeld's Model**

This section contains a review of the literature relevant to Hasenfeld's model and the effects that external environmental forces may have on organizations. The literature is examined here to determine the extent to which Hasenfeld's model has been explored empirically. The terms that were included in the key word searches included: (Human Services Organizations, Child Welfare Organizations, Organizational Change and adaptation, Social Service Organizations, Nonprofit Organizations, Institutions, Organization Theory, Environment, and Child Welfare). Combinations of search terms were employed to narrow the field of entries. The following databases were targeted for the initial searches: Lexus-Nexus, UNIVERse, OCLC FirstSearch, Dialog@CARL, Eureka, Web of Science, Elsevier Science Journals, Medline, PsycInfo, Social Sciences Abstracts, Socio Abs, Psychlit, and the Florida State University library catalogs. Additional sources were obtained through reference lists of articles that were reviewed. The searches were limited to studies included in the dates 1990-2002. Only those articles that can be designated as empirical were included in the discussion that follows.

The categories that are used for analysis of the empirical studies are adapted from Thyer's (1991) model for research analyses and include the following: 1) Purpose/Questions/Hypotheses – includes information regarding the intent of the study; 2) Theory -- includes information about the theoretical underpinnings of the study; 3) Sample – includes information regarding sample size and salient characteristics; 4)

Design – includes information on the characteristics of the research design; 5) Data Analysis – includes information about the techniques that were employed to analyze the data; 6) Measurement – includes information regarding the methods used for observing and measuring the variables of interest; 7) Outcomes – includes the authors’ findings that are relevant to the study of an open-systemic perspective of HSOs; 8) Comments – includes general comments regarding the strengths and limitations of the study/findings. Initially, a brief description will be provided for each article. A critique of the literature will follow, noting the strengths and limitations noted within each of Thyer’s categories listed above.

1. Byington, Martin, DiNitto, and Maxwell (1991): The authors interviewed directors of all the rape crisis centers in Florida to study organizational forms and affiliations.
2. Dill (1994): This qualitative study of nine community based agencies providing AIDS health services investigated key value sets and “institutional myths”.
3. Ezell, Menefee, and Patti (1997): Directors of hospital social work departments were surveyed to identify leadership characteristics, constituency preferences and institutional arrangements that explain managerial decisions about commitment of organizational resources.
4. Gibelman (1990): Secondary data from a national survey of voluntary health agencies were analyzed to assess the effects of the changing environment.
5. Hardina (1990): This study surveyed HSOs in Chicago to explore the effect of funding sources on client inclusion/exclusion practices.

6. Lutjens (1992): Client records from a hospital were analyzed to explore the effects of staffing levels and intensity as well as funding sources on client length-of-stay.
7. Martin, DiNitto, Byington, and Maxwell (1992): This was a qualitative case study of one rape crisis center's transformation process that involved a task force.
8. Scheid and Greenley (1997): The authors surveyed health systems in Wisconsin to explore the effect of the institutional environment on organizational structure and effectiveness.
9. Schmid (1992): This study combined qualitative and quantitative methodologies to study the relationships among structure, environment and effectiveness in Israeli human service organizations.
10. Wernet (1997): Eight human service trade associations in three states were surveyed to explore the effects of the environment on organizational financial and service strategies.
11. Wernet and Austin (1991): This qualitative study employed interviews of human service organizations to describe their leadership and decision-making patterns.

Five studies reviewed dealt with organizational response to the environment (Dill, 1994; Gibelman, 1990; Schmid, 1992; Wernet, 1997; Wernet & Austin, 1991). Two articles involved studying the consequences that environmental factors have on effectiveness (Byington, et al., 1991; Scheid & Greenley, 1997). One article examined the effects of environmental forces on the commitment of resources (Ezell, et al., 1997). One article looked specifically at the impact that funding sources have on the

organization (Lutjens, 1992). One article noted case-study evidence of organizational tasks, in response to environmental factors that led to positive change (Martin, et al., 1992). Moreover, one article dealt specifically with the effect of environment on the provision of services (Hardina, 1990). The fact that most articles only reported or investigated organizational responses to environmental uncertainties seems to suggest that the literature on this topic is primarily exploratory.

Political Economy and Institutional theories, whether explicitly noted or implicitly inferred, seemed to dominate most of the literature that was reviewed and were most often combined as an orientation (Byington, et al., 1991; Dill, 1994; Ezell, et al., 1997; Gibelman, 1990; Lutjens, 1992; Martin, et al., 1992; Scheid & Greenley, 1997; Wernet, 1997). An Open Systems Theory (OST) perspective was explicitly noted in three of the studies (Martin, et al., 1992; Scheid & Greenley, 1997; Schmid, 1992). Open Systems Theory (OST) is “. . . a general conceptual framework about open social systems” which is derived from von Bertalanffy’s (1968) General Systems Theory (Martin & O’Connor, 1989, pp. 40-41). Other theories that were explicitly stated were Resource Dependence (Gibelman, 1990; Hardina, 1990; Scheid & Greenley, 1997), Contingency (Scheid & Greenley, 1997), Niche (Wernet, 1997), Negotiated Order (Martin, et al, 1992), and other systemic perspectives (Lutjens, 1992; Wernet & Austin, 1991). This suggests an interest in the OST perspective with Political Economy and Institutional theories as orienting frameworks in the literature reviewed.

The literature represented in this study primarily involved the use of convenience sampling techniques comprised of particular agencies and organizations or sets of agencies and personnel, which were essentially available because of funded program

evaluation activities. This type of sampling technique does not represent the most empirically sound form of sampling; however, it is often deemed acceptable in the social sciences when considering logistic restraints and the use of human subjects. Most of the sampling frames (even where randomization is employed) may only be representative of the hospital, organization, or association of organizations under study at that particular time when the data were collected. The response rates to surveys (for those reporting response rates) included 59% (Ezell, et al., 1997), a 30% mean across the different organizational associations sampled with a range of 24-50% (Wernet, 1997), 61% (Schmid, 1992), and a high of 97.2% (Scheid & Greenley, 1997). Rubin and Babbie (2001) offered some general guidelines for return rates noting that 50% or better indicates an acceptable level to control for the effects of response bias, with at least 60% considered good and 70% very good. The sampling strategies involved in the studies under review leave a large margin of error in any generalizations that may be drawn from the organizations sampled regarding the nature of HSOs due to their selection procedures (non-probability), their narrow sampling frames, and/or their low response rates (or any combination of the three).

The designs, employed in all the studies in this review but one, included some combination of survey/questionnaire and/or qualitative methodology. The one study (Lutjens, 1992) that included a variant design employed a correlational study from the field of nursing. Lutjens' study primarily focused on comparing the effects of nursing processes, client characteristics, and funding source on the length of clients' stay in the hospital. The emphasis was not on testing theoretical understanding of HSOs, but rather on making an argument for nursing efforts to be considered in payment procedures. The

remainder of the studies employed varying techniques as follows: qualitative, semi-structured, open-ended interviews (Byington, Martin, DiNitto, & Maxwell, 1991; Wernet & Austin, 1991); Survey/Questionnaire (Ezell, Menefee, & Patti; Wernet, 1997); a combination of survey/questionnaire and structured interviews (Scheid & Greenley, 1997); qualitative case studies (Dill, 1994; Martin, DiNitto, Byington, & Maxwell, 1992); manipulation of secondary data (Gibelman, 1990); and, one study that combined secondary data manipulation with qualitative content analysis, case study, and survey/questionnaire (Schmid, 1992).

One benefit in using survey data is that it makes large representative samples of populations possible, which lends to generalizations about the population more effectively than most controlled experiments. The trade-off for such high external validity is the loss of internal validity regarding causal relationships. Therefore, statements about the nature of environmental forces' effects on HSOs, based on survey literature, should be considered suspect. The strengths of qualitative methods of research include its ability to lead to a depth of understanding of the subtleties of the phenomena under study, greater flexibility of design changes than experiments or surveys, and it can often be done with fewer resources than can be found in experimental or survey methods. The weaknesses of qualitative techniques include their subjectivity and the lack of generalizability of the findings (Royse, 1999; Rubin & Babbie, 1997). The designs employed in the research surveyed in this review suggest that the claim of any causal relationships between any of the theoretical tenets and organizational structure and change should be considered suspect.

The data analysis techniques employed in the literature represented a wide range of qualitative and quantitative techniques. The primary finding of this review reveals that data analytic techniques were often inappropriately employed. For example, Dill (1994) employed a grounded theory technique that is supposed to be idiographic in nature and developed in the absence of theory. Yet, she stated that she was beginning from institutional theory and progressing to a test of its suppositions. Another concern in this area involved the use of inferential statistics when the population was confined to the sampling frame under study (Byington, et al., 1991; Hardina, 1990; Schmid, 1992).

Only three studies reported any information on the reliability of measures that were employed (Lutjens, 1992; Scheid & Greenley, 1997; Schmid, 1992), and it was generally in the low to median range. None of the studies reported on the validity of their measures. Although a certain amount of measurement error is inevitable, the absence of acceptable levels of reliability and validity in the tools used to gather data seriously compromises the empirical status of the research (Rubin & Babbie, 1997).

In light of the preceding discussion, any results presented in the literature were (and should be) viewed with skepticism. Limitations in sampling, design, and analysis performed by the studies' authors, give rise to numerous confounding explanations and unexplored possibilities. Therefore, the following discussion of support for the theoretical foundations espoused in this study is merely suggestive.

Limitations in All of the studies, except one (Lutjens, 1992), gave support to an open-systemic perspective that included Institutional and Political Economy theories. Lutjens asserted that only 1% of the variation in the length-of-stay of hospital patients was attributable to environmental factors (i.e., funding source conditions). Wernet and

Austin (1991) concluded that an OST perspective with Population-Ecology and Resource Dependence theories as supporting theories, was the best model for understanding the HSO under study. The rest of the studies presented mixed results regarding the theory or combination of theories that best informed knowledge about HSOs.

This critique of the empirical literature suggests that Hasenfeld's (1992) OST orientation to the study of HSOs, which employs Institutional and Political Economy theory as guiding frameworks, is worthy of continued study using increasingly rigorous methodologies. The interest in his perspective seemed to be sparked in the early 1990s but failed to maintain momentum. The early findings point to the importance of environmental factors in understanding organizations; however, the lack of empirical rigor coupled with little replication among varying populations (such as Child Welfare organizations), seems unable to justify the decrease in scientific inquiry into this area. Any conclusions about the nature of environmental (political-economical and institutional) effects on the organization are to this point, little more than speculation.

Although Hasenfeld developed a provocative model for understanding human service organizations by examining their service delivery systems, the model was never truly empirically tested despite his later admonition for theoretical and empirical grounding. The purpose of this dissertation is to explore the usefulness of an updated version of Hasenfeld's model, which includes political economy, institutional, and network theories for understanding the external variables that influence the service delivery systems of residential child care facilities.

## Conceptual Model

The conceptual model developed to guide this dissertation is represented in Figure B contained in Appendix A. The inverted triangle represents the gradual restriction of resources and options from the societal level to the actual services that are delivered to clients and their families through human service organizations. Variables at each level work to restrict and/or deplete resources and options that are eventually available to clients. The gray lines between each of the components of the model indicate that boundaries between them are often indistinct. The arrows that link the individual components represent a potential multi-directional flow of influence from one component to any other component in the model recognizing that each level may impact the behavior of any other component.

Restrictions and limitations on the resources that are translated into services provided by individual organizations begin with political and economic variables that are external to the organization and are applicable to political economy theory. Resources are further limited by sources of legitimization for the organization such as cultural rules and norms as defined in institutional theory. The relationships that organizations develop with other organizations and institutions also work to limit or maximize resources within the organization and are applicable to network theory. The conceptual model focuses on those theories and independent variables that address phenomena external to the boundaries of the organization; study of the internal influences on organizational structure and service delivery is beyond the scope of this project. Therefore, a brief review and discussion of political economy, institutional, and network theories follows.

## **Political Economy Theory**

Hasenfeld (1992; 2000) considered the political economy perspective useful for understanding the adaptation and mobilization of resources. For as Wamsley and Zald (1976) pointed out, an organization's potential for survival and for the provision of services is dependent (at least in part) on its ability to obtain and utilize resources, power, and legitimacy. The resources needed by the organization to produce services must be obtained from its external environment. The process of negotiation that the organization undergoes to mobilize resources reflects the degree to which it is dependent on the various components of its external environment (Hasenfeld, 2000; Pfeffer and Salancik, 1978). According to Hasenfeld (2000),

The greater the resource dependency of the organization on an element in the environment (e.g., governmental funding agency, regulatory organization, professional association, providers, or clients), the greater the ability of the element to influence organizational policies and practices. Therefore, many organizational practices, such as the service delivery system, will reflect the constraints and contingencies imposed by those who control needed resources. (p. 96)

Political economy, as a perspective for understanding human service organizations, emphasizes the impact of external environment on the internal structure of an organization. Limitations of the political economy perspective includes a lack of consideration for values and cultural norms and the use of a single organization as the unit of analysis, which does not allow for the influence of an organizational field

(Hasenfeld, 2000). Institutional and network theories enhance the political economy perspective by addressing the influence of organizational fields.

### **Institutional Theory**

At the heart of the institutional perspective is the premise that organizational survival is dependent on the ability of the organization to reflect institutional rules (Hasenfeld, 2000). Scott (1995) broadly defined institutions as consisting of “cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior. Institutions are transported by various carriers—cultures, structures, and routines—and they operate at multiple levels of jurisdiction” (p. 33). The rules that the organization must reflect are comprised of three structures: regulative (e.g., laws, regulations, codes); normative (e.g., values and norms); and cognitive (e.g., socially constructed categories and typologies) (Hasenfeld, 2000; Scott, 1995). Whereas political economy stresses the importance of economic and political factors for obtaining legitimacy, institutional theory stresses the importance of regulative, normative, and cognitive cultural structures.

Scott (1995) refers to the three structures of rules that organizations must reflect as the three “pillars” supporting institutions. He explained, “The columns contain the three elements—three ‘pillars’—identified as making up or supporting institutions. The rows define some of the principal dimensions along which assumptions vary and arguments arise among theorists emphasizing one element over the other” (p. 35). The regulative element involves the ability to establish rules and to ensure conformity to the rules by the use of rewards and punishments. The mechanisms for carrying out the regulative function may be formalized (e.g., licensing agencies or courts) or informal

(e.g., shaming or shunning). According to Scott (1995), “Force and fear and expedience are central ingredients of the regulative pillar, but they are tempered by the existence of rules, whether in the guise of informal mores or formal rules and laws” (p. 36). Scott argued that those theorists who emphasize the regulative element have difficulty explaining why institutions develop in the first place but have no trouble explaining why organizations adhere to institutionalized rules.

Another set of theorists presume that institutions are primarily supported by a normative pillar (Scott, 1995). Normative systems are based on values and norms. Scott (1995) defined values and norms as follows:

Values are conceptions of the preferred or the desirable together with the construction of standards to which existing structures of behavior can be compared and assessed. Norms specify how things should be done; they define legitimate means to pursue valued ends. (p. 37)

The normative pillar not only prescribes a desired outcome or goal of organizational behavior but it also provides guidelines for achieving that goal. The normative pillar can be either formal (e.g., specific positions designed to carry out specific behaviors) or informal (e.g., practices that develop over time due to expectations in interrelationships) (Scott, 1995). Scott also noted that the normative pillar enlists a less strict definition of rational behavior in organizations when he stated, “Here choices are structured by socially mediated values and normative frameworks. Actors conform not because it serves their individual interests, narrowly defined, but because it is expected of them; they are obliged to do so” (pp. 38-39).

The cognitive pillar also moves away from a strict definition of rational behavior. According to Scott (1995), “ A cognitive conception of institutions stresses the central role played by the socially mediated construction of a common framework of meaning” (p. 45). In the cognitive paradigm, what a person or organization does is in large part a function of its internal representation of the environment in which the person or the organization exists (D’Andrade, 1984; Scott, 1995). The cognitive pillar rests on the subjective interpretations that relevant actors ascribe to objective phenomena. Scott (1995) stated, “Symbols—words, signs, and gestures—have their effect by shaping the meanings we attribute to objects and activities. Meanings arise in interaction and are maintained—and transformed—as they are employed to make sense of the ongoing stream of happenings” (p. 40). An important element of a cognitive orientation is constitutive rules. According to Scott (1995), these “involve the creation of categories and the construction of typifications: processes by which ‘concrete and subjectively unique experiences are ongoingly subsumed under general orders of meaning that are both objectively and subjectively real’ (Berger & Luckmann 1967, p. 39)” (p. 41).

Institutional theory, according to Scott (1995), has as its foundation three models or pillars—the regulative, normative, or cognitive. Each of these offers a unique basis for understanding an organization’s compliance, mechanism of diffusion, type of logic, clusters of indicators, and bases of legitimacy. Scott (1995) identified two other distinctions within institutions in order to highlight their flexibility and generality:

First, institutions are viewed as varying in their mode of carrier or host.

Institutions may be borne by cultures, social structures, or routines (and perhaps, also by technologies). Second, institutions are described as capable of operating

at—having jurisdiction over—differing levels; some are restricted to operating within organizational subunits, whereas others function at levels as broad as that of world systems. (Pp. 60-61)

Institutional theorists also vary along the levels at which they analyze institutional phenomena. Scott (1995) operationalized level as “. . . the range of jurisdiction of the institutional form” (p. 55). He offered six possible levels of analyses comprising the range of jurisdiction including the world system, societal, organizational field, organizational population, organization, and organizational subsystem. Each of the three pillars can be analyzed at any of the six levels. This study proposes to study selected aspects of institutions at the organizational population and organization levels. According to Scott (1995) an organizational population is “. . . a collection or aggregate of organizations that are ‘alike in some respect,’ in particular to ‘classes of organizations that are relatively homogenous in terms of environmental vulnerability’ (Hannan & Freeman 1977, p. 166)” (p. 57). Scott (1995) noted,

. . . a substantial amount of research relevant to the testing of institutional arguments has been produced. Most of this work treats institutional frameworks as given and asks how they affect organizational structures and functions. That is, in most of the empirical literature, institutions are treated as independent variables and the studies are directed to examining their effects on organizations, organizational populations, or organizational fields. (p. 63).

Therefore, this study focused on institutional effects rather than institutional determinants in order to examine the impact of an external environment on the service structures it provides. The following literature review addresses institutional effects only.

Hasenfeld (2000) argued, “human services are institutional organizations par excellence. Their success depends less on using effective service technologies than on designing structures that conform to dominant institutional rules” (p. 99). He went on to argue that much of human services organizational activity revolves around the development of myths and ceremonies designed to uphold institutional rules rather than activities designed to enhance service performance. He explained that institutionalization may often be more important for survival among human service organizations than service performance (Hasenfeld, 2000). Institutional theory addresses the impact of externally developed rules and norms on the structure of organizations. Political economy addresses the impact of external power and resources on structure. However, an area that was overlooked by Hasenfeld involves the relationships an agency has with other agencies within its task environment. Network theorists have some common interests with institutional theorists when it comes to the organizational field and provides important insight into organizational relationships not readily explained by institutional theory.

