No. 9, 1998-1999

BEST PRACTICE BRIEFS

PUTTING THE PIECES TOGETHER

SYSTEMATIC THINKING is
- an acquired skill
- based on data

A COMMUNITY SYSTEM OF CARE INVOLVES
- common understandings
  - vision
  - outcomes for service recipients
  - shared values for service delivery
- development of linkages
- changes in procedures
- common forms
- feedback mechanisms
- sharing resources
- written agreements

SUPPORT AND ACTION ARE REQUIRED FROM
- the coalition
- participating agencies

OUTREACH PARTNERSHIPS

MICHIGAN STATE UNIVERSITY

DEVELOPING COMMUNITY SYSTEMS OF CARE

Carefully interconnecting agencies into "systems" is a major shift in the way communities deliver human services. The most organized and integrated connections are called "Community Systems of Care." This BRIEF examines the components of a Community System of Care in general and then explores an effort to develop an emergency assistance "system," as an example. The next issue will cover a Community System of Care for very young children and their parents.

WHAT IS A COMMUNITY SYSTEM OF CARE?

Picture Anytown, USA, with a confusing array of health, mental health, child welfare, substance abuse, youth development, and other human service agencies and funding sources. So confusing, that horror stories are a staple of the conversation of parents and other consumers who have attempted to negotiate the separate fiefdoms. This consumer dissatisfaction, concern about poor outcomes, and limited resources allocated for human services are driving change. As a result, we are beginning to see the emergence of Community Systems of Care.

> **A Community System of Care is the organization of public and private service components within the community into a comprehensive and interconnected network in order to accomplish better outcomes for a defined population.**

A Community System of Care represents the application to human services of **systems thinking**—seeing interrelationships and patterns of interconnectedness.

Note: **System** is defined as
(1) A regularly interacting or interdependent group of items forming a unified whole *(Merriam Webster's Collegiate Dictionary).*
2) A functional whole composed of component parts that together generate a level of organization different from the level of organization represented in any individual component part or subset of the component parts.
The word is used to describe, for example, the atom (physics), the rain forest (ecology), product distribution arrangements (business), the cell (biology), the cardiovascular system (medicine), the individual (psychology), the family (human ecology).

A **Community System of Care** is designed to accomplish changes at the agency and interagency levels that can be expected to result in better outcomes at the child/family/adult level. In the patchwork array of public and private human services providers that characterizes most communities, accomplishing better outcomes requires smoothly operating interconnections and working relationships.

The concept of a Community System of Care initially came from federal efforts to promote a better way than institutional care to serve severely emotionally disturbed children. Most of the work on Community Systems of Care across the country has been undertaken for the most challenged group—children and their families with multiple needs requiring interagency involvement from mental health, child welfare, juvenile justice, health, and education. However, the concept is being generalized to other areas. Increasingly, foundations, United Ways and public funding sources are looking for interconnected, seamless services.

A Community System of Care can be developed for any identifiable service population or age group. Community Systems of Care have been formulated for:

- infants and parents
- the aged
- individuals seeking basic needs services
- persons with developmental disabilities
- delinquent youth and their families
- severely emotionally disturbed children and their families

DEVELOPING A COMMUNITY SYSTEM OF CARE

Organizing a Community System of Care involves assembling representatives of community agencies and stakeholders that have a common interest in the population served, in outcomes and impacts, and in existing or potential interconnections. The coalition or multi-purpose collaborative body will include agency directors, influential community representatives, and parents or consumers reflective of the service population.

The members of an effective coalition

- meet frequently over time to develop their trust in each other and their working relationship.
- have a commitment to make services more effective and user-friendly.
- are flexible problem-solvers.
- understand the problems in the present arrangements, the need for change, desired outcomes, and strategies for change.
- have the authority, know-how, and existing or potential resources to make things happen.

