Evaluation
OF THE CAPACITY BUILDING COLLABORATIVE

How Do We Build Organizational Capacity in Child Welfare?

Evaluation Brief
May 2017

Introduction

This is the third of three briefs about organizational capacity in child welfare. It explores models for building capacity that have been applied in child welfare organizations, including the American Public Human Services Association (APHSA) Organizational Effectiveness Capacity Building Model; the Interactive Systems Framework (ISF), which incorporates Getting to Outcomes (GTO) and the Evidence Based System for Innovation Support (EBSIS); and the Children's Bureau (CB) Capacity Building Collaborative approach.

The first brief in the series, *What Is Organizational Capacity and What Does It Look Like in Child Welfare?* (James Bell Associates & ICF International, 2016), describes key capacities including resources, infrastructure, knowledge and skills, organizational culture and climate, and engagement and partnership. The second brief, *How Can Child Welfare Organizational Capacity Be Measured?* (James Bell Associates & ICF International, 2017), summarizes the many instruments for measuring those capacities.

The Collaborative is a partnership of the Center for States, Center for Tribes, and Center for Courts. The cross-center evaluation examines the services and level of collaboration across the Centers.

APHSA Organizational Effectiveness Capacity Building Model

APHSA developed a model to enhance organizational effectiveness in general, and to support innovation in policy, programming, or practice (American Public Human Services Association, 2012). APHSA's goal was to put in place a process of continuous improvement in an organization's performance, performance capacity, and client outcomes. The Organizational Effectiveness Capacity Building Model uses a logic model to describe the interconnected parts of the operating system of an effective organization.

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Under this framework, the organizational system is made up of a **strategy** (encompassing the vision, mission, values, desired outcomes, goals, objectives, plans, and major initiatives); **inputs** (including resources such as people, materials, equipment, and finances); **performance capacities** (including budget/fiscal capacity, support function capacity [infrastructure], workforce capacity, trust and values [organizational culture and climate], data and analysis capacity, and service design); **performance actions** (activities that characterize the system, such as service delivery and product development); **outputs** (the result of system performance/accomplishments); **outcomes** (describing how lives have changed as a result of system performance); and **feedback from the environment** (where data are used to inform strategy, inputs, performance capacity, and activities). This feedback is drawn from clients, community members, other service partners, staff, and legislators.

Under the APHSA model, three tools are used to build organizational effectiveness capacity—the DAPIM (Define, Assess, Plan, Implement, Monitor), Pyramid of Influence, and Markers of Effectiveness. The DAPIM (American Public Human Services Association, 2012) is a five-step process to do the following:

1. **Define** priority improvements.
2. **Assess** observable, measurable strengths and gaps, and identify root causes and general remedies for priority gaps.
3. **Plan** quick wins and midterm and longer term improvements.
4. **Implement** action plans while managing communication and capacity.
5. **Monitor** progress, impact, and lessons learned for accountability and ongoing adjustments.

The Pyramid of Influence is an APHSA-developed model that identifies four major areas of organizational work that function as connected parts of a whole. These include (from the bottom to the top of the pyramid): operations, key processes, structure and culture, and strategy. Strategy is situated at the top of the pyramid because it drives all other organizational efforts that are aligned with it. These organizational capacities are enhanced through support functions such as leadership and tactical expertise. In the real world, under this model, capacities are built most effectively from the bottom up (starting with operations). Operations work involves implementing key processes, service delivery to clients, and management of worker performance. Key processes are the specific processes and procedures that transfer the strategy and structure and culture into direction for carrying out day-to-day work. Under structure and culture, the emphasis is placed on defining and communicating jobs, departments, work teams, policies, and performance expectations. Last, at the top, strategy refers to focusing on what the organization is, what it intends to do and why, how it will do it, and what it needs to be successful.