### **Network Theory**

According to Milward and Provan (1998), “Social network analysis is focused on the structure of relationships among networks of individuals or organizations where the network consists of a set of nodes linked by a set of social relationships” (p. 388). Human service organizations rarely, if ever, provide services to clients in a vacuum. In the field of child welfare for example, residential facilities interact with mental health agencies, school systems, medical facilities, the judicial system, and a host of other agencies to provide a spectrum of services needed by the client(s). Provan and Milward (1995)

asserted, “While focus on organizational effectiveness is clearly appropriate when outcomes can readily be attributed to the activities of individual organizations, not all problems can be solved by the actions of individual organizations” (p. 2). Many researchers, policymakers, and practitioners assume that treatment outcomes will improve as organizations form integrated service delivery networks (Alter & Hage, 1993; Dill & Rochefort, 1989; Provan & Sebastian, 1998). The relationships among organizations in a task environment (e.g., sharing of resources, co-sponsored programs, referrals, case management, etc.) are therefore also important in modeling external determinants of an organization’s service delivery system. Hasenfeld’s (1982; 1992; 2000) approach fails to take into account the impact of relationships among organizations on their service delivery systems. Network theory is applied to this study’s model to assist institutional theory in accounting for those relationships.

The model, illustrated in Figure B (see Appendix A), combines aspects of political economy, institutional, and network theories of organizations to examine the impact of external variables on the internal structure (service delivery systems) of human services organizations. A brief introduction was given to the individual theories that comprise the model. In the following section, an analytical model will be developed from the conceptual model, which examines institutional and network explanations for understanding changes in service delivery systems resulting from a changing political economy.

### **The Analytic Model**

Figure C in Appendix B presents an analytic model of the influence that political and economic variables exert on an organization’s decision to adopt managed care as

mediated by institutional and network variables. This section will delineate the variables and constructs to be included in the model as suggested by the previous review of relevant literature. The method section of Chapter Three will delineate the indicators to be used to measure the variables in the model. The first element of the model, depicted in Figure B, represents the independent variable associated with a political economy perspective of external influence.

### **Variables Associated with the Political Economy of Organizations**

External environmental factors are assumed to have a direct effect on the service delivery systems of human service organizations. As stated earlier, the political economy perspective purports that for the organization to survive and produce its services it must acquire two fundamental types of resources—power and authority (i.e., political), and production (i.e., economic) resources (Hasenfeld, 1992; Wamsley & Zald, 1976). An organization's external environment is key to obtaining these resources. According to Hasenfeld (1992),

The political-economy perspective highlights the importance of the environment, especially the task environment, in shaping the organization's service delivery system. The task environment refers to other organizations and interest groups (including clients) who have a potential stake in the organization either because they control important resources needed by it, or because it can advance their own interests. (p. 31)

Another theory that is a closely related to a political economy perspective is resource dependence. Resource dependence purports that the more an organization is dependent on outside resources, the more it is susceptible to influence from the sources of those

resources (Hasenfeld, 1992; Pfeffer & Salancik, 1978). It is assumed that the political and economic power wielded by external constituents and sought after by human service organizations exerts influence over their internal structures and services configurations.

The variable indicators of the political and economic context are linked under the first box of the model (see Figure D located in Appendix E) and refer to the variability of political and economic resources available to the organization. The first indicator associated with political power is size-related and has to do with the number of geographic sites occupied by the organization (“multiple sites versus independent sites” in Figure D). The intent of including this indicator is to explore whether larger, multi-site agencies enjoy a more diversified array of clients and political resources than smaller, single-site agencies. The second political power indicator (“member of statewide association vs. independent”) involves the role of professional associations that provide legitimacy and certification. The intent of including this indicator is to explore whether organizations that are members of statewide professional organizations have increased political power through advocacy and professional certification. The next indicator (“sectarian vs. non-sectarian”) refers to stakeholders and political power that arise among sectarian organizations that receive at least part of their funding or licensure from the state. A possible assumption here, based on practical experience, is that religiously based organizations may experience conflict between state requirements and their own moral positions.

The first economic power indicator (“profit vs. not-for-profit” in Figure D) affects the strategies (e.g., competition, co-optation, etc.) that organizations adopt to manage their external environments (Benson, 1975). The other economic indicator (“funding

sources of individual organizations”) has to do with economic power with the assumption being organizations with more diversified funding sources and those with less dependence on state funds have more power to determine their service delivery system (Pfeffer & Salancik, 1978). The indicators described above are meant to provide a glimpse into the political and economic context of individual organizations in the study. The study’s focus, however, is on the influence of the intervening variable consisting of the institutional/network context controlling for the political/economic context of the organization.

### **Variables Associated with the Institutional Context of Organizations**

The model suggests that the influence, which the political and economic context asserts on an organization, be mediated by the contexts of the institutional and intra-agency network for that organization. DiMaggio and Powell’s (1983) work on institutional isomorphism may be considered a cornerstone of new institutional theory. They adopted the ecological concept of isomorphism to explain the effect that institutionalization has on diverse organizations within an organizational field and which compels them toward similarity. They also distinguished institutional isomorphism from competitive isomorphism, which involves pressure toward homogenization from competition in the market. According to DiMaggio and Powell (1983), institutional isomorphism occurs because of organizational competition for political and institutional legitimacy. They convey three mechanisms for the diffusion of power and legitimacy—coercive, normative, and mimetic. Each of the pillars associated with institutions has its own mechanism for diffusion of power, which leads to isomorphism among organizations (DiMaggio & Powell, 1983; Scott, 1995).

The regulative pillar of institutions has coercive pressure as its mechanism of diffusion (see Figure D indicators under institutional variables). Coercive power has two primary driving forces, pressure from other organizations that control needed power and legitimacy resources and cultural expectations from the larger society (DiMaggio & Powell, 1983; Mizruchi & Fein, 1999). The indicators of the coercive mechanisms at play for child welfare organizations to adopt managed care include the individual perceptions of the heads of those organizations regarding pressure from: 1) relevant laws, policies, and procedures; 2) relevant regulative and licensing agencies in the state; 3) the various funding sources of the individual organizations; and 4) values of the larger society.

According to Scott (1995), the normative pillar is associated with DiMaggio and Powell's (1983) normative pressures toward isomorphism. Normative pressures arise as a result of professionalization and involve two phases—1) similar training that socializes workers into adopting a particular worldview, and 2) membership in professional associations (DiMaggio & Powell, 1983; Mizruchi & Fein, 1999). The indicators of normative pressure to adopt managed care includes the following: 1) the perceived degree to which an organization's professional associations have adopted managed care according to the Chief Executive Officer (CEO); 2) The perceived degree to which accrediting agencies have adopted managed care; and 3) the similarity of training among the CEOs of the study organizations.

The cognitive pillar has mimetic pressure as its mechanism of diffusion. Mimetic pressure arises from an uncertainty with regard to the focal organization's environment and because of that uncertainty, the organization may choose to mimic the performance of a successful peer (DiMaggio & Powell, 1983; Mizruchi & Fein, 1999). The indicators

for mimetic pressure to adopt managed care include the CEO's perceived pressure from other state welfare systems and other professions' (e.g., physical and behavioral healthcare) adoption of managed care. The institutional variables and indicators discussed here represent a considerable force for understanding how organizations will respond to or resist environmental change. However, institutional theory fails to take into account communication and relational patterns within inter-organizational networks that may impede or facilitate organizational adaptation. Therefore, another intervening variable will be tested, which represents network theory.

### **Variables Associated with the Inter-Organizational Context of Organizations**

Kraatz (1998) proposed variables along four dimensions of inter-organizational networks that may affect individual organizations' adaptation to environmental change, which include network structure, the frequency of imitation of responses within the network, the type of imitation within the network, and the social learning capabilities of individual organizations within the network. The first dimension involves indicators related to the structure of networks (see Figure D under network variables) and includes 1) the size of the network, 2) the homogeneity of the members of the network, and 3) the age of the network. Kraatz postulated the following regarding the structural variables: 1) The smaller the interorganizational network, the more likely individual organizations within the network will adapt their features to environmental change; 2) the more homogeneous the network, the more likely individual organizations will adapt their features to environmental change; and 3) the older the network, the more likely individual organizations will adapt their core features to environmental change (Kraatz, 1998).

The second dimension involves the frequency of imitation of adaptive responses within networks with the indicator being the response that is most often adopted by members of the network. Kraatz (1998) postulated that organizations would adapt those responses to environmental changes that are most frequently adopted by other members of their interorganizational network.

The third dimension of inter-organizational networks involves the patterns of imitation that occurs within them. In this dimension, Kraatz (1998) delineates two types of imitation. Bandwagon imitation involves indiscriminate adoption of adaptive changes by larger members of a network and results in growing adoption within the network. The bandwagon effect is exacerbated by poor communication and environmental uncertainty, as well as fear of loss of competitive edge or prestige within the network. Kraatz hypothesized that organizations within a network will imitate the responses of the larger organizations within their network. The other type of imitation is status-driven imitation and involves the adoption of adaptive responses on the basis of the perceived prestige to be obtained by imitating larger, more visible organizations' previously adopted changes. Kraatz hypothesized that individual organizations would be more likely to imitate the responses of the more prestigious organizations within their network.

The final dimension is based on a social learning process. The social learning process indicated in interorganizational networks is based on member organizations ability to learn from the successes of peer organizations within the network and adopt those changes when it is beneficial to their goals in light of other contingencies that they face (Kraatz, 1998). The indicator for the social learning dimension of inter-organizational networks is the relative performance of organizations within the network

as they adapt to environmental change. Kraatz (1998) also postulated the following with regards to social learning: 1) Organizations will be more likely to imitate the adaptive responses that have been most successful within their network; 2) organizations will be more likely to imitate the adaptive responses of organizations within their network that are the most similar to themselves; and 3) organizations are more likely to imitate the adaptive responses of other organizations within their network when their own performance is perceived to be substandard.

### **Indicators Associated with the Dependent Variable**

The dependent variable in the model presented in Figure D is the degree to which individual organizations adopt managed care principles. We return now to the work of Hasenfeld (1982; 1992; 2000) regarding the most important question to be asked regarding human service organizations—What determines the nature of their service delivery systems? The first indicator is the degree to which CEOs perceive their agencies have adopted managed care principles. The second indicator is the degree to which the organizations' service configurations have changed since managed care was first introduced into the Georgia child welfare system in 1995. The third indicator is the degree to which an agency's policy and procedures have changed during that same period. Finally, an organization's response to managed care may be, at least in part, indicated by the degree to which it changes its funding development and allocation practices. Each of these indicators may be interrelated and may have an effect on the others; however, those interrelationships are subjects for future study.

## **Research Questions**

The overall guiding research question is restated here: What is the impact of the external environmental context of individual organizations on their internal structures and service configurations as they attempt to adapt to a changing political economy? The study will explore this question based on axioms identified in the review of the literature. Popper (1965) identified “axioms” as either conventions or scientific hypotheses to be tested. The following section will first restate some axioms identified from the literature, then construct a more specific set of research questions to be tested based on identified axioms.

### **Axioms Identified from the Literature**

The axioms listed below are derived from the literature discussed in the preceding sections. They are presented as a means of summarizing and organizing the guiding principles to the study. The axioms are organized into sections corresponding to the theoretical orientations used in developing the conceptual and analytic models previously discussed.

#### **Axioms involving the political economy perspective.**

1. An organization’s potential for survival and provision of services is dependent on its ability to obtain and utilize resources (in the form of power and legitimacy) from its external environment (Wamzley & Zald, 1976).
2. The greater the dependence of an organization for a particular resource provided by an element of its external environment, the greater the ability of that external environmental element to influence organizational structure and services (Hasenfeld, 2000).

**Axioms involving institutional theory.**

1. Organizational survival is dependent on the ability of the organization to reflect institutional rules (Hasenfeld, 2000).
2. Institutional rules are enforced through coercive, normative, and/or mimetic pressure placed on the organization by external forces in the institutional environment, which drive the organization towards isomorphism (DiMaggio & Powell, 1983).
3. The more an organization is institutionally embedded in its environment (i.e., the higher its institutional pressure to conform to a certain set of rules), the less likely it is to implement changes that are opposed to the institutional environment (DiMaggio & Powell, 1983).

**Axioms involving network theory.**

1. Strong ties among organizations tend to mitigate uncertainty and promote adaptation to environmental forces to change by increasing information sharing and communication (Kraatz, 1998).
2. Organizational networks tend to promote social learning of adaptive responses among its members over other forms of interorganizational imitation (Kraatz, 1998).

## **Research Questions based on the Axioms**

The research questions listed below delineate the overall question stated previously and are based on the axioms derived from the theoretical model. Each component of the theoretical model assumes its own set of propositions and set of research questions; however, only those questions relating to the interaction of variables in the model are listed here.

1. Is the degree to which a child welfare organization is influenced by its dependence on external sources of power and legitimacy contingent on the degree to which it experiences institutional pressures to behave in a certain manner?
2. Is the degree to which a child welfare organization's service delivery system is influenced by its relationship to external sources of power and legitimacy, be it institutional or political and economic sources, influenced by the nature of interorganizational network relationships?

Although the literature reviewed in this chapter may seem adequate to elicit specific testable hypotheses regarding these questions above, this study will be primarily exploratory in nature and therefore no formal hypotheses will be presented. The methodology, which is discussed at length in chapter three, limits the explanatory ability of the study in several ways including the use of a relatively small, non-probabilistic sample. The use of an exploratory design will allow freedom for the analysis of organizational—environmental relationships without sacrificing explanatory capability that would be associated with a more scientifically rigorous design that used probabilistic sampling. As Royse (1999) has noted,

It is common in social work literature for authors to note that they have conducted an exploratory survey. These are generally recognized by their small samples. Exploratory studies are sometimes conducted prior to applying for federal grant dollars to allow investigators to test out hypotheses or instruments on a small scale. Since science is built by small, incremental steps, exploratory surveys are legitimate even though the knowledge they produce is often seriously limited. (p. 140)

### **Summary of Conceptual and Analytic Models**

This chapter presented a conceptual model for understanding external environmental influences on the internal structures and services of human service organizations. It also presented an analytic model, which was derived from the conceptual model to inform a testable set of research questions regarding the behaviors of human service organizations within the child welfare system in response to the advent of managed care. A set of exploratory research questions for testing the model was derived based on axioms discovered in the review of relevant literature on political economy, institutional, and network theories of organizations. The following chapter presents the methodology employed to explore the efficacy of the theoretical model presented in chapter two.

## CHAPTER 3

### METHODOLOGY

#### **Introduction**

This chapter of the dissertation outlines the methodology that was employed to study the effects of external environmental forces on the internal structure and service delivery systems of human service organizations. The discussion begins with a description of the sample and includes a rationale for the inclusion of subjects in the sample. This will be followed by a presentation of the data collection procedures and instrument that was used to obtain information from the subjects. The chapter concludes with a description of the data reduction techniques planned for analyzing the data obtained by the study.

#### **Sample**

According to Rubin and Babbie (2001), “The ultimate purpose of sampling is to select a set of elements from a population in such a way that descriptions of those elements (statistics) accurately portray the parameters of the total population from which the elements are selected” (p. 261). However, they have also noted that the probability sampling techniques needed to ensure the representativeness of data are not always feasible in social work research. The ideal sampling frame for this study might include all residential child caring organizations throughout the United States. However, the

logistical nightmare of composing and defining the list, much less the sample size needed and the costs involved in conducting a national survey severely limit the possibility of utilizing all child caring institutions given a limited amount of resources. Therefore, the sampling frame for this study is restricted to all residential care facilities (child caring institutions) licensed by the State of Georgia's Office of Regulatory Services (ORS), which is housed under the Georgia Department of Human Resources (DHR).

The study sample may be considered a population (e.g., all child caring institutions licensed by ORS in the State of Georgia) or it may be considered a purposive sample of all child caring institutions in the United States. According to Rubin and Babbie (2001), "Sometimes you may appropriately select your sample on the basis of your own knowledge of the population, its elements, and the nature of your research aims: in short, based on your judgement and the purpose of the study" (p. 254). One form of purposive sampling may include the selection of a subset of a larger population where all members of the subset are easily identified but where enumerating all members would be nearly impossible (Rubin & Babbie, 2001).

Georgia's DHR/ORS defines residential care facilities (child caring institutions) as, "Any facility providing full time residential care for six or more children under 17 years of age outside of their own homes" (Office of Regulatory Services, 2001, p. 1). The following are exempt from the DHR/ORS definition for licensing and inspection purposes: 1) Facilities and institutions operated by federal, state, county, or municipal governments; 2) boarding schools whose primary purpose is education and who adopt and operate under a published academic curriculum that meets the requirements of the State Department of Education; and, 3) temporary recreational facilities and programs

that limit residency to three months, e.g., summer camps. Those agencies that are exempt from licensing by ORS were not included in the sampling frame. According to DHR/ORS,

The Office of Regulatory Services (ORS) is responsible for inspecting, monitoring, licensing, registering, and certifying a variety of child care and health care programs. ORS works to ensure that facilities and programs operate at acceptable levels, as mandated by state statutes and by rules and regulations adopted by the Board of Human Resources. ORS also recommends certification of various health care facilities to receive Medicaid and Medicare funds, through contracts with the Health Care Financing Administration of the U.S. Department of Health and Human Services. (Office of Regulatory Services, 2001, p. 1)

Georgia's DHR/ORS is involved in the inspection and licensing of 1,191 day care centers, 244 group day care homes, 143 residential care facilities, 8 therapeutic camps, and 41 private adoption agencies in the state. The office also registers 7,048 family day care homes and provides annual inspections of a varying sample of these homes.

Many of the 143 residential care facilities, which are licensed by ORS, are subsidiary programs of parent corporations that have other facilities on the list. For example, Chris Homes, Inc. of Georgia has 9 facilities that are included in the DHR/ORS list of licensed facilities. The sampling frame included only one listing for those corporations that are multiply represented in the list, rather than each individual facility, to control for the possible effects of individuals nested within larger groups. Therefore, the final sampling frame consisted of 122 separate corporations that provide residential care to children and are licensed by the state of Georgia's DHR/ORS. Due to the small

size of the sampling frame under study, a power analysis to determine the number of respondents needed to detect a statistical effect size seemed unnecessary.

Self-administered, paper and pencil surveys were sent to the contact person for each of the 122 organizations included in the sample. During the course of the study; however, 8 potential respondents were removed from the sampling frame. Three of these were removed because of undeliverable addresses and disconnected telephone numbers. Two of the eight were removed because their programs had closed down their operations. Two of the eight were removed because, during the data collection phase, it was discovered that they were affiliated with other organizations on the list. One potential respondent was removed because it was no longer licensed by the state to provide residential care. The final sample consisted of 114 separate organizations.

Although the generalizability of results obtained from a non-probability sample is severely limited, the data obtained may provide information for adjusting theory, obtaining funding and resources for more rigorous study, and providing a beginning point at which new knowledge may be built (Royse, 1991). The sample described in the preceding section was used for several reasons: 1) First, because of familiarity with the Georgia system of child care gained by this researcher while employed with a child caring institution of the State; 2) pre-established relationships with many of the key informants within the system may enhance response rates among informants; 3) convenience involved with identifying and obtaining the data in this study; 4) limited resources available to conduct the study; and, 5) the Georgia system of care is currently establishing itself with regards to managed care. The researcher is personally and

professionally familiar with Georgia's system of child welfare and its efforts regarding the inclusion of managed care concepts and strategies.

The personal familiarity with many of the essential actors within the field was expected to aid data collection and especially the response rate to the survey. The sample also promised to provide variability in perceptions of the degree of pressure to adopt managed care principles because it has been a subject of debate and concern among child welfare providers in Georgia for several years. This debate suggests variability among agencies regarding the adoption of managed care practices and techniques. In fact, this researcher was notified in an informal telephone interview (with two executives of a notable professional association of residential childcare facilities) that Georgia does not have any managed care, despite indicating that many managed care techniques had indeed been implemented. Georgia represents an interesting context, albeit convenient, for the study of environmental affect on organizational structure and services.

