

Structuring Systems of Care



The Role of Structure

This Primer is based on a number of premises with regard to the important role that structure plays in systems of care. Specifically:

PREMISE 1: *Certain functions must be organized to implement systems of care successfully, that is, they cannot be left to happenstance.* For example, if there is no structure—that is, no defined arrangement—for how care is to be managed, then it is unlikely that care will be managed.

PREMISE 2: *The structures that are created send a message about values, either undermining or reinforcing the values and principles that have been adopted.* For example, individualized, flexible service provision is a key principle of systems of care. However, if the financing structure attaches dollars only to programs, the principle of individualizing care will be undermined—not that it is impossible to incorporate individualized service provision within this structure, but it is more difficult. The structure in this instance sends a message about how much the system truly values an individualized, wraparound approach.

PREMISE 3: *The structures that are created have very much to do with how power and responsibility are distributed.* For example, a goal of systems of care is to invest families with shared decision-making power and responsibility at the services and systems (i.e., policy, management, and monitoring) levels. A systems-level structure that involves one parent on an advisory committee obviously distributes less power and responsibility than a structure that requires and strengthens the capacity of families to participate in all aspects of systems-level decision making. This latter structure, in turn, distributes less power and responsibility than one that mandates majority representation of families on decision-making or governance bodies and provides funding and support to implement the mandate.

PREMISE 4: *The structures that are created affect the subjective experiences of stakeholders, that is, how families, youth, providers, staff, administrators, and others feel about the system.* In the example given above of the lone parent on a systems-level advisory committee, families are likely to feel that the system, no matter how innovative certain aspects of it are, is being tokenistic.

PREMISE 5: *Structure affects practice and outcomes.* If for no other reason than that structure affects how people feel, it will affect practice and outcomes. For many reasons, the structures that are created can get in the way of or support intended practice and attainment of desired outcomes to lesser or greater degrees. The financing structure noted above, for example, that attaches dollars only to programs, is likely to hinder (though not necessarily defeat entirely) the practice of individualizing services. This, in turn, could frustrate (though, again, not necessarily defeat) attainment of the goal of improving clinical and functional

outcomes. Another desired outcome may be reduction in inappropriate use of hospital beds. If the benefit structure (that is, the services and supports that are allowable) and the provider network structure do not encompass crisis and step-down alternatives, then it is highly unlikely that inpatient hospital utilization will be reduced—at least not without affecting other desired outcomes such as improvement in clinical and functional status of children or reduced recidivism.

PREMISE 6: Structures need to be evaluated and modified, if necessary, over time.

Because system building is occurring in an ever-changing environment and is by its nature not a finite activity, the structures that are created today may not be what are needed tomorrow.

PREMISE 7: New structures replace existing ones; some existing ones may be worth keeping, and some are more difficult to replace than others. This is an admonition not to throw the baby out with the bathwater as there are existing structural strengths in every system that are worth preserving in whole or in part. And, it is an admonition to be strategic as to how much precious time and energy are spent and at what juncture (since timing is (almost) everything), in trying to replace intractable structures.

PREMISE 8: There are no perfect or “correct” structures. Sometimes the most desirable structures for the attainment of system goals are ones that for political, financial, technical, or other reasons cannot be created at the time. Sometimes there is not agreement among stakeholders or even clarity about what the most desirable structures are. The most desirable structures in one community may be very different from the most desirable structures in another. *What is important is that all stakeholders in a given community who are involved in system building take the time to analyze, acknowledge the strengths and weaknesses of, and plan contingencies in response to the structures that are created (or left standing).* This reflection needs to consider how the structures that are created reflect values, distribute power and responsibility across different stakeholder groups, affect the subjective experiences of different stakeholder groups, and affect goal attainment.

ILLUSTRATION 1

To illustrate the role that structure plays, consider the examples provided by Figures 1A and 1B, which describe the organizational structures of two state departments of mental health. Both state departments have system of care-like mission statements and expressed values to create a comprehensive continuum of care for children with emotional disorders and their families.

In the department whose organizational structure is described in Figure 1A, responsibility for children’s services is fragmented across three divisions: the Division of Institutions, which has budgetary and operational responsibility for child and adolescent inpatient and residential treatment facilities; the Division of Community Programs, which has jurisdiction over community mental health centers that provide both adult and child and adolescent outpatient services; and the Division of Special Populations, which includes the children’s director, who has responsibility for special projects related to children such as grant-funded programs and demonstration projects, which tend to include home- and community-based and wraparound services. The children’s director is relatively buried within this organizational structure and lacks line authority over most services and most dollars related to children. This director must negotiate with three division directors, two of whom control the lion’s share of the resources needed to create a continuum of care.

While it is not impossible to create a continuum of care within the structure described in Figure 1A, it is certainly more difficult than it is within the structure described in Figure 1B, where there is a children’s division with line budget and operational responsibility over the entire continuum of care. The structure in Figure 1A sends a message about the extent to which the state truly values an integrated continuum of care, is likely to create frustrations for the children’s director and key stakeholders concerned about the system, and creates confusion for families and providers. In spite of both states having similar values and goals, the structure in Figure 1A is less likely to support achievement of those goals than that in Figure 1B.

FIGURE 1A: State Mental Health Department

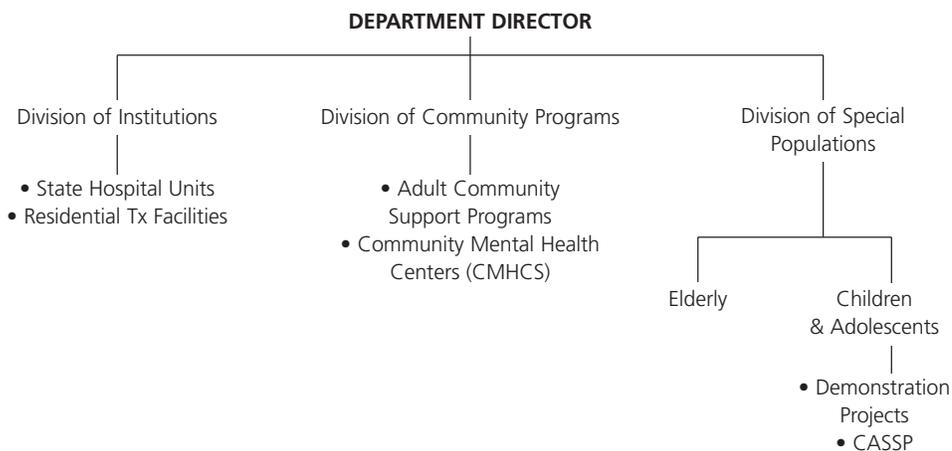


FIGURE 1B: State Mental Health Department



Pires, S. (1995). *The role that structure plays*. Washington, DC: Human Service Collaborative.

System of Care Functions Requiring Structure

There are certain functions within systems of care that need to be structured, that is, organized in some defined arrangement and not left to happenstance. Many functions require structure at both state and local levels. The list of functions that follows provides a good starting point that system builders can add to and adapt, based on their own experiences:

- **Planning** (the planning process itself needs structure)
- **Decision Making and Oversight at the Policy Level** (also referred to as Governance)
- **System Management** (day-to-day management decisions)
- **Benefit Design/Service Array** (borrowing a term from managed care, there needs to be definition of the types of services and supports that are allowable and under what conditions within the system of care)
- **Evidence-Based Practice**
- **Outreach and Referral**
- **System Entry/Access** (also referred to as Intake; how children, youth, and their families enter the system and what happens when they get there)
- **Screening, Assessment, and Evaluation** (three separate functions but are important to link)
- **Decision Making and Oversight at the Service Delivery Level**, including:
 - Care Planning (also called treatment or service planning; planning of services and supports for individual children and their families)
 - Care Authorization
 - Care Monitoring and Review
- **Care Management or Care Coordination**
- **Crisis Management at the Service Delivery and Systems Levels**
- **Utilization Management**
- **Family Involvement, Support, and Development at all Levels** (i.e., policy level, management level, service level)
- **Youth Involvement, Support, and Development**
- **Staffing Structure** (what is the staffing structure; how the functions are staffed)
- **Staff Involvement, Support, and Development**
- **Orientation and Training of Key Stakeholders** (i.e., staff, providers, families, etc.)
- **External and Internal Communication**
- **Provider Network** (network of services and supports)
- **Protecting Privacy**

- **Ensuring Rights**
- **Transportation**
- **Financing**
- **Purchasing/Contracting**
- **Provider Payment Rates**
- **Revenue Generation and Reinvestment**
- **Billing and Claims Processing**
- **Information Management**
- **Quality Improvement** (monitoring, feedback loops, adjustment mechanisms)
- **Evaluation**
- **System Exit** (how families leave the system; what happens when they leave)
- **Technical Assistance and Consultation**
- **Cultural Competence**

In this section of the Primer, each of these functions will be addressed, with examples to illustrate different approaches to structuring these functions and key questions for system builders to consider about the structures they have put in place or are contemplating. As discussed earlier, the types of structures that are created send a message about values, distribute power and responsibility, influence the subjective experience of stakeholders, and affect practice and outcomes. System builders need to continually examine the structures they have built in this context.

Cross-Cutting Characteristics

To be effective, systems builders need to ensure that every structure they build encompasses three fundamental characteristics:

- Cultural competence, that is, structures that support capacity to function effectively in cross-cultural situations;
- Meaningful partnership with families and youth in structural decision making, design, and implementation;
- A cross-agency perspective, that is, structures that operate in a non-categorical fashion.

Reference to these characteristics is woven throughout the discussions of each function requiring structure in this section of the Primer. These characteristics also are described in the second section of the Primer, *The System-Building Process*.

Not every function that needs to be structured within systems of care can be tackled at once. As system builders consider the functions that require structure and weigh the pros and cons of different structural arrangements, they also must think operationally and strategically about which functions to address at which stage in the system-building process. Typically, system builders begin by structuring a planning process, which is the first function discussed in this section of the Primer.

Structure

“Something Arranged in a Definite Pattern of Organization”

- I. Distributes**
 - Power
 - Responsibility
- II. Shapes and is shaped by**
 - Values
- III. Affects**
 - Practice and outcomes
 - Subjective experiences (i.e., how participants feel)

Pires, S. (1995). *Structure*. Washington, DC: Human Service Collaborative.

1.1

Planning

Because system of care building is a dynamic process occurring in a volatile environment, “planning” is an ongoing process that requires structure—perhaps different structures at different times and more or less structure at different times, but structure nonetheless. Staffing is an element of structure, and effective planning processes tend to be staffed. The time and place of meetings, the roles and responsibilities of those involved, how work gets done (for example, through committees or work groups), how information is communicated, and to whom—all have structural considerations in planning processes. The location and time of meetings may discourage some stakeholders from attending or alternatively make it possible for them to participate. Whether meetings are organized or not sends signals about the importance of the process. How information is imparted can value or de-value participants.

Structures for planning may be initiated at the local level and then draw in state-level stakeholders. Or, the state may create a structure for planning and engage local-level stakeholders. The important point is that the structure needs to allow for the involvement of stakeholders at both levels.

1.1A Elements of Effective Planning Processes

- Effective planning processes are staffed.
- Effective processes involve key stakeholders.
- Effective planning involves families early in the process and in ways that are meaningful.
- Effective planning processes ensure meaningful representation of racially and ethnically diverse families.
- Effective planning processes develop and maintain a multiagency focus.
- Effective processes build on and incorporate related programmatic and planning initiatives.
- Effective planning processes continually seek ways to build constituencies, interest, and investment.

Pires, S. (1991). *State child mental health planning*. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center of Children’s Mental Health.

The wrong kind of structure can be as detrimental as no structure at all. For example, a structure that is highly rigid can stifle creativity and the inclusion of key stakeholder groups who are uncomfortable with highly structured processes such as youth. On the other hand, a very loose structure may be frustrating to others whose input also is needed, for example, agency directors. In reality, effective planning processes create a variety of different structures to support system building. This also is important to respond to the racial, ethnic, linguistic, and cultural diversity across stakeholder groups.

Effective system builders typically structure planning processes in ways that create a variety of mechanisms for meaningful involvement of families and youth. In some communities with a strong family organization, families may structure their own

planning process, which is formally linked to the system-building process. There may be a youth council that serves a similar purpose. These mechanisms allow for a broader family and youth voice to influence system-building planning than representation on one planning body might allow.

Other communities may have one planning body with multiple subcommittees or workgroups to facilitate the involvement of a large number of people. The subcommittees or workgroups may be time-limited and typically establish their own guidelines for meeting schedules and places. The point is that meaningful involvement of families and youth requires a planning process structure that is flexible and informed by the needs of families and youth.

1.1B Strategies for Involving Parents (in Planning)

- Providing special orientation and training as well as ongoing assistance to parents who need a better understanding of administrative, budgetary, and other issues that play a role in planning. This might also include consulting with parents prior to a meeting to highlight what they might expect to be covered.
- Having more than token representation of parents at meetings.
- Contracting with community-based organizations or parent advocacy groups to develop and direct a process that ensures sustained and thoughtful parental participation in planning,
- Working through Head Start parent advisory groups, Parents Anonymous, and other parent organizations (such as the Federation of Families for Children's Mental Health and the National Alliance for the Mentally Ill Child and Adolescent Network).
- Asking agencies that work with parents (such as schools and child care centers) to recommend parents to participate in planning.
- Paying a stipend to parents who participate in planning sessions, and providing or paying for transportation and babysitting.
- Holding planning meetings in the evenings or on weekends, in communities across the state, and in locations such as schools, community centers, and other settings that may be more familiar and comfortable to parents than state or local office buildings.
- Conducting surveys to elicit the views of a wide range of parents.
- Using parents or others who work regularly with parents to conduct focus groups that probe the views of selected groups of parents such as teenage parents, single parents, grandparents raising children, foster parents, and adoptive parents.
- Working with family support programs to tap into informal networks such as parent support groups or parents who routinely visit a neighborhood drop-in center.
- Working with home-visiting programs and health clinics to involve parents who may be otherwise hard to reach.
- Working with family preservation and family reunification programs to identify and involve families who have benefited from these services.
- Conducting sessions for planning group members, administrators, and staff led by an experienced facilitator to explore attitudes and stereotypes about different ethnic, racial, and religious groups, and about parents.
- Publicly acknowledging the contributions of parents and other family members.

Emig, C., Farrow, F., & Allen, M. (1994). *A guide for planning: Making strategic use of the family preservation and support services program*. Washington, DC: Center for the Study of Social Policy and Children's Defense Fund.

The planning process structure must encompass mechanisms to build capacity among all stakeholders, recognizing that different stakeholders have different capacities for participation both with respect to information, knowledge, and skills and with regard to practicalities such as availability of transportation and child care, ability to leave work or school to attend meetings, ability to communicate in the English language when English is not one's primary language, and the like. This is true of all stakeholders, not just parents and youth; however, other stakeholders often have more resources available to them to obtain information that is lacking or to accommodate a meeting schedule than do parents and youth.

EXAMPLE 1.1

In a neighborhood-based system of care in the Southeast, system builders engage in an ongoing strategic planning process tied to the budget development process that is structured to ensure organized input from major stakeholder partners, namely, families, staff/providers, and the governing board comprised of neighborhood residents (in the majority), state and local officials, and business and community leaders. The planning process is structured so that, initially, the neighborhood's family council (representing many families in the neighborhood), the staff and providers involved in delivering services, and the governing body each conducts its own annual process to: reflect on and celebrate system-building achievements, identify major unmet challenges, and prioritize goals and objectives for the upcoming year. Each individual partner group structures its individual planning process as it wishes, to accommodate the needs and capacities of its members, but the individual processes are linked one to the other and fit within the overall system-building planning-process timetable. In addition to structuring where and when they meet, individual partner groups also obtain facilitation and technical support for their processes, based on what each needs. For example, the family council utilizes a facilitator trained in working with parent organizations and engages technical assistance in areas such as budget and fund development. The governing body obtains technical assistance on strategic planning and financing.

Results of these individual planning processes are circulated among all of the partners so that discrepancies and differences can be identified. All partners then come together for a day-long retreat to resolve any outstanding differences and finalize consensus on goals for the future. This planning structure produces a strategic plan for the year.

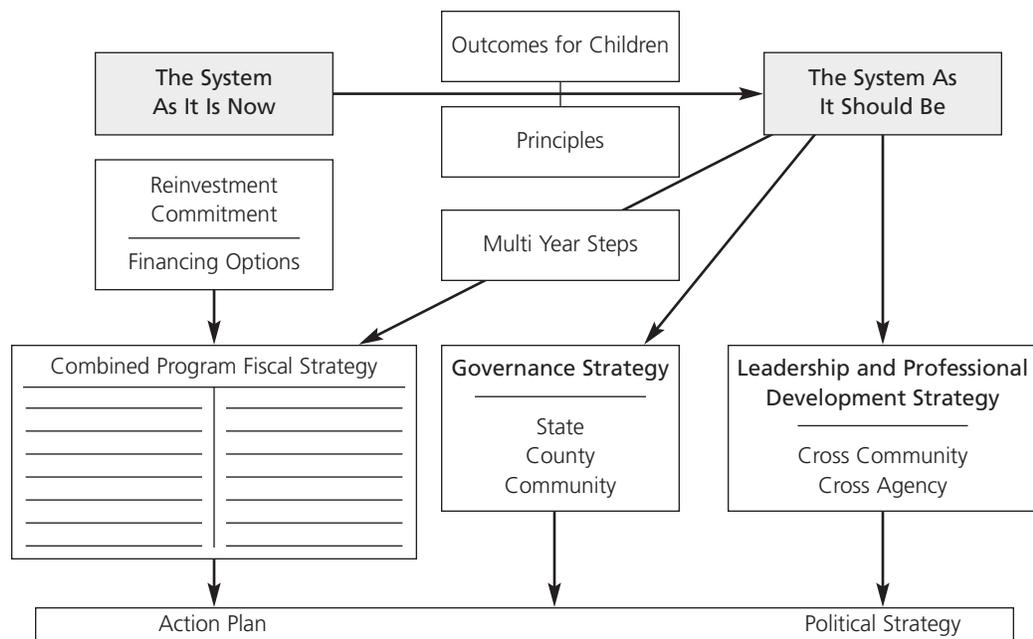
AGENDA OF DAY LONG RETREAT

- Opening
 - Introductions and welcome
 - Review purpose of retreat and consensus building process to date
- Accomplishments during 1999
 - Identify major accomplishments in 1999, based on consensus among partners
- Lessons learned (What facilitated accomplishments in 1999?)
- Unmet challenges in 1999
 - Identify major unmet challenges in 1999, based on consensus among partners
- Lessons learned (What factors contributed to unmet challenges?)
- Priorities for CY 2000
 - Identify major priorities for year ahead, based on consensus among partners
- Strategic Plan
 - Analysis and discussion of strengths, needs, and resources related to CY 2000 priorities
 - Strategies to be implemented
 - Assignment of responsibilities

Illustration 1.1 provides a schematic picture of how to structure the content of a planning process for reforming services for children and families, beginning with an understanding of the current system and moving to a vision of what the system should be, based on values, principles, and desired outcomes. The vision of what the system should be becomes operationalized through a number of strategies, which this diagram organizes as fiscal, governance, leadership, and professional development strategies. These strategies are guided by an action plan and a political strategy.

ILLUSTRATION 1.1

A Planning Process for Family and Children’s Service Reform



Friedman, M. (1994). *A planning process for family and children's service reform*. Washington, DC: Center for the Study of Social Policy.

1.2 Decision Making and Oversight at the Policy Level (i.e., Governance)

Governance—policy level decision making and oversight—should not be confused with system management (discussed separately). **These are two distinct functions.** While it is conceivable that system builders might utilize the same players to perform both functions—for example, in rural communities where, because of limited resources, the same players often perform both functions—the functions themselves are distinct.

1.2A Definition of Governance

Decision making at a policy level that has legitimacy, authority, and accountability.

Pires, S. (1995). *Definition of governance*. Washington, DC: Human Service Collaborative.

To have legitimacy, authority, and accountability, governance structures for systems of care are by necessity interagency bodies. In addition, the most effective governance structures also legitimize the voice of family and youth consumers by including them in governance mechanisms.

Scanning the country examining governance structures for systems of care, one finds a broad variety. Governing bodies for systems of care exist at the state level, at the local or neighborhood levels, and in some places at all levels for the same system of care. Some are created by legislation, some by executive order, some by memoranda of agreement, some by community will. Some are governmental or quasi-governmental bodies, and some are 501 (c)(3) (private, not for profit) entities.

However they look, there are some basic questions to be asked about governance structures. Those listed below are far more important questions to answer initially with respect to governance structures than whether the structure should be a 501(c)(3) or a quasi-governmental or governmental entity or some other arrangement. There are pros and cons to each of these types of governance structures, depending very much on the particular circumstances in a given locality.

Basic Governance Questions

From where does the governance body get its *authority* to govern the system of care? From legislation? executive order? regulation? contractual obligation? interagency memorandum? community will (as expressed through some defined, credible process)? System of care governance structures need to derive their authority from something or someone that has the authority to give it or risk being viewed as tangential.

Is there *clarity* about what the governance body is responsible for governing? For example, in some states there is more than one governance structure for the same system of care—one at the state level and one at the local level. Are the roles and responsibilities of each clear and non-redundant? Even where there is only one governance structure, system builders need to be very clear about what it is governing, or there will be confusion, dashed expectations, and resentment among stakeholders.

Are those who sit on the governance body *representative* of the stakeholders that have an interest in the system of care? Does it include families and youth, state, local, and community representatives, providers, and other representatives? (If there is some stakeholder group that cannot by consensus among system builders sit on the governing body because of potential conflict of interest, in what other, more appropriate ways can this group have input into the governing body? This is an issue that has arisen in some communities, for example, with respect to providers and in some communities has been resolved by creation of a formalized providers forum, which meets periodically with the governance body to offer input and feedback.) If the governance body is not representative, it will be viewed with skepticism, its decisions questioned, and its effectiveness compromised.

Does the governing body have the *capacity* to govern the system of care? That is, does it have the talent, time, staff, data management, and other resources to operate? Many times system of care governance structures get created that are not staffed, have no dedicated resources for their own operations, and whose members have other full time responsibilities. This is a recipe for failure. Systems of care cannot be governed out of hip pockets. Lack of capacity to govern obviously affects outcomes, builds resentment among stakeholders, unfairly assigns responsibility without providing power, and sends a message that system of care governance is not valued. In some communities the system management entity discussed below, in effect, staffs the governance body because governance and system management are subsets of the same entity. In other localities governance and system management may be lodged within two discrete entities. The governance body may be overseeing the system management structure in a contractual relationship, for example, and in this instance needs its own staff and management information capability.

Does the governance structure have *credibility* among key stakeholder groups to govern the system of care? The answer to this question has to do not only with the answers to the questions above but also with how effective the governance body is in communicating to key stakeholders regarding its functions. A governance body may be doing a terrific job, but if key stakeholders do not know about it, it might as well be doing no job.

Does the governance structure embrace the concept of *shared liability* among partners? Systems of care serve populations of children for whom different agencies have legal responsibilities, for example, children involved in the child welfare, juvenile justice, and special education systems. If the system of care governance structure does not assume shared liability to meet these legal responsibilities, system builders are creating a situation of “double jeopardy” for partner agencies that have legal mandates and that

have committed resources for the population to be served by the system of care. The principle of unconditional care, which is so important to the integrity of the system of care, begins with the governing body's embracing the concept of shared liability. Without it, governing bodies in effect leave themselves "outs" that are inherently suspect to partners with legal mandates and to families who are tired of having to navigate multiple systems.

1.2B Key Issues for Governing Bodies

- Has authority to govern
- Is clear about what it is governing
- Is representative
- Has the capacity to govern
- Has the credibility to govern
- Assumes shared liability across systems for target population

Pires, S. (2000). *Key issues for governing bodies*. Washington, DC: Human Service Collaborative.

ILLUSTRATIONS 1.2A & 1.2B

Illustrations 1.2A and 1.2B describe the evolving governance structure in a county in an eastern state with state legislation mandating local systems of care to reduce the numbers of children in out-of-home placements. In this particular county the system-building effort is housed operationally within the Department of Mental Health (DMH), although it is envisioned as an interagency effort. In Illustration 1.2A, it is not clear from whom or what the governing body derives its authority. This structure also does not clarify what the local governing board actually governs, since it makes it appear as if the board simply oversees the DMH effort. Indeed, when asked to whom does the system of care director report and who is accountable for expenditures, both the DMH Director and board members responded, "To me/us." While the board includes representation from the statewide family organization, it does not include representation from families and youth actually served by the project. In addition, providers are not represented on the board. Illustration 1.2A seems to suggest that the staff of the system-building effort "belong to" the Department of Mental Health. There are no feedback loops or communication structures indicated in Illustration 1.2A. Those closest to the frontline, i.e., families, youth, and case managers, are those most removed from the governing body. It is not clear from Illustration 1.2A that the board embraces the notion of shared liability; indeed, it would appear as if DMH has the liability.