STEPS IN JOINT PLANNING TO ACHIEVE A COMMUNITY SYSTEM OF CARE

The components of a Community System of Care will vary according to the population of concern. However, a Community System of Care will always include a common **vision,** anticipated **outcomes** for the population of concern, a statement of **shared values**[1] (also known as guiding principles) as a basis for service delivery. A process of **fact-finding** will formulate an action plan that can result in modified **procedures, common forms,** provisions for **feedback and assessment,** and **sharing of resources.**

Steps 1 and 2. Agreeing on a Common Vision, Anticipated Outcomes, and Shared Values

The coalition develops common understandings for what is desired at the child/family/adult level and at the agency/interagency system level. It can be usefully undertaken by using the Outcome-Asset Impact Evaluation Model© (see **BEST PRACTICE BRIEF** No. 5).

[1] These values also drive the strategic planning and change within a single agency. In a Community System of Care, they are reflected in interagency processes, mechanisms, and structures that result in a comprehensive and interconnected arrangement of service components.

At the child/family/adult level, the coalition develops

- A common vision of the **desired impact** for the population of concern
  - = *a succinct statement developed as the coalition defines its common goals for children/families/adults.*
- An understanding of the **characteristics** related to that impact
  - = *what the population would be like if the desired impact were achieved.*
- An understanding of the desired short-, intermediate-, and long-term **outcomes** related to the characteristics
  - = *change in attitude (short-term), behavior (intermediate-term), and status or life-style (long-term).*

At the agency and service system levels, the coalition develops

- **Shared values for service delivery**
  - = *the characteristics that will make the service delivery more user-friendly and therefore more effective for the persons receiving service. These values may include the following:*
  - **family- or person-centered and driven,** *involving parents as full partners*
  - **strength-based,** *emphasizing the child/family/individual's assets rather than deficits*
  - **culturally competent,** *recognizing and being respectful of cultural practices and beliefs*
  - **individualized,** *developing a plan of care tailored to the child/family/individual's needs and desires and using both formal and informal community/non-agency resources*
  - **providing seamless services** *in the least restrictive environment*

Step 3. Fact Finding

The coalition obtains a realistic picture of the current situation by

- **Identifying** the population of concern with respect to size (how many), identifiers, chronology of development, and points at which the population connects to, or could connect to, needed human services.
- **Describing** the degree to which current services match the supports and activities needed to achieve the characteristics and impacts identified.
- **Assessing** the current service delivery arrangements against expectations implicit in the values (characteristics) that have been identified for the population and for service delivery.
- **Identifying barriers to interconnections.**

