Health Foundation
for Western & Central New York
Investing in Better Health for People and Communities

The County No Wrong Door Feasibility Study

Conducted by:

NYSAC
NEW YORK STATE
ASSOCIATION OF COUNTIES

1925

October 2012

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The Study

The Health Foundation for Western and Central New York commissioned the New York State Association of Counties (NYSAC) in spring 2012 to conduct a study exploring counties' efforts related to the delivery of human services to their residents. The results of that study, recommendations, and research into past efforts designed to streamline human services programs are presented in this report.

The Foundation, in collaboration with community partners, provides support for services and programs that strengthen the health and wellbeing of the elderly and children living in impoverished communities. Recognizing that during challenging economic times, county governments face difficult decisions regarding how to meet the increased demands for human services, the Foundation is looking to support positive and workable solutions for human service delivery to the most vulnerable communities throughout western and central New York. The Foundation is especially interested in providing support for projects that contain many of the principles of No Wrong Door or Integrated Service Delivery projects. These terms are differentiated in the following way:

- ***No Wrong Door (NWD)*** programs seek to attain a seamless and fully integrated system for delivering social services to a targeted population, and often include case management as a key element in which services are coordinated for individuals and their families. This type of service delivery is based on the principal that all people should receive services that address the full spectrum of their issues regardless of which county department they enter (i.e. services can be obtained via any door or entry point- there is no wrong door).

- ***Integrated Service Delivery*** projects are consumer-driven business models with a system of care approach to service delivery. The goal of integrated health and human services systems is a coordinated system that works for the consumer, produces positive outcomes, and reduces costs to governments while maintaining or enhancing service delivery.

In order to make a qualified judgment on the feasibility of supporting counties' future efforts to redesign their human service delivery system, the Foundation commissioned NYSAC to conduct a study on this issue and to report its findings. As part of the feasibility study, NYSAC:

- Created and designed a survey to gauge county interest in human service redesign;
- Reviewed the national landscape with regards to other states' efforts to redesign their human service delivery system;

- Reviewed New York counties' efforts to redesign all or parts of the human service delivery system; and
- Provided recommendations and conclusions on the feasibility of supporting county efforts to transform the delivery of human services to residents.

Project Summary

Methodology
As part of this feasibility study, NYSAC:

1) Surveyed counties on their past, present, and projected human service delivery efforts;
2) Explored two county efforts to streamline human service delivery programs; and
3) Researched three efforts undertaken in other states.

County Survey
NYSAC worked with the Foundation to design a survey that would effectively obtain information regarding counties' efforts related to the delivery of human services to their residents. The survey attempted to determine:
- County efforts and experiences with regards to human service delivery;
- Counties' previous efforts to streamline human services; and
- Future plans by counties for human service redesign.

In July 2012, NYSAC sent the online survey instrument to county executives and county managers of all New York's counties except New York City, with 13 counties providing some level of response. It should be noted six of the responding counties were from the catchment area of the Health Foundation for Western and Central New York. Those six counties represent 37.5 percent of the Foundation's catchment area and therefore enabled a reasonable assessment of interest and feasibility.

National Redesign Case Studies
This feasibility study includes a review of No Wrong Door or Integrated Service Delivery type projects that have been developed and implemented in other States. The review include the states of Washington and South Carolina, and Humboldt County, California because they redesigned their human services delivery system in an attempt to address the existence of an uncoordinated, fragmented, and unresponsive system that often times failed to provide positive outcomes for the clients.

Brief highlights of the three projects are detailed:

- ***Washington State*** began the creation of their NWD project in November 2001, with the goal of combining the programs and services of a large organizational structure and designing a seamless and integrated system that would serve individuals and families with multiple needs.

- **South Carolina** began developing a NWD project in 2007 in an effort to transform its programs and services responsible for serving youths and their families and creating a family driven system of care.

- **Humboldt County, California** began developing an integrated health and human services program in 1999 that included merging six departments: social services, mental health, public health, employment training, veterans' services, and public guardian. The goal was to develop a holistic administrative and program structure that reduced fragmentation and facilitated integrated service delivery.

New York State County Case Studies

To help determine the feasibility of supporting county efforts in redesigning human service delivery by developing NWD or integrated services delivery projects, this research reviewed some efforts counties in New York State have already undertaken to redesign aspects of human service delivery systems. This research focused on two projects implemented by counties. Brief highlights of these projects are below, with a more detailed review provided later in this report.

- **Nassau County,** under the leadership of the County Executive in 2002, set about changing its service delivery system and developed a NWD project that provided existing social service programs in a coordinated manner while achieving improved outcomes for the clients.

- **Monroe County** also set out to change their service delivery system, but focused the redesign on services to seriously emotionally disturbed (SED) children, youths and their families. Modeled after the Federal Child and Adolescent Service System Program (CASSP), Monroe County participated in the State funded Coordinated Children's Services Initiative (CCSI).

Results and Findings

Research conducted as part of this feasibility project revealed a wealth of information that will help the Foundation gauge the feasibility of the Foundation supporting county efforts to transform some or all of their human services by developing a seamless and integrated delivery system.

Analysis of the survey responses revealed that more than 60 percent of the *responding* counties are considering or have considered redesigning the delivery of human services. This rises to 83 percent of counties in the Foundation's catchment area that responded to the survey.

Furthermore, survey responses reveal that when the issue of financial support was included as part of the deliberation process, the number of counties expressing interest in redesigning their human service delivery system increased to approximately 90 percent, with approximately half indicating they would need full outside financial support in order to implement a redesign project.

Research on the national case studies found that while projects were initially designed to provide selected program services for targeted populations, the positive outcomes resulted in expansions to include other programs or populations.

The redesign projects that took place in New York State achieved varying degrees of success, and they could serve as examples for other counties that might be interested in their own redesign.

Introduction

State and local governments often cooperate in planning as well as funding services that affect the everyday lives of their residents. One of the major spending categories for governments is human services, a group of services that often encompasses public assistance, health care, mental health, and child welfare services. The goal of these services is to improve the well-being of individuals and their families.

As is often the case with government functions, human service programs are vulnerable to the ebb and flow of economic conditions. During tough economic times of higher unemployment and/or reductions in available fiscal resources, state and local governments are faced with higher demands for human services and, ironically, fewer resources to fund them. In addition, the populations being served tend to have multiple and costly service needs. In order to meet the demands of service requests the agencies often provide a band aid approach to service delivery that treats the symptom of the illness instead of the disease. In other words, if a client enters a government office because they are homeless, the service provider may find them shelter without ascertaining why the client is homeless. Many times, clients are eligible for multiple services but subject to differing program eligibility criteria, program workers lack knowledge and are not able to access available assistance across the human services spectrum. Human services are often times provided in a disjointed and uncoordinated manner resulting in frustrated clients and/or poor outcomes. The lack of a comprehensive, coordinated approach can have clients re-entering the system multiple times for additional governmental services.

The current economic environment has highlighted the need for state and local government officials to address the challenges of increased demand for human services while government resources dwindle. To this end, government officials are encouraging greater efficiencies among agencies by supporting the development of projects that strive to increase coordination of services, foster collaboration among agencies that often have a shared clientele, and improve outcomes, while hopefully providing efficient allocation of scarce resources.

The Health Foundation for Western and Central New York

The Health Foundation for Western and Central New York, founded in 2002, is an organization dedicated to improving the health and health care of the people of western and central New York. The Foundation, in collaboration with community partners, support services and programs that strengthen the health care system, bolster community supports, promote education and advocacy, and encourage individual behavior change of frail elderly and children ages birth to five living in communities of poverty.

The Health Foundation, in an effort to support workable solutions to the counties' challenges of continuing to provide quality services to the most vulnerable members of the community, commissioned NYSAC to conduct a study on the feasibility of supporting counties in western and central New York (*See Appendix A for List of Counties in the Foundation's Catchment Area),* in developing No Wrong Door or

Integrated Service Delivery types of demonstration projects. These two concepts, which have emerged during previous years, are similar in concept and design, focusing on coordinating programs with a goal of improving client outcomes. No Wrong Door projects are usually government-driven and include a case management element as part of the delivery design. Integrated Health and Human Services systems are often a community service-driven approach to providing coordinated services to clients.

What are No Wrong Door Programs?

No Wrong Door programs seek to attain a seamless and fully integrated system for delivering social services to a targeted population, and often include case management as a key element in which services are coordinated for individuals and their families. This type of service delivery is based on the principal that all people should receive care that addresses the full spectrum of their situation regardless of what type of service they present to or county department office they enter(i.e. there is no wrong door). This principal clarifies that the responsibility of providing for a range of health and social needs lies with the care provider where the client first seeks access to the public service system. It requires intake staff to provide care and/or facilitate access to service delivery that generally falls beyond their specific focus. It removes the onus on the client to negotiate among different services and providers, and thereby aims to reduce the incidence of people "falling through the cracks" of a complex service delivery system. No Wrong Door is a philosophy of public service that strives to give consumers access to services regardless of how or where they first encounter the public human service system. The ultimate goal of NWD programs is to improve access to care while decreasing rates of institutionalization. Some common traits of No Wrong Door programs include:

- *Multidisciplinary teams,* which are often responsible for developing integrated service plans, often consisting of various program staff, community supports, and clients and/or their advocates;
- *Integrated services plans* that are developed based on the clients strengths, needs and or risks;
- *Cross-training* of program staff to ensure general knowledge of all services and processes;
- *Coordinators or lead case managers* who are responsible for ensuring an effective delivery of services for the clients;
- *Monitoring and evaluation*, which is an important element in most NWD programs in order to ensure quality service delivery and desired outcomes are achieved. The monitoring and evaluation process enables leadership to make program adjustments if necessary;
- *Flexible use of funding* to assist the NWD program in providing all the services needed amongst the various programs, departments and or community services; and
- *Co-location* of multidisciplinary teams to improve access to services for clients and to encourage greater team/staff collaboration. The inability of a program to co-locate all the teams of a NWD program should not prevent the seamless sharing of information amongst team members.

[Texas Health and Human Services Commission: Case Management Optimization: Best Practices and Emerging Trends in Case Management, by Navigant Consulting].

What are Integrated Health and Human Services Systems?

Integrated Health and Human Services Systems are consumer-driven business models with a system of care approach to service delivery. The goal of integrated health and human services systems is a coordinated system that works for the consumer, produces positive outcomes, and reduces or flat lines costs to governments while maintaining or enhancing service delivery. Integrated systems are:

- Person centered;
- Self-directed;
- Services with easy access;
- One stop shopping environment;
- Strengths based;
- Care teams;
- Online navigators
- Seamlessly coordinated across systems; and
- Accessed more quickly by clients.

Human services integration is the process of developing seamless coordination between or among systems, departments, or programs. In other words, human service integration attempts to create a holistic approach to serving the clients, using an exchange of relevant data to link the clients with services and information across programs. Integrated service delivery aims to deliver coordinated types of care in a timely fashion taking into consideration the cross relationship of various programs and services.

Integrated systems usually produce benefits for both the clients and the government entity's financial situation in the long term. Furthermore, integrated systems are better able to respond to the clients' needs through prevention type services, which reduce the need for more costly and/or institutionalized types of care and results in better health and well-being of the clients. Some other benefits of integrated systems include reduced fraud and improper payments; improved operational efficiencies; and improved data systems that aid in decision-making and population-based service planning.

[Bridging the Divide: Leveraging New Opportunities To Integrate Health and Human Services: Cari DeSantis, Human Services Consultant: 2011.]

New York State Counties' Interest in Streamlining Health and Human Services Delivery

Summary

As part of this feasibility study, NYSAC worked with the Foundation to create a survey *(See Appendix B for Copy of Entire NYSAC Survey)* which was sent to county executives and county managers in all of the New York State counties outside of New York City in July 2012. This survey was designed to obtain information about county efforts related to the delivery of human services to their residents. Specifically the survey attempted to explore:

- Instances of increased demand for services during the State's financial difficulties and how the counties were responding;
- What efforts were made by the counties to streamline the delivery of human services;
- Instances of previously implemented integrated system or No Wrong Door projects, and
- Interest in participating in future projects designed to improve the delivery of human services to county residents.

After one extension, 13 counties responded to the survey. Of those counties that responded, six counties, or 37.5 percent, are from the Foundation's catchment area. While the overall response rate was below the desired target, the number of responses from the Foundation's catchment area was significant enough to make a reasonable assessment based on the outcomes of the survey.

Delivery of Human Services in New York State

As expected, counties' ability to provide human services is impacted directly by the state's own budget situation and general economic conditions. All of the counties that responded experienced an increase in the human services caseload between the years of 2009 and 2011. Increased pressure for counties to deliver human services resulted from unprecedented reductions in state fiscal support that had long been provided to help counties implement the state's social services programs.