Illustration 1.2B indicates a restructuring of the board, achieved through a process of clarifying roles, responsibilities, vision, etc. Illustration 1.2B makes it clear that the board derives its authority from the County Executive, who issued an executive order creating the board, citing the relevant state legislation. Illustration 1.2B clarifies that the system-building staff are accountable directly to the board and not through the DMH director, whose position on the board is now the same as every other agency director (even though the project remains "housed" in DMH for operational purposes). In addition to representation from the statewide family organization, the board changed its bylaws to increase family and youth membership and ensure representation from families and youth actually being served by the project. The board decided against including providers on the board, citing

concerns about potential conflict of interest, but instead created a Providers Forum, which meets regularly with the board. Communication and feedback loops are shown in Illustration 1.2B by two way arrows, indicating that care managers now have direct input to the board on a periodic basis, in addition to providing input through the system of care director, who functions as staff to the board. Illustration 1.2B shows more clearly the board's intent to assume shared liability for children served through the system of care.

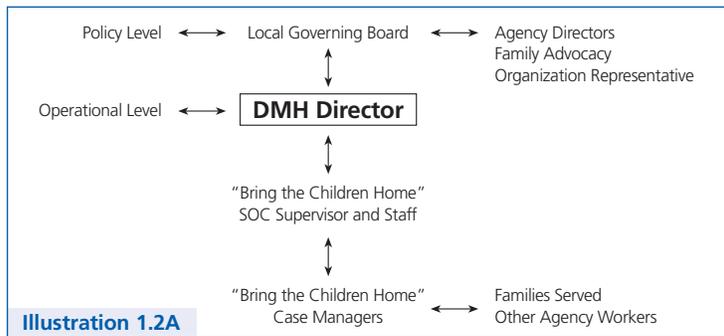


Illustration 1.2A

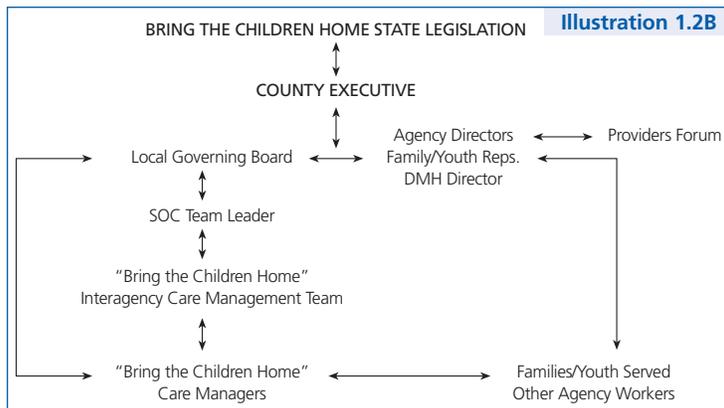


Illustration 1.2B

Pires, S. (1996). *Evolving governance structure*. Washington, DC: Human Service Collaborative.

System Management

System management has to do with day-to-day operational decision making. Again, scanning the country, one finds a variety of system management structures for systems of care. System management may be lodged with a lead state or local agency, an interagency body at either level, a quasi-governmental entity, a private, nonprofit lead agency, or a commercial company such as a managed care organization. System management might be lodged with one entity or co-shared, for example, between a family organization and a lead provider agency or between a commercial company and a state agency or between a commercial company and a coalition of nonprofit providers. When system management is co-shared, clarity as to the roles and responsibilities of each party is critical.

As with governance structures, there are pros and cons to each type of management structure, depending on the circumstances in the state or community. In some localities, for example, particularly where there are many 501(c)(3) organizations, creation of a new 501(c)(3) may be viewed as “creating yet another private nonprofit that will compete for funds.” In other localities, designation of an existing private nonprofit agency to serve as the system manager might not be viable for political or technical reasons (i.e., there may simply be no existing organization with the capacity to perform system management functions). In some states or localities, because of long histories of contention and mistrust across child-serving agencies or because the internal management capability does not exist, it may not be possible to designate a lead government agency as system manager. In still other circumstances, it may not be possible to use a commercial company because of stakeholder resistance to use of profit-making entities or stakeholder beliefs (and, perhaps, the reality) that commercial companies lack adequate knowledge of populations that rely on public systems of care.

The following chart shows characteristics of different system management structures used by CMHS Grant sites.

1.3 Key Characteristics of Interagency (System Management) Structure Models

Characteristic	Nonprofit organization board of directors model	Communication and networking forum model	System management team model
Agency representation	Little to no public agency representation	Middle-level representation from wide variety of agencies	High-level representatives from core child-serving agencies
Family representation	Highest	High	Little to none
Community representation	Little to none	Highest	Little to none
Functions	Policy development, strategic planning, problem solving; Service array development	Information sharing; Networking	Policy development, strategic planning, problem solving; Service array development
Level of authority	Final decision making	Advisory	Final decision making but by consensus usually
Breadth	Specific to nonprofit but including grant	Typically broader than grant, including other cross-agency initiatives	Virtually always broader than grant, community-wide but focused on child health
Institutionalization	Established procedures and bylaws; Standing membership; Future depends on success as service provider No agreements with core child-serving agencies (except service contracts)	Unstructured procedures; Fluid membership; Likely to remain in some forms, possibly with shifts in mission and focus Informal memoranda of agreement among public agencies (generalized statements of intent to collaborate)	Established procedures; Standing membership; Very likely to endure past the grant period Formal interagency agreements (e.g., detail joint programming, pool of funds)

"The system of care model: Implementation in twenty-seven communities" by Vinson, N.B., Briannan, A.M., Baughman, W., Wilce, M., and Gawron, T., 2001, *Journal of Emotional and Behavioral Disorders*, 9, 30-42. Copyright (2001) by PRO-ED, Inc. Reprinted with permission.

Vinson, N.B., Briannan, A.M., Gaughman, L.W., Wilce, M., and Gawron, T. (2001). The system of care model: implementation in twenty-seven communities. *Journal of Emotional and Behavioral Disorders*, 9, 30-42.

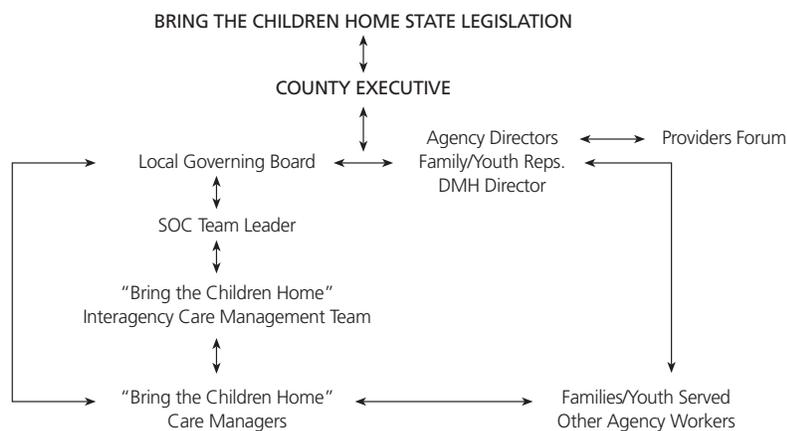
As with governance structures, before determining what type of structure makes sense, system builders need to be able to answer a number of questions:

- Is the **reporting relationship** clear—i.e., is it clear to whom the system management structure reports?
- Are **expectations** clear as to what the system management structure is managing and what information it is expected to provide to the governing body?
- Does the system management structure have the **capacity** to manage—i.e., qualified staff, data management capacity, leadership, etc.?
- Does the system management structure have **credibility** with key stakeholders, or can it create such credibility? For example, let us say that the system management function is being contracted to a commercial company that lacks credibility with certain key stakeholder groups because it is a profit-making entity and/or because it lacks familiarity with the population. With orientation and training, communication, targeted strategies to build relationships with stakeholders, limits set on profits, and the like, in addition to effective performance, is it possible to create credibility? If not, no matter how effective the performance, there is likely to be a constant “energy drain” from system-building efforts caused by the negative perceptions and resistance of key stakeholders.

Following are different illustrations of system management structures that also show the relationship to the governance structure.

ILLUSTRATION 1.3A

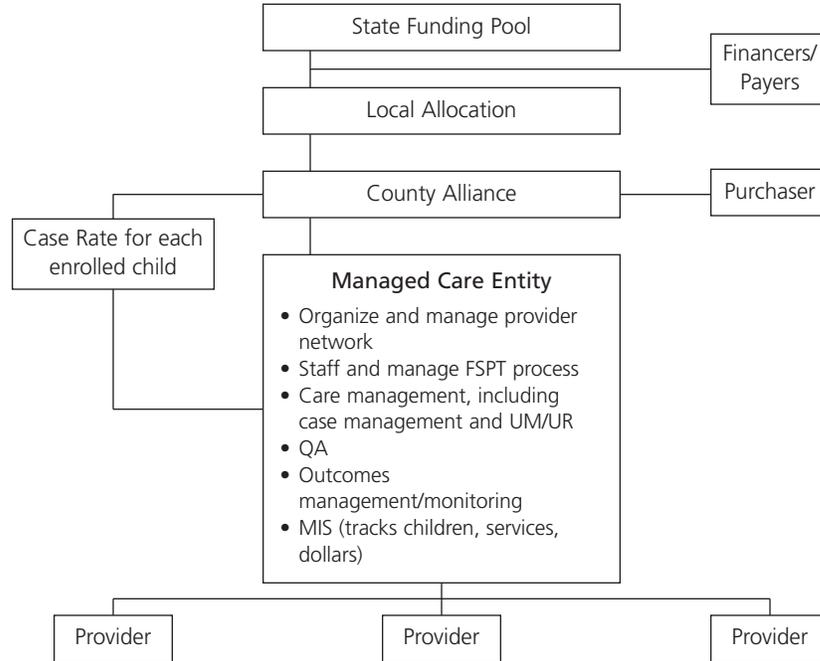
In Illustration 1.3A the governance structure is an interagency body created by executive order; the management structure is an in-house management team with management and clinical/case management staff. In this example, the SOC team leader reports directly to the interagency board (even though the project is “housed” within the Department of Mental Health), and the SOC team leader staffs the governing board (similar to an executive director in a nonprofit organization staffing a board of directors).



Pires, S. (1996). *In-house system management structure*. Washington, DC: Human Service Collaborative.

ILLUSTRATION 1.3B

In Illustration 1.3B the governing body is a countywide purchasing alliance or cooperative that has taken the form of a new quasi-governmental body. The system manager is a commercial managed care company that has partnered with a lead nonprofit provider in the county. The system manager is contractually accountable to the county purchasing alliance. The county purchasing alliance has its own monitoring and quality assurance staff.



Pires, S. (1996). *Contracted system management structure*. Washington, DC: Human Service Collaborative.

While both of these structures are quite different, they each clarify the reporting relationship to the governing body and the expectations as to what is to be managed. Each invests capacity within the system management structure to manage the system of care.

1.4

Benefit Design/Service Array

“Benefit design” is a term borrowed from managed care. It refers to the types of services and supports that are allowable within the system and under what conditions. The benefit design or structure carries a powerful message about values, will certainly affect how key stakeholder groups (for example, families and providers) feel about the system, and will definitely affect outcomes. A key principle of systems of care is that the benefit design needs to incorporate *a broad array of services and supports*, including both traditional and non-traditional services and supports and both clinical services and natural supports. Another key principle is that the benefit structure allow for *individualized, flexible* service provision with attention to the cultural expectations of each child and family. Both state- and local-level stakeholders need to have a voice in structuring the benefit (i.e., defining the service array) because many services will be paid for by state-funding sources such as Medicaid and because the service array needs to reflect local strengths, needs, and capacity.

1.4A Types of Services in Systems of Care

- Assessment and diagnosis
- Outpatient psychotherapy
- Medical management
- Home-based services
- Day treatment/partial hospitalization
- Crisis services
- Behavioral aide services
- Therapeutic foster care
- Therapeutic group homes
- Residential treatment centers
- Crisis residential services
- Inpatient hospital services
- Case management services
- School-based services
- Respite services
- Wraparound services
- Family support/education
- Transportation
- Mental health consultation
- Other, specify

Stroul, B.A., Pires, S.A., Armstrong, M.I. (2001). *Health care reform tracking project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families—2000 State Survey*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support.

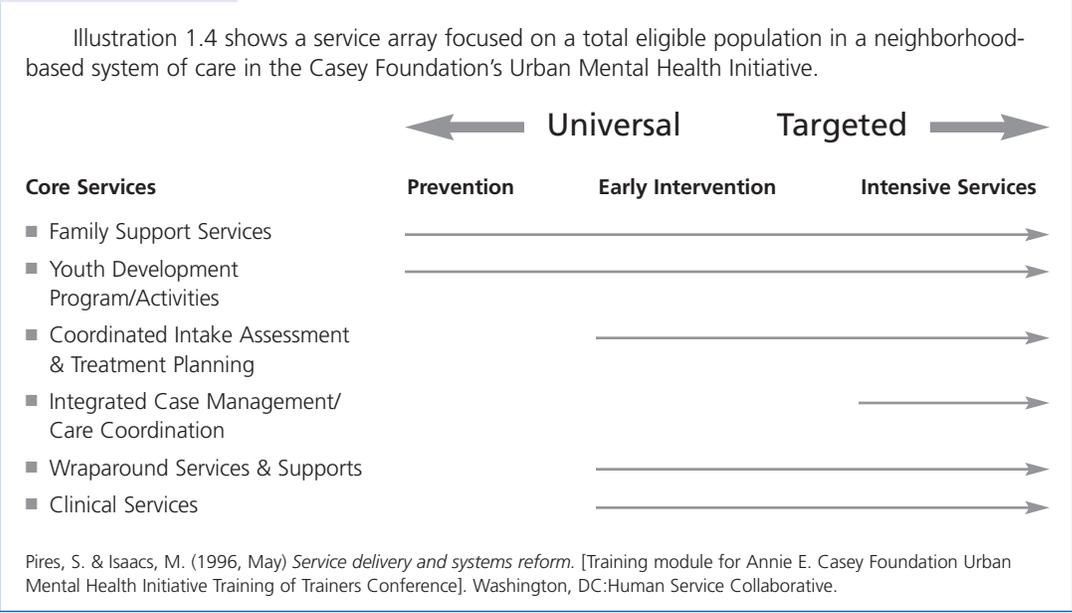
If the benefit structure arbitrarily limits the types of services and supports that are allowable or if it creates arbitrary day or visit limits on particular types of services, it is sending a clear message about the extent to which individualized, flexible care is valued. *Effective system builders do not try to manage costs and care by arbitrarily constraining the benefit (i.e., limiting the service array) but rather by incorporating care and utilization management capabilities, accountability mechanisms, and provider and family partnerships to reduce system dependency, building on strengths and natural supports.*

Use of multiple funding streams (as discussed more fully under Financing 1.23) can support a benefit structure that covers a broad range of services and supports and

individualized care provision. Sound care management, clinical leadership, family partnerships, integration of natural supports, and strong accountability systems can prevent the runaway costs that is the fear associated with a “generous” benefit structure.

Particularly when the system of care is focused on a total eligible population of children (i.e., all children in a county who depend on public services), system builders need to conceptualize a service array that spans prevention, early intervention and intensive services and supports, and universal and targeted services and supports.

ILLUSTRATION 1.4



A challenge facing system builders is that of increasing service capacity to accommodate increased demands in a new, more accessible system of care. Most system builders face the reality that services for children with emotional disorders, particularly home- and community-based services, are underdeveloped. In most states and communities, there are shortages of particular types of providers (e.g., child psychiatrists) and service modalities (e.g., therapeutic foster care). Development of service capacity is very much related to financing strategies, for example, redirecting or reinvesting resources in the development of new or more services, as discussed in the Financing Section (1.23). It also is related to training and retraining of new and existing providers as discussed in the Orientation and Training of Key Stakeholders Section (1.17), and decisions about how to structure the provider network, for example whether to include new types of providers, as discussed in the Provider Network Section (1.19).

Development of needed service capacity is both a state- and local-level issue. Effective system builders develop service capacity development plans to support system building. Two northeastern states, for example, are rolling out service capacity

1.5

Evidence-Based Practice

Historically, systems of care have been concerned about the quality and effectiveness of treatment interventions, that is, of frontline practice. As evidence grows regarding the efficacy of certain home-and community-based clinical interventions and service modalities, and the lack of efficacy of institutional treatment approaches, system builders have become more focused on building evidence-based practice into systems of care. In addition, there is increasing emphasis on building accountability at the treatment level into systems of care and recognition that systems of care cannot achieve desired outcomes without improving the quality of clinical interventions with children and families.

In the 2002 seminal work, *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders**, Hoagwood, Burns, and Weisz define the term “evidence-based” as referring to “a body of knowledge, obtained through carefully implemented scientific methods, about the prevalence, incidence, or risks for mental disorders, or about the impact of treatment or services on mental health problems.” They point out, “Controlled studies of institutional care have found no evidence of benefit (e.g., a lack of positive outcomes) in such settings as psychiatric hospitals, residential treatment centers, and detention centers... The current availability of evidence for effective home-and community-based interventions makes it possible for communities to redirect their approach to care—and many are beginning to do so.”

Hoagwood, Burns, and Weisz also write, “Perhaps it is the optimism that accompanies the beginning of a new century, but...much is now known about the effectiveness, impact, and outcomes of a range of treatments and services for children with severe emotional and behavioral disorders.” Burns identifies a number of shared characteristics of the evidence-based interventions described in their book.

1.5A Characteristics of Evidence-Based Interventions

- They function as service components in a system of care and adhere to system of care values (e.g., individualized, family-centered, strengths based (not pathology oriented), and culturally competent).
- They are provided in the community—homes, schools, and neighborhoods.
- With the exception of multisystemic therapy and sometimes case management, the direct-care providers (often) are not formally clinically trained. They are parents, volunteers, and counselors, although training and supervision are provided by traditionally trained mental health professionals.
- These interventions may operate under the auspices of any of the human service sectors (i.e., education, child welfare, or juvenile justice), not just mental health.
- Their external validity is greatly enhanced because they were developed and studied in the field with real-world child and family clients, in contrast to volunteers in university-based studies.
- When the full continuum of care in the community is in place, they are less expensive to provide than institutional care.

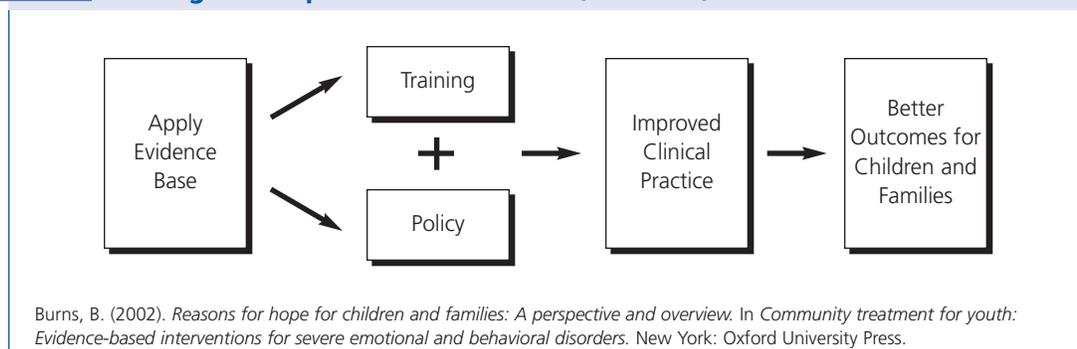
Burns, B. (2002). *Reasons for hope for children and families: A perspective and overview*. In *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.

*Burns, B. & Hoagwood, K. (Eds.). (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press. See also: Marsenich, L. (2002). *Evidence-based practices in mental health services for foster youth*. Sacramento: California Institute for Mental Health.

In the Foreword to the same volume, Jensen writes, “...the current need is...[for] building efficacious treatment interventions within effective, compassionate, and competent systems of care.”

Building evidence-based practices into systems of care has very much to do with how system builders structure a whole range of policies and procedures, including benefit design, financing, reimbursement, credentialing, frontline practice protocols, training, and quality assurance mechanisms. Structural changes are needed to ensure the readiness of providers and clinicians to undertake and learn new ways of conducting frontline practice. System builders and researchers are just beginning to articulate in an organized fashion what types of structural arrangements across policy and practice areas within systems of care at both state and local levels are needed to support incorporation of evidence-based treatment interventions.

FIGURE 1.5 Closing the Gap between Evidence, Practice, and Outcomes



Building evidence-based practices into systems of care requires effective partnerships with researchers, creating structures that include researchers as part of system-building teams. Some states and localities, for example, are creating “Centers for Excellence” as a key element of their system-building effort. These centers provide a vehicle for the identification and dissemination of evidence-based practices to systems of care.

EXAMPLE 1.5

A midwestern state is incorporating Multisystemic Therapy (MST), a home- and community-based treatment approach for youngsters with serious antisocial behaviors who are in or at risk for residential placement and/or involvement with the juvenile justice system, into local systems of care. Working with the researchers who developed the MST model, state and local system builders are building in the careful training, supervision, and quality improvement structures that are characteristic of this evidence-based practice.

As the body of knowledge about evidence-based interventions continues to be developed, system builders may turn to a variety of tools to guide frontline practice. Burns describes six tools to “achieve more relevant and consistent clinical practice.”

1.5B Tools to Support Consistent Clinical Practice*

1. **Best practices** tend to set out fairly general statements about clinical practice. They may be consumer- or provider-developed, based on consensus, and may or may not be specific either to diagnosis or to specific interventions. An example is “Promising Practices in Wraparound for Children with Serious Emotional Disturbance and Their Families” (Burns & Goldman, 1999).
2. **Practice guidelines** for diagnosis-specific interventions are evidence based and may be consensus based as well. They are developed by clinicians and researchers to guide treatment for specific disorders. Those that have been developed for childhood disorders are identified as practice parameters and include attention-deficit/hyperactivity disorder (AACAP, 1991), conduct disorders (AACAP, 1992), anxiety disorders (AACAP, 1993), schizophrenia (McClellan & Werry, 1994), substance-use disorders (AACAP, 1997b), bipolar disorder (AACAP, 1997a), and mental retardation and comorbid mental disorders (AACAP, 1999).
3. **Clinical protocols/manuals** were historically designed to ensure adherence to highly specific types of treatment. Previously, rigid adherence to a verbal script was the approach taken, but manuals of today are more likely to expand on principles for implementing a specific intervention (e.g. Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998b, for MST; and VanDenBerg and Grealish, 1998, for wraparound).
4. **Quality monitoring**, usually developed by clinicians to monitor clinical practice, consists of general indicators to assess treatment such as criteria for admission, treatment continuation, or termination by level of care. They may also include performance indicators that are population-based such as rates of access to care. In the future we may expect to see quality indicators derived from practice guidelines for specific disorders—for example, the American Psychiatric Association Task Force on Quality Indicators for Children is developing a comprehensive set of quality indicators for children and adolescents across multiple clinical conditions.
5. **Fidelity/adherence** measures assess the extent to which a given intervention is provided as intended. Developed in research settings, to date these measures have been utilized in controlled and uncontrolled research but not (broadly) in clinical practice. Among the interventions for youth with severe emotional and behavior disorders, (at least) three have reasonably well-developed methods for assessing fidelity: multisystemic therapy (Henggeler, et al., 1998b), treatment foster care (Foster Family-Based Treatment Association, 1995; Farmer, Burns, Chamberlain, & Dubs, 2001); and wraparound (Epstein, et al., 1998).
6. **Regulations** are specified largely for licensure, accreditation, or reimbursement by regulatory agencies. They may include criteria for client eligibility for level of care, structural quality criteria (staff qualifications and institutional capability), and occasionally practice parameters (e.g., frequency of contact, availability, intensity, duration of care, and caseload ratios).

Burns, B. (2002). *Reasons for hope for children and families: A perspective and overview*. In *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York: Oxford University Press.

*Note: All references cited in this box can be found in *Community Treatment for Youth*.

These tools provide a means for system builders to structure clinical leadership and direction to support effective frontline practice, based on evidence where it exists and on consensus derived from experience where evidence does not yet exist.

While systems of care strive to incorporate evidence-based practices, it is important not to lose sight of the considerations noted in the following box.

1.5C Considerations Regarding Evidence-Based Practice

- The importance of considering and studying clinical interventions in the context of the service systems through which they are provided and with attention to the diversity and complexity of the populations served.
- The importance of using common sense and experience to make decisions about services where an evidence base has yet to be developed.
- The importance of identifying unique and creative practices within systems of care that are candidates for development of an evidence base.
- The importance of not allowing innovation to be stifled by the desire to use only proven interventions.
- The importance of incorporating evidence-based practices into systems of care where we do have data and supporting the use of effective clinical practices through training.
- The importance of broadening the concept of evidence-based interventions to include evidence-based processes that may cut across a number of clinical interventions such as relationship building or the wraparound approach to service delivery.
- The importance of defining what constitutes “evidence” and the research methods considered acceptable for providing evidence, more broadly to ensure their relevance to operating community-based service systems.
- The importance of not perpetuating a false dichotomy between the concepts of evidence-based interventions and systems of care—they go hand in glove.