Markers of Effectiveness is an APHSA tool that helps an organization's leader understand how support functions can spearhead organizational effectiveness initiatives to support an organization's mission and goals. It also guides the persons responsible for directing support functions in providing technical expertise, guidance, and consultation to the organization's leadership team. The tool delineates how the use of training, technical expertise, guidance, and consultation can enhance skills development such as engagement; align all aspects of the organization in support of products, services, and outcomes; and monitor effectiveness using data.

Interactive Systems Framework

ISF is a model Wandersman et al. (2008) developed. ISF describes three interactive systems that help bring science to practice: (1) the synthesis and translation system that extends the products of research into user-friendly formats; (2) the delivery system, which is the front-line level where organizations implement interventions to reach desired outcomes; and (3) the support system, which involves intermediary organizations that provide support and build organizational capacity in the delivery system via training, technical assistance, tools, and feedback so products from the synthesis and translation system can be practiced with fidelity and quality in the delivery system.

The ISF model notes the **general capacity** of the organization is critical for an innovative practice to be installed, maintained, and sustained over the long haul (Flaspohler, Duffy, Wandersman, Stillman, &

Maras, 2008). An organization must have the resources, infrastructure, and culture and climate necessary to support innovation. **Innovation-specific capacity** involves building capacity in leadership, staff, and partners to change mindsets, understand the innovation, and enact the innovation with fidelity with clients. Both general and innovation-specific capacity must be assessed then built, as necessary, so the new policy, process, or practice can be implemented successfully.

The model has incorporated a specific tool for choosing, installing, and evaluating interventions—the 10-step GTO framework (Barbee, Christensen, Antle, Wandersman, & Cahn, 2011; Wandersman, Imm, Chinman, & Kaftarian, 2000). The 10 steps include (1) **identifying** needs and resources; (2) **setting goals** to meet the identified needs; (3) determining what science-based, **evidence-based practices or evidence-informed practices** or casework practice models exist to meet the needs; (4) assessing actions that need to be taken to ensure the evidence-based practices **fit** the organizational or community context; (5) assessing what organizational **capacities** are needed to implement the practice or program; (6) creating and implementing a **plan** to develop organizational capacities in the current organizational and environmental context; (7) conducting a **process evaluation** to determine if the program is being implemented with fidelity; (8) conducting an **outcome evaluation** to determine if the program is working and producing the desired outcomes; (9) determining, through a **continuous quality improvement (CQI) process**, how the program can be improved; and (10) taking steps to ensure the **sustainability** of the program. Six studies have evaluated the efficacy of GTO including randomized controlled trials (Chinman, Acosta, Ebener, et al., 2012, 2013b; Hunter et al., 2014). All the studies found that when GTO is utilized, implementation is achieved and outcomes are reached (e.g., Chinman et al., 2008, Chinman, Hannah, & McCarthy, 2012, 2013a; Chinman, Tremain, Imm, & Wandersman, 2009).

Also embedded in the ISF model is EBSIS (Wandersman et al., 2012), which is the mechanism for building capacity in organizations. Under this framework, innovation capacity is built through (1) training; (2) technical assistance (including coaching, mentoring, and consultation); (3) tools and feedback through CQI systems; and (4) both process and outcome evaluations.

Children's Bureau Capacity Building Center Approach

CB has a long history of providing training and technical assistance to states and tribes to support efforts to prevent and protect children from being abused or neglected, and to find permanent placements for children who cannot safely return home (Barbee, 2013). In 2014, CB established three national Capacity Building Centers (the Centers)—the Center for States, the Center for Courts, and the Center for Tribes. Centers offer services to jurisdictions as they develop and implement national CW policies and programs, with the goal of building organizational capacity and improving CW practice to achieve safety, permanency, and well-being outcomes for children, youth, and families. Centers also support jurisdictions as they participate in the Child and Family Service Review process and Title IV-E Waiver Demonstration Projects. Jurisdictions often work on multiple improvement efforts simultaneously; these efforts require a variety of capacity building services that range in type, scope, and intensity. The Centers make up what is referred to as **the Collaborative**.