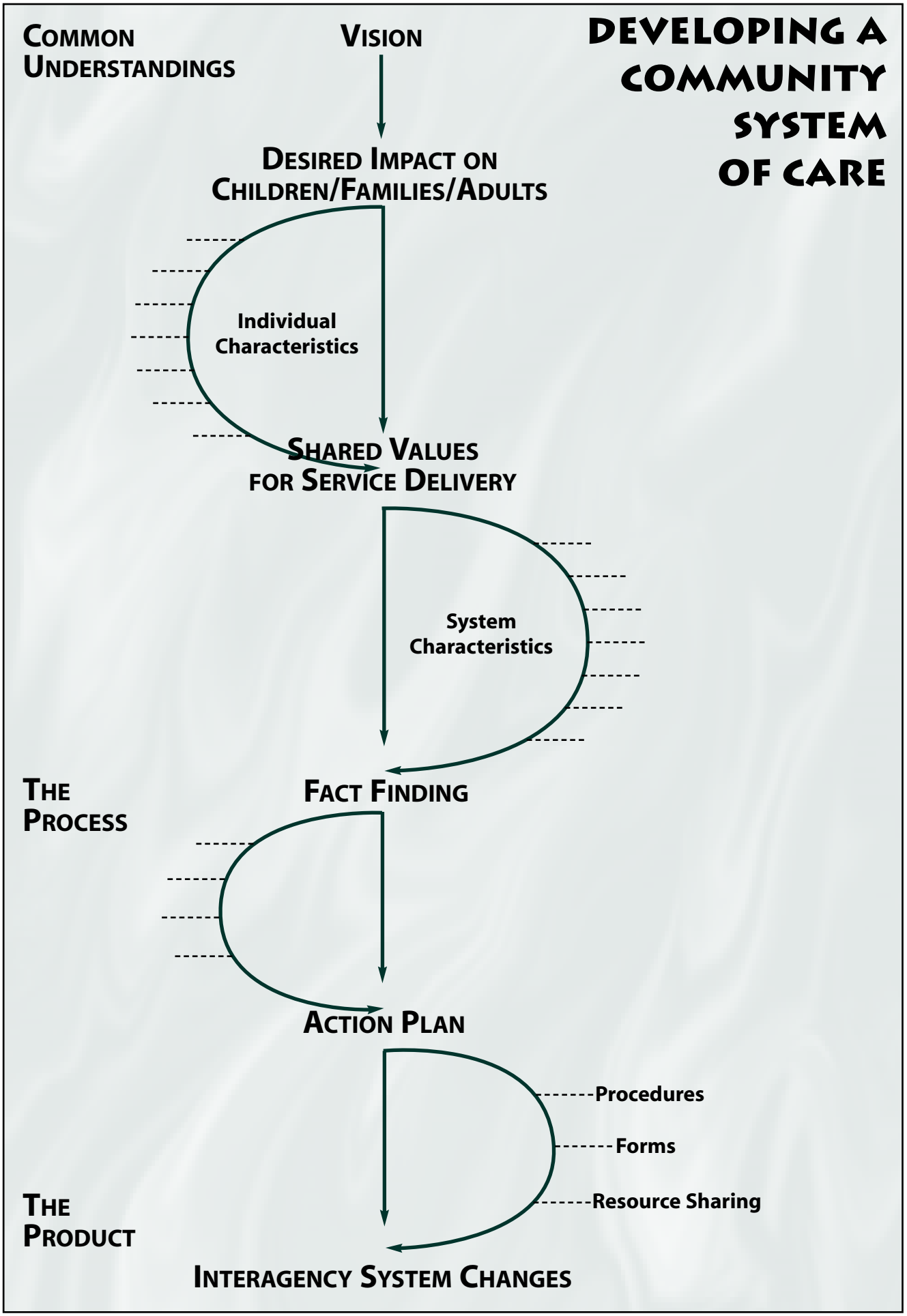
  Reduction of barriers may involve such steps as:
  - *reaching agreement about appropriate sharing of information and maintenance of confidentiality;*
  - *assigning resources to transcend the eligibility limitations of categorical funding sources that limit access by income level, diagnosis, or other criteria;*
  - *assuring that service locations and hours are convenient.*
- **Identifying gaps** in available services, such as
  - *non-availability of a needed service*
  - *insufficient capacity*

In the fact-finding stage, the coalition uses recipients of service and service providers to obtain perceptions and information concerning the strengths, weaknesses, connections, and disjunctures in the current arrangements.

Recognize That

- Most service providers do not see services from the same standpoint as the recipient.
- "Creating new services to fill existing gaps" is generally the initial reaction to the concept of a Community System of Care.