Stroul, B. (2002). *Systems of care: A framework for system reform in children's mental health* [Issue Brief]. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

1.6

Outreach and Referral

A goal of systems of care is to improve access to appropriate services and supports for children and their families within the population focus. If for no other reason than that system building creates significant changes in existing systems, system builders need to structure outreach and referral mechanisms to ensure appropriate access. In addition, most systems of care are trying to reach populations of children and families who have been underserved or inappropriately served in the past such as ethnically and racially diverse children and those in rural areas and inner cities. Failure to structure effective outreach approaches to these populations sends a message about the seriousness of system builders to improve access.

How outreach is structured will affect access. For example, relying on written materials sent by mail or reliance on telephone outreach makes little sense for populations who may not or cannot read the material or who may not have phones. In some communities there is deep distrust of formal delivery systems, and the most effective outreach involves use of natural helpers “reaching out” to families in their natural settings such as supermarkets, places of worship, and the like.

EXAMPLE 1.6

In a city in the South “walkers and talkers,” who are residents from the community, knock door to door in a housing development to sign up children for the State Child Health Insurance Program and explain the benefits to parents, as part of a Casey-sponsored outreach effort that recognizes “the importance of the messenger.”

See *AdvoCasey*, 2 (1) (2000, Spring/Summer) Baltimore, MD: Annie E. Casey Foundation.

In addition to outreach, referral needs to be structured—who can refer? can families and youth self-refer? where are referrals made? The issue of how to structure referral is sometimes cast as a debate between polar opposites—a narrow referral base in which,

— ■ ■ ■ —
*If you build it,
 we will come.*

for example, only partner agencies can refer versus an open referral process in which anyone can refer, including families and youth self-referring. In reality, there is a legitimate tension between the goal of having an “open” system for the target population and that of managing access so that the system is not overwhelmed, with mounting waiting lists and discouraged stakeholders as a result. Families *will* use a quality system (the “if you build it, we will come” phenomenon), and in virtually every community there is significant pent up demand for services—which argues for an open system. On the other hand, nothing can torpedo a developing system faster than growing waiting lists and uncontrolled costs—which argues for a narrower referral base. Many systems of care structure staged referrals, in which the referral base expands as system capacity develops.

There is no one correct answer as to how to structure referrals, which depends, in any event, on such factors as system capacity, resources, extent of pent-up demand, political implications, and the like. What is important is for system builders to analyze such factors, recognize the pros and cons of whatever referral structure is established, and communicate to stakeholders the rationale for the structure that is put in place.

Decisions regarding the structure of outreach and referral mechanisms is a concern of both state- and local-level system builders. State-level stakeholders, for example, may be making referrals to a local system of care through state-run child welfare systems or mental health facilities, and states control resources such as Medicaid and Temporary Assistance to Needy Families (TANF) dollars that can help to support outreach. In addition, information gathered during outreach and referral processes usually has to be submitted in some fashion back to states for reporting and other purposes. Localities, on the other hand, typically are in the best position to design outreach and referral mechanisms that address the particular needs and strengths in the community.

Outreach and Referral Key Questions

- What are our current mechanisms for outreach? How are we reaching out to historically underserved groups in our community, including ethnically and racially diverse families and those isolated in rural areas or inner cities?
- What is the structure of our current referral system?
- What is working with it? What is not?
- Have we explained to stakeholders how and why it operates as it does?

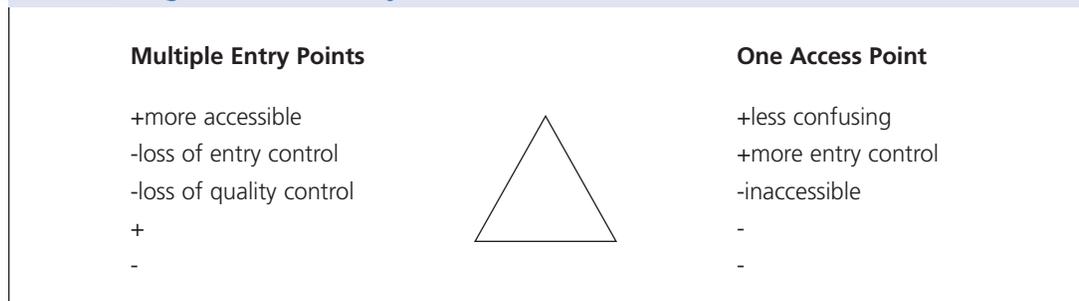
NOTES

1.7 System Entry/Access (Intake)

A goal of systems of care is to provide a more organized gateway or pathway to services and supports for the target population, in contrast to the multiple, typically confusing paths to services posed by the traditional, fragmented delivery systems. System builders sometimes refer to a “centralized intake” or a “system gatekeeper” within systems of care, but that terminology can be off-putting to families and other stakeholders and convey a bureaucratic rigidity that is not necessarily intended. This author prefers to use the terminology, *an organized gateway (or pathway) to care*.

An organized gateway to care does not necessarily mean there is just one place to go to enter the system of care (although it might). Some systems of care decentralize entry to the system of care with multiple entry points with the goal of making the system more accessible for families. The potential downside to this arrangement is loss of control over system entry, including loss of quality control since it can be more difficult to monitor the quality of multiple entry points. Other systems of care centralize the entry to care with, literally, one access point, with the goal of making the system less confusing to families and exerting more control over access. The potential downside to this arrangement is that system entry may be perceived as or may actually be inaccessible to families and too controlling.

FIGURE 1.7A Organized Gateway to Care



System builders need to weigh the pros and cons of various approaches within the context of the goals they are trying to achieve and recognize that different approaches have differing effects on system stakeholders. In one community, for example, families might like multiple system entry points, while in another community families would find that arrangement confusing. What also is important to note is that, regardless of the approach taken, intake can be “centralized”—by investing with the systemwide manager (rather than with multiple decentralized offices) the responsibility for organizing and managing system entry and by effective use of management information systems (MIS) to centralize intake and care management data.

We like having all these places to find out about services.

Creating an organized gateway to care—whether through one entrance point in a community or through multiple entryways—is essential for many reasons, among them the following:

— ■ ■ ■ —
Having one, central place is so much easier for us.
 — ■ ■ ■ —

- Children with or at risk for serious disorders and their families typically are involved in or at risk for involvement in multiple systems (education, child welfare, juvenile justice, mental health, etc.) *An organized gateway to services provides a mechanism to ensure that all of these systems are “at the table” when care planning is done so that families do not have to navigate multiple systems to obtain care.*
- The services and supports requirements for children with or at risk for serious disorders and their families do not remain stagnant. They change, often frequently, over time. *An organized gateway to care that leads to care planning, management, and monitoring ensures that families do not have to re-navigate systems every time services and supports requirements change.*
- Care for children with behavioral health problems, particularly for those with or at risk for serious disorders, and their families needs to be managed—from both a cost and quality standpoint. *An organized gateway to care facilitates the ability of the system to know who is in care, what and how much services and supports are being utilized, and the cost of care so that care can be managed effectively.*

1.7 An Organized Gateway to Care

ELEMENT	PURPOSE
Systemwide Manager	To organize and manage system entry To effectively use MIS to “centralize” intake and care management data
Multiple System Representation	To ensure all systems are “at the table” To keep families from having to navigate multiple systems
Care Planning, Management, and Monitoring	To ensure that families do not have to re-navigate systems for every service and support requirement change
Cost and Quality Management of Needs	To know who is in care To know what and how much services are being utilized To know the cost of care
Family Centered, User Friendly, and Culturally Competent	To maintain families’ dignity To operate from a strengths-based approach To convey system values and goals

Pires, S. (2002). *An organized gateway to care*. Washington, DC: Human Service Collaborative.

1.8 Screening, Assessment, and Evaluation

Screening, assessment, and evaluation are three distinct functions that are closely linked, one building on the other to generate a deeper understanding of the strengths, resources, and needs of individual children and their families. Together these functions enable development of individualized and common (across agencies) plans of care.

Screening is usually the first step of an ongoing process to determine a child's need for services. It serves a triage function to ensure children reach an appropriate level of assessment. In the field of early intervention, that is services for children ages birth to three, screening takes on the added concept of identifying at an early stage children who have a high probability of exhibiting delayed or atypical development. Screenings such as those required under the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) of Medicaid take place on a periodic basis. Screening for purposes of early intervention need not be confined to young children, however. Risk factors are well documented for children and adolescents throughout the age continuum. Early intervention also encompasses the notion of intervening early, regardless of age, before problems reach crisis or intractability stages. This concept of early intervention is a tenet of systems of care for children and adolescents of all ages. Some states and localities are implementing targeted screening initiatives, not just for young children but for other populations as well, for example, children and adolescents in residential treatment, as an avenue to home- and community-based services. Often, these screening mechanisms are implemented using EPSDT dollars.

Assessment is a process of gathering data from multiple sources to create a comprehensive picture of children who need services, with the purpose of identifying strengths and needs in order to plan specific services and supports. **Evaluation** often is discipline-specific (e.g., psychological testing) and is conducted by individuals trained and certified in a specific discipline. It provides closer, more intensive study in a particular area to provide additional data and recommendations to the assessment and care-planning process.

Screening, assessment, and evaluation may involve both state and local stakeholders. For example, state-level stakeholders may be involved for purposes of determining eligibility and referral for certain types of services such as hospitalization or residential treatment. Local stakeholders need to be involved, as they often are best positioned to gather a comprehensive picture of the strengths and needs of children and families and have knowledge about community resources that may be helpful.

A key principle of systems of care is that screening, assessment, and evaluation be strengths- and resources-based and not just “needs-driven,” as is typically the case in traditional service delivery, and that they take into account *both* the child and his or her family's strengths,

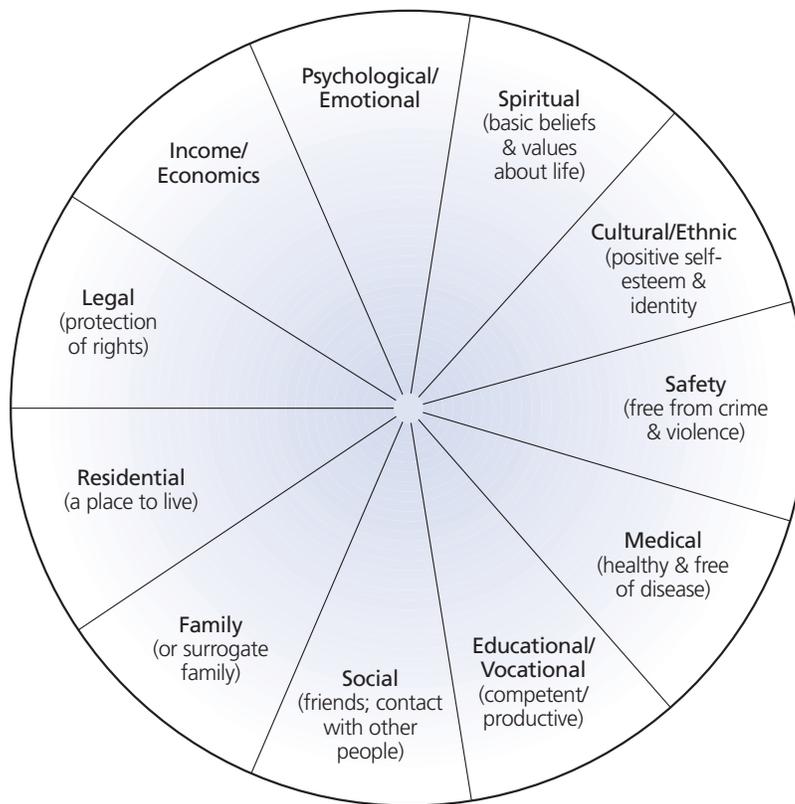
— ■ ■ ■ —
*This is the 6th time
I've told my story
this week.*
— ■ ■ ■ —

resources, and needs. Another key principle is that there should be an integrated, coordinated assessment across child-serving systems so that families do not have to undergo multiple assessment processes, re-telling their stories repeatedly. In addition, system of care principles call for assessments to be comprehensive—encompassing an ecological perspective across life domains—individualized, and culturally appropriate.

The following illustration provides a picture of the multiple life domains that have relevance in a holistic assessment process.

ILLUSTRATION 1.8A

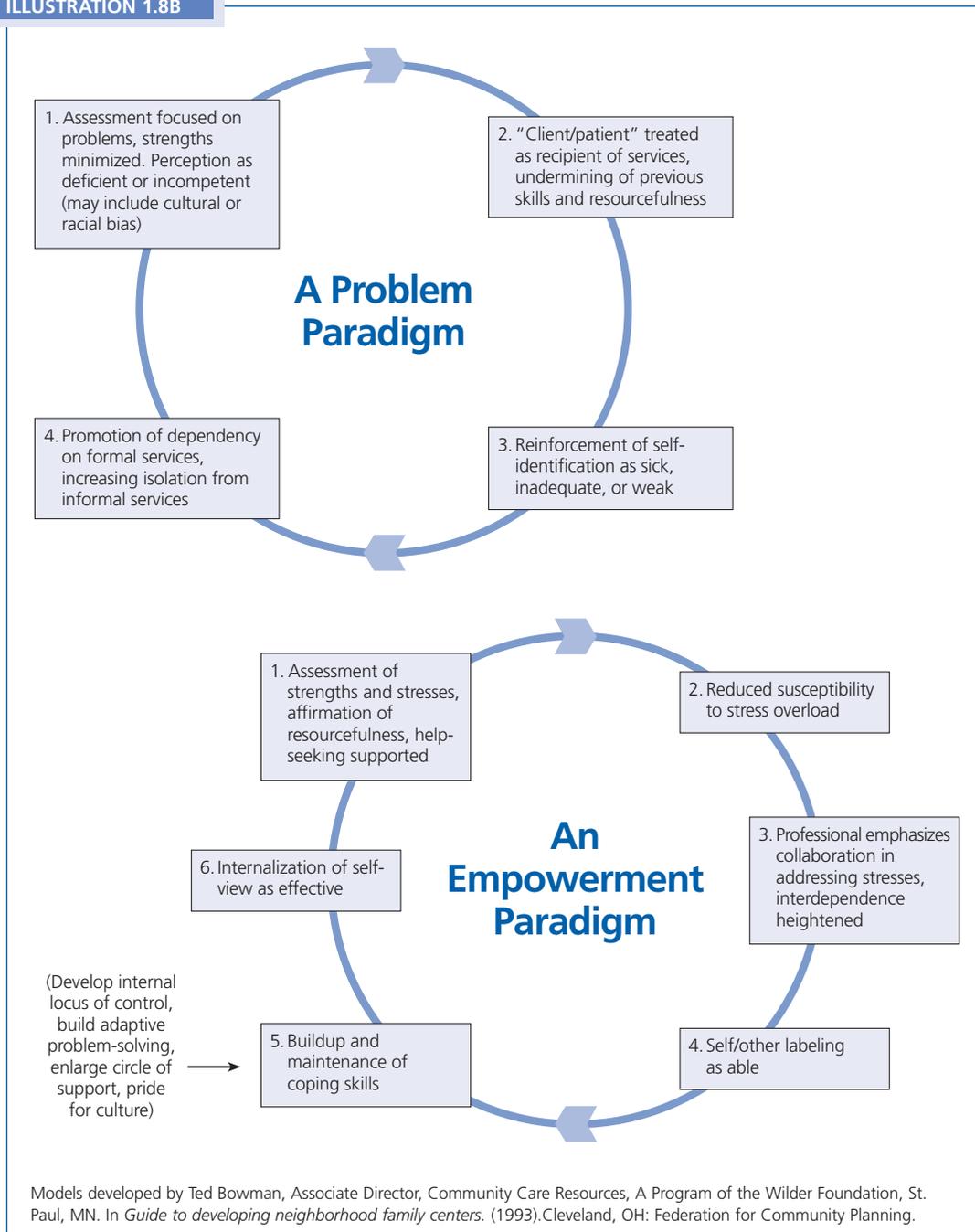
Life Domain Areas



Adapted from: Dennis, K, VanDenBerg, J., & Burchard, J. (1990). *Life domain areas*. Chicago: Kaleidoscope.

System of care principles have implications for how screening, assessment, and evaluation are structured in systems of care. They underscore that screening, assessment, and evaluation are not done to children and families but *with* them as equal partners who have an enormous amount to contribute to a sound analysis of the issues in their lives and potential strategies for addressing them. Illustration 1.8B describes the shift from a problem-oriented to a strengths-based approach in screening, assessment, and evaluation processes.

ILLUSTRATION 1.8B



System builders cannot assume that clinicians involved in screening, assessment, and evaluation processes know how to conduct strengths-based assessments that are culturally competent or that they know how to work in partnership with families. Training, supervision, and quality monitoring are needed. Protocols among child-serving systems have to be structured to ensure that there is buy-in to a coordinated assessment process, including development and use of common screening and assessment tools.

1.9 Decision Making and Oversight at the Service Delivery Level

Decision making and oversight at the service delivery level encompasses three functions:

- Care Planning
- Care Authorization
- Care Monitoring and Review

Care planning, that is, the process for making decisions about which services and supports are provided to individual children and their families, is a continuation of the screening, assessment, and evaluation process. While different staff or entities may be carrying out screening, assessment, evaluation, and care-planning functions, conceptually successful system builders recognize all of these functions as linked in one continuous process. These functions need to embody the same characteristics of being individualized, comprehensive, coordinated across child-serving systems, culturally appropriate, and carried out in partnership with youngsters and their families.

The concept of *individualized* care planning encompasses the concept of wrapping services and supports around children and families, utilizing both clinical treatment services and natural supports. The following box describes essential elements of a *wraparound* approach to service planning and delivery.

1.9A Essential Elements of Wraparound

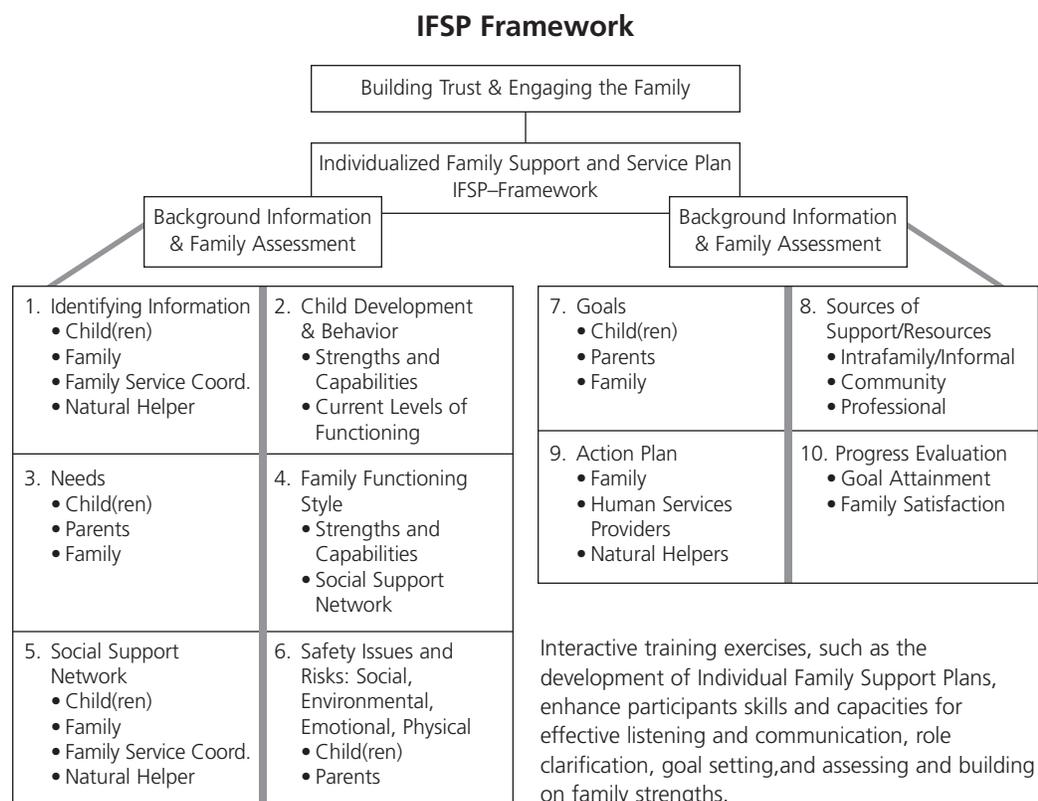
1. Wraparound must be based in the community.
2. The wraparound approach must be a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the plan.
3. Families must be full and active partners in every level of the wraparound process.
4. Services and supports must be individualized, built on strengths, and meet the needs of children and families across life domains to promote success, safety, and permanence in home, school, and community.
5. The process must be culturally competent, building on the unique values, preferences, and strengths of children and families and their communities.
6. Wraparound child and family teams must have flexible approaches and adequate and flexible funding.
7. Wraparound plans must include a balance of formal services and informal community and family supports.
8. There must be an unconditional commitment to serve children and their families.
9. The plans should be developed and implemented based on an interagency, community-based collaborative process.
10. Outcomes must be determined and measured for the system, for the program, and for the individual child and family.

Goldman, S.K., & Faw, L. (1999). Three wraparound models as promising approaches. In B.J. Burns & S.K. Goldman (Eds.), *Promising practices in wraparound for children with severe emotional disturbance and their families. Systems of care: Promising practices in children's mental health* (1998 series) 4. Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

The following illustration presents one example of an individualized care-planning approach.

ILLUSTRATION 1.9

The Individualized Family Support Plan (IFSP) utilized in the Casey Urban Mental Health Initiative is an example of a framework utilizing the concept of individualized care planning. (Note that the IFSP referred to in the following example is not the IFSP or Individualized Family Service Plan for children ages birth to three required under the Individuals with Disabilities Education Act (IDEA), though the IDEA IFSP has many similar characteristics to the IFSP illustration that follows.)



Lazear, K., & Orrego, M. (1998). *Equipo training manual*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Adapted from: Bennett, T, Lingerfelt, B., Nelson, D. *Developing individualized support plans—a training manual*.

Box 1.9B provides examples of services and supports provided through a wraparound approach.

1.9B Examples of Services and Supports Provided Through a Wraparound Approach

- **Family support and sustenance:** providing emergency assistance for the child, paying for utilities, paying for repair of a car engine, paying for a telephone, paying for participation in Weight Watchers, and so on.
- **Therapeutic services:** providing individual/family/group counseling, substance abuse services, a bilingual therapist, a therapist of color, respite care in- or out-of-home, and so on.
- **School-related services:** providing school consultation or an academic coach, utilizing behavioral aides or classroom companions at school, paying for school insurance for a classroom companion, buying a chemistry set for Christmas, and so on.
- **Medical services:** providing a needed medical evaluation, providing medical or dental care, paying for tattoo removal, teaching sex education, teaching birth control, teaching medication management, and so on.
- **Crisis services:** hiring a family member or friend to provide crisis support, utilizing a behavioral aide in the child's home or therapeutic foster home, teaching crisis management skills, and so on.
- **Independent living services:** helping to locate and rent an apartment, assisting a youngster to obtain Supplemental Security Income, hiring a professional roommate/mentor, providing a weekly allowance, teaching money management and budgeting, providing driving lessons, teaching meal preparation, teaching parenting skills, teaching housekeeping skills, and so on.
- **Interpersonal and recreational skills development:** hiring a friend or finding a "big brother," teaching social skills and problem-solving skills, purchasing a membership in an exercise gym, a YMCA membership, horseback riding lessons, art or music lessons, summer camp registration, class trip, fishing license, bicycle, and so on.
- **Vocational services:** providing job training, teaching good work skills, providing a job coach, finding an apprenticeship, providing a mentor at an apprenticeship or other program, paying someone to hire the youth for a job, conducting a vocational skills assessment, and so on.
- **Additional reinforcers:** purchasing items such as a radio, makeup, clothing, punching bag, skateboard, trips, activities, photographs for teen magazine, and so on.

Lourie, I., Katz-Leavy, J & Stroul, B. (1996). Individualized services in a system of care. In B. Stroul (Ed), *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brookes, Publishing Co.

Others have written persuasively about the need for individualized plans of care to include **crisis plans**.

1.9C The Importance of Individualized Crisis Plans

Tannen (1991) warned that setbacks and crises are likely to occur during the course of implementing an individualized care plan. To prepare for this eventuality the plan must include agreed-on approaches for handling crises. The inherent flexibility of individualized service approaches allows support to youngsters and caregivers to be quickly increased or decreased in response to changing needs. For example, an aide may be brought into the home or classroom during a crisis or particularly difficult period. Furthermore, based on the underlying value of unconditional care, individualized services are provided to children and families for as long as they are needed, regardless of youngsters' behavior or the challenges and complexities presented by their needs.

Lourie, I., Katz-Leavy, J. & Stroul, B. (1996). Individualized services in a system of care. In B. Stroul (Ed), *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brookes, Publishing Co.

Care authorization has to do with who or what structure has responsibility and what is the process for approving care plans, thereby authorizing the go-ahead on delivery of services and supports. *How care authorization is structured has the effect of assigning critical responsibility and power, will impact the experience of stakeholders in the system, and will affect both cost and quality goals.*

There are many different approaches to structuring care authorization. For example, in some systems of care, particularly those serving very “deep-end” populations of children and families, screening, assessment, evaluation, and care planning are done at the local level, but then the state may have to approve care plans. In some systems of care using managed care technologies, a lead agency at the local level may be assigned care planning responsibility, but a statewide system administrator such as an administrative services organization (ASO) has to approve the plan. In other arrangements, local systems of care have both care-planning and care authorization responsibilities, and it is not surprising in these arrangements to see the state allocation to the localities capped.