### **Data Collection**

According to Royse (1999), " Surveys have been called 'the single most important information gathering invention of the social sciences' . . . Surveys can be thought of as snapshots of attitudes, beliefs, or behaviors at one point in time" (p. 138). The method for collecting data from the child welfare organizations (Child Caring Institutions) in Georgia was a self-administered, mailed, paper and pencil survey. The following sections provide an overview of the survey methodology employed in this study and justification for using survey research to explore the research questions discussed in the previous section with regard to Georgia's residential child caring institutions. The survey instrument is also presented along with the methodology for item

development used to gather data on the desired variables and constructs. Methodology for implementing the survey, including pre-testing of the instrument, is also included in this section.

### **Survey Methodology**

The survey design for this study is primarily exploratory, even though some examination of possible associations and causal relationships among environmental variables and organizational adoption of managed care principles, were incorporated. Exploratory surveys are often used in the early stages of scientific inquiry into a topic to provide the researcher(s) opportunity to tentatively test hypotheses and ideas prior to applying for funding or investing other considerable costs in a larger, more representative study (Royse, 1999). A cross-sectional design was instituted that enabled the investigation of sociometric variation and the effects of time (e.g., differences in perceptions between 1995 and the present).

Babbie (1990) described three basic types of surveys: 1) cross-sectional (taken at one point in time); 2) longitudinal (taken repeatedly at different points in time); or, 3) cross sectional designs used to approximate longitudinal ones (taken at one point of time but includes information to approximate the effects of time). Although cross-sectional surveys are primarily used to explore populations at one point in time, some devices may be used to approximate the effects of time. The first device involves asking informants (subjects) in the study to provide information relevant to the effects of time (Babbie, 1990). For example, a subject may be asked to report past voting behavior as well as current preferences. Another device may include the use of cohort comparisons within a cross-sectional survey (Babbie, 1990). Obtaining information from former and present

employees of a firm for comparison of their attitudes regarding the organization may be an example of a cohort design within a cross-sectional survey. A third device for approximating the effects of time in a cross-sectional survey involves the logical interpretation of the data that is obtained (Babbie, 1990). An example of logical interpretation may include the assertion that skills obtained by childcare workers in crisis intervention training decline over time based on comparing the length of time since training to knowledge of skills. Longitudinal designs may be effective means for collecting data on the effects of time; however when resources are limited, alternate devices may prove useful to the researcher.

The survey instrument also employed variations on what Babbie (1990) considers a basic design, incorporating aspects of contextual and sociometric studies. A contextual study, according to Babbie (1990), is “when data are collected about some portion of a person’s environment or milieu and used to describe the individual . . .” (p. 67). Studying characteristics of an employing agency to describe its childcare workers would be an example of a contextual study. Sociometric studies, involves the use of entire groups of subjects rather than samples drawn from an entire population (Babbie, 1990). For example, in studying support relationships among childcare workers all workers employed in a particular region may be studied rather than drawing a sample from the population of all childcare workers. The purpose would be to examine all relationships among the subjects being studied (e.g., childcare worker Y may indicate that worker X is her primary support while worker X indicates that she has no relationship at all with worker Y). A contextual design would allow for the examination of such contradictions.

The methodology used to develop the survey instrument and implement the study is based on the Total Design Method (TDM) (Dillman, 1978; Dillman, 1991; Salant & Dillman, 1994). According to Dillman (1978), TDM “. . . is nothing more than the identification of each aspect of the survey process (even the minute ones) that may affect response quantity or quality and shaping them in a way that will encourage good response” (p. 2). The method is based on social exchange theory of response behavior and an administrative plan that is intended to direct implementation.

According to Dillman (1978), “The process of sending a questionnaire to prospective respondents, getting them to complete the questionnaire in an honest manner and return it can be viewed as a special case of ‘social exchange’” (p. 12). Dillman predicates his view of surveys on the works of social exchange theorists such as Homans (1961), Blau (1964), and Thibaut and Kelley (1959) which, “. . . asserts that the actions of individuals are motivated by the return these actions are expected to bring and, in fact, usually do bring from others” (Dillman, 1978, p. 12). Rather than provide a complete discussion and critique of social exchange theory, only a brief discussion will be presented here of Dillman’s understanding as it applies to the Total Design Method of survey research. According to Dillman (1978), social exchange theory,

. . . can be distinguished from economic exchange as follows: under it, future obligations are created that are diffuse and unspecified; the nature of the return cannot be bargained about but must be left to the discretion of the one who owes it; the range of goods, services, and experiences exchanged is quite broad. It is assumed that people engage in any activity because of the rewards they hope to reap, that all activities they perform incur certain costs, and that people attempt to

keep their costs below the rewards they expect to receive. Fundamentally then, whether a given behavior occurs is a function of the ratio between the perceived costs of doing that activity and the rewards one expects the other party to provide at a later time. Thus, there are three things that must be done to maximize survey response: minimize the costs for responding, maximize the rewards for doing so, and establish trust that those rewards will be delivered. (p. 12)

Ensuring the best possible response rates on a survey then, according to Dillman and the Total Design Method, involves providing prospective respondents with the most desirable social exchange possible.

Dillman (1978; 1991) offers several suggestions, which are based on social exchange theory, for maximizing survey response. Suggestions for rewarding respondents include showing positive regard for the subjects, providing verbal appreciation, implementing a consulting approach, showing support for the respondent's values, providing financial and other tangible rewards, and by developing interesting questionnaires. Suggestions for reducing costs for respondents include making the task appear brief as possible, by reducing the required physical and mental effort needed to complete and return the survey, by eliminating the possibility of embarrassment, removing implications for subordination, and by eliminating any monetary costs for the respondent. Dillman also suggests that trust may be established by providing tokens of appreciation in advance, by identifying oneself with a known legitimate organization, and by capitalizing on other exchange relationships.

## **Survey Implementation**

The Total Design Method not only provides a theoretical basis for maximizing response but also provides a systematic method of survey implementation. Dillman (1978) explained, “The TDM is as much a carefully orchestrated set of sequential events as specific principles of design. Planning, timing, supervision, and control are fundamental requirements for its successful use” (p. 20). Dillman proposed that effective administration of a survey is as important to obtaining high quality data as the actual survey instrument and cover letter. Effective administration begins with a good plan. In essence, a good administrative plan identifies all the tasks that are to be accomplished, determines the ways each task is dependent on the others, determines the order of task implementation, and decides the means for accomplishing each task (Dillman, 1978).

Before describing aspects of the survey and its implementation, some strengths and weaknesses of the TDM design should be discussed. According to Dillman (1991),

The major strength of the Total Design Method as a comprehensive system is that meticulously following the prescribed procedures consistently produces high response rates for virtually all survey populations. Response rates typically reach 50-70% for general public surveys, and 60-80% for more homogenous groups where low education is not a characteristic of the population (Dillman, 1978; 1983; Mullen et al, 1987). (p. 234)

Dillman (1991) also reported that another strength of TDM is its theoretical basis, which removes emphasis from individual techniques and stresses the ways in which all aspects of design are interrelated.

Dillman (1991) also listed some weakness associated with TDM. One such weakness is that not all of the specific suggestions for design and implementation of a survey have sufficient supporting empirical evidence regarding their effectiveness. Dillman listed another weakness of TDM as its failure to include the option of monetary incentives to increase response rates. Dillman also identifies the use of social exchange theory as a possible weakness of TDM because it is a theory based on face-to-face interaction between people, and the researcher and respondents rarely interact face-to-face. Another limitation is that TDM proscribes the same methodology regardless of the population under study. Different populations may have different needs and different ideas about what is important to them. Despite the weakness described above, TDM provides a replicable methodology for conducting survey research, which has some empirical support for its efficacy.

TDM provides specific guidelines and suggestions for each aspect of survey research. The survey questionnaire is located in Appendix C and was designed based on TDM guidelines regarding three questions that the researcher should ask about each item that is included in the survey: 1) Will it elicit the desired type of information being sought?; 2) Is the question properly structured?; and, 3) Is the wording of the sentence appropriate? (Dillman, 1978). TDM also offers specific guidelines for the design of the questionnaire, including such considerations as page and question order and structure, printing and formatting designs, use of font and capitalization, etc. Guidelines for the construction of questionnaires follow the TDM design as closely as possible.

Referring again to Figure D, which is located in Appendix E, the Analytic Model is shown with the survey question numbers that correspond to the variable indicators

listed in bold type. The items are located in the survey instrument, which can be found in Appendix C. Items 1- 6 are demographic questions. Items 7-13 correspond with indicators for the political/ economic context variable. Items 2-5, 14, and 17-21 correspond with indicators of the institutional context variable, while items 23-27 correspond with indicators of the network context variable. The dependent variable corresponds with items 28-34. Items 15 and 16 are used to assess respondents' awareness of the principles of managed care.

The survey instrument was presented to eleven experts in the Tallahassee Florida area as a pretest. A pretest involves initial testing of one or more parts of the research design prior to the implementation of the actual study and is performed to illuminate unforeseen problems (Babbie, 1990). The pretest was provided to six professors of social work at Florida State University and five Chief Executive Officers of human service organizations in the Tallahassee area. The survey was administered in booklet format as suggested by TDM methodology and pretest participants were chosen based on their interests and expertise as researchers and/or administrative experience in human services. All six professors of social work completed the survey and provided feedback regarding its form and function. Three of the five chief executive officers completed and returned their surveys and comments for a total of nine respondents. Information obtained from the pretest was used to refine instructions and questions, get an idea of the time it takes to complete, establish face validity, obtain information on the difficulty of its completion, and inform refinement of the final survey.

Pretest participants indicated that it took them an average of 23.2 minutes to complete the survey, with social work faculty reporting an average of 21.5 minutes and

CEOs reporting an average of 26.7 minutes. The range of responses regarding completion time was from 10 to 45 minutes. With regards to face validity, respondents were asked how well they thought the instrument measured CEOs perceptions of the impact of managed care on their organizations in an open-ended format. The majority of respondents (n=6, 4 faculty and 2 CEOs) indicated that the instrument did an adequate or better job assessing perceptions of the impact of managed care. Other respondents answered: 1) “Fair—need more ‘In your opinion’ type questions; 2) “more difficult to assess”; and, 3) “Depends on if they really know what managed care is. Do you want to define managed care for them so you at least have some control over the construct and how it applies to your study?” Respondents were also encouraged to make comments on the survey itself regarding each item’s style, readability, etc. Changes were made to some of the individual items based on the feedback supplied by the respondents.

The TDM design offers specific methodology for implementing self-administered mail surveys/questionnaires. According to Dillman (1978), the first step involves preparing a cover letter that “emphasizes a reasonable explanation of the subject of the study, its benefit to a group with which the recipient identifies, and the individual importance of the respondent to the study’s success” (p. 163). The cover letter, informed consent form, and Internal Review Board’s approval letter are located in Appendix D. The form conforms to the requirements for consent as outlined by the Human Subjects Committee of Florida State University’s Internal Review Board. The consent form and cover letter were mailed along with a copy of the survey instrument and a postage-paid, business reply envelope for return of the completed questionnaire.

One week following the initial mailing, a follow-up postcard was sent to all initial recipients that both offered thanks to those who had already responded and to act as a reminder to those who have not yet responded. Dillman (1978) describes the third step in the TDM survey implementation as follows:

A second follow-up is mailed to nonrespondents exactly 3 weeks after the original mailout. It consists of a cover letter that basically informs them that their questionnaire has not yet been received and includes a restatement of the basic appeals from the original cover letter, a replacement questionnaire, and another return envelope. (p. 163)

Dillman (1978) goes on to suggest one final follow-up to be sent seven weeks after the original mailing to those recipients who have not yet responded. He suggests that the final follow-up be sent via registered mail and include a cover letter, another copy of the questionnaire, and a return envelope.

The implementation of this study followed the TDM design with the exception of three changes involving the final mailing. The first change involved making telephone requests for participation prior to the final mailing after receiving low response rates after each of the first two mailings, instead of having a telephone follow up after the final mailing. This was to alert prospective participants know that the survey was coming and of the importance of their participation. The second amendment was that the final follow-up survey was sent via regular mail instead of registered mail as a cost containment method.

The preceding discussion has presented an exploratory survey design based on the availability of a convenience sample of 117 child welfare organizations (child caring

institutions) that are located in the State of Georgia and that are licensed by the Department of Human Resources' Office of Regulatory Services. The survey and the design for its implementation were presented and were based on Dillman's (1978; 1991) Total Design Method for mail surveys.

### **Data Analysis**

To the methodological purist, the study design presented above would be unworthy of statistical analyses beyond the presentation of descriptive statistics. The use of a non-probability, convenience sample precludes the use of inferential statistics to make assertions regarding population characteristics (Glass & Hopkins, 1996; Tate, 1998). However, as noted by Royse (1999) science often advances through small incremental steps. The statistical analyses employed here may provide the fodder for more rigorous future research that may improve representativeness of results via random sampling of the larger population of child caring institutions beyond the state of Georgia.

Having noted those limitations to data analyses, this study utilized a series of index scores, based on responses to each of the indicators discussed earlier for the political economic, institutional/network, and dependent variables. Therefore, an index score for each of the four main variables, indicated in the analytic model, were included. According to Babbie (1998), "An index score is constructed through the simple accumulation of scores assigned to individual attributes" (p.168). Index scores were created for each of the main indicators for the three main variables and totaled to create a single score for each of the variables to indicate an ordinal scale score of the presence of that attribute (e.g., Degree of Managed Care Adoption). Missing data were addressed by replacement with the mean value. In most cases, the values used to create the index score

were dichotomous and therefore a mean score would indicate neutrality rather than the presence or absence of an attribute. The index score of each of the variables are considered continuous and therefore multiple regression was used to explain the variance of organizational adoption of managed care. Creation of the index scores and the extent of missing data will be further discussed in Chapter 4. Chapter 4 also provides the results of the data collection and analysis techniques performed in this study and described in this chapter.

### **Summary of Methodology**

This chapter presented the methodology that was employed to study the effects of external environmental forces on the internal structure and service delivery systems of human service organizations. A description of the sample and rationale for the inclusion of subjects in the sample was presented. The data collection procedures and instrument that was used to obtain information from the subjects was also presented. The chapter concluded with a description of the data reduction techniques that were employed to analyze the data that were obtained by the study. The results of the methodology are presented in the following chapter.

## **CHAPTER 4**

### **RESULTS**

#### **Introduction**

This chapter presents the results of the survey research described in the previous chapter. The data analyses for this study are divided into three major parts: conducting initial analyses; developing an index scoring scheme; and, performing a regression analysis on the index scores for the model variables. Discussion begins with a summary of the descriptive characteristics of the respondents, as well as the data obtained and is followed by an explanation of the methodology used to assign an index-scoring scheme to the model variables. Discussion of the results concludes with a presentation of the results of a regression analysis on the index scores for the independent variables (i.e., political/economic context; institutional/network context) on the index score for the dependent variable (i.e., managed care adoption). Presentation of the results of the study will be followed by a brief discussion and summary.

#### **Initial Analyses**

The initial analysis consisted of a cursory review of the descriptive data obtained via the survey instrument employed in this study. Limitations of the study will be discussed in-depth later; however, they are mentioned here to highlight the importance of the descriptive data to this study. The sampling frame was insufficient in size to allow for inferential statistical examination of the reliability and validity of the survey instrument. The low response rate of 33% of the possible subjects in the sampling frame further

compounds the possibility of meaningful statistical analyses of the results of the survey and the survey instrument. However, the information will be examined to help identify possible trends that can be studied in future research with a larger probability sample.

### **Descriptive Statistics**

Because of the limitations of the study, the value of the obtained results lies primarily in their descriptive rather than their explanatory value. Descriptive statistics are presented here on items included in the survey according to the variable each represents. The presentation of descriptive results begins with the six items that were designed to obtain demographic information regarding the respondents.

**Description of Respondent Characteristics.** Table 1 provides a synopsis of the items that were designed to elicit demographic information from respondents, along with the frequency and percentage their responses. These items (see Appendix C, items 1 through 6) were intended to assess the similarity of CEOs as a measurement of mimetic institutional pressure; however, the small sample size and the necessity of index scoring resulted in these variables not being included in the final study. The sample size also precluded the use of additional variables as control variables. Therefore, those items are presented here as descriptive statistics only. A total of 67.5% (n=25) of the respondents indicated that they were either the Executive Director, President, or Chief Executive Officer (CEO) of their organization; however, almost a third (32.4%, n = 12) indicated that they were not the primary administrators of their agencies. The respondents were not as homogenous as was hoped for analysis. An additional 18.9% (n=7) indicated other executive positions, such as superintendent, associate director, director/clinical coordinator, etc. Five of the respondents (13.5%) indicated roles that may or may not be

consistent with executive leadership of the organization (e.g., social worker, office manager, lead therapist, executive assistant, and program director). However, people in these roles often have access to information that is relevant to this study and were therefore included in the results.

The majority of the respondents (67.6%, n=25) reported at least five years in their current position. Only three respondents (8.1%) indicated that they had less than one year of experience in their current position. The majority (64.9%, n=24) of the sample had attained at least a master’s level degree at the time of survey administration. Respondents indicated receiving academic training in a variety of areas such as business administration, marriage and family therapy, psychology, public administration, social work, theology, education, counseling, child development and family relations, criminal justice, executive leadership, health care administration, human resource management, etc. Likewise, respondents indicated a wide variety of professional training experience. The gender distribution of respondents was almost equal with females comprising 51.4% (n=19) of the sample and males 45.9% (n=17).

**Table 1: Description of Respondent Characteristics.**

VARIABLE	DESCRIPTION	FREQUENCY	PERCENTAGE
Job Title	Executive Director	17	45.9%
	President	3	8.1%
	Chief Executive Officer (CEO)	5	13.5%
	Other Managerial/Executive	7	18.9%
	Other Non Managerial/Non Executive	5	13.5%
Length of Time in Current Position	Less than One Year	3	8.1%
	One Year to Less than Two Years	2	5.4%
	Two Years to Less than Five Years	7	18.9%
	Five Years or More	25	67.6%
Educational Level	Some College	2	5.4%
	Bachelor’s Degree	10	27%
	Master’s Degree	22	59.5%
	Doctoral Degree	2	5.4%

	Missing	1	2.7%
Academic Training Area(s) *	Business Administration	3	8.1%
	Marriage and Family Therapy	7	18.9%
	Psychology	14	37.8%
	Public Administration	2	5.4%
	Social Work	12	32.4%
	Theology	6	16.2%
	Other	14	37.8%
Professional Training/Experience Area(s) *	Business Administration	10	27%
	Marriage and Family Therapy	7	18.9%
	Psychology	16	43.2%
	Public Administration	1	2.7%
	Social Work	15	40.5%
	Theology	6	16.2%
	Other	12	32.4%
Gender of Respondent	Male	17	45.9%
	Female	19	51.4%

\* Respondents could indicate more than one area of training/experience; therefore, the reported percentages indicate the proportion of respondents that indicated training in each area.

**Political/economic context items.** The next set of descriptive results represents the political/economic context of the organizations under study. These items were designed to elicit information regarding the diversity of political and economic resources available to the organization. The items, responses, frequencies, and percentages of the political and economic context are located in Table 2 below.

With regard to the diversity of political resources available to organizations, 25 (67.6%) of the respondents indicated that they were multi-site agencies (i.e., they owned and operated multiple facilities). Only two agencies (5.4%) claimed any ties to civic or social clubs such as the Lion's Club, Kiwanis, etc. However, 27% (n=10) claimed ties to some religious sect. Seventy-three percent of the sample (n=27) asserted that they were independent organizations and not branches or departments of a larger corporation. Furthermore, 73% (n=27) claimed membership in at least one professional membership organization at the state or national level (e.g., Georgia Association of Homes and Services for Children [GAHSC] or Child Welfare League of America [CWLA]).