All three Centers "subscribe to a common approach to service provision based on their knowledge of research-informed frameworks and models for capacity building and evidence-based approaches to training, consultation, adult education, and distance learning" (James Bell Associates & ICF International, 2015). The approach is designed to help courts, tribes, and public CW agencies build capacity to install innovative policies, programs, and practices to create lasting systems changes. It incorporates Wandersman's ISF, EBSIS, and GTO work, and an approach that dovetails with successful CQI models of change such as the National Child Welfare Resource Center for Organizational Improvement/Casey model (Casey Family Programs & the National Child Welfare Resource Center for Organizational Improvement, 2005). It integrates several useful change frameworks intended to improve the performance of CW systems including the *Permanency Innovations Initiative* approach

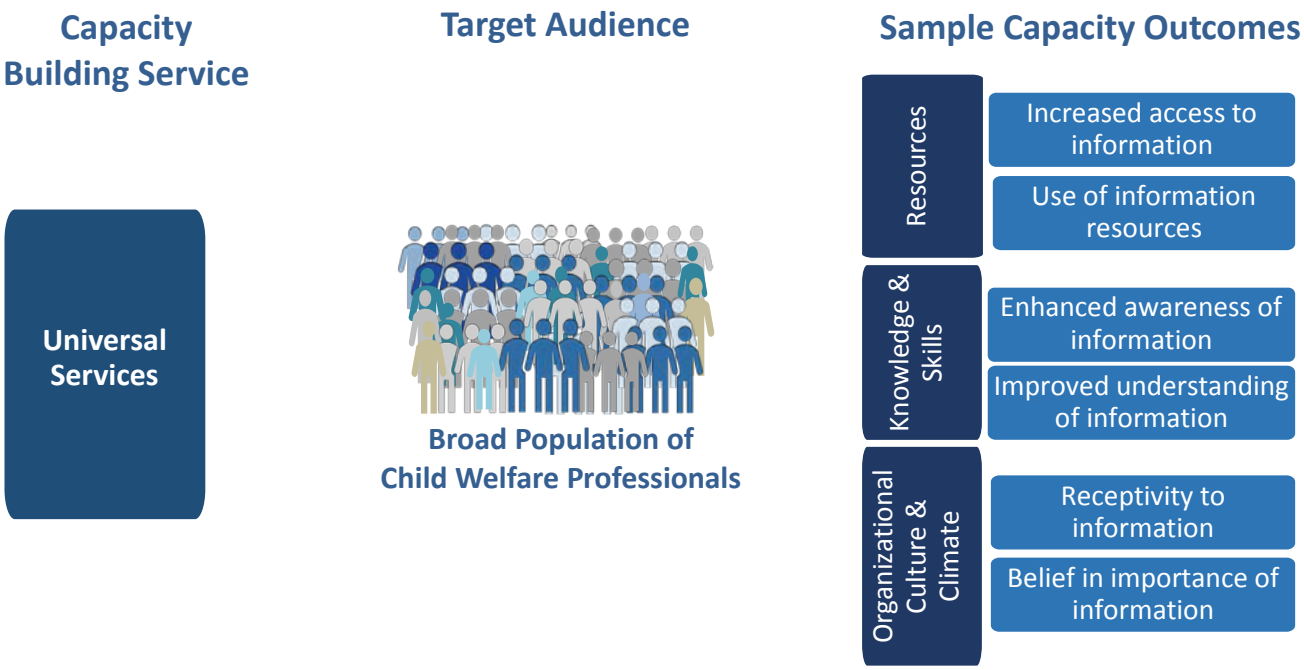
(Permanency Innovations Initiative Training and Technical Assistance Project & Permanency Innovations Initiative Evaluation Team, 2013); implementation science frameworks such as the National Implementation Research Network (NIRN) (Fixsen, Blase, Friedman, & Wallace, 2005); and findings from CW Waiver Demonstration Evaluations (U.S. Department of Health and Human Services, Administration for Children and Families, 2011) and the Cross-Site Evaluation of the CB's Implementation Centers and National Resource Centers (Children's Bureau, 2015; Sanclimenti, Caceda-Castro, & DeSantis, 2016).