Systems of care that rigidly separate care planning and care authorization tend to perpetuate a “we-they” mentality within the system between planners, providers, and consumers of care on the one hand and funders and managers of care on the other. By the same token, systems of care that invest *carte blanche* care authorization responsibility with care planners without incentives to manage utilization and control costs tend to lead to “runaway” systems. In these “runaway systems” costs escalate to the point of jeopardizing whatever quality outcomes the system is producing.

1.9D Safeguards to a Runaway System

- Clinical Leadership
- Family Partnerships/Investment of Families
- Integration of Natural Supports in Care Plans
- Level of Care Criteria
- Cost/Quality/Outcome Monitoring Linked
- Fiscal Incentives/Disincentives
- Care Management

Pires, S. (1995). *Safeguards to a runaway system*. Washington, DC: Human Service Collaborative.

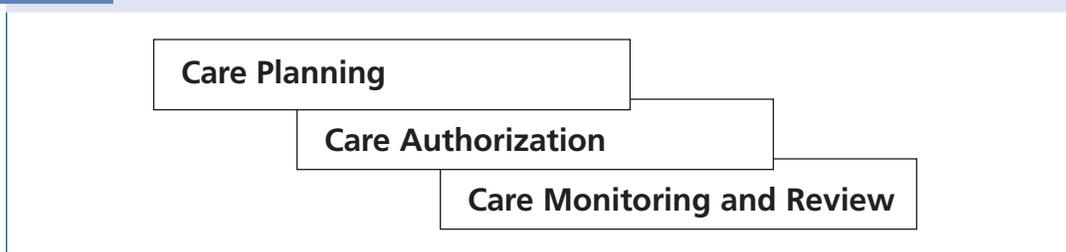
A goal of systems of care is, as much as possible, to align the interests of system funders, managers, providers, and families, which suggests creating structures in which all parties at both state and local levels share responsibility for cost, quality, and youth/family satisfaction outcomes. Those responsible for care planning, for example, need to be as concerned about cost issues, as are system funders and managers, because the reality is that dollars are finite in every system. Unnecessary dollars spent on one child are dollars taken from another. Similarly, funders and managers need to be as concerned about quality and satisfaction issues as much as other stakeholders because

cost control without regard to these issues generates cost pressures in other arenas such as increases in juvenile detention and hospital recidivism.

Care monitoring and review has to do with who or what structure has responsibility and what the process is for monitoring implementation of care plans at the individual child and family level. However this function is structured, it is critical to preventing the “out of sight, out of mind” phenomenon that often characterizes traditional systems where caseloads are overwhelming. In this phenomenon, once a child and his or her family have a plan of care, the system collectively breathes a sigh of relief, moves on to the next child, and puts the first out of mind, not paying attention again until a crisis occurs, a pre-determined length of stay has elapsed, or funding has run out. This phenomenon historically occurs most often in the case of children and families who pose the most complex, serious issues and challenges. Ironically, this is precisely the population to which systems of care want to pay the most ongoing attention in order to avert crises, determine what duration of care does make sense, and ensure costs do not go through the roof.

Care monitoring and review may be structured as a shared responsibility among care or case managers, interagency teams who do care planning, providers, and the families themselves. Care planners, for example, may build “trigger dates or events” into the plan of care to ensure timely review; case managers and/or providers may be charged with reporting back on some regular basis to care planning teams, including families, on care progress. Or, it may be the function of one designated person to monitor and report on care progress. Care monitoring and review may be going on at both state and local levels. For example, at the local level care monitoring and review may be at both the individual child and across children served levels. At the state level care monitoring and review may be conducted only with respect to certain populations of children served such as those using the most expensive services or those at risk of involvement in the juvenile justice system or of placement in residential care. Again, a major goal is to try to align as much as possible the interests of stakeholders at both state and local levels in this process.

FIGURE 1.9A



Care planning, care authorization, and care monitoring and review, while distinct functions, are closely linked. While they may or may not be the responsibility of a single entity, the more there is an alignment of interests and shared outcomes across these functions, the greater the likelihood of meeting quality, satisfaction, and cost goals.

1.10 Care Management or Care Coordination (also called Case Management)

Much has been written about the role and various models of case management or care coordination in systems of care*. It should also be noted that different definitions of case management and care coordination abound. For example, Box 1.10A shows one attempt to define the difference between case management and care coordination in systems of care.

1.10A Comparison of Case Management and Care Coordination	
Case Management <ul style="list-style-type: none">• Little authority over resources• Child centered• Reactive• Service provided to placement• Organization of existing services• Uses current system	Care Coordination <ul style="list-style-type: none">• More control over resources• Family centered• Proactive• Unconditional care• Creation of services when not available• Family and community supports

Community Care Systems. (2000). *Comparison of case management and care coordination*. Madison, WI.

System builders need to define what *they* mean by “case management,” “care management,” and “care coordination” before they can implement effective structures in this area. It should also be noted that some stakeholders, particularly families, may find the term “case management” off-putting. For purposes of this discussion the term “care management” is used, unless the meaning is made clearer by use of case management terminology.

Depending on the population focus, a given system of care may encompass more than one care management approach. For example, if the population includes both children with serious, complex needs and children with less intensive needs, the system may include both intensive care management where care managers have small caseloads and play a very active role in care planning, monitoring, and provision and a more “traditional” case management approach in which case managers engage in more general advocacy, coordination, and monitoring activities on behalf of higher caseloads of children and families.

*See, for example, Friesen, B. & Poertner, J. (1995). *From case management to service coordination for children with emotional, behavioral, or mental disorders: Building on family strengths*. Baltimore, MD: Paul H. Brookes Publishing.

1.10B Case/Care Management Continuum

Children needing only brief short-term services and supports	Children needing intermediate level of services and supports	Children needing intensive and extended level of services and supports
UM-type care management Larger Caseloads	More “traditional” case management Smaller caseloads	Intensive care management Very small caseloads

Pires, S. (2001). *Case/care management continuum*. Washington, DC: Human Service Collaborative.

How case management or care coordination is structured depends both on the population being served and the goals of the system of care. Systems that are serving a total population of children (e.g. all Medicaid eligible children) will include children who use none to few services and children who use a lot of services. Such a system might include both a “utilization management” type of care management for children using few services and intensive care management for children with serious and/or complex needs. In a utilization management approach, care managers typically are managing large numbers of children, generally those using only brief, short-term, and primarily outpatient services. They pay particular attention to “outliers,” that is, children who use either far less or far more service than what one would expect of this population. In the case of children with serious and/or complex disorders receiving intensive care management, care managers typically have very small caseloads and play an active role in advocating for and supporting children and families to access and coordinate services. These care managers may also play a therapeutic role with children and families. Systems serving total populations of children also may include an additional type of case management that is neither intensive nor of the utilization management variety, but rather a more traditional case management role of advocating and brokering on behalf of families whose needs are somewhere in the middle between intensive and brief, short-term services.

In some systems of care, care managers, especially those providing intensive care management services, may lead care planning teams and control flexible dollars to authorize wraparound supports. In other systems of care, because the role of care managers is more one of utilization management at the individual child and family level, care managers provide more of a supportive role to care planning teams and system managers.

There also is wide variation in the type of staff systems of care hire as case or care managers—a decision that needs to be guided by those the system is serving and system goals but is also affected by available resources, politics, and the like. Some systems of care utilize caseworkers already working in public systems to perform care management functions. These workers may be reassigned to the system of care, or they may stay in their home agencies. Other systems of care hire a new, independent pool of care managers. Some systems utilize parents as care managers. Some hire highly trained clinicians, others utilize paraprofessionals, and some use both.

Both state- and local-level stakeholders have an interest in the care management structure. State-level stakeholders, for example, may be involved in defining care management for purposes of ensuring reimbursement of care management services through Medicaid. They also may be reassigning current staff to undertake care management roles. Also, state-level stakeholders may need to be involved in decisions about how care managers in the system of care will interface with case workers in child welfare or eligibility determination workers in TANF offices. Local stakeholders obviously are critical to determining what care management structure will be most responsive to the strengths and needs of families in the community and “doable,” given local capacity.

There are disadvantages and advantages to whatever care management structure or structures are developed, which will depend on system goals, capacity, and politics at both state and local levels; and whatever structure is chosen will affect distribution of power and responsibility, goal attainment, and the feelings of key stakeholders.

There is no one “right” care management structure, but there are values and goals that systems of care are trying to achieve that have implications for care management, whatever structure is adopted. Principles for care management in systems of care include:

- The care management structure needs to support a unitary (i.e., across agencies) care management approach even though multiple systems are involved, just as the care-planning structure needs to support development of one care plan.
- The care management structure needs to support the goals of continuity and coordination of care across multiple services and systems over time.
- The care management structure needs to encompass families and youth as partners in the process of managing care.
- The care management structure needs to incorporate the strengths of families and youth, including the natural and social support networks on which families rely.

ILLUSTRATION 1.10

Illustration 1.10 depicts three different care management structures—one in which existing caseworkers stay within their home agencies, one in which existing case workers are assigned to the system of care, and one in which the system of care hires or contracts for new care managers. There are, as noted, other ways of structuring care management as well.

The pros and cons of the three approaches depicted in Illustration 1.10 will depend very much on each locality's circumstances. For example, the first arrangement (Structure #1), in which care managers stay within their home agencies, may be the easiest (or in some localities the *only* one possible) to implement, allowing for greater initial buy-in to the system of care because it does not entail home agencies having to "give up" staff. It might also allow for greater permeation of system of care values and principles throughout home agencies because those involved in the system of care are not in some other, "outside" location. It might encourage greater interest in the system of care on the part of supervisors, because they remain responsible for supervising staff involved in the system of care. It might create a higher comfort level for staff who, while involved in something new, can remain in their home agencies.

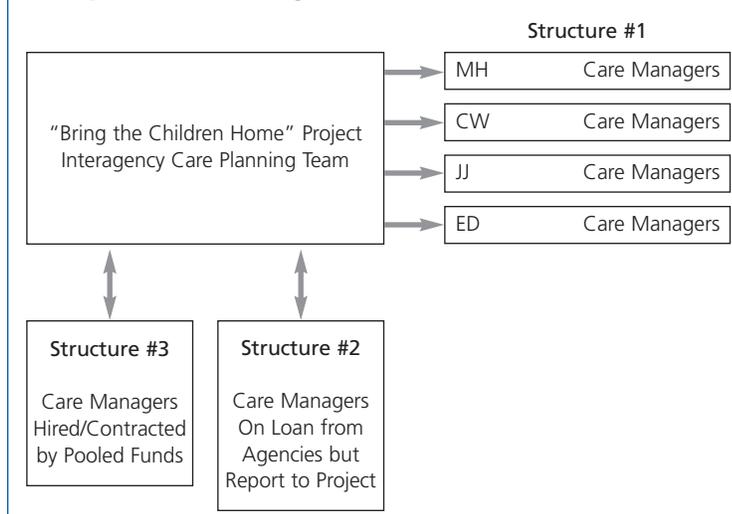
On the other hand, higher comfort levels are not necessarily what is needed in change initiatives like system of care building. Training and staff development is especially critical in an arrangement like that of Structure #1, where the larger culture still is operating in traditional ways and where each agency has its own approach to case management. Particularly if there is not strong buy-in from agency supervisors, these care managers may feel marginalized and de-valued in their home agencies. It may be very difficult to instill a unitary care management approach. There is the danger that caseworkers under such circumstances will revert to "old ways of doing business," which will affect system of care goal attainment. It also may be more difficult in this structure to involve families in care management roles, since this non-traditional approach has to fit within a traditional structure.

In the arrangement in which case managers from home agencies are reassigned to the system of care physically located outside the home agency and reporting to system of care administrators (Structure #2), care has to be taken to ensure that these staff do not feel like they have two masters (one in the system of care and one in their home agencies). Training also is needed, as is team building, to strengthen allegiances to the system of care and a new way of doing business. This arrangement may be or feel more tentative since staff that are on the payroll of a home agency can always be reassigned back to the agency in the event of staff shortages and the like. On the other hand, this arrangement enables the system of care to draw on the knowledge and connections of existing caseworkers while providing greater control over care management than the arrangement in Structure #1. It might also be easier than in the first arrangement to augment this care management staff with paraprofessionals and families in care management roles.

The third arrangement (Structure #3), in which the system of care uses pooled funds to hire (or contract out for) its own cadre of care managers, potentially allows for the most control over the care

management function. On the other hand, the arrangement might serve to reinforce perceptions of the system of care as a "demonstration or special project" which has minimal impact on the functioning of traditional systems. Such an arrangement also may just not be possible to implement in some localities because of lack of new dollars and/or inability to redirect and "pool" existing dollars.

Examples of Care Management Structures



1.11 Crisis Management at the Service Delivery and Systems Levels

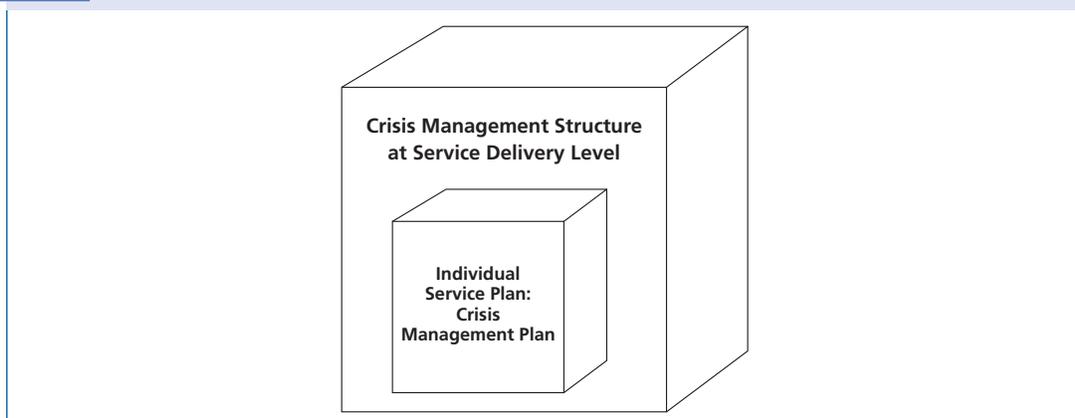
Effective systems of care have in place crisis management structures, that is, they deliberately organize how the system will manage crises that occur at the level of children and their families (in addition to each child and family's having a crisis management plan as part of their individualized services plan, as discussed above). Building child- and family-focused crisis management structures is essential to ensure appropriate support for families at particularly critical times and to reduce reliance (and therefore costs) on inpatient hospitalization and emergency room use.

Effective crisis management structures in systems of care share certain characteristics:

- They ensure availability 24 hours a day, 7 days a week.
- They encompass mobile crisis capacity, that is, the capacity to go to children and families in their natural environments, e.g., at home or school.
- They include trained child and adolescent crisis workers and do not rely on predominantly adult-oriented crisis response workers.
- They teach crisis management skills to families, teachers, and other natural caregivers, building on natural support structures and reducing reliance (and therefore costs) on hospitals and formal crisis response systems.
- They provide practical information to families and follow-up services and supports, including transition to needed treatment services, and linkage to family peer support resources.

When effective crisis management structures are not in place at the service delivery level, there is an enormous cost both to families and to the system itself.

FIGURE 1.11



Effective systems also create crisis management structures for crises that impact the system as a whole such as a major loss of funding, injury to children in care, severe staff shortages, and union strikes. Increasingly, we are reminded that systemwide crises also include community-wide tragedies such as school shootings and terrorist attacks. Effective systems try to anticipate the crises that may occur and make every effort to prevent them, but they also recognize that crises will occur in spite of the best efforts to prevent them and so develop protocols, procedures, and contingency plans to manage them if the need arises. This often requires establishing new kinds of partnerships at state and local levels, for example, with emergency preparedness officials and safety personnel.

EXAMPLE 1.11

A northeastern state has implemented an “early warning system” in connection with its managed care reform to track indicators that, if left unattended, could create potential crises systemwide. The system allows the state to obtain information rapidly on a limited set of indicators linked to stressors systemwide and, by early action in response to trouble areas, to avert crises.

 **Crisis Management at the Service Delivery and Systems Levels Key Questions**

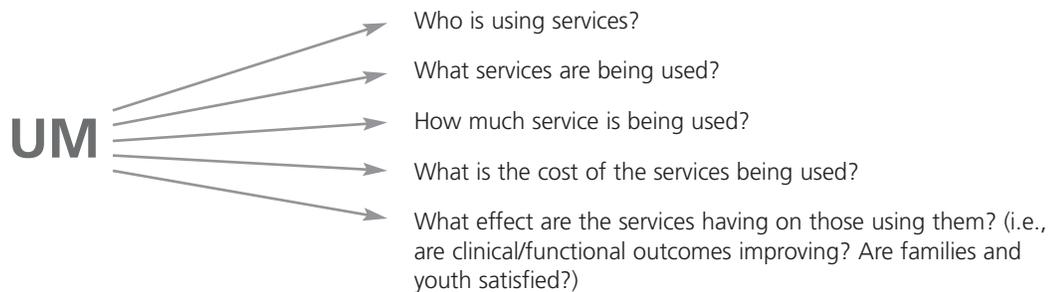
- What is our current crisis management structure at the service delivery level?
- How effective is our current crisis management structure at the service level?
- How does our crisis management structure incorporate a strengths-based approach and one that links families to practical information and peer support as well as clinical services?
- Have we thought about how we will respond to crises that affect the system as a whole?
- Can we build “early warning and rapid response” structures into our system of care?

NOTES

1.12 Utilization Management

Utilization management (UM), a term borrowed from managed care, needs to be structured in systems of care whether or not they are “managed care” systems. Paying attention to how services are being used, how much service is being provided, what services are being provided, and the cost of those services is important from both a cost and quality standpoint. From a cost standpoint, dollars for systems of care are finite (and, typically, not sufficient to the need). Every unnecessary dollar spent on one child deprives another of needed care. From a quality standpoint, children and families can suffer just as much from “too much service” or the wrong service as from not enough service or no service. UM is a function that needs to be structured at both the systems level and at the level of individual children and families.

1.12 Utilization Management Concerns



Pires, S. (2001). *Utilization management concerns*. Washington, DC: Human Service Collaborative.

Some systems of care contract with commercial managed care companies to perform UM functions. Others perform UM functions in-house or contract with a provider agency and or family organization. There are pros and cons to all of these structures, again depending on the circumstances of the given locality. For example, commercial companies may have the technical capacity and data systems to hit the ground running in performing UM functions, while government, provider agencies, and family organizations may have a learning curve in this arena. On the other hand, commercial companies may only have UM expertise with acute care systems and commercial sector populations, while the system of care is providing longer-term care and serving children with serious disorders who historically have relied on the public sector. In this case, the commercial company’s learning curve may be just as long as that of the government agency or local provider or family organizations.

However UM is structured in systems of care, there are certain key principles:

- **UM must be understood and embraced by all key stakeholders**—managers, providers, services planning team members, care managers, families, and youth—which will necessitate training and orientation and involvement in the UM structure. If the UM structure creates the perception and/or reality that UM is solely the purview of management, it will perpetuate a “we-they” attitude between providers, care managers, and families on the one hand and management on the other. UM will be perceived (and perhaps experienced) as a policing function instead of a means to support achievement of system of care quality and cost goals.
- **UM must concern itself with both the cost and quality of care.** As such, it must be structured so that key stakeholders are aware of UM cost and quality objectives. Clinicians, care managers, and families, for example, need to be as familiar with cost issues as are system administrators who, in turn, must be cognizant of quality care concerns. Effective UM structures tie together cost and quality issues at all levels of the system.
- **The UM structure needs to be tied to the quality improvement structure** in the system, that is, UM needs to inform quality improvement and vice versa.

Utilization management is an important function at both state and local levels. Local stakeholders often are best situated to perform UM functions at the level of individual children and families, ensuring that children receive the appropriate type, level, mix, and duration of treatment and making adjustments over time. This is particularly true in the case of children with serious and complex disorders, who tend to use a lot of services, often episodically, over time. Local-level stakeholders may need technical support from state-level stakeholders to perform the UM function. Local stakeholders also need to be concerned about UM, not just for individual children but also for the totality of children for whom they have responsibility, to ensure an efficient distribution of limited dollars. This also is true of stakeholders at the state level, who need to pay attention to utilization patterns and implications statewide.

1.13 Family Involvement, Support, and Development at All Levels (i.e., Policy Level, Management Level, Service Level)

In effective systems of care, families are partners at policy making, management, and service levels of the system with other key stakeholders. Effective systems do not simply invite families to be part of the process—although *asking* families if and how they want to be involved is a critical first step. They also actively support and engage families in a number of ways, for example, by providing tangible supports such as transportation, translation, and child care assistance; by recognizing and drawing on the knowledge and skills that parents bring to the table (e.g., utilizing parents as trainers of other stakeholders); by providing capacity-building support that gives families the information, skills, and confidence to partner such as training and peer and non-peer mentoring; and by asking families how they would like to be involved. Effective system builders recognize that families are diverse—racially, ethnically, linguistically, socio-economically, and in family composition, and thus they utilize multiple strategies and structures for family involvement and support.

— ■ ■ ■ —
Our family involvement works because support and development are structured at all levels of the system.
— ■ ■ ■ —

There are increasing examples of how systems of care are structuring family involvement at the various levels of the system. At the *policy level*, for example, families may comprise the majority vote on governance bodies; they may be part of the team that writes and reviews Requests for Proposals and contracts; they may participate on system design workgroups and on system advisory bodies. At the *management level*, families may be actively involved in quality improvement processes, in evaluating system performance, in helping to recruit and select personnel, and in training activities. At the *service level*, in addition to the role that families play with respect to their own children, they may be service providers, care managers, family support workers, peer mentors, system “navigators,” and advocates on behalf of other families.

ILLUSTRATION 1.13

How Systems of Care are Structuring Family Involvement at Various Levels of the System

LEVEL	STRUCTURE
Policy	At least 51 percent vote on governing bodies As members of teams to write and review RFPs and contracts As members of system design workgroups and advisory boards
Management	As part of quality improvement processes As evaluators of system performance As trainers in training activities As advisors to selecting personnel
Services	As members of team for own children As family support workers, care managers, peer mentors, system navigators for other families

Some systems of care fund family organizations to play various roles in the system of care; some hire family liaisons who work within the system. Some systems form alliances (unpaid) with family organizations and utilize paid family advocates within the system. There are pros and cons to whatever structure is developed for the involvement of families, depending on the particular locale and perspectives of different stakeholders. For example, families involved in some systems of care believe strongly that to be hired or paid by the system leads to co-optation, while families in other systems of care feel just as strongly that the system's hiring of families allows for greater equalization of parent-professional status in the system and ensures that families get "inside" information directly from a family member (i.e., not filtered through a professional).

The points being made here are three-fold:

- Family involvement, support, and development at all levels of the system must be structured, that is, deliberately organized and not left to happenstance, and multiple strategies are necessary to engage the diversity of families affected by systems of care;
- Whatever structures are put in place will have advantages and disadvantages to them, depending on local circumstances and stakeholder perspectives;
- It is incumbent upon system builders, including families, to be thoughtful about the pros and cons of different structures in order to understand how they will affect different stakeholders' experiences, level of involvement, and attainment of system goals.

1.13 Examples of Role of Families/Youth in Managed Care and Systems of Care

- At Systems/Policy Level: Planning & Design, Monitoring, Quality Assurance, Evaluation
- At Service Delivery Level: Service Planning, Care Management, Peer Support
- In Paid Staff Roles: At Systems Level, At Service Level
- Role of Family Organization

Pires, S. (1999). *Examples of role of families/youth in managed care and systems of care*. Washington, DC: Human Service Collaborative.

In the following example, family involvement is the building block on which all other structures of the system of care are based.

EXAMPLE 1.13

In a rural county in a northeastern state, family members took the lead in designing the system of care. They first prioritized services and supports needed, which included: respite; an advocate to help families navigate; information and referral; parent and sibling support; a family center; community supports such as after school activities, crisis services, and concrete assistance. They developed specific recommendations, which became the basis for system of care policies. For example:

- All committees, including the board and steering committee, should have at least 50 percent parent representation.
- Preference for all staff positions should be given to parents of children with special needs.
- Parents should participate as trainers in the training of all staff and volunteers.
- Parents should establish criteria for family-friendly agencies and award those that meet the criteria a "Family Friendly Seal of Approval."
- Families should interview and "hire" those professionals and service providers working with them. Participants and service providers should have an agreement for a trial period after which either can decide to discontinue the contract. There should be scheduled periodic evaluations as part of every agreement to see if the match is successful and if the service suits the provider and the family.
- Families First should stress the importance of sensitivity to language that is respectful and inclusive of parents. Specifically, families should be referred to as "multi-stressed," never "dysfunctional." People using Families First services are "participants," not "clients." The term "advocate" should be used rather than "case manager."

Tannen, N. (1996). A family designed system of care: families first in Essex County, New York. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brookes, Publishing.