With regard to the diversity of economic resources available to organizations, only one respondent reported the agency operated on a for-profit basis. Most reported their agencies had more than one source of funding (78.3%, n = 29); only 4 respondents (10.8%) indicated that their agencies relied on only one source of funding. The majority of respondents (43.2%, n=16) indicated that they received funding from two or three sources. Thirteen (35.1%) agencies received funding from four to eight different sources.

**Table 2: Political/Economic Context.**

<b>VARIABLE/INDICATOR</b>	<b>DESCRIPTION</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
<b>Diversity of Political Resources Available to the Organization</b>			
Multiple versus Independent Sites (Number of Separate Facilities)	1 site only	12	32.4%
	2-3 sites	10	27.0%
	4 or more sites	10	27.0%
	Missing	5	13.5%
Ties to a Civic/Social Club?	Yes	2	5.4%
	No	34	91.9%
	Missing	1	2.7%
Member of a Statewide/National Association versus Non-Member.	Independent Organization	27	73.0%
	Subsidiary of a Corporation	7	18.9%
	Missing	3	8.1%
Member of a Professional Association?	Yes	28	75.7%
	No	8	21.6%
	Missing	1	2.7%
	Number of Associations Listed:		
	0	9	24.3%
	1 or 2	18	48.6%
Sectarian versus Non-Sectarian	3 or more	10	18.9%
	Sectarian	10	27.0%
	Non-Sectarian	26	70.3%
	Missing	1	2.7%
<b>Diversity of Economic Resources Available</b>			
Profit versus Not-for-Profit	For Profit	1	2.7%
	Not-For-Profit	35	94.6%
	Missing	1	2.7%
Number of Funding Sources Available to Individual Organizations.	1	4	10.8%
	2	8	21.6%
	3	8	21.6%
	4 to 8	13	35.1%
	Missing	4	10.8%

**Institutional context (perceived regulative/coercive pressure).** The institutional context items were designed to elicit information on the respondents' perceptions of the pressure exerted by regulative, normative, and cognitive institutional forces. Respondents were first asked how well they knew the policies at the federal, state, and local levels, which affect children and their families. The results of those responses are presented in Table 3. Thirty-three (89%) respondents felt that they knew local policies at an average or above average level. Similarly, 86.5% (n=32) indicated that they had average or better knowledge of state level policies. A slightly fewer number of respondents (n=27, 73%), specified an average or above average knowledge of federal policies that affect children and their families. The level of perceived policy knowledge was addressed to inform the level of perceived regulative pressure experienced by organizations.

**Table 3: How well Respondents Perceive They Know Policy.**

	<b>FEDERAL POLICY</b>		<b>STATE POLICY</b>		<b>LOCAL POLICY</b>	
	Percent	N	Percent	N	Percent	N
<b>Very Well</b>	18.9%	7	35.1%	13	37.8%	14
<b>Well</b>	16.2%	6	32.4%	12	18.9%	7
<b>Average</b>	37.8%	14	18.9%	7	8.1%	3
<b>Not Well</b>	10.8%	4	8.1%	3	2.7%	1
<b>Very Little</b>	10.8%	4	2.7%	1	5.4%	2
<b>Missing</b>	5.4%	2	2.7%	1	2.7%	1

Table 4 presents data collected on items relating to regulative institutional pressure. The majority of respondents (approximately 73%, n=27) indicated that they felt very little or no pressure to adopt managed care principles from federal policies. Only 13.5% (n=5) indicated experiencing some or high levels of pressure from federal policies.

Correspondingly, 70.3% (n=26) indicated little or no pressure from local policies.

However, A higher number of respondents (n=13, 35.1%) indicated that they experienced some or high levels of pressure to adopt managed care principles from state policies.

Other regulative or coercive forces considered in this study included licensing/regulatory authorities, funding sources, and societal pressure. Higher levels of perceived pressure for these regulative forces were reported by 18.9% (n=7), 29.7% (n=11), and 18.9% (n=7) respectively.

**Table 4: Perceived Pressure Regulative/Coercive Pressure.**

	FEDERAL POLICIES	STATE POLICIES	LOCAL POLICIES	LICENSING/REGULATIVE AUTHORITIES	FUNDING SOURCES	SOCIETAL PRESSURE
No Pressure	45.9% n=17	24.3% n=9	40.5% n=15	32.4% n=12	27.0% n=10	37.8% n=14
Very Little Pressure	18.9% n=7	21.6% n=8	29.7% n=11	27.0% n=10	24.3% n=9	21.6% n=8
Some Pressure	10.8% n=4	29.7% n=11	8.1% n=3	8.1% n=3	21.6% n=8	18.9% n=7
High Pressure	2.7% n=1	2.7% n=1		8.1% n=3	2.7% n=1	
Extremely High Pressure		2.7% n=1		2.7% n=1	5.4% n=2	
Do not Know	13.5% n=5	10.8% n=4	13.5% n=5	10.8% n=4	10.8% n=4	10.8% n=4
Missing	8.1% n=3	8.1% n=3	8.1% n=3	10.8% n=4	8.1% n=3	10.8% n=4

Table 5 presents the results of items designed to address the levels of perceived pressure from normative and cognitive institutional forces. Just as the perceived levels of regulative pressure were low, reported levels of normative influences were similarly low. A slight majority of respondents (51.4%, n=19) reported their agencies were accredited by an independent agency. Only 11 (29.7%) of the respondents indicated they perceived any level of managed care integration by accrediting agencies of which they were aware.

However, an increased proportion of respondents reported integration of managed care principles by professional associations (n=17, 46%). Regarding cognitive pressure, the majority of respondents indicated that other states' and other professions' adoption of managed care had no influence to moderate influence on their agencies' decisions to adopt managed care principles. The majority of the respondents indicated little or no influence by other states' adoption of managed care principles (n=20, 54.1%). Only slightly more influence was attributed to other professions' adoption of managed care as evidenced by the largest number of respondents falling into the "some effect" category (n=11, 29.7%).

**Table 5: Perceived Normative and Cognitive Pressure.**

VARIABLE/INDICATOR	DESCRIPTION	FREQUENC Y	PERCENT
<u>Perceived Normative Pressure</u>			
Does an accrediting agency/association accredit your organization?	Yes	14	37.8%
	No	19	51.4%
	Missing	4	10.8%
Perceived degree to which accrediting agencies have integrated managed care.	No Integration	5	13.5%
	Little Integration	3	8.1%
	Somewhat Integrated	8	21.6%
	Missing	21	56.8%
Perceived degree to which professional associations have integrated managed care.	No Integration	8	21.6%
	Little Integration	8	21.6%
	Somewhat Integrated	7	18.9%
	Highly Integrated	2	5.4%
	Missing	12	32.4%
<u>Perceived Cognitive (Mimetic) Pressure</u>			
Perceived affect of other states' adoption of managed care in child welfare on agency's decisions	No effect on my agency's decisions	10	27.0%
	Little effect	10	27.0%
	Some effect	9	24.3%
	Moderate effect	4	10.8%
	Missing	4	10.8%
Perceived affect of other professions' integration of	No effect	8	21.6%
	Little effect	10	27%

managed care on agency's decision	Some effect	11	29.7%
	Moderate effect	4	10.8%
	Missing	4	10.8%

**Network Context: Perceived Relational Pressure.** The network of relationships, which an organization shares with other organizations, also may affect organizational behavior. As previously discussed, survey items in the following four areas addressed the network context of individual organizations: 1) Structure of the network to include size, homogeneity, and age; 2) Imitation of organizations within an organization's network; 3) Patterns of imitation because of size or prestige of the network; and, 4) Social learning based on the performance of other organizations within the network. Table 6 provides a summary of the items used for the network context (i.e., the perceived amount of pressure by members of their organizational network) and the frequencies and percentages of responses for each item.

With regard to the structure of networks, respondents listed between one and eight different organizations as those they considered a part of their organizational network. The majority of respondents (56.7%, n = 21) said the organizations within their organizational network were extremely or somewhat similar. Four of the respondents (10.8%) reported that the organizations in their organizational networks were extremely similar, seemingly indicating perceptions of homogeneous networks. The age of the networks varied as reported from one to forty years.

With regard to imitation of networks, the majority of respondents (n=19, 51.4%) reported that the response to managed care most often adopted by members of their network, was to integrate the best practices of managed care or a few of its principles.

Only two respondents reported that the organizations in their network had fully integrated managed care. Three respondents indicated their network was not concerned with managed care and thirteen respondents (35.1%) either did not know how other organizations had responded to managed care or did not answer the survey question. Eleven respondents (29.7%) indicated that other larger, more prestigious members of their organizational network had at least some influence on their organization's response to managed care. However, the majority of respondents either indicated no influence (n=7, 18.9%), or responded that they did not know (n=10, 27%), or they did not respond to the question (n=9, 24.3%). When asked whether the performance of other organizations within their network influenced their decisions regarding managed care, fourteen (37.8%) indicated that they were at least partially influenced. Five of the respondents (13.5%) indicated that they were not influenced by the performance of other organizations and eighteen (48.6%) either did not respond or did not know.

**Table 6: Network Context**

VARIABLE/INDICATOR	DESCRIPTION	FREQUENCY	PERCENT
<u>Network Structure</u>			
Network Size (# of organizations listed by respondents)	1	6	16.2%
	2	4	10.8%
	3	5	13.5%
	4	4	10.8%
	6	3	8.1%
	7	1	2.7%
	8	2	5.4%
	Missing	12	32.4%
Perceived Homogeneity of Network	Extremely Similar	4	10.8%
	Somewhat Similar	17	45.9%
	No Similarity	2	5.4%
	Do Not Know	7	18.9%
	Missing	7	18.9%
Perceived Age of Network/Duration of Affiliation with Network rounded up to the nearest year	1 Year	4	10.8%
	2 to 5 years	10	27%
	6 to 10 years	5	13.5%
	12 to 20 years	6	16.2%
	27 to 40 years	3	8.1%
	Missing	9	24.3%

<b>Imitation of Network</b>			
What has been the response of most organizations in your organizational network to managed care?	They have integrated managed care	2	5.4%
	They have integrated best practices	8	21.6%
	They have integrated a few principles	11	29.7%
	MC is not a concern of my Network	3	8.1%
	Do Not Know	6	16.2%
	Missing	7	18.9%
<u>Patterns of Imitation</u>			
Have other larger, prestigious, network organizations influenced your decisions regarding integration of managed care?	Yes, Some influence	11	29.7%
	No Influence	7	18.9%
	Do Not Know	10	27.0%
	Missing	9	24.3%
<u>Social Learning</u>			
Has performance of other network organizations influenced your decisions regarding integration of managed care?	Yes, Greatly influence our decisions	1	2.7%
	Yes, Some influence	13	35.1%
	No Influence	5	13.5%
	Do Not Know	10	27.0%
	Missing	8	21.6%

**Outcome Variable: the degree to which organizations adopt managed care.**

The extent to which organizations adopt managed care principles was measured by four indicators: 1) the degree of adoption of managed care principles; 2) the degree to which service configurations changed; 3) the degree to which policy and procedures changed; and, 4) the degree to which funding development and allocation changed. Data for each of the four indicators were elicited by asking respondents their perceptions of the degree of integration of managed care principles/features and the degree that their agencies had changed since 1995. As discussed earlier, 1995 was the year that the possibility of managed care was introduced to Georgia's child welfare system.

Table 7 displays the responses to indicators of the degree of adoption of managed care. When asked to what degree their agency had integrated managed care principles/features, two respondents (5.4%) indicated they had fully integrated managed care features, including the funding mechanisms. Three (8.1%) indicated they had integrated many of the managed care features or principles but had not integrated the

funding mechanisms. Fourteen (37.8%) indicated that they had integrated a few of the best practices of managed care and six (16.2%) indicated that they had not integrated any managed care principles or features. The remaining 32.4% either responded that they did not know if they integrated managed care or failed to respond to the question. The number of managed care principles (from a provided list of 9 principles), which respondents indicated their agencies employed, ranged from 0 to all 9 of the principles, with similar number of responses for the recoded 1-4 category (45.9%, n = 17) and the recoded 5-9 category (40.5%, n = 15). There was also a varied range in the number of those same principles respondents had indicated occurred after 1995; fewer reported 1-4 (35.1%, n = 13) or 5-9 (21.6%, n = 8) than those occurring before 1995.

**Table 7: Degree of Adoption of Managed Care Principles**

INDICATOR	DESCRIPTION	FREQUENCY	PERCENT
To what degree has your agency integrated managed care features/principles?	-Total Integration, including Funding Mechanisms	2	5.4%
	-Integrated many MC features related to service implementation and oversight but no features related to funding.	3	8.1%
	-Integrated a few of the best of managed care features	14	37.8%
	-No integration of managed care features	6	16.2%
	-Not sure or do not know	6	16.2%
	-Missing	6	16.2%
Number of Managed Care principles respondents indicated their organizations currently employ.	0	1	2.7%
	1 - 4	17	45.9%
	5 - 9	15	40.5%
	Missing	4	10.8%
How many of the principles checked in the preceding question were implemented since 1995?	0	2	5.4%
	1 - 4	13	35.1%
	5 - 9	8	21.6%
	Do Not Know	7	18.9%
	Missing	7	18.9%

Responses to questions designed to elicit subjects' perceptions of the changes in their agencies' service configurations, policies and procedures, and funding development and allocation since 1995 are presented in Table 8 below. For service configurations, 56.8% (n=21) indicated that the services that their agencies offered were different than in 1995. These differences were: more services (43.2% (n=16); higher staff to client ratios (37.8%, n = 14); more clients (43.2%, n = 16); changes in group vs. individual services (more groups 10.8%, n = 4; less groups 8.2%, n = 3); shorter duration of services (21.6%, n = 8; more specialized services (37.8%, n = 14). No differences were reported for targeting of clientele (24.3%, n = 24.3%). 75.7% (n=28) of the respondents indicated there was some or much change in agency policies and procedures. 54% (n=20) of respondents indicated some or much funding development changes within their agencies and 59.5% (n=22) said funding allocation had some or much changed. While 18.9% (n=7) of the respondents said that managed care had no influence on their agencies' services, policies and procedures, and funding development/allocation, 56.7% (n = 21) said managed care had some or high influence; 35.1% did not know if managed care influenced their organization or failed to answer the question.

**Table 8: Perceptions of Changes in Policies, Services, and Funding.**

<u>INDICATOR</u>	<b>DESCRIPTION</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
<u>Service Configurations</u>			
Are the services that you currently offer your clients different than in 1995?	Yes, Different than 1995	21	56.8%
	No Difference	11	29.7%
	Missing	5	13.5%
If yes, in what ways?			
More/Fewer Services	More	16	43.2%
	Missing	21	56.8%
Targeted Clientele Different or Same	Different	5	13.5%
	Same	9	24.3%
	Missing	23	62.2%

Higher/Lower Staff to Client Ratio	Higher	14	37.8%
	Lower	2	5.4%
	Missing	21	56.8%
Serves More/Fewer Clients	More	16	43.2%
	Fewer	2	5.4%
	Missing	19	51.4%
More/Less directed towards groups rather than individuals	More	4	10.8%
	Less	3	8.1%
	Missing	30	81.1%
Average duration of services is Longer/Shorter	Longer	4	10.8%
	Shorter	8	21.6%
	Missing	25	67.6%
Services are More/Less Specialized	More	14	37.8%
	Less	1	2.7%
	Missing	22	59.5%
<b>Policies and Procedures</b>			
Degree to which policies and procedures have changed since 1995	No Change	2	5.4%
	Some Change	20	54.1%
	Much Change	8	21.6%
	Do Not Know	4	10.8%
	Missing	3	8.1%
<u><b>Funding</b></u>			
Degree to which Funding Development has changed	No Change	12	32.4%
	Some Change	12	32.4%
	Much Change	8	21.6%
	Missing	5	13.5%
Degree to which Funding Allocation has changed	No Change	10	27.0%
	Some Change	15	40.5%
	Much Change	7	18.9%
	Missing	5	13.5%
Degree of Perceived Influence Managed Care has had on agency's policies, services, funding since 1995	No Influence	7	18.9%
	Some Influence	14	37.8%
	High Influence	3	8.1%
	Not Applicable/Do Not Know	8	21.6%
	Missing	5	13.5%

**Items not included in the analytic model.** Two additional items were included in the survey, which were not a part of the analytic model; responses can be seen in Table 9. Nineteen respondents (51.3%) reported that managed care is or has the potential for being an important tool for improving services to children and families. Eight respondents felt that managed care is or has the potential for being detrimental to services for families and children (21.6%). Nine (24.3%) had no opinion regarding the usefulness of managed care to children and families. When asked to check off a list of fourteen items, which were adapted from Wernet's (1999) elements of managed care, only one respondent indicated that all 14 items were part of managed care. Five respondents

(13.5%) indicated that less than one quarter of the items were managed care elements.

Twelve of the respondents included 4 or 5 of the 14 items as being included. 32.4%

(n=12) indicated between 8 and 11 of the items as being a part of managed care and

10.8% (n=4) did not respond to the question.

**Table 9: Items not included in the Analytic Model.**

<b>INDICATOR</b>	<b>DESCRIPTION</b>	<b>FREQUENCY</b>	<b>PERCENT</b>
Check the statement below that most nearly reflects your opinion regarding the use of managed care in child welfare	-I think managed care is an important tool for improving services to children and families.	3	8.1%
	-I think managed care has potential for being an important tool for improving services to family and children.	16	43.2%
	-I have no opinion regarding the use of managed care on services to families and children.	9	24.3%
	-I think managed care has the potential to be detrimental to services for families and children.	5	13.5%
	-I think managed care is detrimental to services for families and children.	3	8.1%
	-Missing	1	2.7%
	To the best of your knowledge, which of the following features are parts of a managed care system?	Total number of items checked, out of 14 listed features:	
1 to 3 items checked		5	13.5%
4 to 5 items checked		12	32.4%
7 to 9 items checked		8	21.6%
10 to 11 items checked		7	18.9%
All 14 items checked		1	2.7%
Missing		4	10.8%

### **Discussion of Initial Analyses**

Respondents tended to be in administrative positions (e.g., CEO, President, or Executive Officer), with at least five years of experience in their current position. They also tended to be well educated (master's level degree) in a variety of disciplines and indicated diverse professional training backgrounds. The gender of each respondent was almost as likely to be male as female. The respondents' agencies were likely to be multi-

site agencies, with no ties to civic or social clubs, although a relatively large portion claimed some religious affiliation. Most respondents said that their agencies were independent and maintained membership in at least one professional association; most operated on a not-for-profit basis and relied on multiple sources of funding.

The majority of respondents ranked their knowledge of federal, state, and local policies and procedures, which affect children and their families, as average or above average. However, they also indicated that they felt very little or no pressure to adopt managed care principles or procedures from regulative forces in the form of policies and procedures. Similarly, relatively few respondents indicated experiencing coercive pressure from licensing/regulating agencies, funding sources, and/or society in general. Perceived levels of normative and cognitive institutional pressure were low, although there was some reporting of low to moderate levels of pressure in each area. Respondents indicated relatively little pressure from organizational networks to adopt managed care principles.

While few respondents indicated that they had fully integrated managed care principles, including the funding mechanisms of managed care many indicated that they had integrated at least some of the best practices of managed care into their agencies. Most respondents indicated that their agencies' services, policies and procedures, and funding development and allocation had changed since 1995 (when managed care was first introduced to the Georgia system of child welfare). Many indicated that managed care had some effect on the changes in their agencies.