Counties and New York City have lost more than $300 million in annual state financial support over the last several years due to state budget cuts. This is all set against a backdrop in which county government is expected to satisfy a property tax cap where growth is not to exceed 2 percent, or the rate of inflation, whichever is lower. As expected, all but one of the counties responding to the survey indicated that the state's financial difficulties and the increases in their respective caseload were affecting their ability to meet the demand for human services.

Due to this environment, counties are being forced to examine the services provided in order to make a determination on whether or not administrative changes are necessary. Since counties have little control over eligibility or benefits provided to recipients under the state's health and social services programs, counties have looked for efficiencies on

the administrative side. According to the survey responses, all but one county (92 percent of the respondents) stated that they had considered alternative methods for providing services to their residents. As part of this internal review of service delivery to residents, some of the alternatives considered included:

- Contracting with community-based programs to provide services that were traditionally provided by the counties;
- Merging departments and functions to achieve efficiencies;
- Developing an eligibility system that would integrate with the New York State WMS system, thereby allowing workers to accurately complete applications for any program area;
- Establishing a shared resource process based on a merger with adjoining counties within a region;
- Developing a Single Point of Access process or some other integrated process for a targeted population, such as mental health or criminal justice clients; and
- Cross training among agency workers and reassigning of duties among the various streamlined agencies.

Counties' Previous Efforts to Streamline Human Services
The survey also attempted to determine if the counties' consideration for service delivery redesign included developing No Wrong Door or Integrated Services projects. More than 40 percent indicated that they had developed and implemented similar projects, with the respondents indicating that the goals for their project were to achieve operational efficiencies and more client-centered approaches to service delivery. One county did not classify their redesign efforts as either a No Wrong Door or Integrated Services project, but instead stated that their project was a computer systems redesign that included obtaining or developing new software that assisted workers in the benefit eligibility process for multiple programs and services. This system was to include case management software that encompassed task assignment, monitoring, and performance based report capabilities.

Review of the other responses revealed common themes among the counties' efforts to redesign their service delivery system. The approaches centered on providing coordinated services for a targeted population, achieving efficiencies by eliminating, if possible, redundant work processes, or improving service delivery to the clients thereby ensuring that clients were no longer shuffled from door to door or lost through a maze of paperwork or eligibility requirements. Some of the projects described by the counties included the following:

- Single Point of Entry projects designed for specific populations or services. For instance, some of the project designs focused on long-term care services or those clients of the mental health or criminal justice agencies.
- A No Wrong Door model, which was designed as a cross system unit that integrated child welfare services under the department of social services, the department of probation, and the department of community mental health.

- An integrated delivery system for juvenile delinquents and Persons in Need of Supervision (PINS), creating a one stop referral and intake approach through collaborative efforts of various departments and agencies including probation, mental health, youth bureaus, and social services; and
- Merging or combining several departments or agencies into one entity. Under this scenario, programs and services under the merged entities were streamlined, making way for effective coordination of services.

In addition to requesting information on the counties' efforts to redesign their human services delivery system, the survey solicited information on some of the barriers to project design or implementation that may have occurred as well as the outcomes that were achieved by the implementation of these projects.

When asked to comment on some of the barriers encountered during the development and implementation portions of their projects, common themes surfaced.

- *Funding* was cited by most counties as being a significant barrier. The lack of sufficient funding to acquire new information technology system updates, facility updates or pay for innovative services that may not fit into the traditional funding sources were challenges to project development or implementation.

- *Lack of support from New York State* was another major barrier encountered by many of the counties. Throughout the years, New York State created a bureaucratic environment that was resistant to change, and therefore did not encourage counties' changes to their care delivery systems. The responding counties cited instances where the lack of state support was apparent through the many state statutory provisions that prevented the implementation of coordinated delivery of services. For example, many of the eligibility criteria of programs and services differ from program to program and a client eligible for one type of service may not be eligible for others. Under such restrictions, developing a comprehensive and coordinated service plan was difficult, or provided limited improvement over the status quo. The lack of state support is also evident in the number state rules and regulations for the various programs and services. The tremendous amount of rules and regulations imposed by the state often prohibits progressive efforts by counties and creates resource "silos" that direct staff or available dollars to various programs and services, thereby reducing the potential for collaborative efforts among agencies.

- *Resistance on the part of local players* was another barrier encountered by the counties, during the development and or implementation process. Either this resistance came from local agency officials engaging in "turf issues" or from agency staff or union representatives concerned that implementation of new coordinated and collaborative projects had the potential for elimination of staff positions.

- *Unavailability of workload management systems* was a barrier identified by the county that was redesigning their human services computer systems. This county

indicated that the inability to obtain a workload management system with appropriate software prevented them from achieving their desired outcomes.

For those counties that indicated they had developed a No Wrong Door or Integrated Services type of project, the survey also sought information on the results of their projects. While a few of the counties felt that they were too early in their process to draw conclusions, most stated that they had experienced positive outcomes. The county projects were able to realize cost savings and increased efficiencies in service delivery. In addition, there was a noticeable improvement in satisfaction of services provided, with counties receiving positive feedback from clients, families and community partners.

Future Efforts for Human Service Redesign

The remaining series of questions in the survey gauged the level of interest among the counties in developing new No Wrong Door or Integrated Services types of projects. The results revealed strong support for redesigning human service delivery throughout New York State. In fact, more than 60 percent of the responding counties revealed that they are considering redesigning the delivery of human services. When reviewing the responses of those counties within the Foundation's catchment area, the level of expressed interest in developing new service delivery projects increased to approximately 83 percent.

Furthermore, when the issue of financial support was included as part of the deliberation process, interest in redesigning at least some aspect of county human services delivery increased to approximately 90 percent. Only one county indicated that financial assistance would not influence their decision to develop a No Wrong Door type project. When asked the level of support that was necessary for the counties to consider working on such a project the responses were split. Approximately half of responding counties said they would require full financial support while the other half indicated that the availability of matching funds would be a positive incentive. For those counties willing to match outside resources, some stipulated that they thought local buy-in of such projects is more likely to ensure project commitment after the original incentive funds are no longer available. When focusing on just respondent counties within the Health Foundation's catchment area, the required level of financial support changes, with two-thirds requiring full financial support.

Lastly, as part of the deliberation process it was revealed that many counties were considering redesigning service delivery systems for programs under mental health, aging and long term care, youths, housing, criminal justice, and public assistance. Interestingly, the more common program choices seemed to be mental health, aging and long-term care services, and public assistance.

Observations and Recommendations to Facilitate Reforms

The Impact of Continuing Economic Challenges and Demographic Changes will Weigh on Health and Human Service Delivery

The recent recession and continuing poor economic performance have resulted in state and local governmental entities facing many fiscal challenges, including declining revenues, large budget shortfalls and increased demand for human services. These conditions are widespread across New York and the forecast for future economic recovery is not expected to change in a significantly positive way for several years, possibly longer. An increase in the aging population, coupled with a weak labor market, will combine to form an increasing need for services while county government coffers continue to fall short.

A complicating factor for counties in New York is continuing state and federal budget distress, which means additional assistance is unlikely. In fact, it is a near certainty that future state and federal funding will not be enough to keep pace with increasing caseloads, and significant relief from federal and state imposed mandates is not expected.

This fiscal reality means that New York State counties can no longer rely on traditional responses to address the challenges they face. New York, like other states, must support efforts to streamline service delivery to residents. Counties must be provided with the necessary incentives and tools to develop and implement integrated systems of care that provide vital services in a collaborative, coordinated and effective manner. These efforts must go beyond just combining agency resources within county government and reach aggressively across political boundaries, while shifting the focus of service delivery from one that provides services after the fact, to one that intervenes earlier and tries to prevent the need for more intensive and costly services down the road.

Outside Influences that Could Facilitate Service Delivery Reforms

Along with the fiscal climate that could affect counties' decisions regarding human services redesign, recent Federal legislation, such as the Affordable Care Act (ACA), will play a major role in influencing reform efforts. The primary goals of the ACA focus on improving the delivery of health care in the United States. The U.S. Department of Health and Human Services (DHHS), through various guidelines and enhanced funding supports, is encouraging states, as part of their health care redesign, to consider developing interoperable systems that include eligibility and enrollment capabilities for human service programs such as TANF, SNAP, child care, child support, child welfare, behavioral health, long term care, and other support services.

In order to facilitate such integration among state systems, the DHHS recently enacted exemptions to funding rules that encourage leveraging ACA dollars to develop linkages between health and human services systems. This exemption presents the opportunity for states to obtain enhanced federal financial participation for their system redesign projects, including not just health, but also traditional human services components.

New York State has not yet committed to a firm timeline for the broader consolidation of health and human service technology and administrative systems, choosing first to concentrate efforts on streamlining health IT and administrative systems, with a general goal of bringing in human services at some future date.

While the ACA may eventually provide a comprehensive technology platform for an integrated health and human services delivery system throughout New York State, counties are still interested in undertaking a broader redesign of their service delivery models in use today even in the absence of a perfect technology solution. A key streamlining goal will be to ensure that any new service delivery models can easily "plug in" to any statewide technology system developed in the future, as well as adapt organizationally to the new overall structure.

Prior Efforts Can Provide a Roadmap for Future Efforts

Research conducted as part of this project revealed a wealth of information from other states that have developed and implemented No Wrong Door or Integrated Service type projects. Many of these projects were initially designed to provide selected program services for targeted populations, and upon positive results were expanded to include additional programs or populations.

In addition to the national perspective, research identified several service delivery redesigns that occurred in counties within New York State. All of these projects had common themes for development and implementation and achieved varying degrees of success. The common project development and implementation themes identified as part of the review of the national and state landscapes are below:

- Strong leadership of the project is vital to success. Leaders often set the tone of the project. On the other hand, lack of commitment makes it difficult to overcome resistance from other participants such as staff, community providers and even targeted clients. Strong leadership is also useful in engaging community support and participation.
- Clearly defined goals are critical. It is important that all participants are aware of the project's objectives and are working towards a common goal.
- Workgroups should consist of professional staff and representatives from the community who assist in all aspects of the project from initial design to the evaluation process. It is better to activate the workgroups as early in the process as possible.
- It is beneficial if the project design is focused and targeted. Project leaders should determine the nature and scope of the project, including the clients that will be served and how they will be served.
- Fiscal implications of a project design should be considered in addition to how and when various program funds would be used, other resources that will be necessary for the successful implementation of the projects, and how those funds will be obtained.
- Because most projects will encounter barriers, it is important that a process is established to allow for the identification of potential barriers and the solutions

to overcome as many of the identified barriers as possible. Categorizing the solutions to project barriers as either short-term or long-term is important. For example, if it is determined that computer systems updates are necessary, a short-term solution could be to purchase off-the-shelf software, while the long-term solution could be to create and obtain a completely new information system including software and hardware. It is also prudent, as part of this barrier identification process, to identify and explore any state statutes or regulations that could prohibit the successful implementation of the project be identified.

- Upon completion of some of the preliminary elements for project design, recommendations for the next phase of the project should be created. The recommendations for the project should include timelines for implementation, and, if relevant, the number of start-up sites.

- Every project should have an evaluation and monitoring process as part of the implementation phase of the project. As stated earlier in this report, evaluation and monitoring enables project leaders and/or coordinators to continuously review the project's progress in achieving the desired outcomes and, if necessary, institute corrective actions.

Survey Conclusion and Project Feasibility in New York State

It is evident that within New York State there exist opportunities for counties to seek changes to government operations, including the delivery of human services. The research conducted as part of this project revealed that other states, such as California, Washington, and South Carolina, have completely or partially redesigned their human services delivery system and created integrated systems that offer a coordinated approach to services, reducing the likelihood clients would become lost in a maze of confusing programs and services.

In addition to human service redesign projects implemented in other states, the research identified redesign efforts in select New York counties, such as Nassau and Monroe. Many of these projects could provide insight for other New York counties to follow as they consider comprehensive, or even partial, human service delivery redesigns. While not discussed in this study, there are also many other examples of successful service integration in New York and nationally, often on a more targeted service basis.

It is NYSAC's conclusion that there are significant opportunities to reform major health and human service delivery systems and that a number of counties in the Foundation's catchment area have a desire to pursue a more efficient and effective way to deliver services to those most in need. Details of the scope and duration of a project, along with the financial support that would be available from community partners, would have an impact on a county's interest and capacity to pursue reforms.

Additional Research on Human Services Delivery Reforms

National Perspective
As part of the feasibility study, a review of the national landscape of No Wrong Door or comparable projects implemented in other states was completed. Based on the review it is evident that, over the years, many States have designed and implemented projects based on a No Wrong Door or Integrated Services Delivery concept, with varying degrees of success. These include initiatives in Washington State, South Carolina and Humboldt County, California, which are reviewed in detail in this report. These NWD projects attempted to address uncoordinated, fragmented and unresponsive human services delivery systems that often times failed to maximize the use of ever-shrinking resources, or produce positive outcomes for the clients.