The Centers provide three types of capacity building services. Each type of service is expected to result in specific outcomes. Ultimately, the Centers intend to enhance the capacities of the agencies and courts they serve, in five areas or **organizational dimensions**: (1) resources, (2) infrastructure, (3) knowledge and skills, (4) organizational culture and climate, and (5) engagement and partnership.

These capacity dimensions are described in the first brief in this series, *What Is Organizational Capacity and What Does It Look Like in Child Welfare?* (James Bell Associates & ICF International, 2016).

Universal capacity building services make information accessible to a broad audience and are intended to increase the capacity of the overall population of child welfare professionals. Examples include reviewing and distilling research and presenting information in a manner that makes it accessible to a broad audience, posting information on social networking sites, updating Web pages with new information, presenting Webinars, and developing products and tools for general dissemination. Universal capacity building services are intended to increase awareness, understanding, engagement, access, and/or use of information by CW professionals.

Figure 1. Universal Capacity Building Services, Target Audience, and Examples of Outcomes



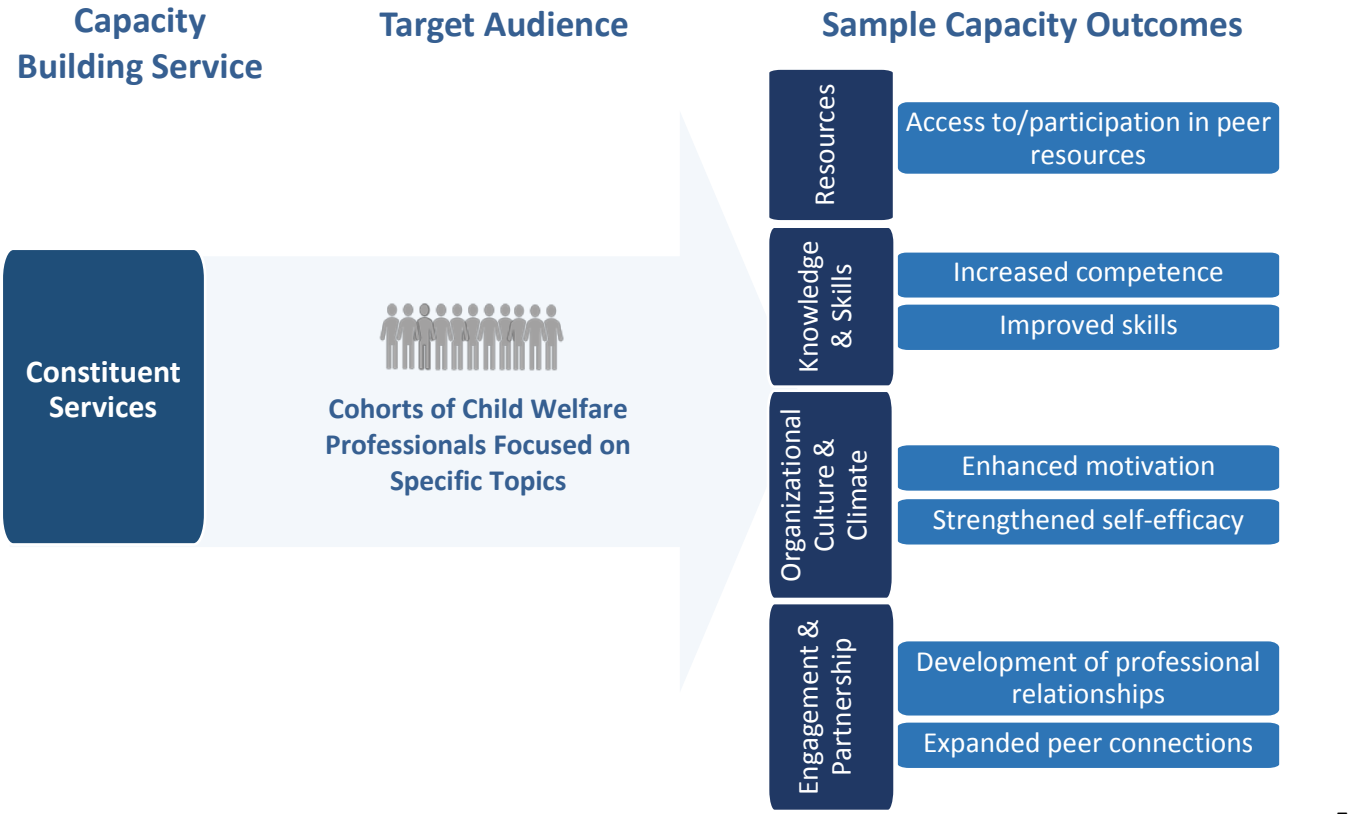
Constituency services are directed to particular constituency groups or cohorts of CW professionals and/or cohorts of CW systems on specific CW topics. Examples include targeted product development, networking opportunities, in-person and Web-based training, and coaching. The goals of these capacity building efforts are to provide opportunities for peer learning, to increase communication and collaboration, and to foster relationships and networks that will support learning and communities of practice. Expected organizational capacity changes and outcomes are illustrated in figure 2.