1.14 Youth Involvement, Support, and Development

Many of the same points made about family involvement pertain to youth involvement as well—i.e., that it needs to be structured at all levels of the system and not left to happenstance, that there are pros and cons to whatever structures are adopted, and that system builders including youth need to recognize the implications of the structures that are adopted. Having said this, however, youth involvement, support, and development also are features of systems of care that require particularly close attention because, frankly, they have not received adequate attention to date.

Systems of care are beginning to recognize the value of incorporating a “youth development” approach, that is, engaging youth as partners in program design and implementation, affirming and drawing on the strengths of youth, and involving youth in service delivery. There is a valuable body of youth development research and practice, which can inform the efforts of system of care builders. The Center for Youth Development and Policy Research has articulated a Youth Development Structural Perspective and has identified barriers to youth participation.

1.14A A Youth Development Structural Perspective

Changing the systems that serve young people will require fundamental changes in assumptions about who is served and what is offered/expected. Answers to each of these key questions flow directly from the youth development perspectives:

WHO: ALL YOUTH, NOT JUST DISADVANTAGED YOUTH

Disadvantaged youth, youth with problems, must be served in the context of a formal support system that addresses the needs of all youth. Policy and programming cannot be deficit driven.

WHAT: PROMOTION OF YOUTH DEVELOPMENT, NOT THE REDUCTION OF YOUTH PROBLEMS

The reduction of youth problems is best accomplished through engaging all youth in activities that develop and apply broad competencies, and encourage and sustain their connectedness and contribution to individuals, groups, and community.

WHERE: COMMUNITIES, NOT JUST INSTITUTIONS OR PROGRAMS

Positive youth development hinges on the existence of supportive communities. Strong institutions and effective programs are critical, but they are only a piece of the solution. Developed one by one, they rarely congeal into a web of community supports.

WHEN: THROUGHOUT ADOLESCENCE AND YOUNG ADULTHOOD, NOT JUST WHEN PROBLEMS ARISE

The nature and array of community supports should change with age, but supports must be readily available for longer periods of time.

WHY: YOUTH ARE CURRENT RESOURCES, NOT FUTURE ASSETS

Smart investors only invest in sound investments. There will never be a national commitment to **invest** in **all** youth adequately. Commitment will come when there is a strong perception that youth are valuable **now** for what they can contribute and that there are current, valued roles that at risk youth can play.

Politz, B. (2000). *A youth development structural perspective*. Washington, DC: Academy for Educational Development. Center for Youth Development.

1.15 Staffing Structure

There are many ways of staffing systems of care. Some systems of care re-deploy—and retrain—existing child-serving system staff. Some hire new staff, including family members and youth. Some contract out certain staff functions; some augment capacity by partnering with other agencies and organizations, and some use a combination of these staffing approaches.

FIGURE 1.15 Staffing Systems of Care



There are pros and cons to all of these approaches. For example, hiring all new staff or contracting out most system of care functions may lead to an attitude of disinvestment on the part of traditional agency staff, which will make it impossible to create the changes needed in traditional systems to support systems of care. On the other hand, utilizing only traditional system staff may make it difficult to create a flexible staffing structure that is essential for a flexible delivery system. Augmenting staff capacity by partnering with other agencies and using their resources extends the reach of the system of care but also leaves it vulnerable if the partner agency's priorities change.

Effective system builders also recognize that the staffing structure must incorporate opportunities for advancement and foster leadership at all levels and among all types of staff, both professional and paraprofessional. There are issues of salary equity among professionals and between paraprofessionals and professionals that need consideration. There are issues related to incorporating natural helpers and staff who reflect the racial and cultural identity of the population being served. There are decisions to be made about which types of staff are needed to staff which functions, and there will be advantages and disadvantages to the decisions that are made.

Systems of care typically must develop their staffing structures within existing parameters or mandates, for example, those created by accrediting organizations or funding sources such as Medicaid, or licensing requirements. Also, systems of care have different access to staff. Rural systems, for example, often have difficulty finding requisite professional staff, while other systems have a plethora of professionals but have difficulty integrating paraprofessional staff such as natural helpers.

Effective system builders try to achieve balance and a range of expertise, a high degree of appropriateness, flexibility, and cultural competence within their staffing structure. However, there is no one correct staffing structure, and local circumstances and characteristics affect the staffing structure in any event.

EXAMPLE 1.15

A rural county in a southern state designed an intensive case management component within its system of care that called for highly credentialed case managers, partly because of the dictates of state Medicaid regulations that required credentialed staff for Medicaid reimbursement purposes and partly because of the culture within the local mental health agency. However, due to both the very rural nature of the county and low salary scales, the system of care could not recruit nearly a sufficient number of case managers meeting the credentialing requirements. Waiting lists for case management ensued, with frustration and poor outcomes the result. In this case the staffing structure, if for no other reason than it was unachievable, hindered goal attainment at many levels of the system. Eventually, system builders redesigned the case management component to utilize parents (some of whom, while highly experienced, lacked the required credentials) and paraprofessionals working under a credentialed supervisor. The supervision structure enabled the system to continue to bill Medicaid for intensive case management services.

 **Staffing Structure
Key Questions**

- What staffing structures make sense for our system of care?
- Are they achievable?
- Are they responsive to the diversity within the population we are serving?

NOTES

1.16 Staff Involvement, Support, and Development

Staff involvement, support, and certainly staff development can and need to be structured in their own right. However, the extent to which staff feel supported and develop their capacities also is affected by the ways in which numerous other system of care functions are structured. For example, if the care management function is structured in a way that allows for small enough caseloads that staff actually can get to know families and in a way that gives care managers latitude and flexibility to work with families and that provides supportive, knowledgeable supervision, staff are likely to feel supported and have opportunity to develop. Similarly, a quality improvement process structured in a way that draws on the knowledge of frontline clinicians and feeds results back to them has the effect of supporting clinicians and providing them opportunity to learn and develop.

Like families and youth, staff at all levels of the system have valuable perspectives and knowledge bases on which the system needs to draw. Involving staff in system design and decision making provides one means to support staff. Staff, like families and youth, also need tangible supports. For example, staff working in dangerous neighborhoods need back up supports. Some systems create “buddy systems,” pairing workers so that, for example, one family might have two care managers who work in partnership with one another and with the family. Staff obviously need adequate compensation, respite, recognition, and time for reflection.

Constraints within systems, for example, budget shortfalls, may hinder provision of adequate staff support. System builders need to recognize the ways in which staff will experience inadequate support, and how lack of support may affect attainment of system goals, and look for potential contingency arrangements. For example, one system was unable to give well-deserved salary increases to staff due to budget shortages so instead, with the involvement of staff, identified several other ways to “compensate” and support staff, including more flexible hours and opportunities for training and enrichment.

Staff, or human resource, development—ensuring that there are adequate numbers of staff with the skills, knowledge, and attitudes to perform effectively in systems of care—is one of the most critical functions requiring structure. Training obviously is one key aspect of staff development and is discussed more fully in the next section (Section 1.17). However, staff development encompasses more than training. The National Institute of Mental Health (NIMH) defines “human resource development” as “the explicit and coordinated efforts of an organization to achieve the right number and right kinds of people in the right places at the right times doing the right things to carry out its mission effectively.”* NIMH further defines human resource development as encompassing a

*National Institute of Mental Health. (September 1992). *Human resource development program, national task force strategic plan*. Rockville, MD.

broad set of activities, including: planning and evaluation (i.e., assessing workforce issues as they relate to the mission of the organization, particularly in the context of systems change); workforce management, including recruitment, retention, distribution and utilization of staff; education and training, including both pre-service preparation and in-service training; and sanctions and regulations such as standards and licensure.

All personnel involved in systems of care, from frontline practitioners to supervisors to system administrators, are being called upon to develop new skills, learn new things, and adopt new attitudes. *As is true of all major change initiatives, few personnel come to systems of care with all the requisite skills, knowledge, and attitudes.* Effective system builders know this and address the issue by structuring ongoing staff development programs that are both informed by and inform quality improvement processes.

Staff development needs to be a concern of both state- and local-level stakeholders. Local-level stakeholders usually can articulate most clearly the strengths and gaps in staff capacity as well as community-wide strategies for addressing staff development requirements. State-level stakeholders may have resources to contribute to local efforts and can utilize local staffing analyses to inform statewide human resource development agendas.

Box 1.16 offers one framework for the types of skills and attitudes that staff hiring and training structures need to encompass.

1.16 Effective Frontline Practice

- A. Hiring procedures include methods to assess and screen out workers with characteristics such as:
 - A confrontational style
 - Hostility in response to client hostility
 - Negativism
 - Labeling clients resistant
 - A controlling personality
- B. Screening procedures include methods to assess and select workers with the following characteristics:
 - Empathy
 - Respectfulness
 - Concern
 - Warmth
 - Genuineness
 - Positive life experiences
- C. Screening, hiring, and training procedures select and develop workers with general skills such as the following (as well as specific skills demonstrated empirically to be helpful with specific client populations they will serve):
 - Attending
 - Observing
 - Listening
 - Discriminating and communicating to content and feelings of the clients' experience
 - Developing a positive alliance
 - Self-disclosure
 - Moving from the general to the specific
 - Goal setting
 - Operationalizing goals
 - Breaking client concerns into specific action steps
 - Contracting skills

Kinney, J., et al. (1994). *Beyond the buzzwords: Key principles of effective frontline practice*. Des Moines, IA: National Center for Services Integration.

Increasingly, systems of care involve families and other key stakeholders in their staff development structures.

EXAMPLE 1.16

In a county system of care in the Northeast, families help to write job descriptions, participate on interviewing panels, and help to orient new staff.

In a medical school in the Northeast, families train residents on children's mental health services from a family's perspective.



Staffing Structure Key Questions

- Do we have a staff development plan that is part of our quality improvement process?
- How do we structure opportunities for staff to be involved in system design and policymaking, including involvement in the design and implementation of our quality improvement structure?
- How have we structured sufficient supports, both tangible and intangible, so that staff feel valued and enabled to perform effectively?
- What are our staff development strategies to ensure that our system of care has an adequate number of staff with the right skills, knowledge, and attitudes?
- How do we involve families and youth in our staff development structures?
- How are our staff development structures culturally competent?

NOTES

1.17 Orientation and Training of Key Stakeholders

Orientation is the function of familiarizing those involved in systems of care at all levels to the basic values, principles, goals, and operations of the system. It is an absolutely critical and sometimes overlooked function that needs to be structured. Orientation can be built into parent support and education activities, into intake structures, into staffing structures, into interagency meetings, into public awareness campaigns, into provider updates, and the like. It is an ongoing function because neither system of care operations nor stakeholders are static.

EXAMPLE 1.17

A small southeastern state includes an orientation handbook as part of its intake structure. The handbook explains clearly the values, principles, goals, and operations of the system of care. Intake staff walk through the booklet with youth and families to increase familiarity with the system upon first contact with it.

Training is closely linked to staff development, family involvement, and provider readiness functions. There are various types of training that need to be structured in systems of care. Some training within systems of care is specialized and targeted to particular stakeholders—for example, training parents and teachers in behavior management skills, training pediatricians to recognize mental health problems, training administrators in program budgeting, training evaluators in participatory evaluation techniques. Some training needs to occur systemwide—for example, cultural competency training, collaboration skill building, parent-professional partnering. *Effective system builders develop training structures to ensure that training is provided in an ongoing fashion and covers both systemwide and targeted areas of need.*

Box 1.17A provides one example of core competencies needed by staff in systems of care.

1.17A Trinity College Competencies for Staff Who Work with Children and Adolescents Experiencing a Serious Emotional Disturbance and their Families

I. Demonstrates respect for children and adolescents experiencing a serious emotional disturbance and their families.

- A. Uses language and behavior that consistently respects the dignity of children and adolescents experiencing a serious emotional disturbance.
- B. Demonstrates holistic understanding of children and adolescents experiencing a serious emotional disturbance and their families.
- C. Involves child or adolescent in all aspects of service planning and support activities.
- D. Provides information as needed.
- E. Communicates understanding of unique issues facing family members.
- F. Solicits family input and collaboration in service-planning and support activities.
- G. Demonstrates knowledge of family support resources.
- H. Provides formal and informal support as needed.

II. Demonstrates knowledge about serious emotional disturbance.

- A. Demonstrates knowledge about the differential characteristics and courses of serious emotional disturbances/disability.
- B. Demonstrates knowledge about psychotropic medications.
- C. Demonstrates understanding of the effects of stressful life events on children, adolescents, and families.

III. Demonstrates understanding of principles of collaborative community-based care.

- A. Understands and demonstrates the principles of unconditional care.
- B. Understands the principles of child and family-centered services.
- C. Understands the principles of community-based care.

IV. Demonstrates knowledge of a variety of approaches to intervention and support for children, adolescents, and their families.

- A. Demonstrates respectful communication and/or counseling skills.
- B. Demonstrates ability to teach simple and complex skills including physical, social, intellectual, and emotional skills.
- C. Demonstrates understanding of a variety of program models and philosophies (and acknowledges that these change as knowledge evolves over time).
- D. Demonstrates knowledge of a range of crisis prevention and intervention approaches.

V. Demonstrates ability to design, deliver, and ensure highly individualized services and supports.

- A. Routinely solicits personal goals and preferences.
- B. Designs personal growth/service plans that “fit” the needs and preferences of the child/adolescent and family.
- C. Encourages and facilitates personal growth and development toward maturation and wellness.
- D. Facilitates and supports natural support networks.

VI. Works in a cooperative and collaborative manner as a team member (agency teams, family members, service recipients, foster parents, concerned others).

- A. Coordinates service and support activities with others.
- B. Assists in building positive team relationships.

VII. Demonstrates knowledge of a variety of service systems for children and adolescents experiencing serious emotional disturbance and their families.

- A. Identifies and accesses wide range of community resources.
- B. Develops and maintains good relationships with community representatives.
- C. Demonstrates knowledge of entitlement and benefit programs.
- D. Integrates community resources into service planning.
- E. Participates in public education and overall advocacy.

Continued on following page.

1.17A Continued

VIII. Demonstrates knowledge of legal system and individual civil rights.

- A. Demonstrates knowledge of legal system.
- B. Demonstrates knowledge of individual rights.
- C. Connects individuals to legal and advocacy resources as needed and/or requested.

IX. Conducts all activities in a professional manner.

- A. Adheres to recognized ethical standards.
- B. Performs work in a positive manner.

X. Pursues professional growth and development.

- A. Seeks out learning opportunities.
- B. Evaluates work effectiveness.
- C. Integrates new learning into daily work practices.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. *Promising practices in children's mental health, 5*. Washington, DC: Center for Effective Collaboration and Practices, American Institutes for Research.

Effective training structures also recognize and utilize the training resources within stakeholder groups. For example, parents and youth can be trainers; providers have training expertise; community resource people and organizations have training expertise; traditional systems have training expertise (and dollars for training).

1.17B Education and Training Opportunities for Workers in Systems of Care

Types of Training Programs	Characteristics
University-based, Academic Program	Preservice doctoral, masters, or specialty degrees
College-Undergraduate	Four-year degree
Learning Center Model	Courses, undergraduate/graduate workshops, consulting, resources
Certificate Programs	Specialized academic programs
Agency-sponsored Training	Formal programs, possible career ladder credit
Agency-based Training and Supervision	Informal training, orientation, in agency in-service training
Specialized Workshops	Sponsored by independent training centers and consultant companies
State Training and Technical Assistance Institutes and Programs	Sponsored with state funding for training on state and local identified needs
Training Conferences	Sponsored by associations
Learning Resources	Journals, newsletters, videos, etc.
Informal Contacts	Informal discussion of work-related issues among practitioners on and off the job
Technology-based Approaches	University-based distance learning, use of Internet

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. *Promising practices in children's mental health, 5*. Washington, DC: Center for Effective Collaboration and Practices, American Institutes for Research.

Effective system builders try to build on or re-engineer existing systems' training programs to make them relevant to systems of care. Some systems of care have been successful in tapping into federal Title IV-E (child welfare) training dollars, particularly to support training across child-serving systems (e.g. child welfare, juvenile justice, education, mental health).

1.17C A Developmental Training Continuum

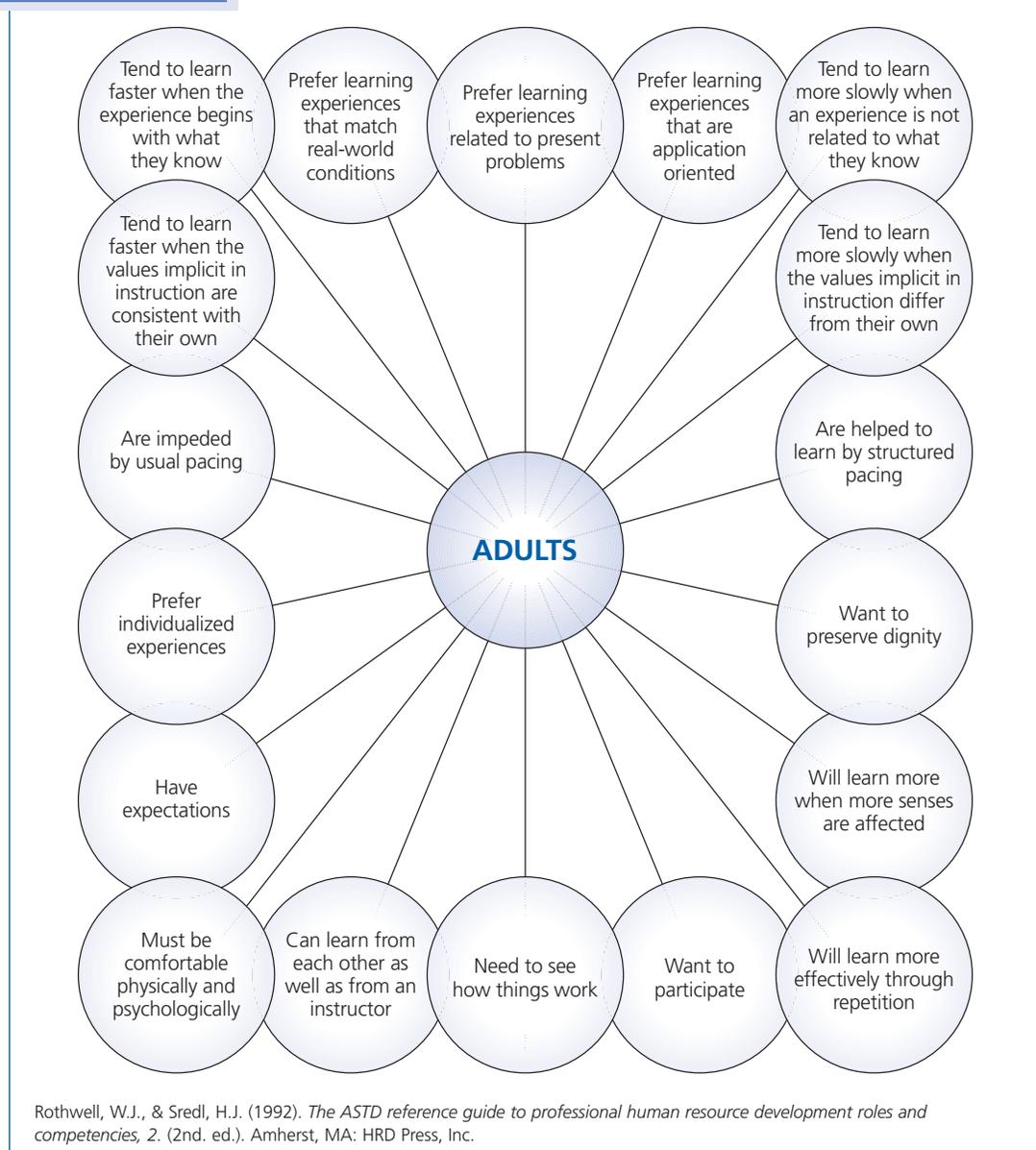
Characteristics of Partnerships between State Agencies, Institutions of Higher Learning, Families, and Communities and Their Impact Upon Practice

	Traditional	Modified	Integrated	Unified
System	State systems/depts. develop policy, professional training along specialty guild lines. Systems promote development, strengthening of specialty focus.	State systems/depts. independently adopt similar philosophy, often promoting collaboration, but continue training and policy with specialty focus.	State systems/depts. begin sharing training calendars, coordinate schedules to avoid overlap-circulate across department boundaries. Funding streams are shared, promotion of cross-training begins.	State systems/depts. begin pooling training staff, merging training events through common purpose, sharing costs/benefits.
Program	Community agencies and institutions of higher education operate in isolation. Disciplines train in isolation from one another and independent of field practice. Instruction is often didactic, using "expert model." No agency administrative support for transfer of training to improve practice.	Community agencies and institutions of higher learning begin joint efforts around research and evaluation. Preservice training remains separate from field.	Community agencies and institutions of higher education begin to collaborate through integration of field staff/families into preservice training. Student field placements cross agency boundaries. Cross-agency training gains support.	Community agencies and institutions of higher education begin to collaborate with larger community. Families and field staff review/input into training curriculum, are co-instructors in preservice. Curricula reflecting current practices and goals are merged into curricula. Training is targeted to prepare new professionals for collaborative work, new models for clinical fidelity in cross-agency teams emerging.
Practice	Participation in professional conferences/workshops, on individual basis within agency boundaries. Services are provided within agency boundaries.	Staff receive training which promotes collaboration, with similar philosophies, but receive it within agency boundaries. Specialty focus predominant. Services remain within agency boundaries.	Service teaming is promoted through cross-agency training which emphasizes similarities in mission/population; need to reduce duplication.	Service teams with full family inclusion are the norm. Redefined specialty practice roles develop to support professional identity while promoting collaboration.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. *Promising practices in children's mental health*, 5. Washington, DC: Center for Effective Collaboration and Practices, American Institutes for Research.

In restructuring old and building new training components, effective system builders also take into account how adults learn best—typically by doing, by being able to apply new skills readily, and by being respected as having much to contribute as well as to learn.

ILLUSTRATION 1.17



Both orientation and training are critical to changing attitudes, increasing knowledge, and building skills. Because there is turnover among key stakeholders, because constant repetition of critical information is essential in major change initiatives, and because the larger field is continually generating new data about effective treatments and practices in systems of care, orientation and training need to be structured as ongoing functions.

1.17D Why Training Fails

1. Training Viewed as Education

In many organizations, training is viewed as a form of education and as a result loses its unique contribution to the organization. Training should be aimed at short-term skill development with immediate contributions to improved performance on the job. Its effectiveness should be continually evaluated as part of a larger, long-term, educational goal for the entire organization.

2. Training Viewed as a Fringe Benefit

Many organizations view training as a right and privilege for all employees and lose sight of its ultimate performance improvement purpose. Unless performance improvement is the goal of training, it cannot be held responsible for results.

3. Classroom Mentality

For most organizations, training occurs in an isolated, protected environment that is far different from that of the performance environment. It is still dominated by the lecture format and conforms to the general framework of classroom instruction. This prevailing belief that training should occur in a classroom and away from the job is one of the reasons why transfer of training from the classroom onto the job is so difficult to effect.

4. Lack of Management Commitment

Managers rarely give more than lip service commitment to training programs. Supervisors and other managers must be willing to actively support the performance improvement efforts through participation and resource sharing.

5. Dumping

Employees are often not expected to integrate the training that they received with their jobs. As a result, training is viewed as an end in itself, which leads to this “dumping” phenomena. Dumping means transferring employees from their jobs into training courses, and then transferring them back to their jobs without any expectations concerning their responsibilities or accountabilities. Clear goals and objectives must be established to make the training job-relevant.

6. Too Much Emphasis on Development and Delivery

If trainers spend too much time on developing and delivering training courses and too little time interacting with the client unit, the results can be disappointing. Appropriate emphasis should be placed on needs analysis, consulting assistance, and follow-up after training to maximize performance improvement on the job.

7. Lack of Performance-Based Evaluation

When training evaluation techniques focus on satisfaction indices only and not on other factors such as performance and impact of the training on organizational results, training will remain little more than entertainment. New accountability mechanisms need to be established that measure the trainees’ transfer of training capabilities.

8. Too Much Content is Covered

Current training techniques tend to cover too much information in any given curriculum. There is always a tendency to add “just one more topic.” In order for training to be effective in improving performance, it should be trimmed down to a manageable size to allow the trainee to process the content in a meaningful manner rather than simply retaining the information in its concrete form.

9. Focusing Exclusively on Knowledge Objectives

Too much training is primarily information-centered and not skill-centered. In an applied performance environment, training professionals must guide subject matter experts to unravel the relationships between knowledge and skill because increased knowledge without skills will rarely contribute to improved performance and organizational results.

10. Inappropriate Trainees

Inappropriate selection of trainees can be a waste of time for the trainees, the trainers, and the organization. Often the wrong population of trainees is selected for a particular training program. They don’t want the training, don’t need the training, do not possess the necessary prerequisites, or will not have the opportunity to use the new skills on the job.

11. Lack of Follow-up after Training

For the most part, trainers see their responsibilities ending when the training is over. This lack of follow-up by the trainers leaves a big question mark as to how the training is being implemented on the job and whether the skills have been appropriately transferred. It is critical to performance improvement that trainers begin to see their role as continuing one.