Because of the low return rate, and lack of information regarding whether those that returned their surveys were representative of the larger population, it is not possible

to generalize these findings to other organizations within the population. An attempt was made to analyze the differences between respondents and those that did not respond by analyzing their similarities and differences, based on information obtained from the Internal Revenue Service's (IRS) Masterfile of non-profit agencies. Only 69 of the agencies included in the sample were incorporated in the masterfile; therefore, the usefulness of comparisons was deemed to be unsatisfactory. However, it is helpful to further analyze the data to inform future inquiry into organizational adaptation to the external environment. Therefore, an index-scoring scheme was utilized to help identify trends in the data that may be more fully explored with more rigorous future study.

### **Index Scoring**

One method of reducing data to manageable units is by creating index scores for each of the variables represented in the model (i.e., Perceived Political/Economic Pressure, Perceived Institutional Pressure, Perceived Pressure from Networks, and the Degree of Managed Care Adoption). According to Kerlinger (1986),

An index is a number that is a composite of two or more numbers. An investigator makes a series of observations, for example, and derives some single number from the measures of the observations to summarize the observations, to express them succinctly. By this definition, all sums and averages are indices: they include in a single measure more than one measure. But the definition also includes the idea of indices as composites of different measures. Coefficients of correlation are such indices. They combine different measures in a single measure or index. (p. 140)

According to Babbie (1998), “An index score is constructed through the simple accumulation of scores assigned to individual attributes” (p.168). The benefit of an index score, in this case, is that it allows for a cumulative score based on several attributes of the same variable. For example in political economy portion of the model, there are two types of possible pressure: pressure resulting from economic sources and pressure resulting from the political power holders in the agency’s environment. The two potential sources may exert different levels of pressure for adoption of a particular form of organizational behavior. Therefore, an index score would allow for variation in pressure from a political/economic single variable. Two very different constructs result in one measure of the intensity of perceived pressure.

In this study, a single index score was created for each variable included in the model (i.e., political/economic pressure, institutional pressure, network pressure, and degree of managed care adoption) by adding each respondent’s scores for each of the indicators of a variable. Figure D in Appendix E shows the constructs underlying each of the variables in the model and their associated survey item numbers. The first step in this process is to recode individual items so that they can be combined into meaningful index scores. The following section discusses the procedures used to recode variables in the creation of index scores for the model variables.

### **Decision Rules for Recoding Independent Variables**

**Political/economic context.** Item #7 was re-coded so that not-for-profit organizations received a higher number than for-profit organizations to signify greater diversity. Item #13 needed no recoding, as higher numbers of funding sources indicated increased diversity of funding sources. Item #8 was recoded so that organizations that were

subsidiaries of larger corporations received higher scores indicating greater access to diverse sources of political power. In item #9, the diversity of political power available was assumed to vary with the number of physical sites operated by an organization and thus no recoding was needed. Item #10 was recoded so that organizations that indicated sectarian ties received higher scores than those that did not and thus represented greater diversity of political power. Item #11 was similar to item #10, with higher scores going to those organizations with ties to civic or social clubs. Item # 12 asked respondents to list the number of professional associations to which they belonged. No recoding was needed as higher number of associational ties indicated greater access to political power. The political economy indicators for each individual were then summed to produce a new variable (Political and Economic Diversity Index Score) with higher index scores indicating access to a greater diversity of political and economic resources by the organization.

**Institutional context.** Items 14 and 17-21 were included in the institutional context. Item 14 was recoded so that higher scores indicated increased knowledge of policies and procedures affecting children and their families at each of the national, state, and local levels. Item 17 was similarly recoded so that higher scores indicated increasing perceived pressure to adopt managed care principles from policy (federal, state, and local), licensing entities, funding sources, and society as a whole. Items 18 and 19 were recoded so that higher scores represented increasing degrees of perceived integration of managed care principles by organizations' accrediting bodies and professional associations. Items 20 and 21 were recoded so that higher scores indicated higher perceived influence of other states' and other professions' adoption of managed care on the respondent's

organization's decisions regarding managed care. The institutional context indicators for each individual were then summed to produce a new variable (Perceived Institutional Pressure Index Score) with higher index scores indicating higher perceived institutional pressure to adopt managed care principles.

**Network context.** Items 22-27 were included in the Network context. Item 22 called for the number of organizations considered to be a part of respondents' organizational networks and needed no recoding. Larger networks were assumed to have higher influence on individual organizations as discussed in the previous chapter. Item 23 was recoded so that higher scores indicated greater perceived homogeneity among a respondent's organizational network. Item 24 needed no recoding, because an increasing number of years associated with an organizational network were considered to be related with the age of the network. Item 25 was recoded so that higher scores were associated with a greater perceived degree of managed care adoption by members of an organization's organizational network. Item 26 was recoded so that higher scores indicated greater perceived influence, by the organizational network, on the respondent's organization to integrate managed care. Item 27 was similarly recoded so that higher scores indicated greater influence of the performance of other organizations within one's organizational network on the decision to adopt managed care principles. The network context indicators for each individual were then summed to produce a new variable (Perceived Network Pressure Index Score) with higher index scores indicating increasing network pressure to adopt managed care principles.

## **Decision Rules for Recoding the Dependent Variable**

Items 28 through 34 were included in the dependent variable “Degree to which Organizations Adopt Managed Care.” Item 28 was recoded so that higher scores would indicate higher levels of managed care integration into respondent’s agencies. Item 29 indicated the number of managed care principles that respondents indicated their agency was currently using. Item 30 indicated how many of those same principles had been integrated since 1995. Item 31 was recoded so that higher scores indicated increased changes in the organization’s policies and procedures since 1995. Items 32 through 33 were recoded so higher scores indicated increasing changes in funding development and allocation, and service provision since 1995. Item 34 was recoded so higher scores indicated greater perceived influence of managed care on respondent’s agencies. The dependent variable indicators for each individual were then summed to produce a new variable (Degree to which Organizations Adopt Managed Care Index Score) with higher index scores indicating increasing adoption of managed care principles and higher influence on organizational structure and services.

Table 10 shows descriptive statistics for each of the resulting index scores. The new index scores were then included in multiple regression analyses. Before discussing the results of the regression analyses, a brief note regarding the limitations of using index scoring is in order. Index scores are only as good as the measures that are used to make them. For example, according to Kerlinger (1986),

Because they are often a mixture of two fallible measures, indices can be dangerous. The old method of computing IQ is a good example. The numerator of the fraction is itself an index since MA, mental age, is a composite of a number of

measures. A better example is the so-called Achievement Quotient:  $AQ = 100 \times \frac{EA}{MA}$ , where EA = Educational Age, and MA = Mental Age. Here, both the numerator and the denominator of the fraction are complex indices. Both are mixtures of measures of varying reliability. What is the meaning of the resulting index? How can we interpret it sensibly? It is hard to say. In short, while indices are indispensable aids to scientific analysis, they must be used with circumspection and care. (p. 141)

**Table 10: Descriptive Statistics on Index Scores**

<b>Index Variable</b>	<b>Range</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Standard Deviation</b>
Political Economy (Items 7-12)	28	9	37	17.18	16.933
Institutional (Items 14, 17-21)	35	16	51	32.53	8.477
Network (Items 22-27)	56	2	58	19.30	9.893
Managed Care Integration (Items 28-34)	28	1	29	12.15	6.065

\*N=37

### **Regression on Index Scoring**

The purpose of this analysis was to examine the effects of three independent variables (political/economy index, institutional index, and network index) on the dependent variable (degree of integration of managed care index). The correlations for all variables are presented in Table 11. Missing data were addressed by inserting the series mean for the derivation of index scores; therefore, no data were missing from the index scores for the variables.

**Table 11: Correlations Among Index Scores**

	<b>POLITICAL ECONOMY</b>	<b>INSTITUTIONAL INDEX</b>	<b>NETWORK INDEX</b>	<b>MC INTEGRATION</b>
<b>POLITICAL ECONOMY</b>	<b>1.00</b>			
<b>INSTITUTIONAL INDEX</b>	<b>.160</b>	<b>1.00</b>		
<b>NETWORK INDEX</b>	<b>.058</b>	<b>-.005</b>	<b>1.00</b>	
<b>MC INTEGRATION</b>	<b>.309</b>	<b>.325</b>	<b>.343</b>	<b>1.00</b>

\* N = 37

### **Preliminary Analyses**

A case analysis was conducted to identify outliers. The studentized residual was used as a case index for the identification of outliers. According to Tate (1998),

*A case index* is an index or number computed for each individual case (i.e., for each subject in the sample). A useful case index for the identification of outliers is the *studentized residual*. This index behaves approximately like a standardized residual with absolute values of approximately 2.5 or 3.0 and larger reflecting possible outlier observations. (p. 49)

In accordance with Tate's guidelines, an outlier was considered to be a residual when its absolute value was in excess of 2.5; one case fit this criterion with a value of approximately 3.2. Because it was not possible to determine why the data did not fit the model, an inspection of the index  $\Delta\beta_{ij}$  (Delta Beta<sub>ij</sub>) was conducted to examine the influence of outliers.

The  $\Delta\beta_{ij}$  index can be defined as the change in the jth regression coefficient when the ith observation is deleted from the sample (Tate, 1998). Tate suggests a two-step

approach for judging whether an outlier has excessive influence on the regression model as follows:

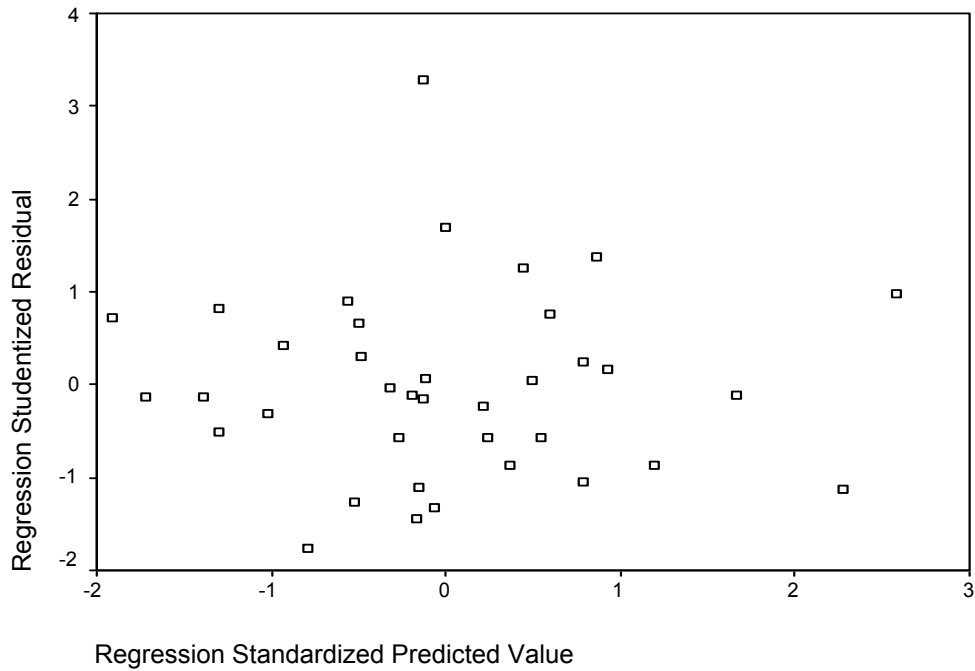
- *Step 1:* For each coefficient, note the point estimate and the largest negative and positive  $\Delta\beta$ s. Determine the proportion change of the point estimate for the  $\Delta\beta$  largest in magnitude ( $\Delta\beta$  divided by the initial point estimate). If the proportion change is relatively small (say 0.3 or smaller), conclude that no observations have excessive influence on that coefficient. If the proportion change is relatively large (say, 0.3 or larger), go to Step 2.
- *Step 2:* Judge *in the context of the threshold of practical importance* whether the changes resulting from both of the  $\Delta\beta$ s are of qualitative importance. If so, one or both observations would be judged influential. (p. 51)

The proportion change associated with the point estimate of the political economy index variable is equal to  $(-.066/.213) \cong -.309$ , a value larger in magnitude than .3. Moving to the second step, the largest and smallest  $\Delta\beta$ s for the political economy index variable was approximately -.07 and .06 respectively and the coefficient for the whole sample was .213. The resulting new  $\Delta\beta$ s (.147 and .269) exercise excessive influence on the model results, judging by a practical importance threshold of .088 (standard deviation of the dependent variable divided by the standard deviation of the political economy index score). The estimated regression coefficient for the institutional index variable was approximately .245. The proportion change of the point estimate of its largest  $\Delta\beta$  was  $(-.050/.206) \cong .245$ , indicating no significant influence. The proportion of change for the network index variable was approximately  $(-.092/.202) \cong .454$ . The influence was judged

to be significant within a threshold value of .061. Tate (1998) suggests that a sensitivity analysis be conducted to determine the influence on model results, by conducting the analyses again with the outlier removed from the sample. Results of the sensitivity analysis are presented following the regression analysis below.

Visual inspection of a scatterplot (see Figure A below) showing studentized residuals versus predicted residuals did not suggest any violations of the assumptions required for multiple regression. That is to say, for every combination of independent variables, the residuals were normally and independently distributed with a mean of zero and approximately of equal width over the range of the predicted dependent variable. However, the assumption that the variables are known exactly cannot be confirmed in this study because the reliability and validity of the instrument is not known. Multiple regression is robust to minor violations of the exact measurement assumption (Tate, 1998); however, whether or not there is a violation of this assumption or the degree of a violation cannot be determined in this study.

**Figure A: Scatterplot of Studentized versus Predicted Residuals.**



### **Regression Analyses**

The regression model is presented in Table 12. According to Tate (1998) the total variability of the dependent variable of a regression model explained by the model is the coefficient of determination and is labeled  $R^2$ . In this study, the total variance of the dependent variable (Degree of Managed Care Adoption Index Score) explained by the model was approximately 28% ( $R^2 = .282$ ). The overall strength of the relationship between the dependent variable and the independent variables (Political Economy, Institutional, and Network Index Scores) was statistically significant at the .05 level ( $F = 4.315$ ,  $F \{.05; 3, 33\} = 2.28$ ,  $p < .011$ ). The overall model was statistically significant at the .05 level, and the Network Pressure Index was a significant predictor of Degree of Managed Care ( $p < .05$ ). To compensate for the possibility of chance in fitting the

model, the adjusted  $R^2$  estimate was used (Adjusted  $R^2 = .216$ ). The standard deviation from the regression line was 5.369 units, and the precision of estimating the range of values in which the true regression coefficient was likely to fall, for a 95% confidence interval, was plus or minus 1.808 units. The ratio of the width of the prediction interval to the range of the dependent variable was .885, indicating that the prediction interval for future predictions was not acceptable given a threshold of 30% of the range of the dependent variable.

**Table 12: Regression Model**

	Degree of Managed Care Integration Index
Political and Economic Diversity Index	.213
Institutional Pressure Index	.206
Network Pressure Index	.202*
F Value	4.315*
Adjusted $R^2$	.216
Degrees of Freedom (DF)	3, 33

\*Significant at the .05 Level.

Table 13 summarizes the effects of each independent variable on the degree of integration of managed care principles index score (dependent variable). The estimated change of .213 units of managed care adoption index score for every unit change in political economy index score, controlling for all other independent variables, was not significant at the .05 level. According to Tate (1998), the threshold of practical importance for an interval independent variable is equal to the standard deviation of the dependent variable (6.065) divided by the independent variable (6.933), which is then

multiplied by .1 (resulting in  $[6.065/6.933] \times .1 = .088$ ). Comparing the threshold of .088 with the 95% confidence interval for political economy in Table 13, some of the points are less in value than the threshold and some are greater. This means that the practical importance of the true effect of the political economy index score on the population is inconclusive. The unique contribution of the political economy index score to the model  $R^2$  ( $\Delta R^2$  in Table 13) is .058.

**Table 13: Individual Effects of the Independent Variables**

<b>Independent Variable</b>	<b>Effect Estimate</b>	<b>95% Confidence Interval</b>	<b><math>\Delta R^2</math></b>
<b>Political Economy Index</b>	.213	-.053; .480	.058
<b>Institutional Index</b>	.206	-.012; .423	.081
<b>Network Index</b>	.202*	.018; .387	.108*

\*Significant at the .05 level.

The effect of the institutional index score on the degree of managed care adoption index score was not statistically significant. Comparison of the threshold value (.072) with the interval for the institutional index score in Table 11 suggests that the population effect is inconclusive. The unique contribution of the institutional context score to the model  $R^2$  was .081 and for every unit change of the dependent variable, there was a .206 unit change in the institutional context score.

The effect of the network index score was significant at the .05 level ( $t = 2.231$ ,  $t\{.05; 32\} = 2.042$ ,  $p = .033$ ). This means an increase of .202 units of the network index score was associated with a one-unit increase in the managed care adoption index score, holding all other independent variables constant. In other words, an approximate one-fifth unit change in the perceived influence of the organizational network to adopt managed care was associated with a unit change in managed care adoption. However, a

comparison of the threshold value of .061 with the confidence interval reported in Table 11 for the network index leads to no conclusion regarding the population effect.

Of the three independent variables, the network index score had a statistically significant effect on managed care adoption; however, its population effect is inconclusive based on the data included in the model. The preliminary analyses indicated that an outlier exerted excessive influence on the model results. The following analyses are based on the removal of the influential outlier from the sample.

**Sensitivity Analysis**

The new descriptive statistics with the outlier removed are reported in Table 14 (N = 36). The new correlations among the variables are reported in Table 15. Subsequent preliminary analyses indicated no violations of assumptions of multiple regression, other than already stated, or outliers with excessive influence on the model results.

**Table 14: Descriptive Statistics on Index Scores with Outlier Removed**

<b>Index Variable</b>	<b>Range</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Standard Deviation</b>
Political Economy (Items 7-12)	28	9	37	17.30	6.995
Institutional (Items 14, 17-21)	35	16	51	32.45	8.585
Network (Items 22-27)	56	2	58	19.30	10.003
Managed Care Integration (Items 28-34)	24	1	25	11.69	5.432

\*N=36

**Table 15: Correlations among Index Scores with Outlier Removed**

	<b>POLITICAL ECONOMY</b>	<b>INSTITUTIONAL INDEX</b>	<b>NETWORK INDEX</b>	<b>MC INTEGRATION</b>
<b>POLITICAL ECONOMY</b>	<b>1.000</b>			
<b>INSTITUTIONAL INDEX</b>	<b>.166</b>	<b>1.000</b>		
<b>NETWORK INDEX</b>	<b>.058</b>	<b>-.004</b>	<b>1.000</b>	
<b>MC INTEGRATION</b>	<b>.406</b>	<b>.340</b>	<b>.391</b>	<b>1.000</b>

\*N = 36

The new regression model is presented in Table 16. The total variability of the dependent variable (Managed Care Adoption Index) explained by the model ( $R^2$ ) after the deletion of the outlier was .38, indicating an increase of the strength of the relationship between the dependent variable and the independent variables, which was significant at the .05 level ( $F = 6.528$ ,  $F\{.05; 3, 32\} = 2.92$ ,  $p < .001$ ). The adjusted  $R^2$  was .321. The standard deviation from the regression line was 4.474. The new precision of estimating the range of values in which the true regression coefficient was likely to fall, for a 95% confidence interval, was plus or minus 1.68 standard deviation units. The ratio of the width of the prediction interval to the range of the dependent variable was .823, indicating that the prediction interval for future predictions was not sufficient, given a threshold of 30% of the range of the dependent variable.