Developing a Community System of Care



Step 4. Developing and Implementing an Action Plan

The plan outlines needed modifications in agency and interagency practices, charting new pathways and interrelationships. This is accomplished through:

- **Developing agreed upon procedures and linkages** between and among agencies. Questions that are explored relate to the process for accessing and receiving services; they will vary depending on the population of concern. Questions may include:
  - *How can potential service recipients be systematically identified and recruited?*
  - *Can there be a common access point? What are the common data across agencies for intake?*
  - *How is the most appropriate primary service provider or service coordinator determined?*
  - *What is the process for interagency service planning? Does the family/individual participate?*
  - *What are the arrangements for smooth access to other concurrent services? Are these informal arrangements based on personal relationships, or are they institutionalized in policy and agreements?*
  - *What happens when current services terminate? What are the transition arrangements?*
- **Creating common forms** such as
  - *common intake form*
  - *integrated (across agencies) plan of service form that summarizes all formal and informal services to be utilized*
- **Adopting common mechanisms for assessment and feedback:**
  - *agreed on assessment instrument(s) to be used across services to identify progress of service recipients*
  - *data reporting forms to document input, output, activities, outcomes, and impacts as a basis for assessing how well the Community System of Care is working and whether outcomes are being achieved*
- **Sharing resources,** which may involve
  - *assignment of staff*
    - *to assist with planning*
    - *to undertake specific tasks or services*
    - *to participate on an interagency service team*
  - *contribution of*
    - *space, equipment, or materials*
    - *dollars, generally involving access to flexible funds or redirection of funds by the local agency*
    - *services, e.g., acting as the fiduciary or data processor*

The resulting products and arrangements from Step 4 should be institutionalized with memoranda of agreement.

A Community System of Care for Basic Needs[2]

Development in Kaytown was precipitated by

- no overall community budget for emergency assistance through three separate agencies
- continual requests to local foundations for more funds
- no incentive and no time for agencies to develop alternative sources of private and federal funding
- lack of consistency across the agencies in responding to the same kind of request
- a growing number of families who were homeless

The Coalition: Five agencies—the United Way, the Salvation Army, the American Red Cross, Housing Resources, and the county department of social services (Family Independence Agency)—organized themselves as the Emergency Assistance Network. Their task: to bring order out of the existing chaos.

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[2] Experience in Kalamazoo, Michigan, triggered this description, but it does not entirely represent the Kalamazoo situation.

They established a common understanding.

Desired Impact (The Vision):

- To keep as many people as possible from homelessness.

The Individual's Characteristics:

- Expectations for self reliance

The Agency/System of Core Values:

- Efficient and effective use of private dollars
- Maximal availability of public and private dollars
- Accessible and available service
- Responsiveness to individual circumstances; user friendly

They secured information on the demands for services, the size of the low-income population, the availability of low-cost housing, and the existing emergency assistance arrangements and shortcomings.

The basic problem, identified, was a lack of low-income housing and a large population of working poor whose wages were insufficient to cover normal expenses. This was not solvable by emergency assistance. Other actions were initiated to increase the supply of low-income housing.

They developed a new organizational plan for emergency assistance.

Clear Delineation of Services

- **A common definition was adopted:**
  "Emergency Financial Assistance is a service designed to alleviate an individual's or family's immediate crises involving a basic subsistence need."
- **Each of the three emergency assistance agencies was assigned responsibility for one component** of emergency assistance rather than trying, as in the past, to provide emergency assistance across all categories.
  Agency 1—**housing emergencies**
  Agency 2—**utility emergencies**
  Agency 3—**medications**
- **Each agency took responsibility for providing**
  - **case work** (assessment, information, referral to make use of community resources to meet client needs) including active problem solving, guidance in money managment, and referral to food pantries (see **BEST PRACTICE BRIEF** No. 8);
  - **financial assistance** when appropriate and within agreed-on guidelines.
- **Common criteria and procedures** were adopted.
  - **Eligibility:** emergency assistance is available only when need cannot be met by public agency resources: *applicant must present proof from FIA that public emergency assistance funds will not be provided.*
  - **Affordability,** i.e., whether household can be self-sufficient after this emergency assistance: *determined by the household's ratio of total expense to current or anticipated income sufficient to meet ongoing rent/mortgage and utilities bills.*
  - **Repeat assistance:** *limited to 1 time in 18 months for housing and utilities, and an annual cap of $150 for prescriptions.*
  - **Casework:** each referred client will receive a face–to-face or telephone assessment and problem-solving assistance even if no financial assistance can be provided.