12. Constraints in the Performance Environment

Performance environments can create obstacles and barriers that may be insurmountable without the support and commitment of management and training personnel. Negative effects due to disincentives, unclear expectations, lack of interpersonal support, and poor supervision can greatly diminish the effects of training programs.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Training strategies for serving children with serious emotional disturbances and their families in a system of care. *Promising practices in children’s mental health (1998 series) 5*. Washington, DC: Center for Effective Collaboration and Practices, American Institutes for Research.

1.18 External and Internal Communication

External communication is a large umbrella that covers efforts to inform those outside the system of care—for example, the public at large, the press, legislators—about system of care goals and operations, achievements, and challenges. External communication needs to be structured for various purposes, among them: to inform the public about system of care availability, to raise public awareness, and to generate support for the system of care. Effective external communication structures are critical to sustain and grow systems of care—baldly put, if no one knows what you are doing, no one will care if you go out of business. Having said that, however, aggressive external communication may also result in a greater demand for services than the system can support. Part of an effective campaign is making the public and policy makers aware of the system’s capacity, particularly in light of perceived or actual demand. *Effective systems of care launch public awareness campaigns, use data from the system to inform legislators and other key policy makers, and ensure that information is available to families who may need or know of other families who may need system services and supports.*

Effective system builders cultivate relationships with the media and with legislators, place editorials in newspapers, help reporters develop feature stories, help reporters make the connection between the local system of care and related national stories such as the *Surgeon General’s Report on Mental Health*, and create billboard campaigns and events that generate good publicity. They also engage in specific marketing approaches to create awareness and buy-in.

EXAMPLES 1.18A&B

- A. On the West Coast one county system of care launched a specific marketing campaign geared to other agencies to create awareness of and buy-in for the system of care, using data strategically to appeal to the interests of each particular agency. For example, with the school system, system builders used data showing improvements in academic performance with involvement in the system of care; with the juvenile justice system, they used data regarding referrals to law enforcement agencies.
- B. In a southwestern city, system builders created a recognizable logo and slogan for the system of care, which appear on posters, on the backs of buses, on buttons, bumper stickers, coffee mugs, and notepads. System builders in this community make sure that the natural gathering places for youth and families—i.e., pediatricians’ offices, schools, public libraries, fast food restaurants, supermarkets, faith organizations—have supplies of these items in sight, along with informational materials and brochures.

Internal communication is equally as important as external communication, that is, putting structures in place to ensure that there is an ongoing exchange of information across key stakeholders within the system of care. *System goal attainment is easily sabotaged by a failure to communicate and/or miscommunication.*

1.19 Provider Network (Network of Services and Supports)

Effective systems of care structure provider networks that have certain characteristics:

- **They are responsive to the population that is the focus of the system of care.** For example, systems of care include children involved in the child welfare system, which has implications for who needs to be in the provider network such as sexual abuse treatment providers, providers experienced with very young children, clinicians well versed in treating attachment disorders and post traumatic stress disorders, etc. Systems of care that are serving children with serious and complex disorders need to anticipate that the population will include an over-representation of children with dual diagnoses of emotional disorders and developmental disabilities and adolescents with both mental health and substance abuse treatment needs, and plan for inclusion of appropriate providers to serve those with dual diagnoses. Systems of care are serving racially, ethnically, and linguistically diverse populations, which has implications for the types of providers needed within networks.
- **They encompass both clinical treatment service providers and natural, social support resources such as mentors, and they include both traditional and non-traditional, indigenous providers.** If a system of care is heavily reliant on a single provider agency such as a community mental health center, it will need to build into the structure requirements for subcontracts with non-traditional, indigenous providers and the flexibility to purchase natural supports.
- **They include culturally and linguistically diverse providers.**
- **They include families and youth as providers of services and supports.**
- **They are flexible, structured in a way that allows for additions to and deletions from the network as system needs change over time.**
- **They are accountable, structured in a way that it is clear they have been organized to serve the needs of the system of care.** Some systems of care, particularly in early stages of development where they do not control major systems dollars, must “beg, borrow, and steal” services and supports from providers who are under contract and primarily responsive to traditional systems. This structure makes it very difficult, if not impossible, to create provider accountability and really change the way services and supports are delivered. It requires strong relationship-building skills between the system of care and the provider community, orientation and training, and augmentation of traditional services with whatever system of care dollars are available.

EXAMPLES 1.19A&B

- A. A midwestern county's system of care encompasses a broad, diverse provider network of over 120 agencies, programs, activities, and individuals. Rates have been established for each type of service and support within the network. Families who have a services and supports plan of care can choose their providers from the system of care's provider list, which typically includes several providers offering the same type of service or support. For example, if the plan of care calls for respite services, a family can choose among a number of respite providers on the provider list.

In this way, families can "vote with their feet" as to the providers they feel are responsive. This provides the system of care with a built-in mechanism for accountability, which surfaces issues regarding providers that consistently are not used by families. This structure allows for a great deal of flexibility and inclusion of many different types of services and supports, including family run programs and natural helpers.

- B. System builders in a county in a midwestern state restructured provider contracts so that a piece of each agency's contract would have to be used to purchase services and supports from indigenous, non-traditional, culturally relevant providers and natural helpers.

The federal Center for Mental Health Services has described areas in which managed care systems might consider standards for provider cultural competence.

1.19 Cultural Competence Standards in Managed Mental Health Care

Provider Competencies

- Understanding of Consumer Populations' Backgrounds
- Clinical Issues
- How to Provide Appropriate Treatment
- Agency/Provider Role
- Communicating Effectively Across Cultures
- Providing Quality Assessments
- Formulating and Implementing Quality Care and Treatment Plans
- Providing Quality Treatment
- Using One's Self and Knowledge in the Treatment Process
- Attitudes

Center for Mental Health Services. (2002). *Cultural competence standards in managed mental health care*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

1.20 Protecting Privacy

Protecting privacy, that is, the issue of maintaining confidentiality, is sometimes raised in system building as an obstacle to a number of system goals such as interagency service planning, utilizing parents in staff or peer support roles, or implementing participatory evaluations. The concern expressed is that such objectives might compromise the privacy of children and families in care.

The issue of confidentiality is certainly an essential one; however, the types of concerns expressed above have largely proven to be red herrings. Many systems of care have found ways to maintain (indeed, some would argue, improve) confidentiality while pursuing system of care objectives like those described above. Effective system builders treat the issue of confidentiality as critical but not as an obstacle. They engage families, staff, and providers to develop structures to protect privacy *and* allow information to be shared across agencies, providers, and family members, who are trying to reduce fragmentation and duplication. In Boxes 1.20A and 1.20B, the Youth Law Center explores issues of confidentiality.

1.20A Confidentiality Need Not Hamper Service Coordination

1. What information is confidential, and what is not?

Generally, only identifiable client information is confidential. Thus, information that does not identify particular individuals such as aggregate statistical information is typically not considered confidential. Even identifiable information, however, may be disclosed under specific circumstances. For example, federal education laws designate certain identifiable information “directory information,” which may be disclosed with appropriate notice to parents.

2. What exceptions exist to the confidentiality requirement?

Some statutes permit agencies to share confidential information for broadly stated purposes such as administration of the program, audits, determination of eligibility for services, and medical emergencies. Others permit disclosure of specific uses of information such as child abuse reports, health records, juvenile court records, and criminal histories. Still others specifically authorize interagency information sharing for the purpose of developing treatment programs or providing more comprehensive services.

3. What information can be released with consent, and what are the requirements for such a release of information?

Virtually all statutes authorize disclosure of confidential information with the consent of the client. Such disclosure generally requires a written release signed by the legally responsible person or entity. For information pertaining to minors, it is important to know whose consent is required. Parental consent is generally both required and sufficient, unless statutes give minors capacity to consent to their own care and release of their own records. The requirements for a valid written release are often set out in statutes and may include the name of the person who is the subject of the information, the name of the person or agency who is disclosing the information, the recipient of the information, the reasons for sharing the information, the nature of the information that will be disclosed, the signature of the person giving consent, and the date the consent is signed, as well as other items. To be valid, consent to release confidential information must be “informed.” The person consenting must understand what information will be disclosed and to whom and the purpose and benefits of the disclosure.

4. What other mechanisms are available for sharing confidential information?

In addition to release of authorized information by written consent, many statutes authorize disclosure of information through other mechanisms such as interagency agreements, memoranda of understanding, and court orders. Again, one must be familiar with the specific requirements of these mechanisms to use them properly. A thorough understanding of confidentiality requirements is only the beginning. Individual providers must implement confidentiality rules in a manner that fosters respect for clients and their privacy.

Soler, M., Shotton, A., & Bell, J. (1993). *Glass walls: Confidentiality provisions and interagency collaborations*. San Francisco: Youth Law Center

1.20B Confidentiality Need Not Hamper Service Coordination

- A. The Principle of Limited Information:** In all agency functions, the information collected and recorded should be limited to data genuinely needed to fulfill the agency's goals. This principle is especially important for agencies with computerized data systems. Seemingly limitless computer memory capacities may encourage staff to collect and record all interesting information whether or not it relates to program goals. In some situations detailed information should not be kept in client files even though it may be relevant to the agency's work. For example, it may be sufficient to note in a client's record the fact that the client received medical care instead of recording the details of the client's medical condition. If another agency has a valid need for more information about the client's medical history, that agency can obtain a specific release for the medical information from the client.
- B. Agency Gatekeeper:** Many agencies designate one individual to act as the "gatekeeper" of confidential information concerning agency clients, fielding requests for confidential information. He or she might be the agency's attorney or an experienced staff member with special training. The gatekeeper's duties may include:
- Maintaining a library of confidentiality materials;
 - Providing training or agency employees;
 - Responding to requests for information and maintaining records of requests and responses;
 - Developing forms for information requests; and
 - Suggesting changes in information-management practices when appropriate.
- C. Confidentiality Oaths:** Several statutes require confidentiality oaths, particularly for researchers, and some agencies use these staff pledges of confidentiality. The oaths are usually written and signed. They constitute promises to use information only for designated purposes and not to disclose the information to any other person or agency unless specifically authorized.
- D. Staff Training:** To follow legal mandates and respect individuals' privacy rights, it is essential for agencies to establish thorough and ongoing programs of staff instruction. Staff training on confidentiality should include:
- The reasons for ensuring confidentiality of information about children and families;
 - The specific client information the agency needs to collect and maintain;
 - The reasons why the agency needs the information;
 - The types of information the agency will share with other agencies;
 - The purpose of information sharing among agencies;
 - The legal provisions, particularly federal and state statutes and regulations, applicable to the agency's work;
 - The importance of clearly explaining to clients why consent is essential;
 - The need for sensitivity to language and cultural issues;
 - The requirements of informed consent, and the necessary elements for written releases;
 - Special issues that arise from the use of automated management information systems.

Soler, M., Shotton, A., & Bell, J. (1993). *Glass walls: Confidentiality provisions and interagency collaborations*. San Francisco: Youth Law Center

The issue of ensuring privacy is a concern of both state and local stakeholders. There are state statutes governing confidentiality of which local stakeholders need to be aware, and community norms and attitudes toward privacy have a bearing on structures to ensure privacy.

Ensuring Rights

System builders need to develop structures that ensure that the rights of children and their families are protected and that stakeholders agree on what those rights are. For example, there are rights with respect to fair treatment, absence of harm, access to care that meets quality standards, treatment with respect and dignity, non-discrimination, self-determination, and the right to grievance and appeal processes without fear of recrimination. Structures to ensure the rights of children and families need to be built at both state and local levels.

Neither traditional systems nor managed care systems have very good records when it comes to grievance and appeals processes. Criticisms of these systems are that either they are unfathomable—it is difficult to figure out how they work—or they take so long that they discourage people from using them. Obviously, grievance and appeals processes structured in such a way will create tensions among stakeholders and diminish system of care credibility. *System builders affirm that children and families have rights by being very clear about what those rights are and by structuring grievance and appeals processes that are understandable, efficient, fair, and tied to quality improvement processes.*

With rights also come responsibilities, and effective systems of care articulate the responsibilities of youth and families, for example, the responsibility to treat others with respect, to observe program guidelines, and the like. Providers and staff also have rights and responsibilities. Again, effective system builders articulate these and create structures to allow for grievances to be aired and appeals to be heard.

Box 1.21 provides an example of model language describing member (i.e., consumer) rights and responsibilities in a managed care system.

1.21 Member Rights and Responsibilities

The contractor must provide and organize services so that the member's rights are protected and respected. The contractor must inform each member, its personnel, and subcontractor and/or provider staffs of these rights. **The member has the right to:**

1. Be free from mental, emotional, social, and physical abuse, neglect, and exploitation.
2. Have medical and other records kept confidential and released only with the member's or the member's legal guardian's permission or in accordance with applicable law.
3. Understand the plan of care and services to be provided, including the names of subcontractors and/or providers.
4. Participate in the development, implementation, and review of the plan of care.
5. Know the name and professional background of anyone who is providing a service.
6. Receive benefits or services regardless of race, color, sex, national origin, handicap, or disability.
7. Require all subcontractors and/or providers to present positive identification before allowing them in the member's home or residence.
8. Have privacy protected.
9. Refuse to receive or participate in any service or activity once the potential consequences of such refusal have been explained.
10. File a complaint or grievance without fear of reprisal.
11. Be in control of time, space, and lifestyle to the extent that the member's health, safety, and well-being are not jeopardized.
12. Be treated at all times with courtesy, respect, and full recognition of personal dignity and individuality.
13. Make and act upon decisions (except those decisions delegated to a legal guardian) as long as the health, safety, and well-being of the member are not endangered.
14. Designate or accept a representative to act on the member's behalf.
15. Not be required to purchase additional services that are not covered by the project.
16. Not be charged for additional services unless prior written notice is given to the member.
17. Make an advance directive including the right to appoint an agent to make medical treatment decisions on his or her behalf if the member becomes incapacitated.
18. Have access to medical and other records with 72-hour notice.

The member has the following responsibilities:

1. To consult the case manager on changes in residence, caregiver, legal guardian, or other situations that directly affect the member's independence or quality of life.
2. To maintain project eligibility, and to notify the project of any changes that may affect such eligibility.
3. To respect subcontractor and provider property that is placed in the member's residence for use by the member or caregiver.
4. To tell the case manager if the member does not understand the plan of care or services included in the plan of care.
5. To keep the project informed of all insurance coverage.
6. To cooperate with subcontractors and/or providers nor in any way interfere with the subcontractor and/or provider performing assigned duties and responsibilities.
7. To not abuse any subcontractor and/or provider performing assigned duties and responsibilities.

Van Dyk, D. & Halverson, C. (2000). *Piloting the health and home program for frail, elderly, long-term Medicaid patients*. Princeton, NJ: Center for Health Care Strategies, Inc.

1.22 Transportation

Effective system builders recognize that both staff and families in systems of care have transportation needs. For example, how will care managers transport themselves and families? Will they use their own cars and be reimbursed for mileage? Will they use agency vehicles, public transportation, taxis? How will transportation be provided to families who need transportation help? Will they be given vouchers? Will there be a system of care van? How will transportation be handled for sending families or staff out of town for training or conferences and the like?

Transportation is an issue particularly, though not solely, for inner city families and for staff and families in rural communities. Systems of care that fail to deliberately organize, that is, structure, a response to transportation needs frustrate the ability of staff to do their jobs well and the ability of families to use services and involve themselves in system activities. *There is no one right way to organize transportation in systems of care, but it is incumbent upon system builders to identify transportation issues and structure a systemic response to them.*

Transportation resources may be available through Medicaid, TANF (Temporary Assistance to Needy Families), protection and advocacy programs, schools, family resource centers, health agencies, community, civic and faith-based organizations, among others. These resources may not be sufficient to the need, but they are worth exploring. In some communities, family organizations are paid by systems of care to provide transportation for families and youth. Some systems of care also have obtained transportation resources through civic associations, businesses, and local foundations.

Transportation Key Questions

- What are our policies and procedures with respect to transportation? For staff? For children and families?
- Have we identified community resources and other agencies to augment transportation capacity?

NOTES

1.23 Financing

The financing structure concerns itself with what funds will be used to finance the system of care and how the funds will be used and managed. As Illustration 1.23A illustrates, there are multiple funding streams across multiple systems that are potential sources of financing for systems of care. Some are controlled at the state level, some at the local level, and some jointly. There are pros and cons to utilizing each type of funding, which can vary based on state and local circumstances. Obviously, both state and local stakeholders need to play a role in determining the types of dollars that can be utilized and for what purposes in systems of care.

— ■ ■ ■ —
*Show me
the money*
— ■ ■ ■ —

ILLUSTRATION 1.23A

Examples of Sources of Behavioral Health Funding for Children and Families in the Public Sector

<p>Medicaid</p> <ul style="list-style-type: none"> • Medicaid In-Patient • Medicaid Outpatient • Medicaid Rehabilitation Services • Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) 	<p>Mental Health</p> <ul style="list-style-type: none"> • MH General Revenue • MH Medicaid Match • MH Block Grant 	<p>Education</p> <ul style="list-style-type: none"> • ED General Revenue • ED Medicaid Match • Student Services
<p>Substance Abuse</p> <ul style="list-style-type: none"> • SA General Revenue • SA Medicaid Match • SA Block Grant 	<p>Child Welfare</p> <ul style="list-style-type: none"> • CW General Revenue • CW Medicaid Match • IV-E (Foster Care and Adoption Assistance) • IV-B (Child Welfare Services) • Family Preservation/Family Support 	<p>Other</p> <ul style="list-style-type: none"> • WAGES • Children's Medical Services/Title V—Maternal and Child Health • Mental Retardation/Developmental Disabilities • Title XXI—State Children's Health Insurance Program (SCHIP) • Vocational Rehabilitation • Local Funds

Pires, S. (1995). *Examples of sources of behavioral health funding for children & families in the public sector*. Washington, DC: Human Service Collaborative.

The use of the term “funding streams” is really a misnomer since these funds typically do not flow together into one pool. Indeed, they are fragmented and tend to be rigidly structured and protected. The world of child mental health financing is one of “boxes within boxes,” a construct that is daunting to virtually all stakeholders.

Effective systems of care try to achieve several goals related to financing through restructuring financing systems, specifically:

- They seek to **maximize federal reimbursement**, principally through Medicaid and Title IV-E (child welfare) in order to generate new dollars for the system of care. Use of the Rehabilitation Services Option under Medicaid, as opposed to reliance on the Clinic Option, is an important avenue to using Medicaid for home- and community-based services. Similarly, use of the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) under Medicaid is an important vehicle for using Medicaid financing to pay for any federally approved Medicaid service, even if it is not covered in the state plan.
- They seek to **redirect dollars** from costly “deep-end services,” such as inpatient hospitalization, residential treatment, and out-of-home care in general, to home- and community-based services and supports by reducing “deep-end” expenditures and reinvesting savings in the system of care.
- They seek to re-direct dollars (as well as other resources) from traditional systems and traditional ways of doing business to the system of care through **realignment and reallocation** of spending.

Some systems of care will **pool dollars** from multiple systems, which creates a large “match fund” as one strategy for maximizing federal reimbursement. Some systems of care promise savings to traditional systems in return for gaining access to those systems’ dollars. In some systems of care, dollars are cut from the budgets of traditional systems and reallocated to the system of care specifically to create new service capacity. Increasingly, systems of care are experimenting with incentive-based financing structures such as capitation and case rate financing (discussed more fully in Section 1.24) in which the state may capitate the county, or the state and/or county may capitate a care management entity or entities.

There are pros and cons to all of these financing structures. Capitation financing, for example, provides flexibility to the capitated entity but also poses risk (as discussed more fully below). A structure that maximizes federal reimbursement can generate new dollars for the system of care but also has specific administrative and technical challenges associated with it, has implications for the types of services that can be provided, and requires that state and/or local dollars are available for match. A structure that redirects dollars from “deep-end” services to home- and community-based services and supports through reinvestment strategies provides an important means of funding a system of care, but it requires “front door” spending, i.e., creation of some home- and community-based service capacity, before “back door” (“deep-end”) dollars can be redirected. Otherwise, children and families have nowhere to go.

Box 1.23A provides examples of financing strategies that can be used in systems of care. It begins with the principle that “Program Drives Financing,” that is, that financing structures should support programmatic requirements, rather than financing structures dictating program design and practices.

1.23A Financing Strategies to Support Improved Outcomes for Children

FIRST PRINCIPLE:

- Program Drives Financing

REDEPLOYMENT:

- Using the Money We Already Have
- The Cost of Doing Nothing
- Shifting Funds from Treatment to Prevention
- Moving Across Fiscal Years

REFINANCING:

- Generating New Money by Increasing Federal Claims
- The Commitment to Reinvest Funds for Families and Children
- Foster Care and Adoption Assistance (Title IV-E)
- Medicaid (Title XIX)

RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN:

- Donations
- Special Taxes and Taxing Districts for Children
- Fees and Third Party Collections Including Child Support
- Trust Funds

FINANCING STRUCTURES THAT SUPPORT SERVICE GOALS:

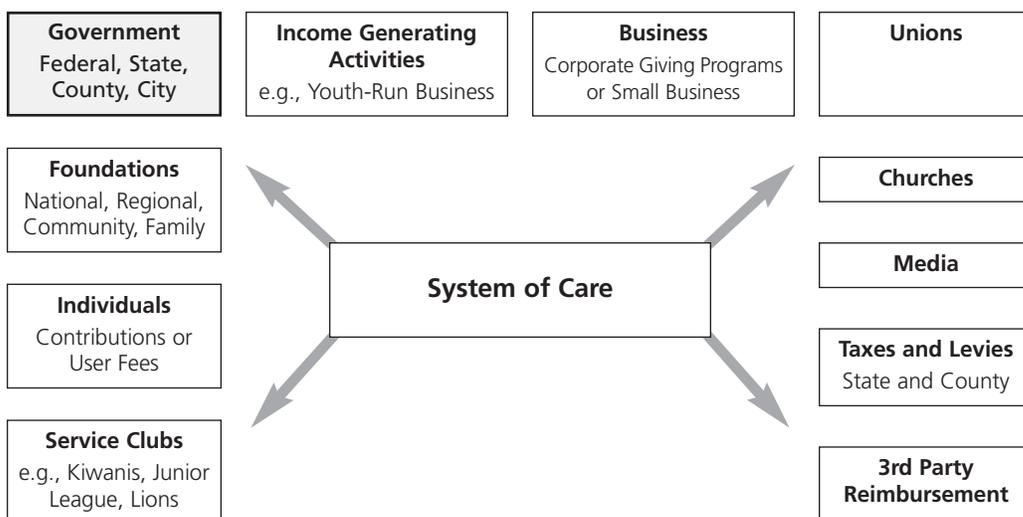
- Seamless Services: Financial claiming invisible to families and children
- Funding Pools: Breaking the lock of agency ownership of funds
- Flexible Dollars: Removing the barriers to meeting the unique needs of families
- Incentives: Rewarding good practice

Friedman, M. (1995). *Financing strategies to support improved outcomes for children*. Washington, DC: Center for the Study of Social Policy.

Virtually all systems of care rely on discretionary grant dollars, including federal and foundation grants, demonstration grants, one-time legislative allocations, and the like. These dollars provide critical start-up and leverage funds and are an important source of flexible dollars.

ILLUSTRATION 1.23B

Where to Look for Money and Other Types of Support



Pires, S. (1994). *Where to look for money and other types of support*. Washington, DC: Human Service Collaborative.

It is incumbent upon systems of care to be creative and aggressive in using multiple funding sources. However, *systems of care that rely solely on discretionary dollars will not sustain themselves over time*, and, arguably, are not truly systems of care in that they are not fundamentally altering traditional delivery systems by changing the ways in which they spend their dollars. Instead, they are creating a delivery system that is an alternative to, but not a reform of, traditional systems.

Box 1.23B provides an overview of funding sources tapped by sites funded by the Federal Comprehensive Community Mental Health Services for Children and their Families Program (i.e., CMHS sites).

As part of the financing structure, systems of care must decide who will control and manage dollars. In some systems of care, dollars for the system of care are lodged with a lead government agency, for example, the state or county mental health agency, even though they include dollars from many agencies across traditional systems. In other systems of care, dollars are lodged with a new quasi-governmental agency or contracted out to a commercial or a nonprofit care management entity. In still other systems, dollars are placed with an interagency body at the state and/or local level, and in others, dollars may remain with their home (categorical) agencies, which agree to reimburse the system of care for expenditures affecting their respective populations.