**Table 16: Regression Model with Outlier Removed**

	Degree of Managed Care Integration Index
Political and Economic Diversity Index	.262*
Institutional Pressure Index	.181

**Table 16: Continued.**

Network Pressure Index	.202*
F Value	6.528**
Adjusted R <sup>2</sup>	.321
Degrees of Freedom (DF)	3, 32

\*Significant at the .05 Level

\*\*Significant at the .001 Level

The new effect of each independent variable on the dependent variable is reported in Table 17. The estimated change of .262 units of the political economy index score for every unit change in the dependent variable index score was significant at the .05 level ( $t = .953$ ,  $t\{.05; 31\} = 2.383$ ,  $p = .023$ ). Judging within a practical importance threshold of .078, the population effect was inconclusive. The unique contribution of the political economy index score to the model  $R^2$  was .110. The effect of the institutional index score on the dependent variable was not significant at the .05 level. The unique contribution of the institutional index score to the model  $R^2$  was .08. The .202 unit change in network index score associated with a unit change in the dependent variable (i.e., the approximate one-fifth of a unit change in perceived network pressure associated with a one unit change in managed care adoption) was still significant at the .05 level ( $t = 2.67$ ,  $t\{.05; 31\} = 2.383$ ,  $p = .012$ ). However, comparison with a threshold value of .061 still did not give conclusive evidence of a population effect. The unique contribution of the network index score to the model  $R^2$  was .138.

**Table 17: Individual Effects of the Independent Variables with the Outlier Removed**

<b>Independent Variable</b>	<b>Effect Estimate</b>	<b>95% Confidence Interval</b>	<b><math>\Delta R^2</math></b>
<b>Political Economy Index</b>	.262*	.038; .485	.110*
<b>Institutional Index</b>	.181	-.001; .363	.080
<b>Network Index</b>	.202*	.048; .355	.138*

\*Significant at the .05 Level.

The excessive influence of the outlier was illustrated by the results of a second regression analysis conducted as a sensitivity study. The variance explained by the model increased from approximately 28% to 32%. The unique contribution of the index of political economy score became statistically significant when the outlier was removed from the sample.

### **Summary of Results**

Descriptive data, including frequencies and percentages of each indicator for the model were presented. Index scores were created to reduce the data for regression analyses. Regression on the dependent variable revealed statistical significance in the amount of managed care adoption variation by the political economy and network contexts of individual organizations. In other words, the diversity of an organization's political and economic resources, and the degree of perceived pressure to adopt managed care principles from the organizational network, were significant predictors of the degree to which the organization adopted managed care principles. However, the amount of variance explained was not sufficient to provide a precise prediction equation and the population effects were inconclusive.

The quantitative results presented in this chapter should be considered with caution. Although the face validity of the survey instrument was assessed via pre-testing, limitations in sampling and response rates preclude in-depth statistical modeling to

further address the validity and/or reliability of the instrument. However, with that disclaimer in mind, there are some patterns revealed in the data, which raise some interesting questions. These questions and the limitations of this study will be discussed further in the following chapter.

## **CHAPTER 5**

### **DISCUSSION AND CONCLUSIONS**

#### **Introduction**

What is the impact of the external environmental context of individual organizations on their internal structures and service configurations, as they attempt to adapt to a changing political economy? This final chapter first provides a summary of the study and the resulting findings, which were undertaken to answer this research question. The findings are then applied to a reconsideration of the conceptual and analytic models. It then provides a discussion of the limitations to the study's findings due to design and analysis considerations. An update to the relevant literature is provided and the discussion then moves to an exploration of the implications of the study findings for future research, social work practice, and human services organizations.

#### **Study Summary**

The research problem was to examine the impact of the external environmental context of individual organizations on their internal structures and service configurations. A portion of the Georgia child welfare system was studied to understand its response to the introduction of managed care principles into its political economy. Managed care was first introduced to Georgia's child welfare system in 1995 and has arguably helped to shape its current configuration. An initial inquiry was conducted with the Executive Director and Assistant Director of the Georgia Association of Homes and Services for

Children (GAHSC), one of the largest professional associations for child caring institutions in the state. These individuals reported that managed care does not exist in the state of Georgia in any form. However, when asked about specific principles, which are generally accepted as elements of managed care (e.g., continuums of care, utilization reviews, etc.), both indicated that each of these principles were currently a part of organizational functioning among child caring institutions of Georgia. Indeed, the Child Welfare League of America's Managed Care Institute identified Georgia as having at least one managed care program for child welfare (McCullough & Schmitt, 2000). Although some representatives of the child welfare field in Georgia may deny that managed care is a part of their operations, there remain some questions regarding the influence that the external environment has had on the adoption of managed care in Georgia.

A mailed survey was designed and administered based on the Total Design Method (Dillman, 1978; Dillman, 1991; Salant & Dillman, 1994) to address the research questions proposed in this study. The sample included all residential child caring institutions that were listed as being licensed by the State of Georgia at the time the study was conducted. The final sample consisted of 114 separate child caring institutions. Of those 114 institutions, 37 responded for a response rate of approximately 33%. The results of the survey and their limitations are summarized below.

## **Interpretation of Statistical Analysis**

This section provides a summary and interpretive discussion of the data obtained by the study.

### **Summary and Interpretation of Descriptive Data**

Respondents tended to be in administrative positions (e.g., CEO, President, or Executive Officer), with at least five years of experience in their current position. They also tended to be well educated (master's level degree) in a variety of disciplines and indicated diverse professional training backgrounds. A respondent's gender was almost as likely to be male as female with a ratio of 1.12 females to each male respondent. This ratio may seem odd, considering social welfare administration has historically been perceived as male-dominated (Dressel, 1992). However, Chernesky (1998) reported, "...women hold approximately 40% of CEO positions in child welfare ...agencies" (p. 203). One recent study obtained a clearly female-dominated response of 63.2% females and 36.8% males in a stratified random sample (Hopkins & Hyde, 2002). The respondents' agencies were likely to be multi-site agencies, with no ties to civic or social clubs, although a relatively large portion (27%, n=10) claimed some religious affiliation. Most respondents said that their agencies were independent and maintained membership in at least one professional association. All but one of the respondent's agencies operated on a not-for-profit basis and 78.3% reported that their agencies relied on multiple sources of funding.

The majority of respondents ranked their knowledge of federal, state, and local policies and procedures, which affect children and their families, as average or above average. However, they also indicated that they felt very little or no pressure to adopt

managed care principles or procedures from regulative forces in the form of policies and procedures. Similarly, relatively few respondents indicated experiencing coercive pressure from licensing/regulating agencies, funding sources, and/or society in general. Perceived levels of normative and cognitive institutional pressure were low. Respondents indicated relatively little pressure from organizational networks to adopt managed care principles.

While few respondents indicated that they had fully integrated managed care principles, including the funding mechanisms of managed care, many indicated that they had integrated at least some of the best practices of managed care into their agencies. Most respondents indicated that their agencies' services, policies and procedures, and funding development and allocation had changed since 1995 (when managed care was first introduced to the Georgia system of child welfare). Many indicated that managed care had some effect on the changes in their agencies since that time.

Because of the low return rate, and lack of information regarding whether those that returned their surveys were representative of the larger population, it is not possible to generalize these findings to other organizations within the population. An attempt was made to analyze the differences between respondents and those that did not respond by analyzing their similarities and differences, based on information obtained from the Internal Revenue Service's (IRS) Masterfile of non-profit agencies. Only 69 of the agencies included in the sample were incorporated in the Masterfile; therefore, the usefulness of comparisons was deemed to be unsatisfactory.

## Summary and Interpretation of Regression Analyses on Index Scores

Index scores were created for each of the variables represented in the model (i.e., Political/Economic Context; Institutional Context; Network Context; and, Degree of Integration of Managed Care) by recoding the corresponding survey items and summing each respondent's answers into new variables (i.e., Political and Economic Diversity Index; Institutional Pressure Index; Network Pressure Index; and, Degree of Managed Care Integration Index). Regression analyses were performed on the resulting model.

Preliminary visual inspection of the data did not suggest any violations of the assumptions required for multiple regression. However, a review of the delta beta case index revealed the presence of an influential outlier in the data. Therefore, a sensitivity analysis was conducted by redoing the regression with the outlier removed from the sample. In the initial analysis, the effect of the network index score was significant at the .05 level ( $t = 2.231$ ,  $t_{\{.05; 32\}} = 2.042$ ,  $p = .033$ ), indicating that an organization's organizational network was perceived to be a significant influence on whether an organization incorporated managed care principles into its internal structures and services. Neither the political/economic diversity of the organization nor the perceived institutional pressure experienced by the respondents had statistically significant effects on the integration of managed care principles. However, the results notably changed in the sensitivity regression analysis with the outlier removed. The sensitivity analysis suggested a statistically significant individual contribution by the political/economic index score, as well as the network index score, to the variance in managed care integration by individual organizations. Thus, political/economic considerations, as well as, the influence of other organizations within one's organizational network, were

perceived as having significant influence on the integration of managed care principles. The remainder of this discussion will be based on the regression results with the outlier removed because of its undue influence in a small sample. The results will first be discussed with reference to the research questions, which guided this study.

### **Discussion of the Impact of Study Findings on the Research Questions**

Research Question #1: *Is the degree to which a child welfare organization is influenced by its dependence on external sources of power and legitimacy contingent on the degree to which it experiences institutional pressures to behave in a certain manner?*

Organizations with greater access to a diverse array of political and economic resources tended to adopt managed care principles. Institutional pressure did not predict managed care adoption. Organizational dependence on external sources of political and economic power for legitimacy was not influenced by the degree of institutional pressure to conform. These findings provide insight into the external influences on organizations' adoption of managed care: the most influential pressures were access to political and economic sources of legitimacy.

Research Question #2: *Is the degree to which a child welfare organization's service delivery system is influenced by its relationship to external sources of power and legitimacy, be it institutional or political and economic sources, influenced by the nature of interorganizational network relationships?* The respondents for this study did not perceive institutional pressure as a significant predictor of their organizations' internal structures and services. However, political and economic diversity was a statistically significant predictor. The behavior of organizations within an organizational network was

perceived by respondents to be the most influential predictor of organizational adoption of managed care.

Primary Research Question: *What is the impact of the external environmental context of individual organizations on their internal structures and service configurations, as they attempt to adapt to a changing political economy?* The findings from the regression analysis suggest that respondents perceived the behaviors of other organizations within their organizational network as the most significant predictor of their organization's adoption of managed care principles. The political and economic context was also perceived as a significant predictor of organizational adoption of managed care principles. However, there was no statistically significant support of the institutional context as being a predictor of managed care adoption. Limitations in study design and analysis restrict the conclusions that can be drawn from this study.

### **Study Limitations**

Two criteria are critical for evaluating the soundness of a research design: external and internal validity (Campbell, 1957; Campbell & Stanley, 1963); both present limitations for this study. The discussion begins with the limits on external validity. Next Kerlinger's (1986) "maxmincon" principle for analysis of threats to the internal validity of the study is discussed.

#### **Limits to External Validity**

According to Kerlinger (1986), "external validity means representativeness or generalizability" (p. 300). Cook and Campbell (1979) stated that external validity can be considered in two distinct ways: "(1) generalizing to particular target persons, settings, and times, and (2) generalizing across types of persons, settings, and times" (p. 71). The

plan for this study was to achieve a survey response rate sufficient for stating that the sample represented the population from which it was drawn; however, the return rate of 33% was unacceptable to infer representativeness. Whether the population is defined as all child-caring institutions licensed by the State of Georgia or all child-caring institutions in the United States; the distinction does not affect the judgment of external validity. In either case, the response rate is inadequate to claim that the sample is representative of the population; therefore, the results cannot be generalized beyond those that responded to the survey. Limitations to external validity also increased because it was not possible to thoroughly compare the characteristics of respondents with nonrespondents.

These limitations, while important to acknowledge, are common in studies of organizations where probability samples and randomization are rarely feasible. The form of external validity that is more often feasible in research of this type is “(2) generalizing across types of persons, settings, and times” (Cook & Campbell, 1979, p. 71). Here, Cook & Campbell (1979) argued that external validity might be improved via conducting several smaller investigations that employ similar haphazard samples focusing on similar questions; in fact, this may be preferable to conducting one study that has a larger population. Applying these arguments to the present study, it becomes possible to conclude that its validity is increased because it was based on axioms developed in other similar studies of organizations. Results will be strengthened as other studies are conducted in a similar fashion. The discussion now will turn to the limits to internal validity of the current study.

## Maximization of Systematic Variance

Simply stated, the maxmincon principle calls for the design of research in ways that “maximize the systematic variance under study; control extraneous systematic variance; and minimize error variance” (p. 286). The first aspect of internal validity to be addressed is the systematic or experimental variance. According to Kerlinger (1986),

The experimenter’s most obvious, but not necessarily most important, concern is to maximize what we will call the *experimental variance*. This term is introduced to facilitate subsequent discussions and, in general, simply refers to the variance of the dependent variable influenced by the independent variable or variables of the substantive hypothesis. ...Although experimental variance can be taken to mean only the variance due to a manipulated or *active* variable, like methods, we shall also consider *attribute variables*.... (p. 287)

The process of maximizing the variance of the independent variables was limited in this study because of the fuzzy nature of organizational theory. Although efforts were made to make the variables as different as possible, there is considerable overlap between each of the three theories involved in the study (i.e., political economy theory, institutional theory, and network theory). For example, funding sources are discussed in both political economy theory and institutional theory. There are subtle differences in the ways each theory addresses an attribute, but efforts to make these as distinct as possible may not have been as successful as hoped.

It should be noted that the extent of missing data and nonrespondents may also limit the maximization of systemic variance. As discussed in the descriptive statistics presented in Chapter 4, there were considerable amounts of data missing from

respondents' surveys. The missing data were substituted with the system mean when computing index scores, because in most cases the mean represented a neutral response to the item—neither supporting nor rejecting patterns evidenced in the other data. However, the large extent of missing data and subsequent imputation of values may either have inflated or deflated the systematic variance. Another limitation in the maximization of systematic involved the fact that only one respondent indicated that his or her organization was a for-profit enterprise, and therefore, it is possible that the variable should have been excluded from the study.

### **Control of Extraneous Variance**

Controlling extraneous variables “means that the influences of independent variables extraneous to the purposes of the study are minimized, nullified, or isolated” (Kerlinger, 1986, p. 287). Kerlinger proposed a number of methods for controlling extraneous variance, which include: 1) to eliminate the extraneous variable as a variable; 2) by incorporating randomization in the selection and placement of subjects; 3) build the extraneous variable into the design of the study by including it as an independent variable; 4) match subjects according to different values of an attribute; and, 5) statistical control. It is impossible to include all the possible variables that influence the response of organizations to their external environment. Some aspects of external influences and internal influences on organizational structure (e.g., organizational culture, leadership, and organizational learning) were not included in the analysis and presumably have some affect on organizational behavior. The low response rate adds to the possibility of increased extraneous variance in the study because there may be some systematic similarity between those they chose to respond to the survey that differs from those that

chose not to participate. There are many possible variables, which were not included in the study that may explain significant amounts of the variance in an agency's internal structures and services.

### **Minimization of Error Variance**

The final aspect of the maxmincon principle involves the minimization of error variance. According to Kerlinger,

*Error variance* is the variability of measures due to random fluctuations... There are a number of determinants of error variance, for instance, factors associated with individual differences among subjects. Ordinarily we call this variance due to individual differences "systematic variance." But when such variance cannot be, or is not identified and controlled, we have to lump it with the error variance. ... Another source of error variance is that associated with what are called errors of measurement: variation of responses from trial to trial, guessing, momentary inattention, slight temporary fatigue and lapses of memory, transient emotional states of subjects, and so on. (pp. 289-290)

The absence of established reliabilities and validities for the measurement tool designed for this study makes it impossible to minimize the error variance in this study. The possibility for measurement error is highly possible due to the extent of missing data discussed earlier and the fact that indices were based on theoretical groupings of survey items rather than empirical groupings. Any measurement error due to improper theoretical groupings of survey items may be obscured by the limited sample size of this study. Furthermore, there was some evidence that respondents did not fully understand managed care and the survey instrument, with the latter assuming a certain level of

understanding of managed care principles. This further dilutes the instrument's internal validity. Despite the serious limitations presented here, the current study represents an attempt to further knowledge on the environmental influence on internal structures and service configurations by moving beyond the typical case study approach that seems so prevalent in the current literature.

### **Recommendations for Future Research**

The results of this study suggest that respondents' perceptions of what, or who, influenced their agencies' decisions to adopt managed care principles was primarily the performance, behaviors, and actions of other agencies, which they considered a part of their organizational network. To a lesser extent, they also perceived sources of economic and political resources and power to influence their agencies' adoption of managed care principles. Future research on external environmental factors' effects on organizations should attempt to adopt and/or establish reliable and valid measures of external influences to inform and compare with the perceptions of administrators. Although it is not often practical in studying organizations as a unit of analysis, future research should attempt to obtain random samples of large populations so results can be generalized beyond a specific, limited sample.

Multiple regression may not be the appropriate statistical methodology for this type of study due to the possibility of the data being nested in groups along the theoretical constructs previously discussed. Therefore, Hierarchical Linear Modeling (HLM) may be an appropriate methodology for future studies and would have been used had the response rate been higher. Future research should also attempt to ascertain the relationship of internal environmental variables, as well as external environmental

variables on the service configurations and internal structures of human service organizations. The length of the survey instrument may have been a deterrent for completion and response by CEOs and administrators. Future research should seek to refine instruments to be as brief and easy to complete as possible to maximize response rates.

### **Implications**

This section begins with an update of the literature relevant to the proposed analytic model. Implications are then drawn from the study findings for human service organizations and social work practice and research. Although the study was exploratory, and must be understood in the context of the various limitations discussed herein, it is possible to glean an understanding of potential implications for social workers and future research.

### **Literature Update**

As stated in Chapter 2 regarding the dearth of literature regarding Hasenfeld's (1992) approach to human service organizations, there have been no attempts in the literature to test the validity of the approach specifically. However, some literature informs the model indirectly. For example, Sherer and Lee (2002) found evidence that institutional theory is enhanced by examining resource dependence in studying the practices of law firms. Similarly, Wooten (2001) found support for combining institutional and resource dependency theories for explaining the practices of public accounting firms' practices in hiring and promoting women. No evidence was found for the support of combining network theory with institutional and political economy perspectives.

## **Implications for Human Service Organizations**

The data resulting from this study have some important implications for the proposed conceptual model (see Figure C, Appendix B) based on the work of Hasenfeld (1982; 1992; 2000). The proposed conceptual model indicates that an organization's services and internal configurations are constrained by elements of its external environment. The current study provides support for this model to a limited extent. First, the importance of political and economic sources of power was not supported as the primary influence on internal structures and service configurations; however, it was perceived as a significant influence on managed care adoption to a lesser extent than organizational network influences. Institutional pressures were not supported as significant contributing factors to the adoption of managed care principles either. However, this may be the result of limits in the design and data collection techniques used in this study. For example, the subjective perceptions of respondents may have been influenced by the social desirability of acknowledging peer organizations as the most influential factors rather than licensing agencies, other professions, other states, or social pressures to adopt managed care principles. A design flaw, rather than an incorrect logical assumption about institutional pressure, is probable as the reason for not finding support for institutional theory as a predictor of managed care adoption. The organizational network was perceived as having the most influence over the adoption of managed care. The conceptual model requires further testing. These findings call for a revised analytic model (see Figure E, Appendix F).

The revised model represents the findings suggested in this study, with the network and political/economic contexts of the external environment contributing

distinctively to the adoption of managed care principles (i.e., internal structure and service configurations) of the organization. However, the institutional context should be included in subsequent research because it has received support in other research involving external factors (Greening & Gray, 1994; Ingram & Simons, 1995). The applicability of the proposed model for understanding external environmental influences on the internal structures and service configurations needs further study.