Washington State No Wrong Door Project
In November 2001, Washington State authorized the creation of one of the earliest and most comprehensive NWD projects. Designed to serve individuals and families with multiple needs, the project was based on a large organizational structure overseeing multiple agencies and programs serving several populations. Washington's NWD demonstration project was initially designed to focus on a target population that often required multiple, complex and expensive services from different agencies falling under the purview of the Department of Social and Health Services (DSHS). It should be noted that Washington's project served as the model for other states to develop similar programs.

The Department of Social and Health Services was created to provide State human service programs under one agency and often provides an array of services including food assistance, behavioral health, and medical assistance to children, families, vulnerable adults and seniors. The goal of this agency was to provide comprehensive assistance to clients with many and interrelated needs.

The underlying problems in Washington stemmed from long-time practices where DSHS staff became more specialized in specific program areas. As a result, separate program-funding streams emerged and different accountability requirements were established. This dynamic in providing social service programs resulted in separate and uncoordinated service plans for the same client. Service provision at DSHS became "a maze of eligibility doors, and encounters with various social/health providers with different perspectives who did not communicate with each other about the needs of shared clients."

Realizing that the model for providing services needed to be reformed, DSHS authorized the creation of the NWD Case Coordination Project. The goal of this project was to "more effectively and efficiently serve clients who have multiple needs and receive services from several administrations or program areas by increasing the ability of case managers and other field staff to plan and coordinate their services."

Project Design

Defining the Target Group/Client

Under the direction of the Secretary of the Department of Social and Health Services, the Research and Data Analysis (RDA) Division was given responsibility for overseeing the NWD project, which was to be both a research and a quality improvement project. The first stage of the project entailed selection of the target population that the NWD Case Coordination project would serve. Using available client data from fiscal year (FY) 99, staff of the RDA division determined that DSHS served more than 1,261,853 individuals, of which more than 10 percent of the clients received services under multiple programs of the agency. In other words, approximately 120,165 individuals were intensely shared clients. Upon completion of the data analysis, staff presented their findings and recommendations on the three shared client groups that should be selected for participation in the NWD pilot project. They recommended selecting the following groups:

- *Persons with multiple disabilities* - The members of this group often exhibited challenging behaviors and often have safety and placement concerns and/or crises. These clients were served by multiple programs under DSHS such as mental health, aging and adult services, alcohol and substance abuse, and developmental disabilities. According to information provided by RDA, approximately 24,913 individuals fell into this target population.

- *Troubled children, youth and families* - This targeted group included 92,733 individuals from 25,585 families in which at least one of the children received services from the child welfare or juvenile rehabilitation systems and some other family member received other services from DSHS.

- *Long-term TANF families* - This group included individuals and families that had been receiving TANF funding for at least 36 months. In addition, someone in the household also received another form of DSHS program assistance, including but not limited to disability assistance, mental health services, and juvenile or child welfare services. For this target population 8,728 individuals from more than 2,483 households were eligible for participation in the new demonstration project.

Developing the New Case Management System

Once the shared client groups were selected and approved for the pilot project, an executive committee, consisting of top managers of all DSHS program areas, was given $210,000 and six months to develop a case coordination system. The goal was to create models of care that provided services to the clients in an efficient and cost effective manner while improving client satisfaction with services.

With a target implementation date of January 2002 the NWD executive committee appointed three design teams, made up of experienced case managers and field staff, to be responsible for developing case management models for the three shared client types.

In addition, the executive committee appointed five resolution teams responsible for providing solutions to various issues as they arose from the work of each of the design teams.

As part of the next stage of the NWD project design, the teams conducted exhaustive research, reviewing information derived from: focus group meetings with shared clients; interviews with case managers and field staff; group discussions with regional administrators about past case coordination problems; and case coordination conferences in which the design teams met with other professionals involved in other integration type projects.

- **Client Concerns With Case Management Design**
  A review of the information gathered from the various focus groups and interviews with clients and staff revealed that there needed to be a cultural change within the organization in order to facilitate positive outcomes from their service delivery system. The various meetings revealed an organizational environment in which information about DHHS program and service rules and guidelines was not shared among the various agencies' staff or with the clients. There appeared to exist, the belief that too much information leads to over utilization of services. Over utilization of services by clients was to be avoided and withholding information would lead to less utilization of services.

  Another revelation by the participants of the forum regarded the lack of effective communication by the DSHS organization. Clients expressed frustration with the agencies' staff. Clients had difficulty gaining access to workers due to the workers' failure to respond to the clients. This lack of communication often resulted in clients being left with the impression that agency staff had very little if any respect for clients. Clients did not believe the agency staff wanted them to participate in the decision-making process when it came to services.

  Another concern with the organization's environment pertained to the lack of coordination among programs. Staffs from the various programs were either unable or unwilling to provide information on all of the available services the clients may be eligible to receive. It appeared that "the right hand did not know what the left hand was doing." Accessing different services, with different forms required, often on a frequent basis, proved challenging and frustrating to the clients. Clients also discussed the multiple locations to access various programs and services. While face-to-face interaction with agency staff was ideal, visiting multiple locations is challenging for some clients, especially the disabled. This type of service delivery system often serves as a deterrent for clients that need multiple services

- **Staff Concerns With Case Management Design**
  During the focus group and interview sessions, the design teams received valuable feedback from program staff of various agencies. Like the clients that participated in the forums, staff expressed concern with the lack of knowledge of the different program and service guidelines. Staff indicated that it was difficult to develop comprehensive and coordinated service plans if they were unaware of the eligibility criteria for all the programs under the Department's purview. The staff also expressed frustration with the varying utilization skills of the clients. In some instances the clients worked well with the agency staff and were diligent in following up with their service plans. In other instances the clients were challenging to work with and made developing a service plan with positive outcomes extremely difficult.

  The agency workforce was another issue that came up in focus groups. The Department was unable to retain quality professional staff for a significant amount of time. Staff turnover was high resulting in constant changes of the clients' caseworkers. Oftentimes clients would have multiple caseworkers over a 12-month period. Concern was also expressed with the inconsistent manner in which services are provided to clients. In some instances, staff was communicative and highly involved in clients' cases, while in other instances the staff did not appear very committed.

Setting Guiding Principles under the New Case Management System

After careful consideration of the workshops and interview feedback provided by both the DHHS staff and the clients, several core values were created and served as the guiding principles for developing the Washington State NWD Case Coordination project. These core values included:

1. Recognizing that DSHS was accountable to many stakeholders and must therefore provide comprehensive services to customers (clients) in a timely and efficient manner, while measuring customer satisfaction and program outcomes;
2. Creating a respectful environment by acknowledging staff and customer diversity, providing quality services in unique settings and supporting staff and their decisions to serve the customers well;
3. Providing flexible customer-driven, culturally-relevant services that respond to the needs of each individual and family;
4. Maximizing state and community resources available to the customers by working in multi-system teams to combine natural and professional supports and using the broadest definition of family and community possible; and
5. Maintaining a diverse and knowledgeable workforce that is respectful of the customers and supportive of their colleagues while working towards a positive change.

Determining Necessary Elements for Implementation

The three design teams working collectively and as individual groups began the next phase of the NWD project design. The next phase of the development process included the selection of key elements that would be included as part of the project. Using the information obtained from their research as well as the core values developed for the project, the design teams selected several key elements:

- *Multi-disciplinary teams* comprised of appropriate DSHS staff members, local organizations from the community, clients or client advocates, and customer or family supports. These teams would be responsible for developing integrated service plans and providing services that support the desirable outcomes for the customer. *(See Appendix C for examples of multidisciplinary team members)*

- *Client centered integrated service plans* would be developed by the multi-disciplinary teams at team meetings and based on the programs already available from DSHS. Specifically the service plans would be based on the clients' strengths, risks, and service needs and could include service objectives; duration; frequency and type of services to be provided; and who would be responsible for each of the stated actions.

- *Cross training* of staff is vital to ensuring service continuity and would be available at each of the demonstration sites. Staff would be available to ensure that members of the multi-disciplinary teams have an understanding of all of the services and processes to be provided to the clients. Under the project design, initial training would be provided to the multi-disciplinary teams as part of the startup of NWD, but as the project continued, periodic training of new staff would occur at regional locations.

- *Service brokers/coordinators* are staff members or contracted service providers with extensive knowledge of all programs who would be assigned the tasks of performing comprehensive client assessments including, eligibility determinations, assisting the clients in defining their service needs and utilizing the services offered. In other words, a service broker/coordinator would coordinate any joint planning and coordinated delivery of services for the client and, when necessary, convene or facilitate the functions of a multidisciplinary team. (See Appendix D for Coordination Flow Chart).

- *An information technology application* was an element the design teams considered vital to a successful care coordination project. In order to ensure that all team members had access to the most updated and relevant client information, including integrated service plans and required documentations, it was determined that an easy-to-use, internet-based application would be selected

- *Monitoring and evaluation of the project, including the service plans, services provided and service outcomes* is an element that is key to the successful implementation of NWD. This process would result in continuous assessment of the implementation of Washington's NWD project, ensuring that stated objectives are being achieved and allowing for adjustments when necessary. During the first year of the project the evaluators would be responsible for regular site visits to observe project operations. Those observations lead to reports detailing performances of each site, including the existence of any problems or issues that needed corrections. In addition, this project element included an outcome evaluation process, in which the established performance measures of the shared client groups was compared to the service outcomes of other DSHS clients with similar backgrounds.

In addition to the key elements that were considered vital to a successful No Wrong Door Case Coordination project, the design teams identified the project elements, of co-location of teams and flexible use of funding as desirable for the project but not necessary for its successful implementation. Details of these two additional elements are:

- Flexible use of funding, allowing multiple disciplinary teams to provide services to the project participants from all available resources. The teams were able to provide a variety of services to the clients as long as they adhered to the budgetary constraints and funding for services provided complied with the various programs' restrictions.

- Co-location of teams, entailing housing all members of the teams on one site in order to maximize productivity. This element facilitated improved communication and better working relationships among the workers and made it easier for the shared clients to access services.

Integration Constraints and Recommended Solutions

As is often the case in project design, challenges or obstacles to implementation can surface along the way. To the greatest extent possible efforts must be made to address these challenges during the design phase.

In Washington, once the design teams had completed development of the major components in the NWD project, the resolution teams were responsible for developing solutions to the various integration constraints identified by the design teams. The following project constraints and solutions were identified:

- *Lack of a common screening tool for multiple needs clients and their families.* In order to ensure effective coordination of services, the NWD project required client-centered integrated service plans that met all of the client's needs. It was determined that the best way to accomplish coordinated services was the creation of a common tool that identified all client

information, including past utilization of services, and allowed staff to perform intake and assessments. The recommended solution was a simple client registry form to be used for the initial project start-up. As the project continued, common screening tools were created as an assessment and screening mechanism for various DSHS services provided to the clients when they entered Washington State's human services system.

- *Lack of a shared consent form used by all project participants* prevented the agency from obtaining relevant client information and posed another constraint to the project. Without a common consent form, the teams were not authorized to provide various program services to participants. The resolution team recommended the creation of such a consent form. The Secretary of the Department of Social and Health Services authorized the shared form, which was then approved by the Assistant Attorney General.

- *Lack of cross-program knowledge among the members of the multidisciplinary teams* was another constraint. In order for the NWD project to achieve its goal of effectively providing services to clients, it was important that every member of the teams have knowledge and understanding of all available services and programs. Therefore, the resolution teams developed a process to achieve cross-program knowledge through on-site training. The training was held for the multi-disciplinary teams throughout the various regions of the state. During the start-up phases of NWD, part-time coaches were available to increase staff knowledge and skills at each of the project sites.

- *Information technology* is a key element necessary for improved communication and delivery of effective program services. The resolution teams, for both the short and long term, had to address several issues for information technology including the selection of appropriate software products, storage capabilities and the eventual building of a custom application system. In the short term it was recommended that the initial project sites avail themselves of "off the shelf" software products that had the desired features. For the long term, if it was determined that the pilot project would be expanded and a custom application system would be developed.

- *Flexible use of funding across program areas* was originally determined to be a desired but not necessary component for the successful implementation of the case coordination models. While the project could have proceeded utilizing the current program funding restrictions, the lack of funding flexibility became a project constraint that the design team felt needed a resolution. Therefore, the resolution team recommended the initiation of policies that would attempt to provide some funding flexibility when providing services.

- *Program restrictions on fund use* presented a challenge. For the short term, a process was established in which the teams identified programs and services

to be provided to clients, but program restrictions prevented the use of funds in a flexible manner. Teams and supervisors consulted with management and the budget division to find workable solutions. The long term solution entailed the gathering of data regarding instances when the ability to use funds in a flexible manner was needed. The information gathered led DSHS to address the barriers to flexible fund use either through seeking state statutory changes or through requesting a waiver process.

Project Start-Up

Upon completion of the design of Washington's No Wrong Door Case Coordination Project, a detailed report was submitted to the executive committee who authorized the next phase of the project. Beginning in January 2002 and based on the recommendations contained in the report, the Department of Social and Health Services authorized a demonstration project with between 6 to 12 start-up sites. Half of the sites were located in rural areas serving at least 50 clients and the other half were located in urban areas and served at least 100 clients. The demonstration project operated for approximately 3 1/2 years.