Tailored capacity building services are services individualized to match the needs and strengths of the jurisdiction through indepth assessments of strengths and needs and the creation of workplans. Tailored service provision uses a CQI-based change framework that includes 12 stages, anchored in the research literature, that lead to systemic change in CW.

These 12 stages are—

1. Identifying a problem or outcome that needs to be addressed
2. Forming teams to guide the change process, facilitate communication, and perform tasks
3. Gathering data, exploring the problem in depth, and identifying who is most affected
4. Developing a theory about the causes of the problem and how to address them
5. Identifying, researching, and selecting from among possible solutions
6. Adapting existing interventions or designing new ones
7. Assessing readiness and planning for implementation of the intervention(s)
8. Building capacity to support implementation
9. Piloting and/or staging implementation of the intervention(s)
10. Collecting and using data to adjust the intervention and/or implementation strategies
11. Evaluating to measure implementation quality and short- and long-term outcomes
12. Making decisions to further spread, adjust, or discontinue the intervention

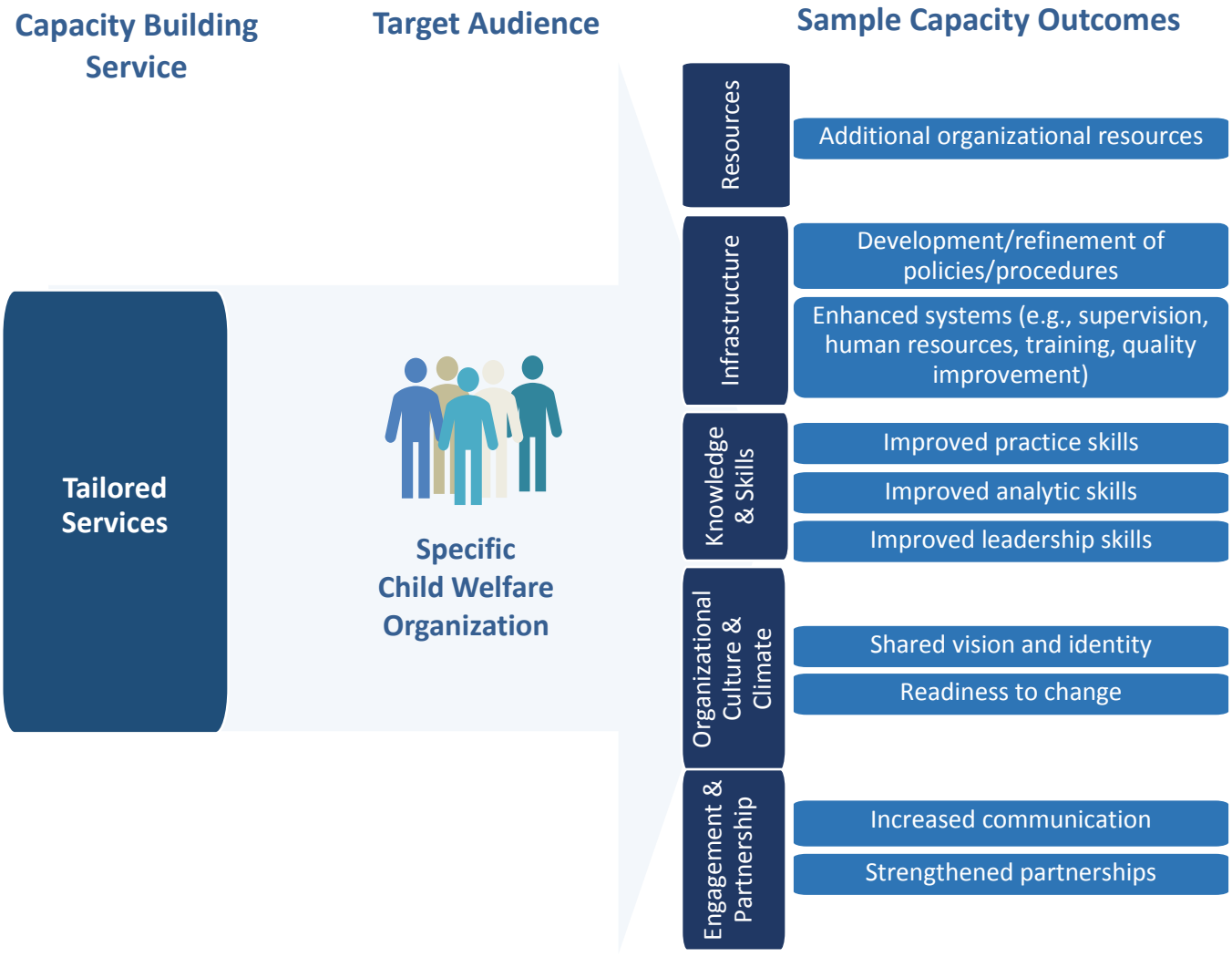
Figure 2. Constituency Capacity Building Services, Target Audience, and Examples of Outcomes



The Collaborative's approach includes examining readiness for change, clearly defining the problem, developing a change theory with short- and long-term outcomes, identifying appropriate interventions, building capacity to support implementation, and collecting and analyzing data at every step to inform implementation. Capacity building involves work in jurisdictions (e.g., estates, tribes, court improvement programs) so the jurisdictions themselves are knowledgeable about these 12 stages and how to utilize them as they implement new interventions.