Clarity for Referral Sources

- A service **directory,** with charts indicating agency eligibility requirements and the process for accessing emergency assistance, was commissioned and widely distributed.
- **Communication** with referring agencies and system-wide **training** of their staff were undertaken to clarify the constraints on emergency assistance because of limited funds, and to emphasize the limitations of the Network in resolving problems of poverty.
- Two meetings a year are held to gather **input and feedback** from local referral sources.

Common Forms for Paper Work

- A **common referral and intake form** was developed and provided to other agencies to promote ease of access.
- A **common reporting form,** and transmittal of monthly reports by computer, documents and provides for analysis of individuals served, amounts expended, other resources obtained.

Management of Funding

- The foundations established the amount of funding they would provide annually.
- Each emergency assistance agency identified and accessed other relevant sources of funding with in its area of responsibility (e.g., utility company, free clinics, pharmaceutical companies, state and federal housing grants, etc.).
- A community foundation established an endowment.
- Quarterly meetings of the five network agencies are held to review performance and needs against budget and to problem solve. Annually the group decides on the allocation of foundation funds among the three provider agencies for emergency assistance.

Recognize That

- **Developing a Community System of Care cannot substitute for a lack of funds.**
- **Community Systems of Care driven primarily by the motive to contain expenditures cannot fully accomplish the desired impact for individuals/families.**
- **A Community System of Care is an "open" system, subject to change and incremental growth.**

GETTING FROM HERE TO THERE

Developing a Community System of Care requires

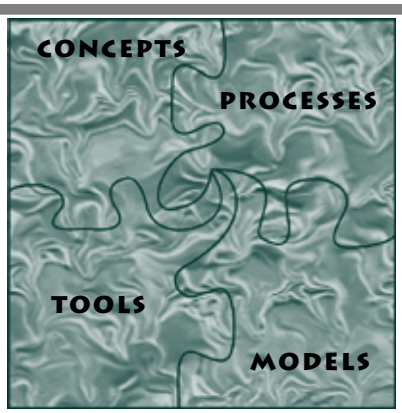
- one or more directors, community leaders, or middle managers who invest energy and enthusiasm to **champion** the effort
- **staff resources** to arrange meetings, to obtain and develop materials, to prepare minutes and reports, and in general to promote and facilitate a careful planning process
- special **actions** by the coalition and by each agency, as outlined below

The coalition or multi-purpose collaborative body is most effective in developing a Community System of Care when it

- develops an explicit **written assignment** for a committee or workgroup that includes
  - expected outcomes
  - timelines for the completion of identified tasks
- takes responsibility for developing new **resources** or pooling existing resources, and assigns a fiduciary agency
- develops **memoranda of agreement** that specify roles, responsibilities, resources (see **BEST PRACTICE BRIEF** No. 7).
- requires **periodic reporting** on
  - progress in planning
  - obstacles to implementation
  - accomplishing outcomes in service delivery
- encourages the development of **policies and procedures** by the group and at the individual agency level
- develops a systematic **cross-agency training plan**
- requires ongoing **feedback** on process and outcomes from collected data and from comments of service providers and of persons served
- **trouble shoots** and **problem solves**

A Community System of Care will be most effective when the director of each participating agency and supervisors

- provide **clear messages** concerning agency policy and expectations for revised mode of operations
- **authorize and accommodate** the time required for **participation** of staff members in initial interagency systems planning and oversight and in service teams
- build recognition for interagency work into **job descriptions**
- build recognition and incentives for interagency work into **staff evaluations**
- formally **adopt interagency forms and procedures**
- involve staff in **interagency training**
- insist on written **memoranda of agreement** concerning assignment of staff, other resources, and funding
- develop **written policies** supporting the Community System of Care
- make the Community System of Care the **expected agency standard** for serving that population



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