The design of the NWD project was based on the premise that no increase in program funds would be available and services would be provided within the current funding allocation. However, the Secretary of DSHS provided the new staff and financial resources necessary to implement the project over four years, from the period of July 1, 2001 through June 2005. The recommended allocation of $2.41 million (an average of $602,077 per year) was made available to support the chosen pilot sites with staff training, software development, intensive case management and the monitoring and evaluation of the demonstration project. (See Appendix E for a copy of project's implementation budget)

Finally, seven startup sites serving the three shared client groups were selected. The locations by shared client groups are detailed below:

NWD Work First
- Puyallup
- Seattle
- Spokane

NWD Troubled Youth
- Yakima
- Seattle

NWD Disability Crises
- Vancouver
- Wenatchee

Early Findings

The implementation of Washington State's No Wrong Door project began in January 2002 at the seven startup sites. Approximately nine months into the operation of the NWD startups the first evaluation was done. The evaluation was based on observations of the new operating procedures, input from staff participants in various focus groups, and interviews with program or agency staff and the community partners. Information gathered in the evaluations was reported to the Sectary of the Department of Social and Health Services (DSHS). In anticipation of a statewide expansion of the project, the

evaluation report on the early implementation of the NWD Case Coordination project, identified some initial successes, as well as challenges to the project implementation.

Major Achievements

Early findings from the evaluation report did find successes in various aspects of the Washington State project implementation at the seven startup sites. Highlights of these achievements include the following:

- *Better coordination among DSHS staff*- Six of the seven startup sites provided services in an improved and coordinated manner resulting in more satisfied clients who became more engaged in their case management. There appeared to be excitement about the program among the staff and the clients. There was improved communication, participating staff gained a broader perspective on the needs of the clients, and both the clients and staff were working together to achieve desired outcomes.

- *More complete service integration*- Recognizing that service integration was an important element of this project, the startup sites implemented a process that: utilized natural supports and community partners, achieved earlier detection of clients' multiple needs, provided earlier program intervention, and used a client centered and strength based approach to service delivery.

- *Better client outcomes*- Service integrated approaches resulted in clients who were more engaged and consistently supported by various members of the teams. In other words, better outcomes flowed from the clients' commitment to setting goals appropriate to their priorities and abilities, while working with the various team members on creating a single comprehensive plan of action. Based on client and staff interviews it was found that coordinated efforts by the client's team often resulted in better, safer, less expensive arrangements that served as a model for other clients in similar situations.

Challenges in Washington State

While the early findings for the implementation of Washington State's NWD case coordination project revealed many successes, the early evaluation identified some challenges to implementation. Some of the challenges to the implementation of the NWD project were:

- *Client resistance to participation* is often encountered with new projects and can affect its successful implementation. It appeared that the later in the service process the client was reached, or the more failures that clients were encountering, or the more issues that clients were experiencing, the more likely it was for clients to express hesitancy about participating in a new pilot program. In fact, some clients failed to show up for case meetings, or refused to participate in the program.

- *Staff resistance to participation* was another challenge in Washington's NWD project. The development stages of the project identified concern with the quality of staff and service delivery and the high turnover rate of professional staff. These concerns, difficult to address, carried over into the NWD project and resulted in the inability to enroll some program staff to participate in the project. It also created challenges for some sites in developing trust within the newly formed collaborative networks.

- *Inflexible funding* was an obstacle for the NWD project from its inception. Except for the project support dollars provided by the Secretary of DSHS, there was no additional funds for the startups. The inability of staff to redirect program dollars was seen as very problematic. It is commonly agreed that most case coordination programs are very labor intensive and therefore result in higher upfront costs to the agency, but the development of better service plans also results in program savings over the long term. The inability to redirect the anticipated long-term savings to other aspects of the project created a disincentive for staff to invest extra time. Funding restrictions prevented the cost savings from one program being used to fund alternative less costly services in other programs. This situation sometimes resulted in more costly services being provided to the clients or no services being provided at all, if specific programs had insufficient resources.

Further plans for Washington State's No Wrong Door Case Coordination

It appeared that successes to the implementation of Washington State's No Wrong Door Case Coordination project outweighed the challenges encountered. Therefore, the Secretary of the Department of Social and Health Services authorized the expanded and long term implementation of the project. In order to facilitate expanded and long term implementation, the DSHS created three service integration initiatives modeled after NWD.

In April 2003, the Secretary of DSHS issued a directive that No Wrong Door would become the "Coordinated Services Charter," modeled on the NWD Work First Startups. Under this initiative the various DSHS agencies and their staff, service contractors, and community partners provide services to clients in a coordinated manner without duplications. The goal was to create a single point of entry while integrating services and leveraging resources for clients receiving more than one DSHS program. Some of the components of this new initiative include earlier screening of multiple needs clients; developing partnerships with community organizations, and more "holistic" interventions.

Another initiative, the *"Family and Communities Together Initiative,"* was led by the agency's economic services unit and the children's administration. Together these two departments would attempt to collaborate with the individual communities with the goal of preventing people from becoming stuck in the system by maximizing resources that support prevention.

The third initiative created by the DSHS was the *"Medicaid Integrations Project,"* led by the agency's Medical Assistance Administration, Aging and Disability Services, and Health and Rehabilitative Services would focus on providing services for the frail elderly and disabled. Some components of this initiative include: using a single contractor to combine the delivery of long term care services, acute medical care, mental health, and chemical dependency treatment for a reduced cost; and a program to connect nursing home residents with doctors willing to make house calls.

These three expanded service integration initiatives demonstrate the Department of Social and Health Services' commitment to providing coordinated services of care to the most vulnerable populations of Washington State.

[No Wrong Door: Designs of Integrated, Client Centered Services Plans for Persons and Families with Multiple Needs. Washington State Department of Social and Health Services/ Management Services Administration/Research and Data Analysis Division: August 2001;]

[Early Achievements in Service Integration: What We Can Learn from No Wrong Door Startups: Washington State Department of Social and Health Services/ Management Services Administration/Research and Data Analysis Division: August 2003;]

South Carolina: No Wrong Door
Like Washington State, the leaders of South Carolina realized that the state's human services delivery system was fragmented and did not always achieve positive results for the clients. This ineffective and inefficient system of care was most evident in South Carolina's services to youths. The agencies responsible for providing services to the youth operated in silos, often resulting in gaps of services. The clients of "youth serving" agencies and their families were not receiving the most effective and coordinated types of care and many were falling through the cracks. It was determined that South Carolina needed a service delivery system that:

- offered increased access to care;
- included more family involvement in the design of service delivery; and
- improved the quality and competence of the workforce for those agencies that were responsible for serving the state's youth.

In an effort to address the service delivery issues for South Carolina's youth, the state leadership established the Joint Council on Children and Adolescents. In August 2007 the council was charged with transforming the way services were provided to youth and their families by creating cost effective and seamless systems of care using a No Wrong Door approach. The council was comprised of representatives from: South Carolina's departments of mental health, alcohol and substance abuse; juvenile justice; social services, disabilities and special needs; the Governor's Office of Continuum of Care; Commission of Minority Affairs; Behavioral Services Association of South Carolina; SC Faces and Voices of Recovery; Federation of Families of South Carolina; National Alliance of Mental Illness – SC; SC Primary Health Care Association; and two parents of children with serious mental illness.

Key Elements of South Carolina's No Wrong Door Project

As part of the project-design, the members of the Joint Council on Children and Adolescents developed several elements deemed vital to the successful implementation of South Carolina's NWD project. Details of the key elements of the project include the following:

- *The creation of an electronic common screening tool referred to as the Global Assessment of Individual Needs – Short Screener (GAIN-SS) -* This screening tool was used by all provider agencies as a mechanism for early identification of youths with substance abuse and mental health issues that required follow up services.

- *Workforce development-* In order to address some of the inadequacies of the agencies' workforce prior to South Carolina's implementation of NWD, ten core competencies for child and adolescent service providers were developed and served as the guide for the training curricula. These curricula served as the foundation to creating a cross-agency trained workforce. The ten core competencies of the curricula were:
  - Understanding childhood and adolescence substance abuse;
  - Understanding mental health issues;
  - Diagnosis of co-occurring disorders in children and adolescents;
  - Normal childhood and adolescent development;
  - Treatment knowledge for children/adolescents;
  - Screening, assessment and referral;
  - Crisis management;
  - Families and communities as partners;
  - Cultural competency; and
  - Professional and ethical responsibility.

The curricula for the service providers were established and implemented for the staff of provider agencies. The cross training of provider staff was primarily accomplished through a series of statewide webinars and served as the model to train the trainers of each provider agency.

- *Development of a family-driven system of care that fosters family involvement in service design-* The development process consisted of a team from the five adolescent-serving agencies reviewing various state policies and procedures to identify those policies and procedures that when implemented would result in a service delivery system that:
  - Improved access to information;
  - Provided youths and their families with the ability to make informed decisions; and
  - Valued the cultural and linguistic diversity of the youths and their families.

- The review process resulted in several recommendations that served as a guide for proposed changes to service delivery.

- *Monitoring and evaluation* performed periodically enabled the Joint Council to assess whether the project was achieving the desired outcomes or if adjustments to project design were necessary.

Preliminary Findings

In June 2008, South Carolina began implementing the No Wrong Door project based on the key design elements developed by the Joint Council on Children and Adolescents. The project was implemented at eight pilot sites to start. By 2009, NWD was implemented statewide.

During the early implementation stages of South Carolina's NWD project, the participating agencies used the GAIN-SS tool and screened more than 1000 clients. By September 2010 the total number screened was 5,595 and 91 percent of those screened had at least one positive indicator requiring treatment. The available data was further broken down to look at one full year of service provision under NWD. For the period for October 1, 2009 to September 30, 2010, the participating agencies screened 3,774 clients of which 89 percent were found to have positive indicators for treatment.

The analysis of the GAIN-SS data also revealed that during that period 40 percent of 1,518 of the clients screened were referred for services with more than half of those referrals being directed to alcohol and other drug abuse service providers, with the average wait for appointments being five days. The remainder of the referrals were directed to mental health providers. The average wait for appointments was four days. Using the information obtained from the GAIN-SS tool enabled NWD to coordinate needed services and link juveniles and their families with services designed to meet their needs.

In addition to an increase in the number of clients identified and referred for coordinated services, South Carolina's NWD project brought about other significant outcomes including:

- Better coordination among staff on behalf of the clients. Staff of the various agencies were better trained, which resulted in increased sharing of resources and knowledge;
- Expansion of NWD to provide family-driven services to other clients of the human services system including those individuals and families on public assistance; and
- Institutionalizing the Joint Council of Children and Adolescents. Legislation was enacted that made the council permanent and included its powers and duties in state statute.

As a result of the monitoring and evaluation process, the Joint Council determined that the project was successful in achieving its intended objectives of identifying barriers or constraints that were contributing to service delivery failures. This process provided the leadership with valuable insight on the project design as well as changes that would be necessary for future expansion. Some of the lessons learned by South Carolina's project leadership included:

- Establishing projects and/or programs with a narrower focus and fewer priorities;
- Ensuring more information sharing across the participating agencies;
- Developing a mechanism for creating a true buy-in approach by all of the participating agency directors; and
- Utilizing grant funding (i.e. federal funds or infrastructure grants) may require a longer implementation time, perhaps up to five years.

[No Wrong Door: an Initiative of the S.C. Joint Council on Children and Adolescents: Tidwell and Associates, Inc: August 2010.]
South Carolina Department of Social Services: Annual Accountability Report, July 1, 2010 – June 30, 2011, Fiscal Year 2010 – 2011: Lillian B. Koller, State Director: February 2012.]
[South Carolina's Child and Adolescent Infrastructure Grants: Ritchie Tidwell:]
[Public Mental Health in South Carolina: John H. Magill, State Director of Mental Health: 2011.]

Humboldt County, California
Humboldt County, California is a rural county located 250 miles north of San Francisco, with a population of approximately 135,000 people, including a large Native American community. During the 1990s, Humboldt County was a distressed county with a poverty rate two times higher than the state average, a median income lower than the state average, and use of various public assistance services that exceeded the state average. In addition, Humboldt County experienced a decline in their business infrastructure resulting in high unemployment. The economic stresses in the county caused the human services delivery system to be "taxed beyond capacity." Humboldt County's human services delivery system had become fragmented and ineffective, resulting in dissatisfied clients, low morale among the staff and many court actions filed against the county.