Tailored services are planned with the goals of increasing the knowledge and skills of individuals in specific jurisdictions and fostering improvements in organizational and system capacity. Services are intended to achieve measurable changes in capacity, expressed by outcomes that include changes in organizational readiness, infrastructure, policies and procedures, and sustainable improvements in organizational performance.

Figure 3. Tailored Capacity Building Service, Target Audience, and Examples of Outcomes



Implications

All three of these capacity building approaches—APHSA Organizational Effectiveness Capacity Building Model, the ISF, and the CB Capacity Building Center Approach—recognize that capacity building is a complex and multidimensional effort. Organizational capacity building is dynamic, and the work is conducted in challenging environments, typically characterized by staff and leadership turnover, multiple and shifting priorities, and fiscal constraints. The models speak to the need to attend to various components of the organization, levels within organizations, and broader system partners to function optimally and effectively lay the groundwork for—and ultimately integrate and sustain—improved practice. Two of these models, APHSA and ISF, have been used to build capacity and support integrating new practices in CW agencies, and have been evaluated (Parry, 2011; Pipkin, Sterrett, Antle, & Christensen, 2013). The third model—the CB Capacity Building Center Approach—was recently developed, and its use by the Capacity Building Centers is currently being evaluated by James Bell Associates and ICF International. Evaluations of these models recognize the need to build on implementation science and understand the mechanisms of the model, the circumstances that support effective implementation, and how these components link to the achievement of capacity building outcomes.

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