### **Implications for Social Work Practice and Research**

Social work administrators are faced with the daunting task of managing the performance of their organizations in the face of extreme environmental forces, which often work to restrain services to clients. This study sought to identify the external environmental forces that are most likely to influence the service delivery system and internal structures of social welfare or human service organizations, in order to inform the task of strategic planning for social work administrators. A contemporary context for studying the effects of external environmental forces on organizational structure and service delivery systems is managed care, a relatively recent attempt to correct a failing child welfare system. The introduction of managed care brings many challenges to child welfare systems, including challenges within “delivery system structures, quality control of services, and development of preventive and early intervention programs” to name a few (Barker & Wernet, 1999, p. 178). It should also be noted that managed care has far reaching implications for social work as a profession. Gibelman (2002) remarked,

The impact of managed care on social work has been the subject of extensive professional discussion. Concerns center on the changing role of the social worker, the requirement to use some intervention strategies over others, the

demand for a growing expertise in measuring the outcomes of service, and ethical compromises inherent in a managed care environment. (p. 18)

However this, often controversial, method of providing systemic checks and balances provides a perfect subject for study.

Because managed care is such a controversial issue, within both social work and child welfare, it is understandable why there was resistance to its adoption within Georgia's child welfare system. In 1995, the topic of strategic action among members of the Georgia Association of Homes and Services for Children (GAHSC) seemed to be: How do we act preemptively to managed care to have some control over our system? GAHSC and its member organizations subsequently invested considerable resources to exert control over how managed care would be implemented, if at all. The results of this and other studies (see for instance, McCullough & Schmitt, 2000) suggest that many child caring institutions in Georgia have incorporated at least some of the principles of a managed care system despite claims to the contrary.

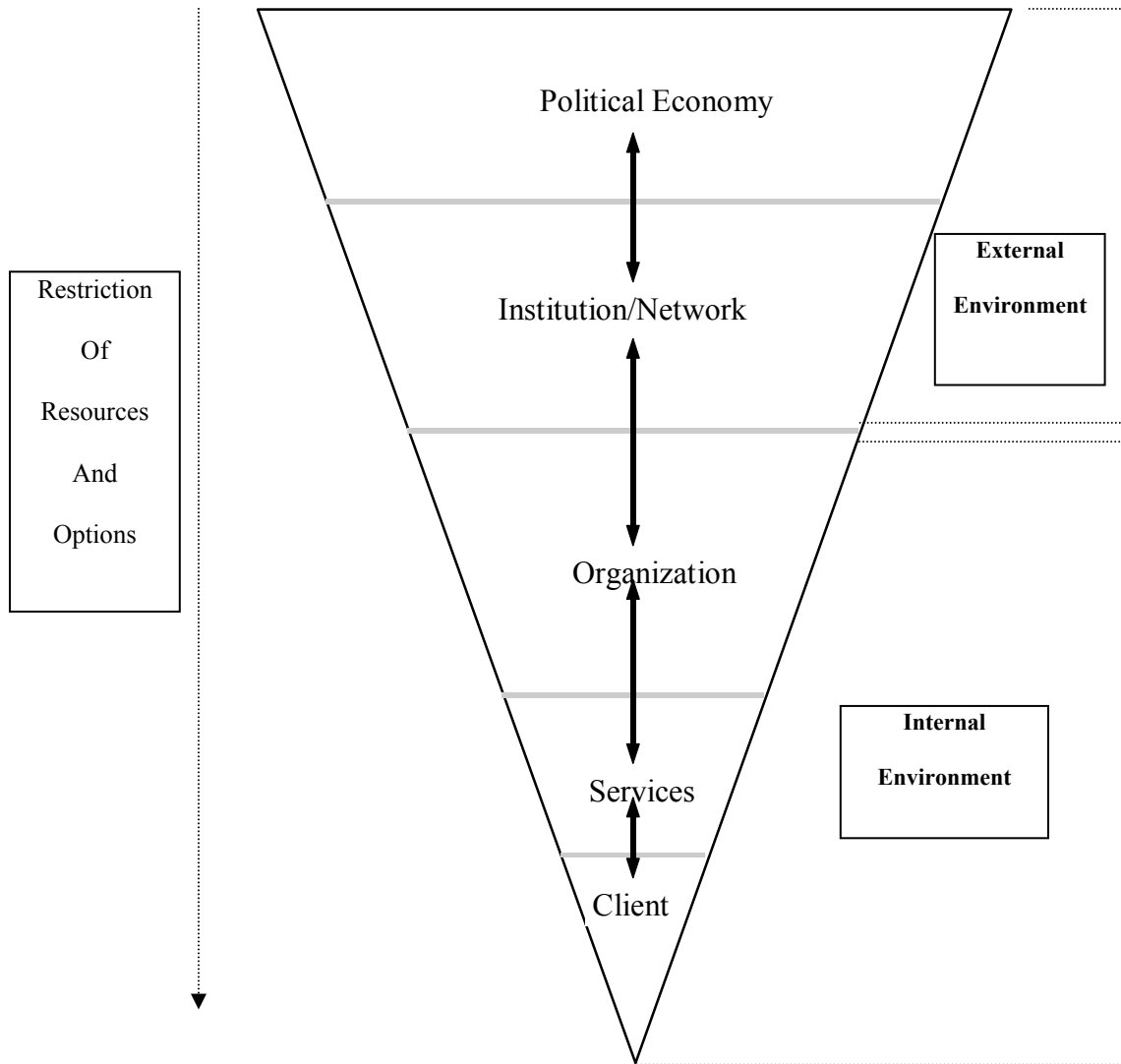
The challenge facing social work administrators is to understand the forces that shape their organizations, so strategic planning and service implementation may best address the needs of the client. There is a crisis in child welfare and human services, which must be addressed (Stoesz, 2000; Videka-Sherman & Viggiani, 1996). According to Weil (2000), "The central administrative challenge is to lead the process of system reform in child welfare" (p. 499). Social work administrators and practitioners need to lead the way to realizing a solution to that challenge by systemic thinking in the context of human service organizations. Understanding external environmental influence on child

welfare organizations, indeed human service organizations, is key to implementing meaningful reform.

**APPENDIX A**

**FIGURE B: THEORETICAL/CONCEPTUAL MODEL**

**Figure B: Theoretical/Conceptual Model**

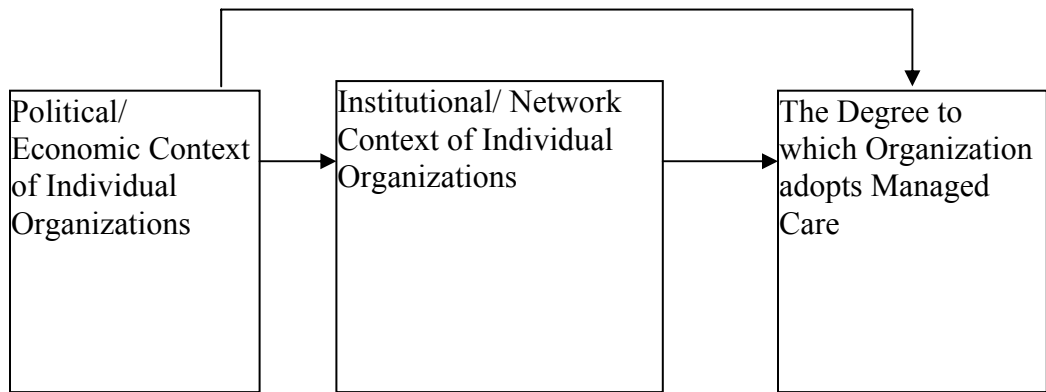


Gray lines between variables indicate fuzzy boundaries.  
Arrows indicate multi-directional influence.

**APPENDIX B**

FIGURE C: ANALYTIC MODEL

**Figure C: Analytic Model.**



**APPENDIX C**  
**SURVEY QUESTIONNAIRE**

# Survey of Georgia's Residential Child Caring Institutions

## Part A: Information about Yourself

1. Please indicate your job title:

- EXECUTIVE DIRECTOR
- PRESIDENT
- CHIEF EXECUTIVE OFFICER
- OTHER: \_\_\_\_\_

2. How long have you been in this job?

- LESS THAN ONE YEAR
- ONE YEAR TO LESS THAN TWO YEARS
- TWO YEARS TO LESS THAN FIVE YEARS
- FIVE YEARS OR MORE

3. What is your educational level?

- HIGH SCHOOL DEGREE OR EQUIVALENT
- SOME COLLEGE
- COLLEGE DEGREE:
  - ASSOCIATE
  - BACHELOR'S
  - MASTER'S
  - DOCTORATE (please describe e.g., Ph.D., D.S.W., D. Min., etc.):

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4. Please indicate the discipline(s) of your **academic** training.

- BUSINESS ADMINISTRATION
- SOCIAL WORK
- PUBLIC ADMINISTRATION
- THEOLOGY
- MARRIAGE AND FAMILY THERAPY
- PSYCHOLOGY

- OTHER (Please Indicate)
- 

5. Please indicate the discipline(s) of your **professional** training and experience.

- BUSINESS ADMINISTRATION
  - SOCIAL WORK
  - PUBLIC ADMINISTRATION
  - THEOLOGY
  - MARRIAGE AND FAMILY THERAPY
  - PSYCHOLOGY
  - OTHER (Please Indicate)
- 

6. What is your gender?

- FEMALE
- MALE

### **Part B: Information about Your Agency**

7. Is your agency designated as for profit or not for profit?

- FOR PROFIT
- NOT FOR PROFIT

8. Is your agency an independent organization or a subsidiary of a larger corporation?

- MY AGENCY IS A SUBSIDIARY OF A LARGER CORPORATION
- MY AGENCY IS AN INDEPENDENT ORGANIZATION

9. How many separate physical sites does your agency operate?

FOR ADMINISTRATIVE PURPOSES \_\_\_\_\_

FOR SERVICE PROVISION \_\_\_\_\_

TOTAL \_\_\_\_\_

10. Is your agency formally affiliated with a religious denomination or organization?

- YES
- NO

11. Is your agency formally affiliated with a civic or social club (e.g., Masons, Shriners, etc.)?

- YES
- NO

12. Is your agency a member of a professional association?

- YES  NO

If **Yes**, Please indicate which associations (Check all that Apply)

- Child Welfare League of America (CWLA)
- Georgia Association of Homes and Services for Children (GAHSC)
- National Organization of State Associations for Children (NOSAC)
- National Association of Child Advocates (NACA)
- Coalition for America's Children
- Others (Please List any others not included above)

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13. Please estimate the rank of each of your current and past funding sources based on the percentage each source provides or provided to your total budget. Place a check mark beside each source from which you received funding and then rank these by placing a number (1=Highest Percentage, 2=Next Highest Percentage, etc.) in the columns to the right of the source. Please rank each relevant source for **both** time periods.

	1995 Rank by Percentage	Present Rank by Percentage
<input type="checkbox"/> Federal Government Sources	_____	_____
<input type="checkbox"/> State Government Sources	_____	_____
<input type="checkbox"/> County Government Sources	_____	_____
<input type="checkbox"/> County Government Sources	_____	_____
<input type="checkbox"/> Municipal Government Sources	_____	_____
<input type="checkbox"/> Private Foundations	_____	_____
<input type="checkbox"/> Sectarian Sources	_____	_____
<input type="checkbox"/> Fund Raising	_____	_____
<input type="checkbox"/> Other _____	_____	_____

- Other \_\_\_\_\_

**Part C: Information about Your Knowledge and Opinions**

14. How well do you feel you know federal, state, and local policies, which affect your organization’s work with children and their families? (Place a check under the appropriate response for each policy level)

	Very Well	Well	Average	Not Well	Very Little
Federal Policies					
State Policies					
Local Policies					

15. Check the statement below, which most nearly reflects your opinion regarding the use of managed care in child welfare. (Please check only one)

- I think managed care is an important tool for improving services to children and families.
- I think managed care has potential for being an important tool for improving services to families and children.
- I have no opinion regarding the effects of managed care on services to families and children.
- I think managed care has potential to be detrimental to services for families and children.
- I think managed care is detrimental to services for families and children.

16. To the best of your knowledge, which of the following features are typically parts of a managed care system? (Check all that apply and list any other features that you are aware of and which are not included here.)

- System Design
- Performance Contracting
- Gatekeeping
- Deflection from Substitute Care
- Substitutability of Services
- Capitation
- Preauthorization
- Utilization Review
- Case Management of High-Volume Users
- Comparability of Services

- Least Restrictive Environment       Cost Efficiency
- Efficiency of Treatment               Treatment Protocols
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_

17. To what degree has your agency experienced pressure to adopt managed care practices from each of the sources listed in the table below? (Place a check under the appropriate response for each potential source of influence.)

	No Pressure	Very Little Pressure	Some Pressure	High Pressure	Extremely High Pressure	Do Not Know
Federal Policies						
State Policies						
Local Policies						
Licensing/Regulating Agencies						
Funding Sources						
Society in General						

18. A. Does an external professional association or agency accredit your agency?

- YES                                       NO

If yes, what is/are the accrediting body(ies)? \_\_\_\_\_  
 \_\_\_\_\_

B. In your opinion, to what extent have your agency's **accrediting bodies** adopted principles of managed care for child caring institutions such as yours? (Please circle one number)

1	2	3	4	5
NO		HALF		TOTAL
ADOPTION		ADOPTION		ADOPTION

19. In your opinion, to what extent have the **professional associations** to which your agency belongs adopted principles of managed care for child caring institutions such as yours? (Please circle one number or if your agency does not belong to any professional associations check here \_\_\_\_\_ and move on to the next question.)

1	2	3	4	5
NO		HALF		TOTAL
ADOPTION		ADOPTION		ADOPTION

20. Based on your knowledge of other States' adoption of managed care into their child welfare systems, how much does this affect your agency's decisions regarding managed care principles? (Please Check One)

- NO EFFECT ON MY AGENCY'S DECISIONS
- LITTLE EFFECT ON MY AGENCY'S DECISIONS
- SOME EFFECT ON MY AGENCY'S DECISIONS
- A LARGE EFFECT ON MY AGENCY'S DECISIONS
- TOTALLY AFFECTS MY AGENCY'S DECISIONS

21. Based on your knowledge of other professions' (e.g., the medical profession) adoption of managed care into their systems, how much does this affect your agency's regarding managed care principles? (Please Check One)

- NO EFFECT ON MY AGENCY'S DECISIONS
- LITTLE EFFECT ON MY AGENCY'S DECISIONS
- SOME EFFECT ON MY AGENCY'S DECISIONS
- A LARGE EFFECT ON MY AGENCY'S DECISIONS
- TOTALLY AFFECTS MY AGENCY'S DECISIONS



\_\_\_\_\_ Years.

25. What has been the most common response that the agencies in your **organizational network** have had to managed care? (Check Only One)
- They have adopted managed care principles into their operations.
  - They have adopted the best practices of managed care into their operations.
  - They have adopted a few of the principles of managed care into their operations.
  - They have not adopted any principles of managed care.
  - Managed care is not a concern among my organizational network.
  - I do not know if they have adopted any managed care principles.
26. Has your agency's decisions about managed care, at least in part, resulted from imitating the behaviors of larger and/or more prestigious agencies within your **organizational network**?
- YES, IT GREATLY INFLUENCED OUR DECISIONS
  - YES, IT SOMEWHAT INFLUENCED OUR DECISIONS
  - IT HAD NO INFLUENCE OVER OUR DECISIONS
  - I DO NOT KNOW IF IT HAS INFLUENCED OUR DECISIONS
27. Has the performance (good or bad) of other agencies within your **organizational network** influenced your decisions regarding adoption of managed care principles?
- YES, IT GREATLY INFLUENCED OUR DECISIONS
  - YES, IT SOMEWHAT INFLUENCED OUR DECISIONS
  - IT HAD NO INFLUENCE OVER OUR DECISIONS
  - I DO NOT KNOW IF IT HAS INFLUENCED OUR DECISIONS

28. To what degree has your agency adopted managed care features?
- We have totally adopted a managed care system, including similar funding mechanisms.
  - We have adopted many of the managed care features that are related to service implementation and oversight; however, we have not adopted any features related to funding.
  - We have adopted a few of the best of managed care features.
  - We have not adopted any of the managed care features.
  - Not sure or do not know.
29. Which of the following practices does your agency currently use as part of its operation? (Check all that apply)
- Pre-authorization of payment by a third party payment source prior to admittance of a client to our program.
  - Our agency is compensated on a formula-based, pre-determined amount regardless of the amount of services that are needed to treat our clients by some or all, funding sources.
  - Our agency is granted payment based on the outcomes we achieve with our clients by some or all, funding sources.
  - Our agency attempts to place or maintain clients in the least restrictive environment possible given their treatment needs, even if that means referring them to other agencies.
  - Our agency offers an array of services (either in-house or by referral) to help clients find the most efficient forms of treatment that will help them reach their goals.
  - Our agency either provides an array of services in-house or we contract with other agencies to provide a continuum of care for clients that should meet any level of need which he or she may have.
  - Whenever possible our agency attempts to deflect clients from care by referring them to less intensive in-home supports.



- My agency offers **more/fewer** services than it did prior to 1995.
- My agency targets **different/the same** clientele than it did prior to 1995.
- My agency has a **higher/lower** staff to client ratio than it did prior to 1995.
- My agency serves **more/fewer clients** than it did prior to 1995.
- My agency's services are **more/less** directed at client groups (rather than individuals) than it was prior to 1995.
- The average duration of services that my agency offers is **longer/shorter** than it was prior to 1995.
- My agency's services are **more/less** specialized than they were prior to 1995.
- Other Changes in Services: (Please List)

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34. To what degree do you feel managed care has influenced any changes in your agency's policies, funding, services, etc. that have occurred since 1995?

- NO INFLUENCE
- SOME INFLUENCE
- HIGH INFLUENCE
- NOT APPLICABLE/DO NOT KNOW

Thank you for taking the time to complete this survey! Your individual participation in this project is essential for a better understanding of child caring institutions in Georgia. Please use the following space to make any comments that you felt this instrument did not elicit and as extra space for question # 23. **Please enclose your completed survey and your signed Informed Consent Letter in the enclosed postage paid envelope.**

**Part D: Other Comments/Additional Answers.**

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**APPENDIX D**

**HUMAN SUBJECTS APPROVAL AND INFORMED CONSENT FORM**

Dear \_\_\_\_\_,

I am writing to garner your assistance in an important research project regarding licensed child caring institutions located in the State of Georgia. In short, I am studying the effects of external environmental forces (e.g., funding sources, organizational affiliation, etc.) on the service structures of individual organizations. Although there is extensive literature on the effects of environment(s) on organizations, only a small portion of it is based on studies conducted with child welfare agencies or even human service organizations in general. Some literature suggests that human service organizations may behave differently than other forms of organization; however, this concept is relatively untested. It is important to understand how child caring organizations and other human service organizations are affected by their environment(s) so that administrators and policy-makers can improve collaborative decision-making.

The enclosed survey is designed to obtain information that will lead to a better understanding of how licensed child caring institutions respond to their environment(s). Your individual participation in this study is essential for a full understanding of child caring institutions in Georgia and will be greatly appreciated. If you are willing to participate in this important project—please read, sign, and return the enclosed “Informed Consent” form along with your completed survey.

This research is sponsored by Florida State University and is being conducted by Johnny Jones, M. S. W. who is a candidate for the Ph.D. degree in Social Work and a previous middle management employee of a child caring institution located in Georgia. The project is being conducted under the supervision of Wendy P. Crook, Ph.D. who is assistant professor and director of the doctoral program at Florida State University’s School of Social Work.

Thank you in advance for your participation,

Johnny M. Jones, M.S.W.