In an attempt to respond to the economic factors affecting Humboldt County, a group of community leaders and interest groups partnering with the Humboldt Area Foundation collaborated in identifying solutions to the infective and inefficient human services delivery system. The goal of the collaborative effort was to maximize the resources of the county-administered system by developing a new system of care that better met the needs of the residents. Important in meeting this challenge was creating a new vision to serve as the project's guiding principle. The leaders came up with these three guiding principles:

1. The goal of services provided was to help clients achieve health and independence through programs and services that were based on the client's strengths, needs and available services;

2. The focus of service delivery was shifted to prevention and early intervention initiatives, while intensive treatment was available when necessary;
3. The community was to share the ownership and commitment for health and human services with the non-profit agencies and the public.

Project Implementation - Phase I: 1999 to 2004

In 1999, the California Legislature enacted the County Integrated Health and Human Services Program (AB1259, Strom – Martin) and authorized the county to fund and provide services through an integrated delivery system. Under the provisions of the legislation, six departments were merged to form the Department of Health and Human Services (DHHS). Merged departments included social services; mental health; public health; employment training; veterans' services; and public guardian As part of this merger process the administrative infrastructure (information services; employee services; and financial services) for each department was moved to one location. The ultimate goal of the integration project was to develop a holistic administrative and program structure that reduced fragmentation and facilitated integrated service delivery.

As part of the project design and implementation, six key elements vital to an integrated human services system were identified:

- *Shared vision, goals, and principles of practice, responsibility and accountability for success* - This element was based on the premise of working in a collaborative manner. Everyone involved - staff, community providers, and even the clients- was supportive and knowledgeable of the objectives of the new service delivery model.

- *A culture of services focused on the whole person/family* - This element of the project required a change in how services were provided to the clients. In order to successfully transition to an integrated service delivery system they shifted from programs and services provided based on individual or categorical funding streams to a service model that includes a holistic approach, focusing on improved outcomes for the whole person or family. This element developed a service model invested more on prevention initiatives that, in addition to overcoming clients' problems, also prevented new problems from emerging.

  One of the ways that Humboldt County incorporated this element was by creating the "Three by Five Design." This concept included three service strategies of prevention initiatives, early intervention services, and focused treatment interventions for high-risk populations. These service strategies were aimed at five target populations: children, youth and families, transition age youth, older adults, and the community. The "Three by Five Design" helped change the culture of the agency to a client-centered service delivery system that focused on individual and family recovery, self-sufficiency, and well-being.

- *Integrated funding streams and shared resources* - Incorporating this element included an examination of all available funding to determine which of the

various program funds had the most limitations, which funding sources had the least limitations, and which funds could be used as a match for other sources of revenue. Integrated funding allowed DHHS staff to work together creating person-based outcomes facilitated by the flexibility that is inherent in combined resources. Finally, because DHHS was able to identify flexible funds, the agency was able to allow some of those dollars to serve as a match for other sources such as Federal dollars of private philanthropy dollars.

- *Reorganization of centralized and decentralized functions*- This process entailed an examination of all of the agencies' services and supports. As detailed earlier, it was determined that the agency's administrative infrastructure would be integrated and moved to one location. During this process, the leaders came to the realization that although service delivery should be integrated and centralized in more rural areas of the state such as Humboldt County, access to services was better provided in a non-centralized manner. In other words, the clients were better served by having access to services in multiple locations and through various means scattered throughout the county. These options included rural health clinic networks and community resource centers, or using mobile engagement vehicles that were equipped to provide a wide variety of services in those parts of the county where it was needed most. Providing access to centralized services in an appropriate decentralized manner encouraged service delivery driven by the needs of the community.

- *Community engagement and partnership*- Successful incorporation of this element into Humboldt County's service integration model required trust and commitment among the various stakeholders, including members of the community. Humboldt County developed plans and mechanisms to encourage collaboration among multiple agencies, centralized leadership, as well as resource and information sharing. This was a several-year process.

- *Quality leadership and appropriate leadership for each stage*- Throughout every aspect of the project, leaders set the tone and direction, serving as a positive role model as the community and the organization shifted to an integrated human service delivery model. In addition, leaders had to be able to access every aspect of the project and make determinations when changes in strategies were required. For the first stage of the Humboldt County project, community leaders were identified, trained and encouraged to work as the community transitioned to a new service-delivery system. As the project moved towards the integration stages, the leaders had to analyze programs and funding streams, develop organizational structures and operationalize the vision of the project even in an environment where change was resisted. Most importantly, the leaders had to maintain open and honest communication with all of the partners and stakeholders revealing both successes and failures of the development and implementation process.

Early Achievements of Phase I

In addition to creating a more holistic approach to service delivery by creating the Department of Health and Human Services through the merger of the six departments, Humboldt County's service integration project achieved several other accomplishments, including:

- During phase I of this project, Humboldt County began the process of partnering with community and family resource centers in order to improve access to services through capacity building throughout the community. During the period of 2004 to 2009 DHHS provided funding to six family resource centers.

- One of the results of AB1259 was the increased ability to fund sustainable services to seriously emotionally disturbed minors. Based on the desire to maximize the use of flexible funding, DHHS negotiated with the California State HHSA, Departments of Social Services and Mental Health to use wrap around funding to provide strength based services to minors placed in New Horizons Regional Facility.

- The passage of AB 1259 also provided the county with the ability to develop and implement a consolidated foster care placement review process. As part of the project, Humboldt County established an integrated placement team to ensure an enhanced foster care system review took place. The enhanced review was performed by a co-located and integrated team of professionals from DHHS, Probation, Education and other cooperating entities. Enhanced funding was made available to the team to serve SED minors.

- Building on the collaborative model included as part of the project design, DHHS developed a "consolidated Title IV-E" training plan package that would allow Humboldt County to increase revenue by claiming for previously unreimbursed staff and community trainings.

Project Implementation: Phase II: 2005 to 2009

This phase of Humboldt County's human services integration project authorized the expansion of the project. Phase II of the project was developed to assist in the continued transformation to a fully integrated human services delivery system for the three Department of Health and Human Services primary program areas of mental health, social services, and health started under Phase I.

Humboldt County continued its integration process by adopting a two-pronged approach with the goal of maximizing service transformation. The first part of the approach included continued centralization of administrative and program support services through co-location of major services. The second part of the integration approach centered on building co-located decentralized services for clients in partnership with community stakeholders.

As part of the transition to a decentralized process, Humboldt County developed new community partnerships such as resource centers, which are community-based agencies that are able to provide a variety of services to county residents. This decentralization process saw Humboldt County partnering with family and community resource centers located throughout the county to provide a host of DHHS service and support to those in need. (It should be noted that this partnership with the community family resource centers actually began during Phase I.) In other words, part of the implementation process for this phase centered around providing integrated services but in multiple locations (decentralization) depending on the needs of the residents. The type of services provided by the resource centers included parenting classes, food and clothing distribution, case management and counseling.

In addition to developing service delivery partnerships with community resource centers, county leaders instituted a "Rapid Cycle" process that would initiate the use of evidence-based programs. A "rapid cycle" process is a structured method that facilitates efficient changes within an organization, which in this case would be to utilize evidence-based programs that are measurable and outcome based.

Under this phase of the process, Humboldt County determined that they would focus programs for the population serviced by DHHS, the Probation Department, as well as those individuals and families included in the work plan for the California Mental Health Services Act. The Leadership identified six evidence-based programs to implement as part of this project phase:

- *Incredible Years* is a prevention program that serves parents with children between the ages of 2 -12 who exhibit conduct and behavior problems. The primary objective of this program is to prevent, reduce and treat aggression. This program began operating in October 2004 and until June 2010, various services were provided to 371 parents with 523 children;
- *Functioning Family Therapy* provides treatment for families with youths between the ages of 11-16 that are at risk of behavioral issues including delinquency violence, substance abuse, school conduct issues, and family conflict. This program also began operating in October of 2004 and through December 2010 had served approximately 230 youths;
- *Aggression Replacement Training* provides services and treatment for potentially violent adolescent youths 12-18 who have been placed in the North Coast Regional juvenile detention facility. This is a prevention initiative designed to work with adolescents and teach them to understand and replace aggression or antisocial behavior with positive alternatives. This program was implemented in February 2005 and through December 2010 approximately 235 youths participated in the program;
- *Family to Family* develops family resources and team decision making models for families with youths at risk of out of home placements. Working with the Annie E. Casey Foundation, the goal of this initiative was to improve the child welfare system in communities. This program has been in operation since May 2005 and has worked with many families in the decision making process when placement decisions needed to be made;

- *Parent Child Interaction Therapy* offers intensive treatment, providing improved parenting skills to parents of children 2-7 with behavioral problems. This program was launched in October of 2004 and until 2011 has served 43 parents with 39 children; and
- *Multidimensional Treatment Foster Care* provides foster care and after care services for youths 12-16. It should be noted that this program has been suspended pending the restructuring of Humboldt County's child welfare system.

Some Outcomes/Results

Based on the early findings, Humboldt County's integrated service delivery system transformation has met with more successes than failures and has had more opportunities for expansion. Humboldt County's integrated system has achieved the major accomplishment of improved outcomes for different residents of the county. Highlights of these improved outcomes include the following:

- A decrease of 8.5 percent from 2001 levels in the caseload for elderly individuals receiving In-Home Supportive Services. This is significant because the statewide caseload has increased by 70 percent during the same time period. It was determined that Humboldt County's integrated service delivery system maximized the used of flexible funding as well as an improved collaborative effort to more appropriately identify and enroll patients while monitoring the outcomes.

- Because of an integrated system that partnered child welfare, mental health and public health services, Humboldt County saw a dramatic decrease in group home expenditures. In fact, those expenditures have decreased by more than 72 percent since 1997. In addition, there was a noticeable decrease of 82 percent for group home placements of youths removed from their homes due to abuse and neglect.

- Humboldt County, which was the only county to obtain state funding to provide various mental health and substance abuse treatment for youths in local secure treatment facility, has seen a dramatic decrease in the number of youths that recidivate to juvenile detention facilities. Recent data from 2009 revealed that only about 22 percent of Humboldt County's youths who received the intensive treatment recidivated back to a secure facility. This is compared to the nationwide average of 50 percent to 80 percent of youth who are returned to a secure facility.

In light of these positive outcomes from Humboldt County's integration project, the leaders have decided to expand the project. The county plans to increase the number of community and family resource centers available throughout the county. Due to the positive outcomes achieved through some of the evidence based programs developed during phase II, the county began developing more integrated projects to serve more targeted populations including adults, older adults, and transition age youths.

[Humboldt County Department of Health and Human Services: AB 315 Integrated Services Initiative 2011-2016: Strategic Plan Update: Phillip R. Crandall, Director]
[Humboldt County Department of Health and Human Services: AB 315 Integrated Services Initiative 2007-2010: Strategic Plan: Philip R. Crandall, Director]
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County of Humboldt: Department of Health and Human Services: Evidence Based Practice (EBP) Systems Change to Insure Success: Rose Jenkins Conference, October 3-4, 2006]
[Humboldt County Department of Health and Human Services: AB 1881 Phase II Strategic Plan: Transformation Towards an Excellence Based System: Philip R. Crandall, Director]

New York State County Redesign Efforts

The No Wrong Door/integration projects that have been conducted in New York State tend to be more limited than those implemented in other states.

The integrated projects in New York State were either initiated by the availability of federal funding, such as Substance Abuse and Mental Health Services Administration (SAMHSA) grant programs, or by the county leadership's desire to address a void in their service delivery system.

While most of the projects from other states explored in this report set about to develop broad and sweeping changes, New York's examples focused on changes of a smaller scale. These projects consolidated or merged fewer programs or departments and focused on a narrower service population.

Nassau County and Monroe County both developed pilot projects that integrated services and offered some type of case management component to service delivery. The results of these projects were mixed.

Nassau County, New York

Social service delivery in Nassau County was heavily influenced by the historical ambivalence towards those in economic need. The process to obtain and maintain program assistance was cumbersome and complex, resulting in low participation in social service programs.

Furthermore, human services programs in Nassau County operated under programmatic and federal, state and local funding restrictions, which were designed to focus on the specific issues presented by the clients, rather than their other potential or actual needs. For instance, if a family was homeless, they were provided with shelter beds. If an elderly individual or veteran was hungry, then attempts were made to provide them with food stamps. No attempts were made to investigate the multiple

elements in these clients' lives that resulted in their situation. When other problems were identified, staff did not have the authority to intervene, especially since "moving beyond one's job title" was discouraged.

Recognizing that Nassau County's human service delivery system was ineffective, inefficient, and uncompassionate to the clients, in 2002 the county executive convened a workgroup consisting of the county's health and human service leadership, department staff, and community based organizations. This workgroup was charged with developing a No Wrong Door project that provided existing social service programs in a coordinated manner. The development of Nassau County's NWD project was guided by three key principles:

1. In order to achieve better outcomes for the clients while not increasing their problems, there must be a system that operates in a teamwork environment that is integrated, and interoperable.
2. There should be a single point of entry or one stop approach to service delivery.
3. It was necessary and important to create an environment where clients are cooperative and responsive to service designs. Coordinated services would be provided to clients in a compassionate and respectful manner.