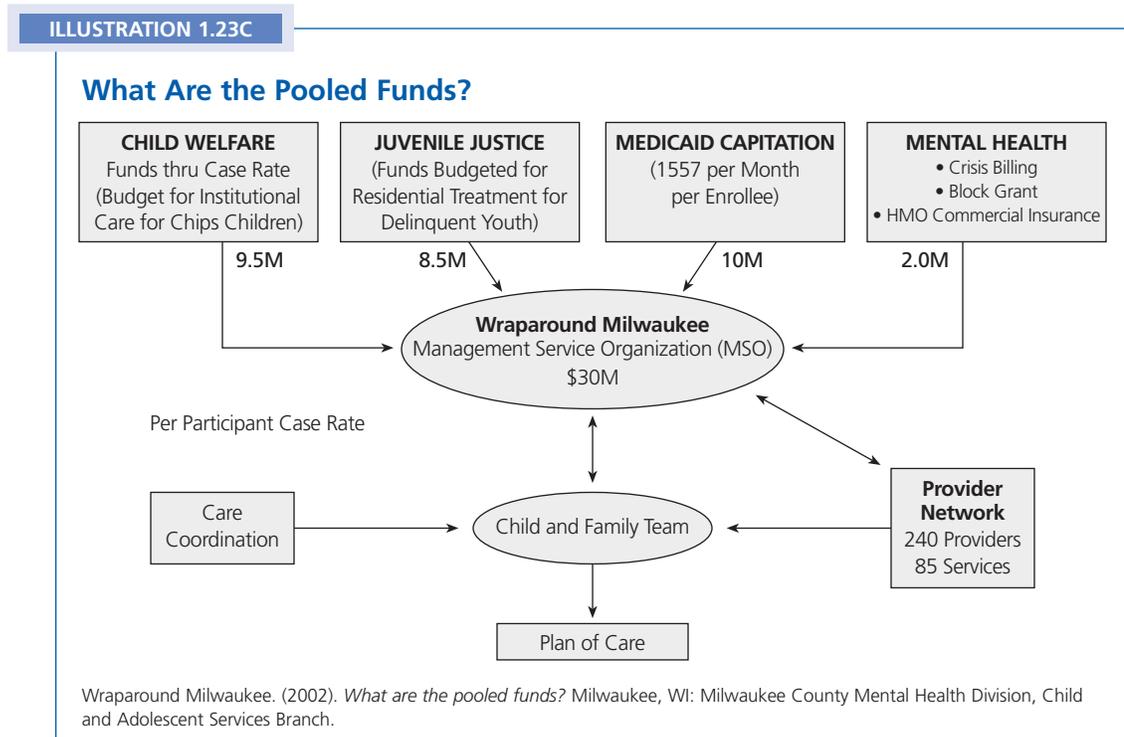
There are obviously pros and cons to these financial management structures, many of which have to do with control, accountability, and flexibility. When dollars remain with home agencies, for example, the system of care has less control and flexibility (and, arguably, also less accountability) than when cross-system dollars are placed with the system of care itself. Structures that accord the system of care greater control, flexibility, and accountability facilitate attainment of system of care goals and help to alleviate some of the frustrations that typically are associated with financing issues.

1.23B Sources of Funds (In Addition To CMHS Grant Funds) Used Across Sites

SOURCE	SYSTEM	DESCRIPTION
State	Mental Health	General fund, Medicaid (including FFS/managed care/waivers), federal mental health block grant, redirected institutional funds, and funds allocated as a result of court decrees
	Child Welfare	Title IV-B (family preservation), Title IV-B (foster care services), Title IV-E (adoption assistance, training, administration), and technical assistance and in-kind staff resources
	Juvenile Justice	Federal formula grant funds to states for juvenile justice prevention, state juvenile justice appropriations, and juvenile courts.
	Education	Special education, general education, training, technical assistance, and in-kind staff resources
	Governor's Office/Cabinet	Special children's initiatives, often including interagency blended funding
	Social Services	Title XX funds and realigned welfare funds (TANF)
	Bureau of Children with Special Needs	Title V federal funds and state resources
	Health Department	State funds
	Public Universities	In-kind support, partner in activities
	Department of Children	In states where child mental health services are the responsibility of child agency, not mental health, sources of funds similar to above
	Vocational Rehabilitation	Federal- and state-supported employment funds
	Housing	Various sources
Local	County, City, or Local Township	General fund
	Social Services/Child Welfare	Locally controlled funds
	Juvenile Justice	Courts, probation department, and community corrections
	Education	Local schools (including in-kind donations of staff time), school district, and school supervisory unions
	County	May levy tax for specific purposes (mental health)
	Food Programs	In-kind donations of time and food
	Health	Local health authority-controlled resources
	Public Universities and Community Colleges	
	Substance Abuse	In-kind support
Private	Third Party Reimbursement	Private insurance and family fees
	Local Businesses	Donations and in-kind support
	Foundations	Robert Wood Johnson, Annie E. Casey, Soros Foundation, and various local foundations
	Charitable	Lutheran Social Services, Catholic Charities, faith organizations, homeless programs, and food programs (in-kind)
	Family Organizations	In-kind Support

Koyanagi, C. & Feres-Merchant, D. (2000). For the long haul: Maintaining systems of care beyond the federal investment. *Systems of care: Promising practices in children's mental health*, 3. Washington, DC: American Institutes for Research, Center for Effective Collaboration and Practice.

Illustration 1.23C provides one example of a financing structure in which funds from several sources are pooled and managed by a county entity.



The financial management structure also must concern itself with who controls dollars, makes decisions about how dollars are spent, and has authority to spend within the system of care itself. For example, in some systems of care, care managers are allocated a budget that they control, enabling them to purchase services and supports flexibly in a wraparound approach. Similarly, systems of care may allocate budgets to interagency service planning teams. These approaches help to integrate financial and clinical considerations in service provision, which, as noted earlier, is highly desirable in systems of care that have both cost and quality of care goals. On the other hand, such a structure requires training of frontline workers and excellent communication between fiscal and clinical staff to ensure efficient use of dollars. Other systems of care may require greater top down approval of decisions made at the service planning and care management level in the interests of exercising more control over spending. The risk in this structure is a constant tension between those concerned about cost goals and those concerned about quality of care.

A key element of the financial management structure is the budget structure. Systems of care sometimes must operate within traditional, line item budget structures imposed by the larger governmental system. However, effective system builders recognize the importance of translating line item budgets to *program budgets*, which give a much

clearer picture of the costs of all of the activities that make up systems of care. A good program budget is a strategic tool that reflects mission, values, and priorities. *It is an excellent learning and advocacy tool for system stakeholders.* Illustration 1.23D below shows a program budget for a neighborhood-based system of care.

ILLUSTRATION 1.23D

Program Budget for a Neighborhood-Based System of Care

Cost Categories	Proposed Total Costs	Neighborhood Governance	Family Leadership	Family Service & Support	Removal of Barriers	Community Organizing	School Linkage	Tracking and Evaluation	Volunteers	Partnership Building	Exec. Direct. & Support
Personnel Salaries	446,000	21,000	29,000	190,000	21,000	26,000	35,000	15,000	30,000	18,000	63,000
Fringe	133,000	6,300	8,700	57,000	6,300	7,800	10,500	3,900	9,000	5,400	18,900
Building Occupancy	93,600	8,700	12,300	36,800	2,400	4,300	4,000	2,500	4,300	2,500	15,800
Professional Services	109,000	17,600	22,100	32,400	3,600	2,700	2,700	18,600	2,700	2,900	3,700
Travel	43,700	12,300	5,300	10,300	9,000	1,200	3,000	500	500	500	1,600
Equipment Costs	6,000	600	600	600	600	600	600	600	600	600	600
Food Services	25,000	0	4,000	1,000	18,000	0	1,000	0	1,000	0	0
Subcontracted	89,000	0	0	89,000	0	0	0	0	0	0	0
Insurance	13,500	2,700	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Operating Supplies & Expenses	21,500	1,800	700	8,600	200	1,300	2,100	500	1,500	4,100	4,100
Other (Parent stipends, transportation, child care)	84,000	0	40,000	9,000	35,000	0	0	0	0	0	0
Equipment Lease	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
Property	25,000	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500	2,500
GRAND TOTAL	1,115,100	80,000	125,900	459,900	84,300	51,100	64,100	45,800	55,300	36,800	113,900
Revenue Totals Across Sources	Revenue Allocation by Program										
Foundation	217,100	40,000	30,000	25,000	28,300	24,000	0	22,800	12,000	15,000	20,000
ADM-State	258,800	2,500	28,400	157,900	3,000	20,000	0	5,000	12,000	5,000	25,000
County-CFS	124,900	20,000	30,000	30,000	10,000	5,000	0	3,000	12,000	2,000	12,900
DOE	70,100	2,500	1,600	0	0	0	60,000	0	0	0	6,000
Family Preservation Grant	373,400	5,000	20,000	230,000	35,000	0	0	12,000	18,000	14,000	39,400
In-Kind	29,300	0	10,000	10,000	5,000	1,00	0	0	800	0	2,500
Donations	21,300	5,000	900	5,000	1,000	100	2,100	3,000	500	800	5,000
Other Grants	20,200	5,000	900	5,000	1,000	100	2,100	3,000	0	0	3,100

Pires, S. 2000. *Program budget for a neighborhood-based system of care.* Washington, DC: Human Service Collaborative.

Because the program budget shows the amount of funds spent by activity, it creates a picture of the system’s priorities. For example, over 50 percent of the resources of the system depicted in Illustration 1.23D are spent on family services and supports and family leadership activities. A program budget provides a tool for involving stakeholders in program prioritizing. In addition, by identifying revenue sources by program activity, it provides a picture of who is paying for what. It shows which activities, for example, may be too heavily dependent on one funding source. At its heart, a program budget is a political document that can be used to build stakeholder buy-in and consensus.

EXAMPLE 1.23

In a neighborhood-based system of care in the southeast, all stakeholder partners—families, staff/providers, and governing body—received training and technical assistance in understanding and developing program budgets and in the use of program budgeting as a strategic device for identifying priorities, airing differences, and building consensus. Workshops were held with families and with staff, and consultation was provided to the board. In addition, facilitation was provided for an all stakeholders meeting to review and reach consensus on a program budget as part of the system’s strategic planning process.



Financing Key Questions

- Have we identified all of the possible financing streams, public and private?
- How does our financing structure support flexible, individualized service provision?
- How does the financing structure enable the system of care to be accountable?
- Have we developed a program budget? How do we use it to inform our strategic planning and advocacy efforts?

NOTES

1.24 Purchasing/Contracting

Systems of care typically have to contend with larger state and/or county procurement structures. Even within this context, however, it is usually possible to make choices as to how to structure the procurement of services and supports for the system of care, and each of these choices has pros and cons associated with it, as the following discussion of four potential choices illustrates (and there are, obviously, other possible choices as well):

- **Pre-Approved Provider Lists:** Some systems of care pre-qualify providers as potential resources for the system of care and then draw on them as the need arises. These are cost reimbursable structures in which providers get paid for services after they provide them. Such an arrangement gives the system enormous flexibility to individualize services and supports for children and families. However, it can create an overload on some providers; also, it may disadvantage small, indigenous providers who do not have the cash flow to exist viably within a cost reimbursable structure. (A possible tinkering with this structure would be to provide fixed price contracts [see below] for a certain amount of service for those providers whom the system absolutely wants and needs in the provider network but who cannot exist within a strictly cost reimbursable structure.)
- **Fixed Price Contracts:** Some systems of care have in place (either intentionally or inherited) fixed price or fixed service contracts in which providers make available a designated amount of service (usually stated as number of service units or days) at a rate per service unit up to a specified amount. This arrangement creates predictability and a certain funding stability for providers; on the other hand, it is not particularly flexible and poses the risk of families' having to "fit what is available," rather than the other way around.
- **Capitation or Case Rate Contracts:** Capitation contracts provide prospective, preset funding that is assigned on the basis of the number of persons in the target population (i.e., covered by the system of care's benefit plan). Providers receive per capita funding, that is, funding for every person covered by and enrolled in the system, regardless of whether every person uses services or not. In return, the provider assumes the risk of serving everyone in the population who shows up for services within the total payment allocation. The capitated (per person) rate is determined by estimating how many persons can be expected to use services and the amount and type of service they can be expected to use and translating that use to a cost. It spreads the cost of serving those who do use services over a larger population.

Arguably, capitation makes sense only for systems of care that are serving a total eligible population (for example, all children in a given community) and not for systems of care that are serving only "deep-end" populations or those at risk for deep-end services (i.e., children with or at risk for serious disorders), who can be expected to use services. For this latter population, **case rate** contracting structures may be more

appropriate. Case rate contracts provide prospective, preset funding per actual user of service (as opposed to potential user), based typically on the child's meeting a certain diagnostic or level of functioning or service profile such as children with serious disorders. Rates are determined by estimating the amount and type of services that these children can be expected to use. In this arrangement, the contractor is not at risk for the number of persons who use services but only for the amount and type of service that is used. In contrast, the contractor with a capitation contract is at risk both for the number of children who use services as well as the type and amount of services that are used. Capitation is obviously a riskier arrangement for the provider than is case rate contracting, though case rate contracting also carries risk.

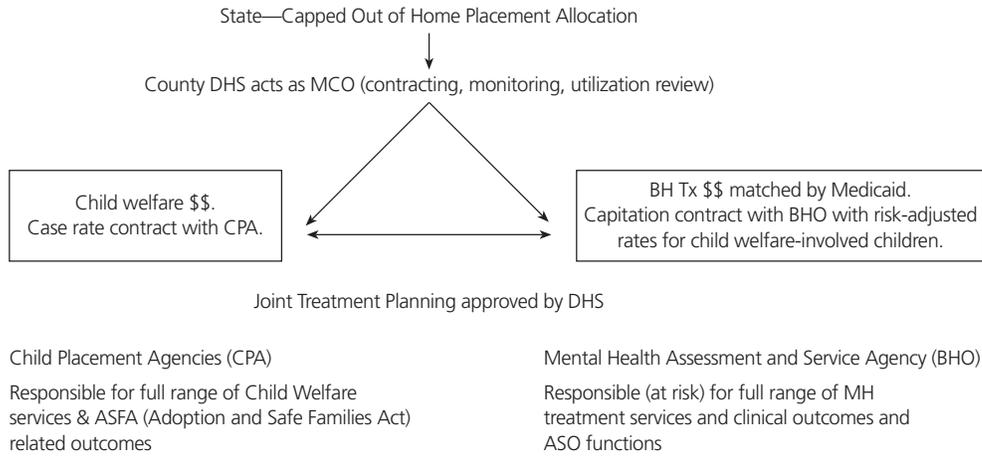
Risk-based contracts using capitation or case rate financing have both advantages and disadvantages. They allow contractors a great deal of flexibility, which can be used to individualize services and supports for families in a wraparound approach. They also allow systems of care as purchasers to integrate cost and quality of care considerations by tying flexibility at the provider level to accountability and adherence to system of care-determined outcomes and performance measures. They also by definition pose risk to both providers and purchasers (and thus to families). If the capitation rate paid to the contractor, for example, is too low, it creates an incentive for the contractor to under-serve by not reaching out to families who may need service and/or by providing insufficient service to those who do seek service. A rate that is too high places the system of care in the position of overpaying for services.

- **Performance-Based Contracting:** Performance-based contracting ties provider payment to performance and can be built into virtually any contracting structure. The advantages to it are that it creates greater control for the system of care as purchaser over the quality of services and supports provided, and it can create greater clarity of expectations for providers. On the downside, particularly if performance measures are unclear or beyond the capacity of the provider to meet, this structure can lead to tensions between purchasers and providers that will ultimately affect system goal attainment.

Illustration 1.24A shows a risk-based contracting structure using both capitation and case rates.

ILLUSTRATION 1.24A

Risk-Based Contracting Arrangement



Pires, S. (1999). *El paso county, colorado risk-based contracting arrangement*. Washington, DC: Human Service Collaborative.

Illustration 1.24B creates a framework for understanding the risks associated with the different contracting structures.

ILLUSTRATION 1.24B

Progression of Provider's Risks

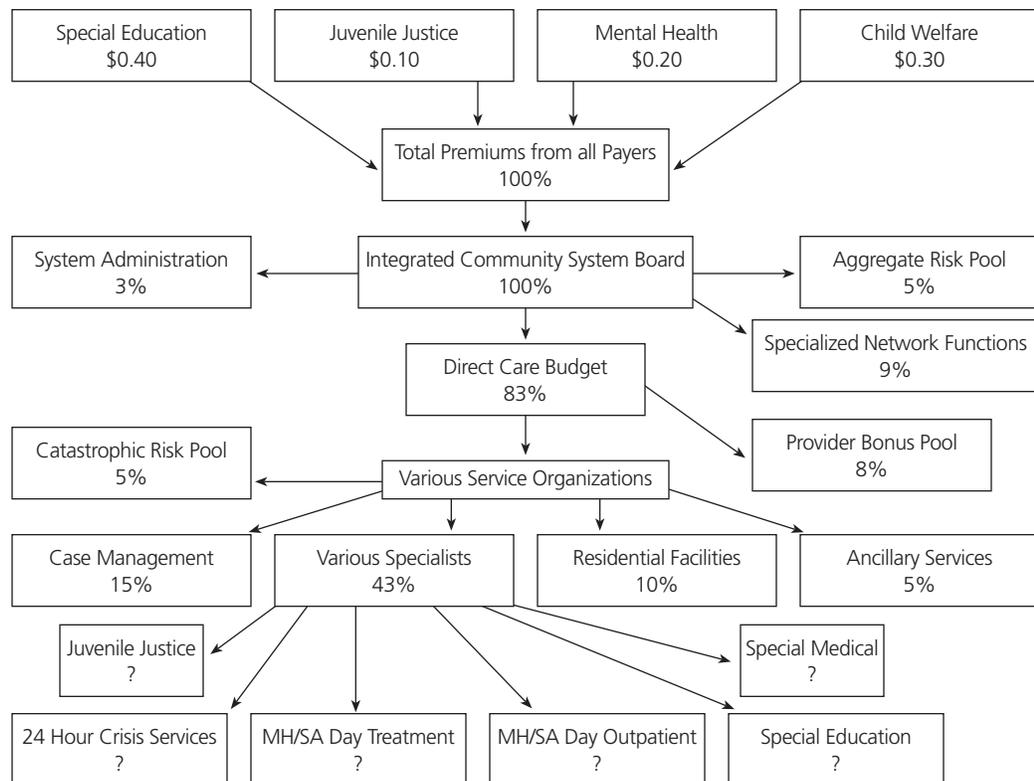
System of Care as Purchaser Risk	Degree of Provider's Risk	Type of Reimbursement	Unit of Risk	Nature of Risk: Uncertainty
Highest Risk ↑ Lowest Risk	Lowest Risk ↓ Highest Risk	Fee for Service: paid at "usual and customary" rate (e.g., up to 80% of U&C)	The service unit; procedure; visit; day, etc.	The cost of producing the unit of service is above the Xth percentile paid by most insurers
		Discounted Fixed Fee per Discrete Unit of Service	Each discrete type of service unit	The above risk <i>plus</i> variation in the variable component of the cost of producing each unit
		Discounted Global Fee	Global package of discrete services bundled into one price	All of the above risks <i>plus</i> variation in the number and types of discrete units consumed by each patient given the global package
		Case Rate	Each patient identified as an instance of that case	All of the above risks <i>plus</i> variation in the number and types of services consumed by each patient
		Capitation	Each enrolled member	All of the above risks <i>plus</i> variation in the number of members who become patients
		Percent of Premium	Each contract sold	All of the above <i>plus</i> all operating expenses

Broskowski, A. (1996). *Progression of provider's risks*. In *Managed care: Challenges for Children and Family Services*. Baltimore, MD: Annie E. Casey Foundation. www.aecf.org.

Illustration 1.24C shows an approach to allocating dollars and risks in a risk-based contracting structure.

ILLUSTRATION 1.24C

An Illustration of a Premium Allocation Formula and Risk Distribution System



Broskowski, A. (1996). *An illustration of a premium allocation formula and risk distribution system*. In *Managed care: Challenges for Children and Family Services*. Baltimore, MD: Annie E. Casey Foundation. www.aecf.org.

EXAMPLES 1.24A&B

- A. A midwestern state moved from a traditional fee for service to a performance-based, capitated contracting structure for foster care. Providers receive fixed funding based on the expected number of children they will serve, with incentives to prevent children from entering or remaining in foster care. Providers that reduce the number of children in placement settings can use the savings to reduce caseloads and improve services. Since moving to the new contracting structure, adoptions have risen, and lengths of stay in foster care have decreased.
- B. A southern state replaced a contracting system in which each child-serving system issued its own, separate RFP with one that puts approved, qualified providers on a "provider list." Agencies purchase services from providers on the list at a rate not to exceed Medicaid rates. Providers in this arrangement have no guarantees as to a specific number of placements or units of service or funding amounts. On the other hand, they do not have to grapple with multiple contracting requirements and differential rates across systems.

1.25 Provider Payment Rates

Systems of care may or may not have control over provider rate structures, that is, how much providers will be paid for particular types of services and supports. The rate structure may be determined by another system such as Medicaid. However, system builders need to understand that the adequacy and equity of the rate structure will have a significant effect on system of care goal attainment and, obviously, influence how providers feel about the system.

The rate structure will affect the availability of services. If rates for particular services are too low, they may be in short supply; if rates are too high for certain services, those services may be oversupplied, potentially causing overuse. The rate structure carries its own incentives and disincentives for providers to develop or refuse to provide certain services and supports. Not only the sufficiency of the rate but also the equity of the rate structure is important. If there are unwarranted differentials within the rate structure, for example between providers of similar services, that will cause tension within the system and incentives to use certain providers over others.

EXAMPLE 1.25

A northeastern state mental health agency developed state of the art standards for children's services within its system of care. However, the rates paid by Medicaid were too low to support the standards. This created frustration on the part of stakeholders and hindered attainment of quality care goals. Options being explored within the state to address the issue are advocacy to raise Medicaid rates, augmentation of the rates with general revenue, and stronger utilization management structures to alleviate Medicaid's concern over runaway costs if rates are raised.

If systems of care do not control the rate structure, they will need to develop other types of incentives to engage providers, for example, allowing providers greater flexibility and control, offering training and staff development opportunities, providing more timely reimbursements, and providing back up supports for serving families with particularly difficult or complex situations. The important point for system builders is to analyze the incentives and disincentives created by the rate structure so that contingency steps can be taken, if necessary.

Some systems of care have experienced the problem of losing providers to other systems because rates paid by other systems for the same services are higher than those provided within the system of care. This situation aggravates fragmentation in children's services and lack of service capacity within systems of care. *Effective system builders look at the issue of rates systemically across children's systems and try to create equity in rate structures.*

1.26 Revenue Generation and Reinvestment

Revenue generation and reinvestment as used here have primarily to do with the structure that determines who gets to claim and reinvest both federal match dollars under Medicaid and Title IV-E that are generated by the system of care as well as savings created by the system of care through reducing reliance on “deep-end” spending. In addition, it has to do with the structure for collection of revenues through third party billing and federal financial participation (FFP) claiming.

Some systems of care have fallen victim to losing the dollars they have generated by maximizing Medicaid revenue and/or by creating savings from reducing use of “deep-end” services. Instead of reverting to the system of care, the dollars generated or saved have gone back into state or county coffers for other purposes. *Effective system builders recognize that they need to obtain assurances up front that dollars generated by maximizing federal participation or by creating savings will come back into the system of care for purposes of serving more children or creating new service capacity.* In addition, effective system builders ensure that the system of care has a structure in place to collect revenues not only from these sources but also from other third-party billing sources such as insurance companies.

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Where’s the incentive to save?
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System builders also need to consider whether a fee structure is warranted and tease out the pros and cons of charging fees for certain services based on ability to pay. Charging fees that are manageable for families helps to finance the system so that more children can be served; in addition, it also may encourage greater attention on the part of stakeholders (families and providers, for examples) to the issue of value, that is, whether the service or support being considered is worth the price involved. On the other hand, fees may discourage families from seeking or using services. System builders need to consider thoughtfully the advantages and disadvantages of implementing a fee structure and of the particular fee structure that is chosen, if one is.

1.27 Billing and Claims Processing

It is not surprising to see even well-developed systems of care with billing and claims-processing structures that thwart the goals of the system of care. For example, billing codes left over from a categorical system may make it virtually impossible to “code” flexible, individualized, wraparound services. There may not be a billing code for

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But we don't have a code for coordinating activity... important system functions such as interagency coordination or family support. Similarly, claims-processing systems may be structured in such a way that there are long delays in payments to providers, which may create unintended consequences of providers' withholding services.

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Billing and claims-processing systems may be rigidly structured in an effort to control costs and create tighter accountability. However, too rigid systems can create incentives among providers to utilize service components, however restrictive or traditional, that are “easily billable” or, as noted, to withhold service or refuse to participate in provider networks—all of which will frustrate system of care goal attainment. Effective system builders need to examine the support (or lack thereof) created for systems of care by billing and claims processing structures.

Billing and claims process concerns both state and local stakeholders. Certain types of billing and claims-processing data such as that pertaining to Medicaid or Title IV-E ultimately must be reconciled at state levels. Certainly in these areas, billing and claims-processing structures at the local level must be compatible with state systems and requirements. Local-level stakeholders, however, have to live with billing and claims-processing structures on a day-to-day basis, which has a bearing on access to and quality of services. They, too, must be closely involved in design or re-design decisions.

1.28 Information Management

Effective system builders try to develop management information systems (MIS), which provide “real time” data to support decision making and accountability. Specifically, effective information management systems support system builders to carry out the following functions at all levels of the system:

- **Tracking:** Who is providing what to whom at what cost?
- **Measuring and Assessing:** What effect is what we are doing having—on children, on families, on staff, on providers, on other child-serving systems, on taxpayers?
- **Communicating:** Packaging and providing information to different audiences (e.g., to service providers, legislators, families, case managers, administrators, the general public).