## **Informed Consent Form**

By completing the enclosed survey and by signing below I am agreeing to participate voluntarily in the research project being conducted among Georgia's residential child caring institutions for the intended purpose of furthering knowledge concerning the effects that external environment(s) have on human service organizations. Participation involves the completion of the enclosed survey questionnaire regarding my agency's relationships to various aspects of its external environment. Participation in the completion and return of the survey should take approximately one hour.

I understand that there are no foreseeable risks or discomforts associated with my participation beyond the slight discomfort of providing information regarding myself and my agency and the expenditure of time that it will take to complete and return the survey. Benefits for participation may include an increased self-awareness of my agency's relationship to certain aspects of its external environment and the altruistic benefit of contributing to the knowledge base of organizational theory.

I understand that although names are collected on this form and surveys are identified by a code number that is linked to the survey mailing list, confidentiality of my responses will be maintained to the extent allowable by law. I understand that neither my name nor the name of my agency will be linked to the responses that I provide during reporting of results and that results of the survey will be reported on at the aggregate level and not on an individual basis. Grouped results will be published in a dissertation and/or in professional journal(s).

**I understand that participation in this project is my choice and that there will be no penalty should I choose not to participate at any time in the process.** I am acknowledging my informed consent by completing and returning the survey to the person conducting the research in the enclosed return envelope. **By signing this informed consent form, I am showing that I have read and understand the informed consent process and I agree to participate in this project.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

If you have questions about the research project or if you would like to obtain information regarding the results of the study, you may contact Johnny Jones, M. S. W. at (850) 421-8485 or by e-mail at [jmj7043@garnet.acns.fsu.edu](mailto:jmj7043@garnet.acns.fsu.edu) OR Wendy Crook, Ph.D. at (850) 644-9750 or e-mail [wcrook@mailier.fsu.edu](mailto:wcrook@mailier.fsu.edu).

Office of the Vice President  
for Research

Tallahassee, Florida 32306-2763

(850) 644-8673 • FAX (850) 644-4392

## APPROVAL MEMORANDUM

from the Human Subjects Committee

**Date:** August 24, 2001

**From:** David Quadagno, Chair *DQ/ph*

**To:** Johnny Jones, M.S.W.  
10075 Spring Sink Road  
Tallahassee, FL 32305

**Dept:** Social Work

**Re:** Use of Human subjects in Research

**Project entitled: Organizational Change and the Institutional Contexts of Managed Care and Child Welfare in Georgia**

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be exempt per 45 CFR § 46.101(b)2 and has been approved by an accelerated review process.

**The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.**

If the project has not been completed by August 23, 2002 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

Cc: W. Crook

APPLICATION NO. 01.385



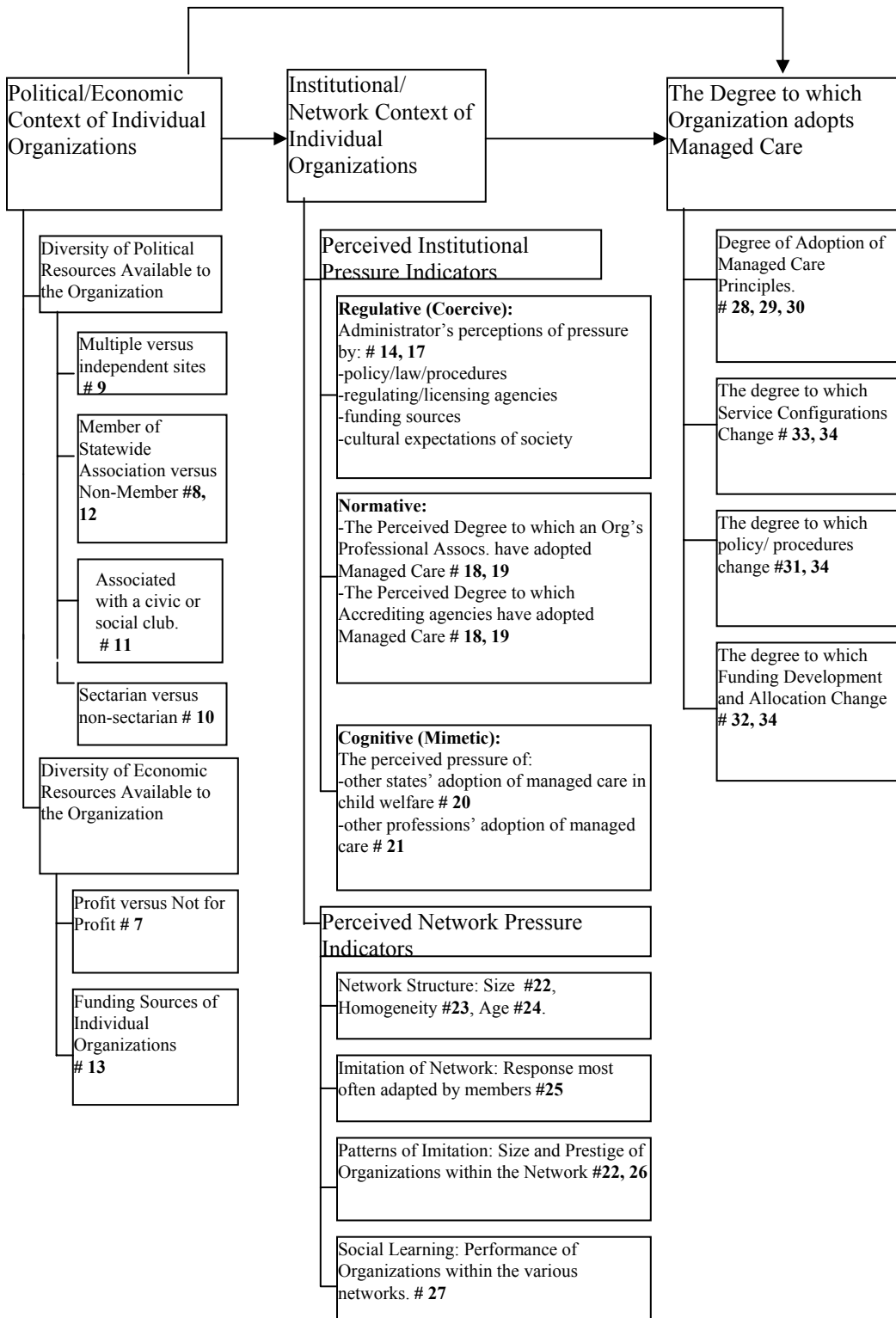




## **APPENDIX E**

**FIGURE D: ANALYTIC MODEL WITH INDICATORS AND CORRESPONDING SURVEY ITEMS.**

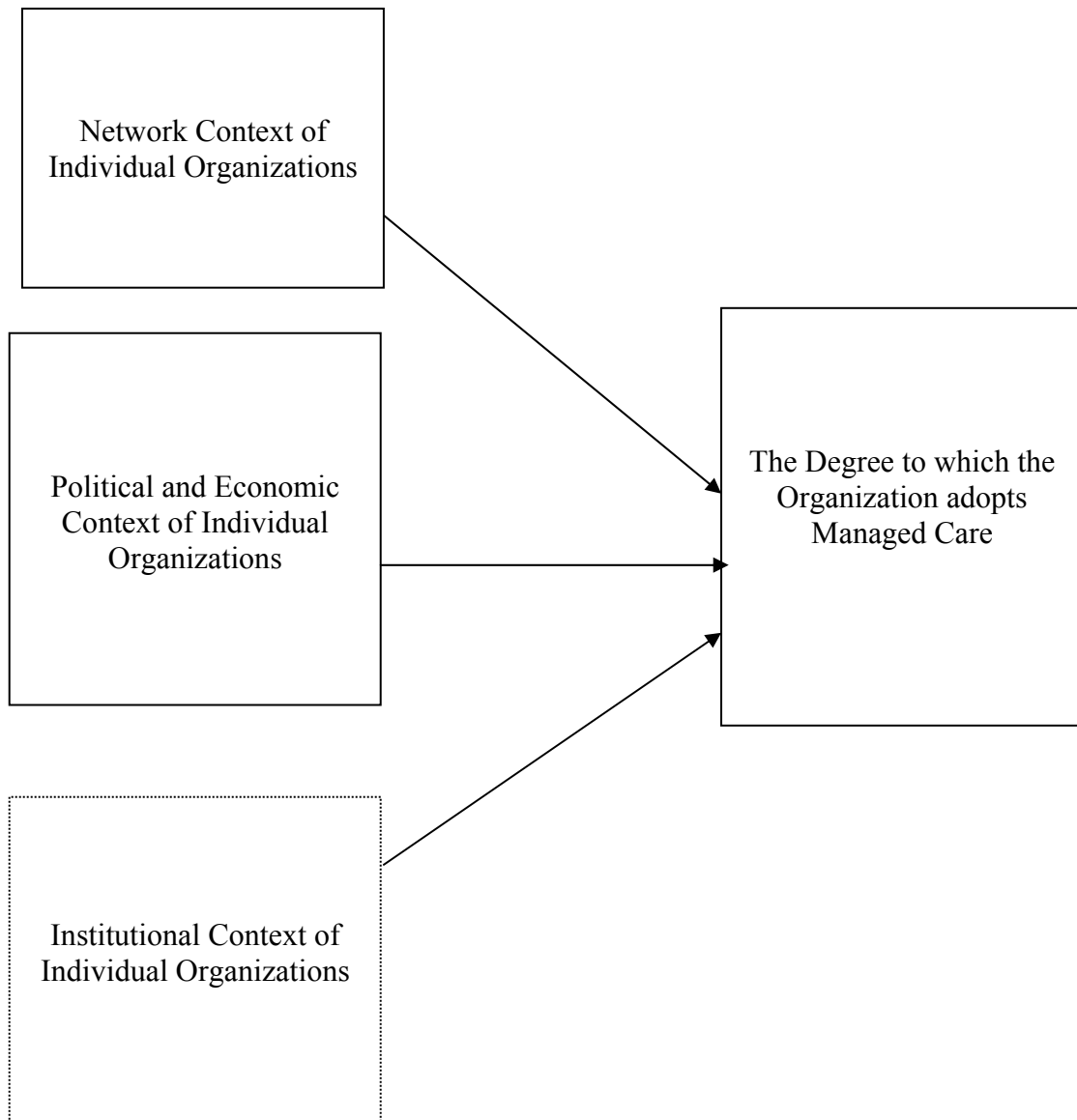
**Figure D: Analytic Model with Indicators and Corresponding Survey Items.**



**APPENDIX F**

FIGURE E: REVISED ANALYTIC MODEL.

**Figure E: Revised Analytic Model.**



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- Wulczyn, F. W. (2000). Federal fiscal reform in child welfare services. *Children & Youth Services Review, 22*(2), 131-159.

## BIOGRAPHICAL SKETCH

Johnny Millard Jones Jr.

### EDUCATION

- 1997 – Present Florida State University, School of Social Work, Tallahassee, Florida  
Candidate for the Degree: **Doctor of Philosophy** in Social Work  
Achieved ABD status in January of 2000; Graduation anticipated in May of 2003. Dissertation successfully defended March 27, 2003.  
Policy/Administration Track Concentration
- 1990 – 1993 Southern Baptist Theological Seminary's Carver School of Social Work  
Louisville, Kentucky  
**Master of Social Work and Certificate in Theology**  
Individuals, Families, and Groups Concentration
- 1987 – 1990 Georgia State University, Atlanta, Georgia  
**Bachelor of Arts**  
Major: Experimental Psychology Minor: Sociology  
Certificate in Child and Family Services

### TEACHING EXPERIENCE

University of South Carolina

- August 2002 – Present **Instructor**, University of South Carolina's College of Social Work, Full-time Faculty.

Spring 2003 Courses:

SOWK 735 (Master's Level): Advanced Social Work Practice with Organizations and Communities III: Administrative Skills.

SOWK 718 (Master's Level): Capstone: Systems Analysis of Social Work Practice.

Fall 2002 Courses:

SOWK 732 (Master's Level): Foundations of Social Work Practice with Organizations and Communities.

SOWK 722 (Master's Level): Foundations of Social Work Practice with Individuals and Families.

Other Teaching Responsibilities for 2002 – 2003 Academic Year:

**Field Liaison:** 13 students in Columbia, Charleston, SC and Augusta GA (7 second year students and 6 first year students).

**Doctoral Student Mentor:** Mentor for Doctoral Student Michael Campanella in his first year of doctoral study.

Florida State University

1997 – 1999 **Teaching Assistant**, Provided classroom and grading support to faculty in graduate and undergraduate courses, including the following substantive areas: Social Welfare Policy and Programs; Practice Evaluation; Groups; Personnel Administration; and, Family Therapy. I assumed independent responsibility for an undergraduate course in human behavior and the social environment, which emphasized individual and family development and behavior.

1999 – 2002 **Doctoral Peer Advisor**, Acted as peer advisor to a total of 4 doctoral students entering the program.

#### RESEARCH EXPERIENCE

2001 – 2002 **Research Associate**, *Refugee and Entrant Project, Lawton and Rea Chiles Center for Health Mothers and Babies, Florida State University*. Conducted two extensive literature reviews in the areas of services for refugees and entrants and community collaboration models. Prepared monographs using systematic research synthesis methodology as deliverables to the Florida Public Affairs Center.

- 2000 – 2002 **Research Consultant**, *Welfare Reform Capacity Study, Florida State University School of Social Work*. Performed data analyses, prepared logic models, and wrote reports summarizing the service delivery systems of welfare reform programs in Florida.
2000. **Research Assistant**, *Developmental Services Equitable Rate Study, Center for Prevention & Early Intervention Policy, Florida State University*. Performed statistical analyses of large state databases, conducted and summarized the results of a national survey, collected qualitative data based on provider interviews, and conducted a relevant literature review.
- 1999 – 2000 **Research Assistant**, *Evaluation of the Administrative Component of Florida's Byrne Fund Program. The Institute for Health and Human Services Research, Florida State University*. Performed all aspects of research and program evaluation, including data collection, analyses, and reporting. Primary involvement was in the evaluation of programs that were federally funded via the Florida Department of Community Affairs.
- 1999-2000 **Research Assistant**, *Evaluation of Florida's Multijurisdictional Task Forces, The Institute for Health and Human Services Research, Florida State University*. Involved in all aspects of research and program evaluation, including data collection, analysis, and reporting. Principle responsibility was for the evaluation of programs federally funded via the Florida Department of Community Affairs.

## PROFESSIONAL EXPERIENCE

- 1994 – 1997 **South Area Director of Ministries**, *Georgia Baptist Children's Homes and Family Ministries, Inc.* Clinical director for Extended Care, Family Services, and Immediate Care Programs. Responsible for approximately 35 staff members. Initiated improvements used in the behavioral modification level system. Chaired the agency's social worker job description revisions committee. Served on the agency-wide long range planning committee and contributed to the development of programmatic goals for the agency. Also conducted speaking engagements and other fund raising activities on behalf of the agency.
- 1993 – 1994 **Program Coordinator, Family Service Unit**, *Georgia Baptist Children's Homes and Family Ministries, Inc.* Supervised approximately 10 staff members. Led treatment team in the

development and implementation of individualized treatment plans with children and their families for the purposes of family reunification. Monitored budget for the unit and acted as community liaison with schools and other service providers.

#### OTHER PROFESSIONAL EXPERIENCE/INTERNSHIPS

- 1993            **Internship**, *Home of the Innocents, Pediatric Convalescent Unit, Louisville, KY*. Provided support to families with children in residence through case management, brokering of resources, advocacy with the community, and served as medical social worker on the multi-disciplinary treatment team.
- 1992            **Internship**, *Gheens Family Resource Center, The Southern Baptist Theological Seminary, Louisville, KY*. Provided free clinical services (e.g., counseling, a discussion and support group, and after school support) to residents of Seminary Family Housing.
- 1991-1992      **Internship**, *Home Emergency Learning Project (Family Preservation Unit). Department of Human Services, Louisville, KY*.  
  
Worked with families to prevent out-of-home placement of at-risk-children through intensive in-home support (based on the Homebuilders Model of family preservation).

#### PUBLICATIONS

##### REFEREED ARTICLES

- Jones, J. M. & Crook, W. P. (In Press). Briar Patch Revisited: one homeless family's experience with the social policy system. *Journal of Family Social Work*.

##### MONOGRAPHS/TECHNICAL REPORTS

- Jones, J. M. & Crook, W. P. (2002). Services for refugees and entrants: a review of the literature. Florida Public Affairs Center.
- Jones, J. M., & Crook, W. P. (2002). Community collaboration models. Florida Public Affairs Center.

Falconer, M. K., Jones, J. M., & Knapton, B. M. (2000). Evaluation of Florida's multijurisdictional task forces. Institute for Health and Human Services Research: Florida State University.

McNeece, C. A., Crook, W. P., O'Quinn, N. K., Rasmussen, D., & Jones, J. M. (1999). Evaluation of the administrative component of Florida's Byrne Fund Program. Institute for Health and Human Services Research: Florida State University.

#### CONFERENCE PAPERS/NATIONAL PRESENTATIONS

Jones, J. M. & Crook, W. P. *Social Welfare Policy and Homelessness: One Family's Story*. Paper presented at the Social Welfare Policy & Practice Symposium of the Council on Social Work Education's 47<sup>th</sup> Annual Program Meeting. *March 2001*

Arnold, E. M., McNeece, C. A., & Jones, J. M. *The Turning Point: Client Outcomes in a Program for Homeless Substance Abusers*. Paper presented at the Fifth Annual Conference of the Society for Social Work and Research: "Making the Connection: Social Work Research and Practice". Atlanta, GA. *January 2001*.

Jones, J. M., & Crook, W. P. *Evaluation of a State Policy for Decentralized Administration of Anti-Drug Programs*. Paper presented at the Policy Conference: "Politics, Policy, and Social Change". Atlanta, GA. *June 2000*.

#### MANUSCRIPTS/PROJECTS IN PROGRESS

Crook, W. P. & Jones, J. M. Sapp and Harrod's brief locus of control scale: a comparison of homeless subjects' responses with a normed population. *Psychological Reports*

Jones, J. M. External environmental forces and organizational behavior: a study of managed care and child welfare organizations. *Dissertation*

Jones, J. M. Crisis intervention programs for abused children and adolescents: A systematic research synthesis. *Children & Youth Services Review*

Jones, J. M. & Crook, W. P., Understanding Child Welfare Organizations. *Administration in Social Work*.

Jones, J. M. & Sherr, M. E. Recruitment and retention of new social work faculty: a family integrated strategy. *Journal of Social Work Education*.

## **COMMUNITY/UNIVERSITY SERVICE**

### Community Service

2002 – Present United Way of Columbia’s Outcomes Evaluation Committee

1994 – Present Trainer, Therapeutic Crisis Intervention

### College of Social Work Service

2002 – Present Member, Education Technology Committee, University of South Carolina, College of Social Work

2002 – Present Member, Publications and Media Committee, University of South Carolina, College of Social Work

2002 – Present Member, Special Events Committee, University of South Carolina, College of Social Work

2002 – Present Editorial Board, *Arete*, Journal of the College of Social Work, University of South Carolina

## **PROFESSIONAL ASSOCIATIONS**

2001 – Present National Association of Christians in Social Work

2001 – Present Society for Social Work and Research

2000 – Present Council on Social Work Education

1993 – Present National Association of Social Workers

## **AWARDS RECEIVED**

Diana DiNitto Policy Scholarship, Florida State University, Tallahassee, FL  
*November 2001*

Office of Graduate Studies’ Dissertation Grant Award, Florida State University,  
Tallahassee, FL *Fall 2000.*

Dianne H. Montgomery Scholarship for “Best Specialization Area Paper” Florida  
State University, Tallahassee, FL *April 2000.*