Project Development: Phase I - 2002 to 2008

Beginning in 2002, using the guiding principles detailed above, the workgroup set about designing the NWD project, which included several key elements:

- *The creation of a new organizational structure* including the selection of the agencies that would participate in this project. This new organizational structure, vertical in design, included the following seven agencies: health; DSS; seniors; mental health/chemical dependency/developmental disabilities; youth board; veteran's affairs; and the office of physically challenged. A deputy executive was appointed to oversee its management.

- *Consolidation (co-location) of the seven agencies,* including infrastructure functions, into one site was another element of Nassau County's project. Prior to the development of this project, the seven departments were located in five separate buildings that had various structural problems, such as leaking roofs, asbestos and faulty electrical systems. Rehabilitation of those buildings would have cost Nassau County approximately $40 million. Therefore, a new state of the art facility was secured for this new organization. In September 2005, more than 1200 employees and all of the resources of the seven agencies, including the infrastructure functions such as accounting and finance, human resources and staff development, were relocated to the new building. The co-location enabled clients to access all the programs and services of the seven agencies under the same room.

  - During the consolidation phase of the project, a warm environment with a reception area for clients, a professionally staffed children's room, a library, information tables, and program activities, was created in the new building. Absent were barriers and Plexiglas partitions. Client meetings

took place in private booths allowing for interactions that were more compassionate and dignified. Safety of the agencies and staff was maintained by installing a sophisticated security system.

- In addition to the positive environment created at the new location, co-location of the agencies facilitated the implementation of a "One Stop Approach" to service delivery. Under such an approach, clients accessed all the programs and services of the seven agencies in a coordinated manner. This single point of entry design enabled the county to meet a continuum of needs for the clients by working in a collaborative manner.

- *Staff training* focused on improving staff proficiency in customer service, comprehensive assessments, interventions, and interviewing skills. These training modules included: "case of the week;" cross-training; quality teams; on site MSW programs; staff development; and internships from schools of social work, nursing, medicine, public administration, psychology, and business.

- *Information Technology* was a key element included as part of NWD. As part of the development of NWD the PATHHS (Providing Access to Health and Humans Services) system was introduced and was completed in cooperation with New York State. The PATHHS project enabled the collection and imaging of documents and tracked benefit eligibility information. This system eliminated duplicative functions such as data entry. With support from New York State, Nassau County purchased 700 personal computers and developed a web-based application with standardized e-mail for all health and human service agencies.

- *A quality management program* was the final element. This element served as the monitoring and evaluation process for all aspects of the project in order to ensure that NWD was being implemented in a manner that would achieve the intended results and, if necessary, institute changes that would better achieve the desired outcomes for the clients. This NWD quality management program included: quarterly management reports; client input surveys; client focus groups; and tracking systems to analyze and monitor traffic flow, client activities and interdepartmental referrals.

Early Results of Nassau County No Wrong Door Project

Nassau County's NWD project created a new environment within the health and human services agencies. Services were provided in a collaborative manner with staff from all the agencies functioning as part of a team on behalf of the clients. The analysis of the "NWD project and of service delivery outcomes since its inception revealed significant improvement in client outcomes as well as an increase in the number of clients served. These improved outcomes were accomplished without an increase in staffing. Some of Nassau County's NWD accomplishments include:

- The number of clients served by the agency increased by 174 percent between the years of 2006-2008;

- The number of referrals to domestic violence counselors increased by 47 percent when comparing the available data from September 2004 to August 2005 versus September 2007 to August 2008;
- The Behavioral Health Unit, established under this project, began assessing approximately 153 individuals per month;
- As of 2008, the time a family remained homeless was reduced by 46 percent;
- 73 children were diverted from the foster care system through the use of "family unification vouchers and housing support services;
- The number of Person In Need of Supervision (PINS) cases filed was reduced dramatically, from 25.9 percent of probation intakes to 4.2 percent of probation intakes.
- The number of available staff has remained stable, even with an increase in the client population, but the wait time for clients has been kept to under two hours;
- Client satisfaction increased from 69 percent in 2004 to 82 percent in 2009; and
- Savings of approximately $10,185 per caseworker and $666 per client.

Project Expansion Phase II: 2008 to 2009

Based on the success of the NWD project in 2008, Nassau County expanded the NWD concept to other areas of the community, established several DHHS outstations in community health centers and offered HHS services and programs in challenged local school districts. In addition, Nassau County identified those areas in the county in which residents most frequently applied for various services and programs offered under the health and human services agencies. The county created 10 interagency councils, comprised of collaborative representation of community providers such as hospitals; social service agencies; police; libraries; religious organizations; and the business community to provide services. The local councils collaborated to provide services to the most vulnerable of the community's population, while serving as a portal of care for the residents. The interagency councils established priorities and agendas that ensured the objectives of NWD and the needs of the community were met.

[No Wrong Door: Proving to Be the Right Solution: Pat Grace, the Westbury Times, Online Edition Friday August 18, 2006]
[No Wrong Door Technology Implementation: Executive Summary Nassau County, NY: Thomas R. Suozzi, County Executive and Mary R. Curtis, Deputy County Executive.]
[No Wrong Door: A Model for Bio-psychosocial Health Care in the 21st Century: Louise Skolnik, DSW, Professor Emerita, Adelphi University and Shelly Sechecter, APRN, BC, Division of Community Health Nassau County Department of Health.]
[Healthy Nassau Campaign: Great Neck Record: Opinion: July 6, 2007]

Monroe County, New York: Youth and Family Partnership

Project Description
New York State, like many other states, has a human service delivery system that is fragmented, inefficient, and ineffective. There is very little if any coordination among agencies serving the same clients and each agency has their own eligibility criteria, case management services, physical locations, program policies or funding services etc. Service delivery plans, if developed, are based on the availability of programs or services and fail to adopt a holistic approach, which would ensure that the most obvious and immediate needs of the client are addressed.

Responding to Federal initiatives supporting integrated service delivery for targeted populations, New York State established an integrative system of service delivery for serious emotionally disturbed (SED) children modeled after the federal Child and Adolescent Service System Program (CASSP). The goal of this federal initiative was to encourage the creation of local and community based programs that provided a coordinated child-centered system of care for seriously emotionally disturbed children.

New York State's initiative known as the Coordinated Children's Services Initiative (CCSI), was funded under the auspices of the New York State Office of Mental Health. It created multi-agency collaborative projects at the county level, whose goal was to reduce the number of institutional placements among children with emotional and behavioral issues through the provision of coordinated services to the children and their families.

The targeted population to be served under this collaborative project were severe emotionally disturbed children between the ages of 5-21 who were at risk of residential placements and had needs that cross the boundaries of several agencies. This initiative was based on the core guiding principles of: interagency coordination; integrated service delivery; flexible funding; services designed to focus on the unique needs of the children and their families; service planning that is based on the strength of the entire family; and service plans that are designed with the families input.

In addition, New York State's CCSI included a state leadership team comprised of decision makers from the seven agencies that collaboratively designed this project (Council on Children and Families, Division of Probation and Correctional Alternatives, Office of Children and Families Services, Office of Mental Health, Office of Alcoholism and Substance Abuse, Office of People with Developmental Disabilities and the State Education Department) and two family representatives. The primary responsibility of the leadership team was to assist the counties in their implementation efforts projects, including addressing the barriers identified by each of the counties.

Project Design Elements
Similar to other integrated or coordinated service delivery initiatives, New York State required county projects to include several key design elements including:

- *Decision-making teams* which consisted of professionals from various provider agencies and representatives of the client and their families. The teams worked in a collaborative manner and developed individualized community based plans that focused on the strengths of the child and the family. The ultimate goal of those plans was to keep the family intact by keeping the child in its natural environment.

- *A committee of county system leaders* comprised of local department heads, school officials, and a parent of an SED child. The committee was responsible for identifying and resolving cross system problems and coordinating services across all service systems. This committee was also responsible for identifying barriers, including regulatory and statutory, that may negatively impact the implementation of the project. The committee was also responsible for devising workable solutions to removing the barriers. For those barriers that were deemed statutory or regulatory in nature, the committee referred them to the state leadership team for a solution.

- *Flexible use of funds* was another critical component of the CCSI initiative. Flexibility in the way available funds were used enabled providers to meet the individualized needs of the children and their families by providing goods and services without the constraints of traditional funding streams. Flexible use of funds also provided valuable insight into the type of services and resources lacking in the community. Under the CCSI initiative available funds were used to support services in five major categories:

  - *Respite services* provided family members with temporary relief from the stress of raising a SED child. Examples of such services included child care during school vacations, services when a emergency situation developed in the family or even in home services such as youth "companions;"
  - *Recreational activities* designed for special needs children that required specialized staff was found to be lacking in the various communities. Flexible use of funds allowed for such opportunities as karate lesson, camp visits, and even dance lessons to be provided for children;
  - *Youth employment opportunities* were another of the categories that flexible funds were used on behalf of the child. Flexible funds were used to provide transportation, job coaches or even job stipends;
  - *Tangible services* were provided to SED children and their families. These funds were used to provide children and families with basic items such as food, clothes, shelter and utility assistance; and
  - *Mental health services* were also provided with flexible funds. While the Medicaid program supported mental health services it was limited in the amount of therapeutic care that was authorized. Flexibility in funding enabled providers to increase the intensity and duration of various mental health services.

The CCSI project also required counties to include an evaluation component. It was important to have clear documentation of the results of the project. The evaluation process included an identification of the desired outcomes of this initiative, the markers for success, and the measurement tools to be used. For the most part, the evaluation of the CSSI projects focused on four areas:

- Child and family functioning - Beginning at the initial intake stage and throughout the child's participation in the system, the child and families' ability to function in everyday life was monitored and assessed using various available instruments.
- Residential placement rates - Because a key goal for CCSI was the reduction of residential placements it was important that the evaluation process monitor those rates. The rate of placement and length of stay for children being served was reviewed over time to determine the trends in service utilization.
- Cost - Because the major reason for developing integrated or coordinated systems of care is the high cost of services, it was important to monitor the fiscal implications of the project. Review of data can help the project leaders determine if savings or cost avoidance occurred.
- The project needed to assess whether the child and family was satisfied with the service delivery. The level of satisfaction was determined through the use of a client survey instrument.

Project Implementation

New York State began working with counties to develop and implement an integrated and coordinated service delivery system using the core guiding principles of CCSI in order to reduce the number of congregate care placements for youths. New York State began the first phase of the project development by targeting those counties with highest rate of residential placements in proportion to the number of youths residing in the counties. For the selection process of phase I, New York State released a request for proposal (RFP) to the 21 counties that had the highest portion of residential placements in 1993.

Monroe County was one of the initial counties selected for Phase I of CCSI development and received approximately $358,996 in state funding. Monroe County was an ideal candidate for participation because it had one of the highest rates of youths placed in congregate care outside of New York City and Westchester County. In 1993, Monroe County had more than 470 youths placed in congregate care. Between the years of 1993 and 1998, Monroe County participated in New York State's CCSI project with mixed results. Available data reveals that the number of congregate placements varied from year to year with a low of 423 in 1995 to a high of 483 in 1998. This variation in the caseload trend for Monroe County is different than the caseload trends for the other seven counties that were selected for participation in Phase I of New York State's CCSI project. On average, the other seven counties experienced downward trends in their congregate care placements.

Project Review and Adjustments

In 1999, Monroe County still had the highest number of youths placed in congregate care outside of NYC and a foster care admission rate that was almost twice the rate of comparable counties in New York State. These statistics caused the leaders of Monroe County to review their child welfare delivery system. Review of the program revealed that Monroe County's services for SED children at risk for residential placement was still fragmented and still did not focus on the strengths of the children and their families. Monroe County continued to have a service delivery system in which residential care was easy to access and children tended to have long-term placements (2+ years). The shortfalls in Monroe County's child welfare system often resulted in inappropriate and insufficient services being provided to the children and their families. Monroe County established a leadership team, comprised of the directors and deputy directors of the county offices of mental health, probation and community corrections, social services, and the youth bureaus. This leadership team, working with representatives of Meridian Consulting Services, set about developing a more comprehensive and effective approach to service delivery for youths on the verge of residential placements. This initiative, called the Monroe County "Youth and Family Partnership" employed a cross system approach to service delivery.

Continuing to build on the core guiding principles of the CCSI project, the leadership team developed Monroe County's Youth and Family Partnership initiative. Under the principles of this initiative, children and families served would be:
- Viewed as active participants in the service planning;
- Allowed to participate in this initiative regardless of lack of willingness to participate in past initiatives;
- Provided services that are based on strengths of the children and families as identified in an individualized service plan;
- Provided coordinated services that ensured members of the families understood their responsibilities; and
- Provided services regardless of race, religion, disability or national origin.

The core principles established by the leadership team guided every aspect of the development and operation of the initiative. Consistent with the requirements of NYS CCSI project and other integrated service delivery systems, the Youth and Family Partnership initiative was a care coordination project that was designed to provide services to children with a mental health diagnosis and had a high risk of being placed into congregate care. The implementation of this project was done in two phases, with the first phase serving members of the target population (children under 16 with a PINS or JD adjudication). After 15 months, the youth and family partnership was expanded to provide services to the rest of the target population of SED children at risk of out of home placements.