How MIS systems are structured can make people’s jobs more difficult or easier and can frustrate or support goal attainment. Staff, for example, will buy-in to and use only MIS systems that make sense to them. Everyone has heard stories of staff that keep a “shadow” paper file because the MIS system does not make sense to them, or they view it as unreliable, or they do not know how to use it, or it is too cumbersome to use. Families will buy into systems of care only if the information provided to them makes sense to them, which is why effective system builders enlist staff and families, providers, and agency partners in designing MIS systems.

Most systems of care have to navigate existing MIS systems, for example, those in child welfare, Medicaid, mental health, and often systems at both state and local levels. A goal of systems of care is to create integrated or at least compatible MIS systems across child-serving agencies. That is often an enormous and time-consuming undertaking for systems of care, particularly for those that are not focusing on a total eligible population of children but on a subpopulation such as those in or at risk for out-of-home placement, which is a much smaller number of children. In this case, the large existing MIS systems may have little incentive to make substantial changes. On the other hand, systems of care that are focusing on a smaller number of children often are able to structure their own MIS capability, drawing on data from the larger system.

EXAMPLE 1.28

System builders in a midwestern city partnered with management information specialists to design an Internet-based clinical and financial software package that integrates family service plans with service data, allows providers to bill on-line (reducing reimbursement time from five weeks to five days) and maintains provider contract data. The MIS system supports integration of cost and quality outcomes and facilitates the flexible, responsive service delivery approach that is the guiding principle of the system of care. Some 300 people—care managers, administrators, families, evaluators, providers—use the system, which is reducing paperwork processing enormously. Access safeguards are built into the system. System builders used a “train the trainers” approach to build the capacity within the system of care to expand knowledge about how to use the system.

1.29 Quality Improvement (QI)

Effective systems of care concern themselves with *quality* issues. In its simplest form, quality has to do with whether what is being done is making any difference for the better in the lives of the children and families being served, for the taxpayers who support the system, and for the community in which the system operates. This is a question that needs to be asked and responded to continually; it is not a one-time query and response. To ask and answer this question—and the many subsets of questions attached to it—system builders need to develop structures that measure quality, that provide feedback loops, and that have response (i.e., quality improvement) capabilities.

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*I wouldn't mind
paying that tax if
I knew it was
helping.*
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Effective system builders structure the QI process to reflect the system's values and goals, and key stakeholders including families and youth are involved in the design and implementation of QI—through committee structures, participation in focus groups, involvement in targeted assessments, and the like.

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*But is our life
any better?*
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Box 1.29A describes steps in the quality process.

1.29A Steps in the Quality Process

- Discussions about values
- Evolution of principles for action
- Development of guidelines for interventions
- System guidelines
- Clinical guidelines
- Ethical guidelines
- Measuring performance
- Outcomes
- Report cards
- Processing feedback

Manderscheid, R. (1998, May). From many into one: Addressing the crisis of quality in managed behavioral health care at the millennium [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research*, 25 (2).

System builders need to be clear about *what* they are measuring for quality. There are many different aspects of systems of care that can be measured for quality. *The most fundamental, however, is the quality of the interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided.* This can be measured by looking at treatment efficacy and service outcomes such as clinical and functional outcomes, by measuring the satisfaction of those involved in the interaction—families, youth, and clinicians—and by considering issues of value, that is, analyzing cost as compared to effectiveness and satisfaction.

Box 1.29B gives an example of a framework for considering outcomes at several levels—that of the child and family being served, the larger community, and cost issues.

1.29B A Framework for Addressing Family Needs Comprehensively

Level of Family Need	Targeting of Service	Form and Cost of Service	Outcome for Family	Impact on Community
Support and Prevention	<ul style="list-style-type: none"> Sexually active teenagers Families in low-income neighborhoods 	<ul style="list-style-type: none"> Sex education, contraceptive programs, clinics Family resource center 	<ul style="list-style-type: none"> Teens do not become pregnant Parenting skills improve 	<ul style="list-style-type: none"> Reduced incidence of social problems associated with teen pregnancy Stronger neighborhoods
Early Intervention	<ul style="list-style-type: none"> Pregnant teens and teen parents Parents of developmentally disabled infants and toddlers Recently unemployed 	<ul style="list-style-type: none"> Early identification of need Prenatal and perinatal services Linkages to service to meet special needs of the parents and children 	<ul style="list-style-type: none"> Improved birth outcomes Economic stability and physical security in spite of risks Reestablish stable family circumstances without public assistance Children enter school ready to learn 	<ul style="list-style-type: none"> Reduced incidence and prevalence of environmental induced developmental disabilities such as FAS/FAE Reduced truancy Reduction in violent activity and other risky behavior by youth
Focused Intervention	<ul style="list-style-type: none"> Families with substantiated reports of child abuse or neglect Families without homes Families with children at risk or involvement with juvenile justice system 	<ul style="list-style-type: none"> Income, food, and housing assistance to establish a basic level of economic security and physical safety, job training and assistance in locating employment Parenting education More intensive service to meet special needs of parents and children Less-intensive, home based family preservation services Family reunification services 	<ul style="list-style-type: none"> Establish stable family situation with public assistance Parents learn how to provide a safe and nurturing environment for their children Facilitate return of children to biological parents or to another permanent living arrangement 	<ul style="list-style-type: none"> Fewer families experience crises that threaten their viability Lower probability of long-term dependency on public assistance
Crisis Intervention	<ul style="list-style-type: none"> Families at imminent risk of having a child removed from the home (child welfare, juvenile justice, mental health, developmental disability, etc.) 	<ul style="list-style-type: none"> IFPS Kinship care Family foster care Therapeutic foster care Residential facility 	<ul style="list-style-type: none"> Help parents resolve crisis that undermines their ability to provide a safe and nurturing home for their children 	<ul style="list-style-type: none"> Reduced isolation of children from their families and communities

Usher, C. (1998,May). Managing care across systems to improve outcomes for families and communities [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research*, 25 (2).

System builders also need to be clear about *how* they are measuring quality, as there also are many different ways to measure—some yet to be discovered in what is a relatively new area of endeavor for systems of care. Some systems of care measure clinical and functional outcomes as one means to assess quality. Some measure systems outcomes, for example, the number of children in out-of-home care. Some measure parent and youth satisfaction. Some measure cost, access, and service utilization patterns. Some measure public opinion. *Effective system builders structure QI processes that incorporate multiple measures and that rely on multiple sources—youth and families, providers, staff, community stakeholders—for information to gauge quality.*

Box 1.29C provides one example of outcomes measures in a system of care using multiple measures from multiple sources and intended for multiple audiences.

1.29C Full Ongoing Outcome Data Set for California System of Care Model Counties			
WHAT	SOURCE	WHEN	PRIMARY AUDIENCE
System level measures and outcomes Placements State hospital: number, length of stay, cost Group Home: number, cost Acute psychiatric hospital: bed days, cost Restrictiveness of living environment (Restrictiveness of Living Environment Scale—ROLES)	State data systems County data Clinician/case manager	Collected monthly Collected monthly Entry, exit, annual	State and local policy makers, interagency partners, program managers
Educational performance (for youth in selected special education/mental health programs) School attendance School performance Juvenile justice (for youth in selected mental health/juvenile justice programs) Recidivism: arrests and citations by type of offense	School records Achievement tests Court records	Ongoing annually Ongoing, one-year pre- and post-program	Program managers, interagency partners, local policy makers
Consumer level measures and outcomes Functioning, competence, and impairment from caregiver, consumer, and clinician perspectives Child Behavior Checklist Youth Self-Report Child and Adolescent Functional Assessment Scale Satisfaction (Client Satisfaction Questionnaire 8) Family Empowerment Scale	Caregiver Child Clinician Caregiver, child Caregiver	Entry, six months, annually, and discharge Sampled periodically	Clinicians and consumers, program managers, local policy makers Consumers, program managers

Rosenblatt, A., Wyman, N., Kingdon, D., & Ichinose, C. (1998, May). Managing what you measure: Creating outcome-driven systems of care for youth with serious emotional disturbances [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research*, 25 (2).

Box 1.29D provides examples of various instruments used to measure outcomes related to children’s mental health.

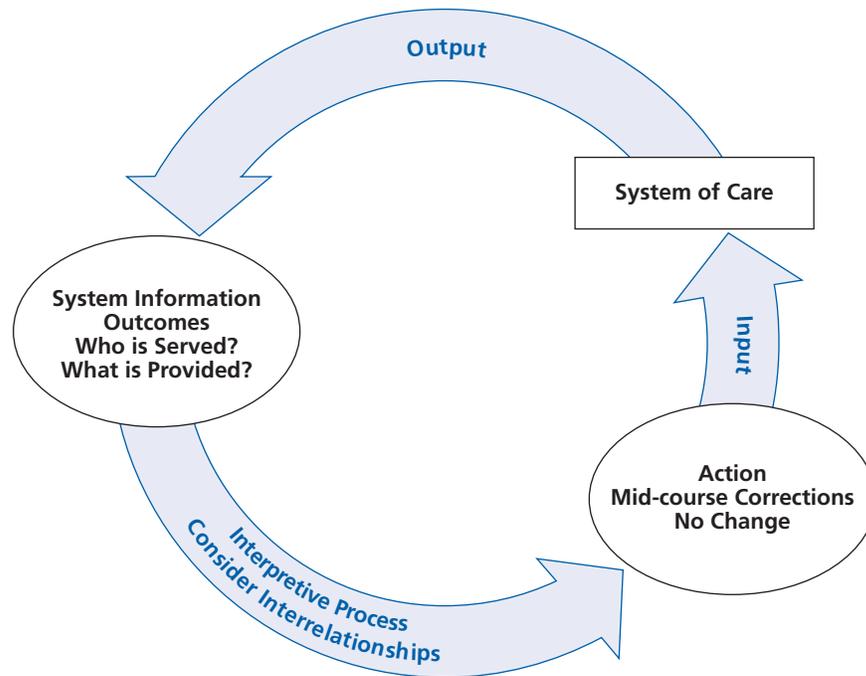
1.29D Child/Adolescent Mental Health Instruments			
INSTRUMENT	DOMAIN	DATA SOURCE	METHOD
Child Behavior Checklist (CBCL)	Symptomatology	Parent/caregiver	Self-report questionnaire
Child and Adolescent Functional Assessment Scale (CAFAS)	Level of functioning	Case manager/clinician	Completed after interview with child or family member
Family Assessment Device (FAD)	Family functioning	Parent/caregiver	Self-report questionnaire
Consumer Satisfaction Questionnaire (CSQ-8)	Consumer satisfaction	Parent/caregiver	Self-report questionnaire
Family Satisfaction Questionnaire (FSQ)	Consumer satisfaction	Parent/caregiver	Self-report questionnaire

Koch, J.R., Lewis, A., & McCall, D. (1998, May). A multistakeholder-driven model for developing an outcome management system [Special Issue on System Accountability in Children’s Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research*, 25 (2).

Effective system builders also recognize how critical it is to structure QI processes that not only ask about quality but also respond to issues that surface through the asking. *Structures that amass data about quality but fail to do anything with the data create frustration among many groups of stakeholders—e.g., staff, families, legislators—and raise credibility issues that can affect attainment of system of care goals and system sustainability.* Effective QI structures incorporate mechanisms that provide regular feedback about quality issues—good and bad—to system stakeholders at all levels, and initiate in a timely way improvement steps in response to quality concerns.

ILLUSTRATION 1.29

Ecology of Outcomes: Using the Results



Hernandez, M., Hodges, S., & Cascardi, M. (1998, May). The ecology of outcomes: System accountability in children's mental health [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research*, 25 (2).

Effective system builders strive to incorporate cultural competence into their QI structures. Historically, there have been disparities in data collection, analysis, and reporting with respect to diverse populations. Working with stakeholders from diverse communities, system builders can build data specificity for diverse populations into the system and ensure that interpretation of data reflects the experience of diverse families. Box 1.29E describes factors that historically have contributed to data disparities with respect to racially, ethnically, and linguistically diverse communities.

1.29E Factors Contributing to Data Disparities in Diverse Communities

FACTOR	ISSUE
<p>Barriers for Diverse Community Participation (Individual and System Specific)</p>	<ul style="list-style-type: none"> • Level of trust with the formal system of care and the perception of the process as intrusive or meaningful • Level of individual's fluency and familiarity with the English language • Level of sophistication of the system's Limited English Proficiency standards and guidelines to provide meaningful linguistic supports and compliance with Title VI of the Civil Rights Act • Availability and extent of the training provided to data collectors representatives of the predominant culture • Availability, participation, and training of bilingual and/or bicultural data collectors representatives of the communities served • Lack of formal partnerships with community-based organizations (and ISOC) that can function as "bridges" for the data collection protocol • Lack of access to services • Lack of awareness and understanding of the importance of data collection and analysis on behalf of diverse recipients of services
<p>Framework for Understanding Community Context and Needs</p>	<ul style="list-style-type: none"> • Overall relevance and applicability of the questions and tools for ethnically and racially diverse communities • Degree to which the specific questions and tools are relevant for specific communities • Level of relevance of the answers to the questions based on the context of the community and culture • Lack of understanding of diverse community characteristics and needs which may remain excluded from the data collection process and analysis
<p>Racial and Ethnic Categories</p>	<ul style="list-style-type: none"> • Adherence to the minimally defined federal ethnic and racial categories may contribute to the exclusion of specific populations from participation (or data analysis) due to their absence in the classification standards • Ethnic and racial self-reporting may influence erroneous race/ethnicity selections due to lack of comprehensive categories representative of the individual's "identity" or simply lack of knowledge on behalf of the individual
<p>Data Collection, Analysis, and Presentation</p>	<ul style="list-style-type: none"> • Aggregate data profiles exclude diverse communities from specific data analysis • Disaggregate data profiles run the risk of excluding specific populations due to small data samples or cells within the context of specific statistical analysis
<p>Applicability of the Data</p>	<ul style="list-style-type: none"> • Lack of data specificity does not allow for applicability of the results to all populations or communities • The presentation of the data may target the predominant culture ("one size fits all" approach) and is not applied to inform communities of the status of their particular cultural group • The format in which the data is presented is beneficial or detrimental to a particular subset of the population by inclusion or elimination, or by limiting the analysis of the data to specific variables that may not be as relevant within the context of disparities
<p>Availability of Instruments and Tools</p>	<ul style="list-style-type: none"> • Availability of standardized instruments with specific populations and different socio-economic levels • Availability of the instruments in different languages

Aristy, J. (2002). *Factors contributing to data disparities in diverse communities*. Washington, DC: Georgetown Child Development Center.

1.30 Evaluation

Evaluation is viewed here as a larger umbrella than QI (though QI data certainly will help inform evaluation). QI is fundamentally a *management* mechanism to track progress, measure quality, and make adjustments as needed. Evaluation as used here is essentially a *policy* tool; that is, evaluation gauges the value or significance of the system of care as a means to guide policy at the governance level.

Box 1.30 describes examples of evaluation information reported to key stakeholders in a statewide system of care.

1.30 Evaluation Information Reported on the Contract Outcome Report

- Percentage of parents satisfied with services
- Percentage of children satisfied with services
- Percentage of collateral providers satisfied with services
- Percentage of children with improved school behavior
- Percentage of children with a history of arrest who avoided re-arrest during services
- Average change of score (difference) between CBCL scores at beginning and end of services
- Percentage of required data forms actually submitted for analysis

Rouse, L., Toprac, M., & MacCabe, N. (1998, May). The development of a statewide continuous evaluation system for the Texas children's mental health plan: A total quality management approach [Special Issue on System Accountability in Children's Mental Health]. Hernandez, M. (Ed.) *Journal of behavioral health services and research*, 25 (2).

Increasingly, effective system builders are recognizing the importance of developing *participatory* evaluations in which stakeholders help to shape the focus and process of evaluation and are included in the interpretation and dissemination of results and findings. Evaluations that are structured in a way that leave key groups of stakeholders such as families, staff, providers, or diverse communities questioning methods or results will create credibility issues for evaluators. On the other hand, evaluators in a participatory structure must be careful not to compromise objectivity.

EXAMPLE 1.30

In a rural area in west central Florida, a group of community residents are engaged in a participatory evaluation of the development of their neighborhood system of care. Self-selected neighborhood evaluation team members participated in joint training with university researchers.

A bottom line is that evaluation needs to be viewed by stakeholders as an essential element in and connected to system building and not as some phenomenon that occurs “out there,” which may or may not be useful. A criticism of the research community is that it conducts evaluations that are not useful to policy makers and practitioners; on

1.32 Technical Assistance (T.A.) and Consultation

Effective system builders utilize consultants and technical assistance *strategically and for a variety of different purposes*. The following provides a loose taxonomy for the various purposes of technical assistance and consultation:

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But why T.A.?
— ■ ■ ■ —

- **Technical Assistance:** provision of specialized, practical knowledge on a particular aspect of system building, for example, on maximizing federal revenue or on partnering with parents or youth.
- **Consultation:** providing advice and opinions.
- **Coaching or Mentoring:** acting as a “trusted guide,” providing direction, prompting, instruction.
- **Facilitation:** providing support to system building processes such as a stakeholder planning process.
- **Persuasion:** acting as “provocateur” or “national expert” when systems are stuck or when local system builders cannot carry the message themselves, sometimes simply because it is difficult to be a “prophet in one’s own land.”
- **Training:** teaching and skill building to prepare or qualify trainees to perform as required.

There is a certain blurring of boundaries across these areas, but at the least it may help system builders think about the kinds of support needed, for whom, and at what stages of development.

Effective system builders try to avoid lurching from one technical assistance demand or encounter to another, but instead create a structure for identifying and responding to requirements for outside support. The structure needs to be flexible, take into account strengths and needs across system features and stakeholders, and make connections among all of these. For example, the parent coordinator may identify a need for technical assistance related to engaging parents in system building at all levels. At the same time, system builders have identified a need for training of clinicians on conducting strengths-based assessments and on partnering with families in developing individualized services and supports plans of care. On the one hand, technical assistance is needed; on the other, training—but they are related to each other. The training related to clinicians’ skills, attitudes, and knowledge can have an impact on the engagement of parents systemwide. The technical assistance provided to the parent coordinator on engaging parents systemically can have a bearing on the readiness and capacity of families to partner in the service-planning process.

Effective system builders also think strategically about the **uses of national, local, and peer** technical assistance resources. There are pros and cons to all. National consultants bring knowledge and experience from having worked in multiple states and local communities and can bring a needed “national perspective.” However, they may be less intimately knowledgeable about the local system, and it may not be possible, for reasons of time, money and travel, for the national consultant to be involved closely over a sustained period of time. Local consultants may have the advantage of being more available and perhaps more knowledgeable about local dynamics. Also, it is a worthwhile goal to build local technical assistance capacity. However sometimes, precisely because they are more intimately involved, local consultants may carry “baggage” that makes it difficult for system builders to use them or throws into question their objectivity. Peer technical assistance providers, that is, colleagues working in other systems of care, often bring very practical knowledge and the perspective of those who have “walked in the same shoes.” However, peer consultants also may be limited by their knowledge of only their own system, be unable to “translate” from their own system to another, and, because they are working in other full time roles, may be available for only brief or periodic consultation.

Following is an illustration of peer T.A. activities.

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She was DHS Director; how can she possibly be objective?

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We need a national perspective to shake things up.

— ■ ■ ■ —
We need local T.A. capacity.

1.32 Peer T.A. Activities

JURISDICTION	SUBJECT	IMPACT
1. Community and neighborhood-based service delivery to achieve outcomes for children and families.		
Jefferson County, Kentucky, consulting with Stark County, Ohio	Developing a neighborhood-based strategy for providing supports and services to children and families.	Helped Stark County redesign their school-based services initiative using Kentucky's Neighborhood Place and Family Resource Center model.
Santa Barbara and San Diego Counties, California (teams from each consisting of county staff, schools, and parents)	Involving parents in planning for system reform. Creating cross-system professional development program.	San Diego immediately involved parents in its cross-systems professional development program as participants and planners. Santa Barbara developed a cross-agency training program.
2. Innovative financing strategies		
New Jersey, New York, Vermont, and Missouri Depts. of Mental Health and Child Welfare Services	Integrating behavioral health and child welfare services in a managed care environment.	Developed a Working Paper on <i>Meeting the Mental Health Needs of Children: Integrating an Approach to Managed Care</i> . Monthly telephone calls among the four states continue as they work on issues collectively.
Cross-systems teams of state and local staff from Michigan, Missouri, and Vermont	Determine what the key opportunities and challenges are to creating public sector managed care plans that complement and work with local governance boards.	A paper was developed which clarifies the challenges and opportunities, and suggests ways that local governance boards can become involved in managed care planning and implementation.
3. Strategies to link schools with other human services and community supports in order to improve students' school success		
Grady Health System of Atlanta, Georgia, and Mt. Sinai Medical Center of New York City	Learning how a large institutional medical system can work better for adolescents. How can teenage pregnancy be prevented through the use of an abstinence-based program?	Grady Health System has built a new Adolescent Reproductive Health Center, using many of the principles learned from Mt. Sinai.
The School District of Philadelphia and the San Diego Unified School District	How to meet students' and families health and social services needs within a school environment.	Both Districts have developed more responsibility to schools and school clusters to use their resources to support student health and social services. Philadelphia increased its use of "blended funding" for student support services.
4. Developing comprehensive community care to meet the mental health needs of children and their families		
Vermont Department of Mental Health with Kansas Keys Consulting (a parent advocacy group)	Developing and sustaining local family advocacy networks on behalf of children with emotional problems.	Family advocates will be added to Vermont's community mental health centers.
Stark County, Ohio, consulting with Jefferson County, Kentucky	Successful models of governing and financing an integrated, family-centered approach to mental health service delivery.	Developed specific recommendations for Jefferson County to link finance and program staff and to build sustainable funding for mental health services. Tools developed include a financing matrix, IV-E fiscal plan, and Family Treatment Plans to track pooled funds.

Center for the Study of Social Policy. (1998, December). *Learning from colleagues: The experience of the peer teaching assistance network*. Washington, DC.

Cultural Competence

Cultural competence is not a stand-alone function. As noted in the Introduction, it is a quality or characteristic that needs to be infused within every structure that is built in systems of care and within the system-building process as well. Rather than having a full-blown stand-alone “cultural competence section,” this Primer tries to model the integration of cultural competence into all aspects of system building by addressing issues related to cultural competence within each section in *I. Structuring Systems of Care* and by addressing cultural competence as a core element of *II. The System-Building Process*. For example, within the *Quality Improvement* section (1.30), attention is paid to the disparities in data collection, analysis, and reporting that historically have been the case with respect to diverse populations and the importance of structuring quality improvement programs that are culturally competent. In the section on *Purchasing/Contracting* (1.25), there is discussion of how certain types of contracting arrangements may disadvantage small, nontraditional, or indigenous providers serving diverse communities and the importance of structuring purchasing mechanisms that ensure outreach to and inclusion of these providers. The section on *Outreach and Referral* (1.6) discusses the importance of structuring ways of reaching out to diverse communities that traditionally have been underserved. These are examples of how the Primer attempts to treat cultural competence as an intrinsic element of every system of care function and within the system-building process.

While the Primer treats cultural competence as an intrinsic element of every system of care function, it also is essential that system builders create structures that pay attention to cultural competence issues *across* functions and within the ongoing system-building process. For example, some states and localities create planning and implementation teams or workgroups whose role it is to assess cultural competence issues and needs within system of care structures and within the system-building process and develop and oversee appropriate responses and strategies *on an ongoing basis*.

Isaacs* has identified a number of core components that need to be in place to “build a solid infrastructure” for cultural competence development within systems of care:

- Commitment from the top leadership of the organization to cultural competence and diversity;
- Willingness to conduct organizational cultural competence self-assessment;
- Needs assessment and data collection (both quantitative and qualitative) to assist in knowledge development about the culturally diverse groups and communities within the state;
- Identification and involvement of key persons of color in a sustained, influential, and critical advisory capacity to the organization;

* Isaacs, M. (1998). The state of the states: Responses to cultural competence and diversity in child mental health. In *Towards a culturally competent system of care* (Vol. 3). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children’s Mental Health.

- Development of mission statements, definitions, policies, and procedures that explicitly state the agency’s cultural competence values and principles;
- Development of a cultural competence strategic plan with clear and measurable goals and anticipated outcomes;
- Commitment to recruitment and retention of staff who are reflective of all communities served and populations utilizing services;
- Commitment to ongoing cultural competence training and skill development for all staff at all levels of the organization;
- Development of certification, licensure, and contract standards which include cultural competence requirements and measures;
- Targeted service delivery strategies that are culturally appropriate and centered around improved outcomes for children and families;
- Development of an internal capacity, within the organization, to oversee and monitor the implementation process (specialized job positions, internal teams, MIS capacity, performance standards, etc.);
- Evaluation and research activities that provide ongoing feedback about progress, lead to needed modifications, and guide next steps;
- Commitment of agency resources (human and financial).

As discussed throughout the Primer, these core components have implications for the types of structures that are created in systems of care and how the system-building process conducts itself.



Cultural Competence Key Question

- How are we ensuring that cultural competence is built into every system of care function and the system-building process?

NOTES