The Monroe County Youth and Family Partnership initiative structure included care coordinators, staff members who had a cross knowledge of the programs and services under the various child services agencies such as mental health, social services, and probation. The care coordinators served as the primary staff responsible for ensuring quality service delivery to the families. Some of the duties of the care coordinators included:

- Developing an effective relationship with the families by learning about their culture, background, and circumstances;
- Arranging periodic team meetings with the children and their families;
- Working with the team in all aspects of developing an individualized service plan;
- Making referrals to the appropriate service entities based on the service plans;
- Monitoring the progress of the families ensuring that their plans, including any adjustments, are implemented; and
- Ensuring that the families are satisfied with the service delivery and outcomes.

Other elements included as part of Monroe County's initiative structure were:

- The creation of strength-based child and family teams comprised of family members, community providers, and other informal support systems. Working with the care coordinators these teams created individual plans that included an array of services that focused on the families' strengths rather than on the families' deficits. Periodic meetings were held with the families to track their progress ensuring the desired outcomes were achieved.

- Using the county's existing community networks, family advocates were available to provider peer support and assistance to families during their participation in the initiative. The family advocates also assisted in the transition to other community or natural supports.

- As demonstrated by various No Wrong Door or Integrated Services Systems of Care, the availability of flexible funding often plays a key role in ensuring that children and their families received the complement of services needed in a non-traditional manner. Monroe County's mechanism for incorporating flexible funding into the initiative was the development of a capitated rate for services. Using Medicaid and child welfare services funds, Monroe County developed rates of payment that covered the cost of all services provided, including care coordination, community services and supports, and also foster care services. If it was determined that the capitated rate paid for services was higher than the actual cost of all the services provided, Monroe County redirected those funds for the expansion of services or increased the number of youths participating in the program.

- The leadership team included an evaluation element as part of this initiative in order to determine the success of this project and whether adjustments were necessary for future implementation. The team identified several areas for which the outcomes would be assessed, including:
  - Cost of the initiative;
  - Out of home placements;
  - Types and lengths of services provided;
  - Child and family functionality; and
  - Satisfaction of the clients and their families

Results/Outcomes

The Monroe County Youth and Family Partnership began operation in early 2002, with an initial caseload of 25 children and their families and eventually the project was expanded to serve 100 children and families. Review of the available data and literature revealed that the implementation of Monroe County's Youth and Family Partnership created a foundation for future initiatives to offer coordinated systems of care. Specifically Monroe County created a system of care that resulted in improved family satisfaction, improved family functionality, and county cost savings. Finally, the project has a system in place that offered continuous quality improvements.

When reviewing the three-year evaluation results from some of the outcome data, the results appeared mixed and inconsistent. Under the categories of the Child and Adolescent Functional Assessment Scale (CAFAS), the overall functionality of the children and their families improved by 71 percent in year two, which was higher than the rate of 69 percent achieved in year one. By year three the total functionality rate dropped to 53 percent. When looking at the subcategories under the CAFAS such as schoolwork, community, substance abuse, and family social supports, year two had the highest improvement rate while year three experienced a decline in functionality improvements.

Family satisfaction, another area included as part of the evaluation process, revealed similar results as the functionality category. Year two had the most improvements in the subcategories with year three experiencing declines in the clients' level of satisfaction. For example, the percentage of families reporting improvements and families recommending the program from year two to year three went from 88 percent to 81 percent and 91 percent to 84 percent respectively. It should be noted that overall family satisfaction did increase year to year from 82 percent to 86 percent.

Fiscal implications, specifically the cost of the program, revealed some interesting results. Similar to the other outcome areas evaluated, year two seems to have had the most positive changes. The available data looked at per child per month cost for residential placements and program services. The monthly spending per child decreased from year one to year two. On the other hand the monthly spending for year three saw a decrease in monthly spending for Youth and Family Partnership services and an increase in spending for residential services. The monthly spending per child for residential placement was higher than in year one. Since one of the goals of the project was to reduce the number of out of home placements the results of year three seemed to indicate consistency issues with the implementation of the Youth and Family Partnership.

The evaluation of Monroe County's Youth and Family Partnership show that while integrated and coordinated systems of care produced some positive results, more challenges within the child welfare system remained. The implementation of the project did not adequately adjust family thinking or provide the right type of supports. Under the Youth and Family Partnership, there still existed an environment of separateness. Staff continued to work in a vacuum and there was insufficient collaboration among the

agencies and the teams. Monroe County residential placements remained high and the children and families still needed stabilization and focused intervention, which could include time away in residential placements.

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Appendix A: Counties within Catchment Area

List of Counties within Catchment Area of the Health Foundation for Western and Central New York

Western New York Counties
- Allegany
- Cattaraugus
- Chautauqua
- Erie
- Genesee
- Niagara
- Orleans
- Wyoming

Central New York Counties
- Cayuga
- Cortland
- Herkimer
- Madison
- Oneida
- Onondaga
- Oswego
- Tompkins

Appendix B: Survey of County Efforts to Streamline Service Delivery

Survey of County Efforts to Streamline Service Delivery

The New York State Association of Counties (NYSAC) is seeking data from counties that recently streamlined, or combined county departments (or offices) in order to improve efficiency in service delivery, while maintaining or lowering costs. We are primarily interested in gathering data in the area of health and human service delivery consolidation (including aging, substance abuse, mental health, etc.) We are also interested in knowing if your county would be interested in this type of restructuring in the future, or if you are currently considering this type of reform.

NYSAC, in conjunction with the Health Foundation for Western and Central New York, is working on a project to determine the feasibility of a "No Wrong Door" pilot project in select counties throughout New York State. While the initial phase of this study would focus on western and central New York, we are hoping that it could provide a useful template for other New York counties. Therefore it is important for us to gather statewide data from the counties. One of the major components of this feasibility study is a survey of the counties within New York State. NYSAC has developed this survey in order to obtain information on some of the efforts by counties to provide health and human services in a more coordinated and efficient manner, and to identify counties that are interested in a "No Wrong Door" pilot project. We recognize that time is a limited resource and we appreciate you taking time to complete this survey. Thank you for your attention to this important research.

If you have any questions about this survey please contact Dave Lucas, NYSAC Director of Finance and Intergovernmental Affairs, at (518) 465-1473 or at dlucas@nysac.org.

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✱1. The Need for Continued Government Efficiency

During difficult economic conditions, New York State counties are facing severe budget deficits and significant challenges in providing services to New York's vulnerable population. In addition, the State imposed property tax cap limits counties' ability to generate increased revenue to continue to provide many valuable and necessary local services for New York. As counties' resources continue to decline, they are faced with determining how to ensure the most vulnerable individuals and families continue to receive services in an effective and efficient manner. A few mechanisms for accomplishing efficiencies or effectiveness in service delivery being considered by States are "No Wrong Door" or "Integrated Health and Human Service Systems."

"No Wrong Door." This type of service delivery is based on the principle that all people should receive care that addresses the full spectrum of their "health issues" regardless of what type of service they present to (i.e. there is no wrong door). This principle clarifies that the responsibility of providing for a range of health and social needs is the responsibility of the care provider/service where the client first seeks access to the public service system. It requires services to provide care and/or facilitate access to service delivery that fall beyond their specific focus. It removes the onus of negotiating different services and providers from the client and thereby aims to reduce the incidence of people "falling through the cracks of a complex service delivery system." No Wrong Door" is a philosophy of public services that strives to give consumers access to services regardless of how or where they first encounter the system.

"Integrated Health and Human Services Systems." This is a fully integrated health and human services system that operates a seamless, streamlined information exchange, shared services and coordinated care delivery that is a consumer focused market place experience. This program is designed to improve consumer outcomes, improves population health over time, decrease poverty, increase employment possibility and bend the health and human services cost curve in an affordable direction in the future. Some key principles of an integrated system include: person centered individualized and integrated case management, care coordination, appropriate services available in natural settings, streamlined, data rich, and performance rich. The goal of an "integrated system" is a coordinated system that works for the consumer, produces positive results and reduces cost to the government. Unlike a "No Wrong Door" approach to service delivery, which is generally controlled and driven by government, an "Integrated Health and Services System" could be community service driven with support being provided by a

government entity.

The Health Foundation for Western and Central New York is an organization dedicated to improving the health and health care of people and communities of Western and central New York. This organization primarily focuses on services and programs that increase health capacity for the frail elderly and young children living in poverty. The Foundation, in collaboration with community partners supports programs and services that strengthen the health care system, bolster community supports, promote education and advocacy and encourage individual behavior change.

As mentioned, the Health Foundation is exploring opportunities to assist in the delivery of human services to the people and communities in western and central New York, with the hope that we can create a template for statewide use. The Foundation is hoping to obtain information on the level of interest that may exist among counties to develop and implement "No Wrong Door" pilot projects. For more information on the Foundation's work, see www.hfwcny.org.

General Contact Information

1. Name _____

Name	
County	
Title	
Phone	
Fax	
E-mail	

2. For calendar years 2009 and 2010, how has the average caseload for human service programs compared over these years?

◯ Increase

◯ Decrease

◯ Stable

3. For calender years 2010 and 2011, how has the average caseload for human service programs compared over these years?

( ) Increase

( ) Decrease

( ) Stable

4. In light of the current economic conditions that your county may be facing, are you having difficulties meeting the demands for human services types of assistance?

( ) Yes

( ) No

5. In order to meet the demands for human services types of assistance, has your county considered any alternative methods for providing services?

( ) Yes

( ) No
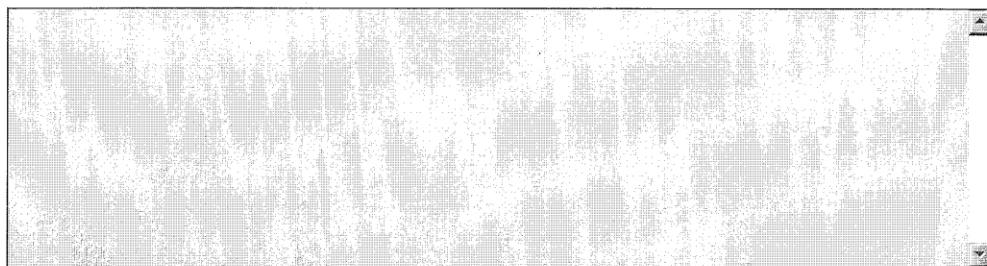
If yes, please describe

6. Has your county developed and implemented an integrated approach to providing health and human services?

( ) Yes

( ) No

( ) If yes, please describe your county's new integrated approach including which programs and services were included as part of this project.

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7. Was the development of an integrated (consolidated) approach in order to achieve operational efficiencies or to create a client centered approach for service delivery?

◯ Operational Efficiencies

◯ Client Centered Approach

◯ Both

8. Please provide details on any barriers that your county encountered as part of developing and implementing an integrated system. (i.e. staffing, training, union concerns, computer systems, availability of resources to research/develop/implement reforms).

9. Please provide details on the results experienced by your county's participation in an "INTEGRATED HEALTH AND HUMAN SERVICES SYSTEM"or "NO WRONG DOOR" project. (i.e. costs savings, increased efficiencies, impact on staff and recipients)

10. Did your county's participation in an "INTEGRATED HEALTH AND HUMAN SERVICES SYSTEM" or "NO WRONG DOOR" project require any additional resources to implement?

◯ Yes

◯ No

If yes, how much (approximate amount)

11. Has the county's experience and results been positive or negative? (i.e. for the county budget, staff, recipients)

12. Has your county considered or is currently considering developing an "INTEGRATED HEALTH AND HUMAN SERVICES SYSTEM" or "NO WRONG DOOR" approach to providing health and human services? (whether many areas or just two programs)

◯ Yes, (If yes please answer question 13)

◯ No, (if no please answer question 15)

13. If under consideration, which programs and/or services are you hoping to incorporate into this approach?

14. If your county is considering developing or implementing an intergrated systems of "No Wrong Door" project, Please provide details on an potential barriers that may be encountered as part of the development of such a project. (i.e. staffing, training, union concerns, computer systems and or availability of resources).

15. If some financial support was available, would your county consider participating in the developing of an integrated system or "No Wrong Door" project for the delivery of health and human services?

◯ Yes, if yes please answer question 16

◯ No

16. If your county would be interested in developing an integrated system or "No Wrong Door" project, please indicate the level of financial assistance that would be required?

◯ Full financial support that covers the full cost of the project

◯ Matching dollars (Specific percentage required)

◯ No assistance required

If matching grant, please include the percentage amount required to participate in such a project

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Appendix C – Washington Multidisciplinary Team Model

MULTI-DISCIPLINARY TEAM

COMMUNITY PARTNERS	NATURAL SUPPORTS	DSHS PROGRAM AREAS

HOSPITALS

FRIENDS

CHILD CARE   JUVENILE JUSTICE

UNIVERSITIES

NEIGHBORS   CHURCH

CHILD WELFARE   HEALTH CARE

HEAD START

EXTENDED FAMILY

SUPPORTS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

PARKS & RECS & YMCA

HOME & COMMUNITY SERVICES

PARENT TO PARENT CONSUMER NETWORKS

JOB SKILLS TRAINING

CHEMICAL DEPENDENCY TREATMENT

PUBLIC HEALTH

SCHOOLS

MENTAL HEALTH

BUSINESSES

JOB DEVELOPMENT

Appendix D – Case Coordination Flow Chart

NO WRONG DOOR: IDEAL FLOW CHART FOR CASE COORDINATION

Customer

Point of Contact

Benefits/Services/
Supports Provided
or
Exit the system

Screening
Broker*

Involuntary Contact
or
Engagement Services

Services
Coordinator*

*See next page
for visual
representation
of team
members*

Multidisciplinary
Team

Service Plan
Developed

Benefits/Services/
Supports Provided

Progress
and
Outcomes
Evaluated

Transition to
Ongoing Services
Or
Natural Support
Systems
Or
Exit the System

Appendix E – Washington State NWD Budget

Estimated Added Annual Staff Hours & Replacement FTEs by Program
(6 pilot sites, 150 new cases served each year per type of shared client)

Assumptions

A. First year startup "learning curve."
B. Second year less time is spent on case for first year cases.
C. Each year, a new cohort of clients is added.
D. No offsetting timesaving are assumed. All team time is regarded as "added" time.

LONG TERM TANF

	TANF	GAUX-SSI	Refugee	MHD	DASA	CA	DDD	DVR	JRA	AASA
Number of Cases in Rural and Urban Sites Combined	150.0	52.2	21.0	79.0	38.8	49.7	14.6	17.1	0.9	3.1
Total Additional Staff Hours Needed from Program	5850.0	1017.4	410.3	1540.5	757.0	968.2	285.5	333.5	16.8	60.0
FTEs needed to replace hours 100% Time on Task	2.8	0.5	0.2	0.7	0.4	0.5	0.1	0.2	0.0	0.0
FTEs needed to replace hours 70% Time on Task	4.0	0.7	0.3	1.1	0.5	0.7	0.2	0.2	0.0	0.0

TROUBLED CHILDREN, YOUTH AND FAMILIES

	TANF	GAUX-SSI	Refugee	MHD	DASA	CA	DDD	DVR	JRA	AASA
Number of Cases in Rural and Urban Sites Combined	81.5	51.3	0.8	90.4	60.4	146.2	18.3	8.3	12.9	4.2
Total Additional Staff Hours Needed from Program	1589.2	1000.5	16.5	1762.9	1178.0	2851.4	357.2	162.2	252.4	82.0
FTEs needed to replace hours 100% Time on Task	0.8	0.5	0.0	0.8	0.6	1.4	0.2	0.1	0.1	0.0
FTEs needed to replace hours 70% Time on Task	1.1	0.7	0.0	1.2	0.8	2.0	0.2	0.1	0.2	0.1

PERSONS WITH MULTIPLE DISABILITIES

	TANF	GAUX-SSI	Refugee	MHD	DASA	CA	DDD	DVR	JRA	AASA
Number of Cases in Rural and Urban Sites Combined	16.5	68.3	1.2	140.0	65.9	25.1	30.3	9.5	1.3	68.4
Total Additional Staff Hours Needed from Program	321.0	1332.0	24.3	5165.8	2395.7	979.9	591.4	185.4	25.8	2666.6
FTEs needed to replace hours 100% Time on Task	0.2	0.6	0.0	2.5	1.1	0.5	0.3	0.1	0.0	1.3
FTEs needed to replace hours 70% Time on Task	0.2	0.9	0.0	3.5	1.6	0.7	0.4	0.1	0.0	1.8

TOTAL FOR ALL PILOT TYPES AND SITES

	TANF	GAUX-SSI	Refugee	MHD	DASA	CA	DDD	DVR	JRA	AASA
Total Replacement FTEs 100% Time on Task	3.7	1.6	0.2	4.1	2.1	2.3	0.6	0.3	0.1	1.3
Total Replacement FTEs 70% Time on Task	5.3	2.3	0.3	5.8	3.0	3.3	0.8	0.5	0.2	1.9

The two FTE replacement rows in each description are alternate versions of the FTE impacts.
The first simply divides the total added staff hours by the number of hours in a full-time annual worker (2088 hours).
The second row divides the total added staff hours by the 70% time a fulltime worker spends working (1462 hours).

HEADQUARTERS SUPPORT FOR NO WRONG DOOR PILOTS

ASSUMPTIONS ABOUT SUPPORT NEEDS

Cross Training

- Two days training per year, for about 10 team members per site.

- One quarter time coach per site per year, to facilitate new coordination models.

- Two hours of training in first year, per customer.

Technology Applications

- Enhance Client Registry by adding family indicator, team notification of new services, and speedier updates. (1 FTE in Year 1, .5 FTE in further years).

- Purchase web-base software for team (includes basic license and user fees).

- One fulltime IT manager to maintain software and evaluate pilot site needs. (I FTE per year)

- Purchase 10 computers for community partners per year.

Headquarters Support

- Plan and coordinate implementation in Secretary's office. (1.5 FTE, project manager and .5 secretarial supports).

Evaluation and Monitoring

- Evaluate customer outcomes (satisfaction, effectiveness and cost savings for pilot versus comparison sites. (1.25 FTE and contracted programmer time).

- Conduct a process evaluation to describe implementation (1 FTE).

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Budget and FTEs for Headquarters Support

	7/1/01-6/30/02		7/1/02-6/30/03		7/1/03-6/30/04		7/1/04-6/30/05	
	$	man months	$	man months	$	man months	$	man months
Training	$102,800	0.0	$171,600	0.0	$171,600	0.0	$68,800	0.0
Information Technology	$202,063	22.8	$148,908	20.7	$153,402	20.7	$156,662	20.7
Headquarters Staff	$71,765	13.5	$104,633	18.0	$108,244	18.0	$111,189	18.0
Evaluation	$208,231	20.9	$229,677	27.8	$235,064	27.8	$163,668	17.5
GRAND TOTAL	$584,859	57.1	$654,818	66.5	$668,310	66.5	$500,319	56.2

DETAILED BUDGETS FOR HEADQUARTERS SUPPORT

NO WRONG DOOR (*TRAINING*) SIX (6) SITES JANUARY 1, 2002 - AUGUST 31, 2004

	7/1/01-6/30/02		7/1/02-6/30/03		7/1/03-6/30/04		7/1/04-6/30/05	
	$	Person Months	FY03	FY03 (MM)	FY04	FYO4 (MM)	FY05	FY05(MM)
Salary Class & Range								
Salary Total								
Benefits								
Benefit Total								
Miscellaneous								
ED - Rental								
EF –Printing								
EG - Training								
EQ - Equipment								
ER—Purchased SVC Contracts								
Contracted 2 day training	34,000		34,000		34,000			
contracted coaches	58,800		117,600		117,600		58,800	
contracted customer training	10,000		20,000		20,000		10,000	
EZ – All Other								
Surveys								
Interpreters								
G – Travel								

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	7/1/01-6/30/02		7/1/02-6/30/03		7/1/03-6/30/04		7/1/04-6/30/05	
*TE -RDA Cost REC (655 Per MM)								
TZ - ISSD Charges								
*CR Not Figured on Admin - Indirect								
Miscellaneous Total	102,800		171,600		171,600		68,800	
Grand Total	102,800	0.00	171,600	0.00	171,600	0.00	68,800	0.00

NO WRONG DOOR (*INFORMATION TECHNOLOGY (IT)*) SIX (6) SITES
SEPTEMBER 1, 2001 - AUGUST 31, 2004

Salary Class & Range	7/1/01-6/30/02		7/1/02-6/30/03		7/1/03-6/30/04		7/1/04-6/30/05	
	$	Person Months	$	Person Months	$	Person Months	$	Person Months
ITAS 4 (4771/4938/5086/5239)	47,710	10.00	29,628	6.00	30,516	6.00	31,434	6.00
WMS BAN 2 (5816/6016/6197/6383)	58,160	10.00	72,192	12.00	74,364	12.00	76,596	12.00
SEC SUPP 20% Time (2,586/2677/2752/2649)	6,206	2.40	6,425	2.40	6,605	2.40	6,358	2.40
*RDA Admin-Indirect	2,240	0.37	2,040	0.25	2,040	0.25	2,040	0.25
Salary Total	114,316	22.77	110,285	20.65	113,525	20.65	116,428	20.65
Benefits								
ITAS 4 (4771/4938/5086/5239)	10,717		6,793		7,154		7,267	
WMS BAN 2 (5816/6016/6197/6383)	12,004		15,179		15,950		16,225	
SEC SUPP 1/4 Time @2,586	1,926		2,049		2,171		2,141	
Benefit Total	24,647		24,021		25,275		25,632	
Miscellaneous								
ED – Rental								
EF –Printing								
EG – Training								
EQ – Equipment	42,000		5,100		5,100		5,100	
ER-- Purchased SVC Contracts								
EZ – All Other								
Surveys								
Interpreters								
G – Travel	4,000		4,000		4,000		4,000	
*TE -RDA Cost REC (655 Per MM)	8,122		5,502		5,502		5,502	
TZ - ISSD Charges								

*CR Not Figured on Admin--Indirect							
Miscellaneous Totals	63,100		14,602		14,602		14,602	
Grand Totals	202,063	22.77	148,908	20.65	153,402	20.65	156,662	20.65

NO WRONG DOOR (*HEADQUARTERS SUPPORT*)

	7/1/01-6/30/02		7/1/02-6/30/03		7/1/03-6/30/04		7/1/04-6/30/05	
Salary Class & Range	$	Person Months	$	Person Months	$	Person Months	$	Person Months
Pilot Manager (5531/5725/5897/6074)	46,440	9.00	68,700	12.00	70,764	12.00	72,888	12.00
SEC S 1/2 Time (2586/2677/2757/2840)	11,637	4.50	16,062	6.00	16,542	6.00	17,040	6.00
Salary Total	58,077	13.50	84,762	18.00	87,306	18.00	89,928	18.00
Benefits								
Pilot Manager	10,077		14,749		15,506		15,768	
SEC S 1/2 Time	3,611		5,121		5,432		5,493	
Benefit Total	13,688		19,871		20,938		21,261	
Miscellaneous								
ED - Rental								
EF - Printing								
EG - Training								
EQ – Equipment								
ER—Purchased SVC Contracts								
EZ – All Other								
Surveys								
Interpreters								
G – Travel								
TE – Cost REC								
TZ - ISSD Charges								
Miscellaneous Total	0		0		0			
Grand Total	71,765	13.50	104,633	18.00	108,244	18.00	111,189	18.00

NO WRONG DOOR (*EVALUATION*) SIX (6) SITES SEPTEMBER 1, 2001 - AUGUST 31, 2004

Salary Class & Range	7/1/01-6/30/02 $	Person months	7/1/02-6/30/03 $	Person months	7/1/03-6/30/04 $	Person months	7/1/04-6/30/05 $	Person months
PRJ Director (5160/5341/5501/5666)	46,440	9.00	64,092	12.00	66,012	12.00	67,992	12.00
RI 2 (K) (4428/4583/4720/4862)	39,852	9.00	54,996	12.00	56,640	12.00	9,724	2.00
SEC SUPP 1/4 Time (2,586/2677/2752/2649)	5,819	2.25	8,031	3.00	8,256	3.00	7,947	3.00
*RDA Admin - Indirect	2,025	0.61	2,700	0.81	2,700	0.81	1,700	0.51
Salary Total	94,136	20.86	129,819	27.81	133,608	27.81	87,363	17.51
Benefits								
PRJ Director	10,077		14,181		14,921		15,165	
RI 2 (K)	9,265		13,061		13,766		2,329	
SEC SUPP 1/4 Time @2,586	1,806		2,561		2,714		2,676	
*RDA Admin - Indirect	0		0					
Benefit Total	21,147		29,803		31,401		20,170	
Miscellaneous								
ED – Rental								
EF –Printing			2,000		2,000		4,000	
EG - Training								
EQ - Equipment	6,000							
ER—Purchased SVC Contracts	65,000		37,000		37,000		37,000	
EZ – All Others								
Surveys	3,000		3,000		3,000		3,000	
Interpreters	1,000		1,000		1,000		1,000	
G - Travel	4,685		9,370		9,370			
*TE -RDA Cost REC (655 Per MM)	13,264		17,685		17,685		11,135	
TZ - ISSD Charges								
*CR Not Figured on Admin - Indirect								
Miscellaneous Total	92,949		70,055		70,055		56,135	
Grand Total	208,231	20.86	229,677	27.81	235,064	27.81	163,668	17.51