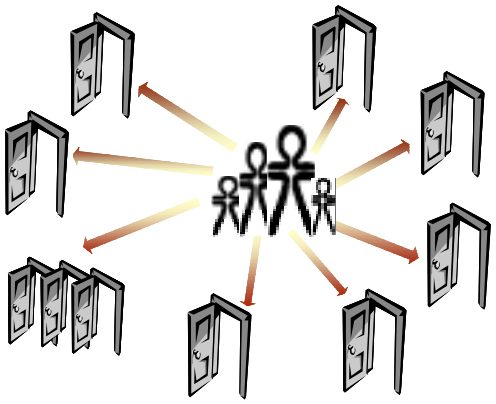
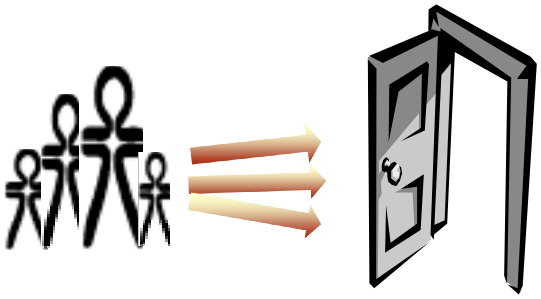


# No Wrong Door:
# Designs of Integrated, Client Centered Service Plans for Persons and Families with Multiple Needs



**August 2001**

*Washington State Department of Social and Health Services*
Management Services Administration
Research and Data Analysis Division

# No Wrong Door:
## Designs of Integrated, Client Centered Service Plans for Persons and Families with Multiple Needs

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August 2001

When ordering, please refer to Report 11.99

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*This project would not have been possible without the participation of the following persons:*

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# EXECUTIVE SUMMARY

## PURPOSE

The Cabinet of the Department of Social and Health Services (DSHS) created the No Wrong Door – Case Coordination Project in November 2000 to design integrated case coordination models for persons and families served by several different DSHS programs. The models were presented to Cabinet in July 2001 for approval, so that startup projects could be put in place by January 2002.

## TYPES OF SHARED CLIENTS

The DSHS Cabinet chose three types of shared clients and families, based on data from the FY99 Client Services Data Base. They were:

### PERSONS WITH MULTIPLE DISABILITIES

These clients often had challenging behaviors. They received services from two or more of the following DSHS programs: mental health (MHD), aging and adult services (AASA), alcohol and substance abuse (DASA), and developmental disabilities (DDD). In FY99, there were 24,913 people in this group.

- Over nine in ten used medical assistance (94%) and mental healthcare (93%).
- Almost five in ten received disability SSI or GA grants (46%), aging and adult services (46%), or alcohol and substance abuse treatment (44%).
- About two in ten used DDD services (20%) or children's services (17%).
- 11% used TANF grants, 6% used vocational rehabilitation services.

### TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES

These children and youth were defined in two ways. First, they could have received juvenile rehabilitation services from Juvenile Rehabilitation Administration (JRA) while also receiving child welfare services from Children's Administration (CA), a disability related grant (SSI or GAU/X), mental health or alcohol/drug treatment, or services from DDD or AASA. Second, they could have been members of a child welfare "family case" while at least one family member was also receiving services from juvenile rehabilitation, a disability related grant (SSI or GAU/X), mental health or alcohol/drug treatment, or services from DDD or AASA.

In FY99, there were 92,733 people in this group, grouped into 25,585 family cases. These Children, Youth and Their Family members used the following DSHS services:

- 94% used medical assistance
- 60% used mental health services and 54% used TANF grants

- 40% used alcohol or drug services and 34% used SSI/GA grants.
- 12% used developmental disabilities services
- 6% used vocational rehabilitation and 3% used aging and adult services.

### LONG-TERM TANF FAMILIES

These families had difficulty leaving TANF (36 months on the caseload) AND someone in the household had also received a disability related grant (SSI or GAU/X), mental health or alcohol/drug treatment, or services from CA, JRA, DDD or AASA. In FY99, there were 8,728 people in this group, in 2,483 household units. In these households, one or more members used the following DSHS services.

- 100% used medical assistance.
- About half (53%) used mental health services.
- About one in three received a SSI/GAU check or received AASA services (35%), and/or used child welfare services (33%).
- 26% used alcohol or drug services.
- About one in ten were refugees (14%), used DVR (11%) or DDD (10%).

## KEY ELEMENTS OF NO WRONG DOOR MODELS

Three design teams of experienced case managers and field staff, from all DSHS programs, met together for a week. Each team focused upon one shared client type, and contained staff from programs serving those clients. All three teams reached agreement on key elements that the "ideal" case management model should include in the long run.

The Design Teams greed upon the key elements after reviewing the evidence from:

- ***Focus groups*** of shared clients and their caregivers who talked about their experiences in receiving multiple services from different DSHS programs.
- ***Interviews*** with case managers and field staff about their perceptions of case coordination problems for particular shared clients.
- ***Group discussions*** with regional administrators about past case coordination problems.
- ***A case coordination conference*** where the teams met and interviewed professionals who had been involved in innovative, integrated case coordination projects in Washington and other states.

The key elements of the long-term case coordination model were:

- ***A multi-disciplinary team,*** comprised of appropriate DSHS program staff members, local community organizations, natural supports to the customer/family, and the client or advocate (when possible), to develop an integrated service plan.
- ***A client-centered integrated service plan,*** based on the client's strengths, risks, service desires and service needs.
- ***Cross training*** among the multi-disciplinary team, to insure a general understanding of each other's services and processes.
- ***A service broker/coordinator**** to coordinate the joint planning and coordinated delivery of services for the customer. *(*Note: a lead case manager may provide this function.)*
- ***Information technology applications*** that are secure and easy-to-use, to help the team communicate with each other about each shared client.
- ***Monitoring and evaluation*** of the service plan, services and outcomes to allow the team to make model changes, when appropriate.
- ***Flexible use of funding*** among the multi-disciplinary team to insure that the client receives services for which he/she is eligible.
- ***Co-location*** of the team to make it easier for the shared client to obtain services and to allow the multi-disciplinary team to learn to work well together. If co-location was not possible, the out-stationing of some service providers and the nearby office location of others could be tried.

The project's executive team, comprised of top managers from all DSHS program areas and chaired by the Deputy Secretary, reviewed the above key elements and recommended them for approval by the DSHS Cabinet. They specified clearly that two elements of the long-term model (flexible funding and co-location) were desirable, but not essential for startups.

## SHORT- AND LONG-TERM SOLUTIONS TO FIVE MAJOR INTEGRATION CONSTRAINTS

The design teams defined five areas where resolution was needed. The Cabinet appointed constraint resolution teams to recommend resolutions to five major areas of possible constraint to the startups. These were:

### A SHARED CONSENT FORM

The Deputy Secretary of DSHS requested that an existing DSHS committee, working on policies to disclose client information, work on developing a shared client consent form. This committee developed a form, which was finalized by the executive team, approved by the Assistant Attorney General, and became an official DSHS official form.

### CROSS-PROGRAM KNOWLEDGE

The training team recommended periodic trainings in regional sites for each of the core interdisciplinary teams in each of the startup sites. It also recommended part time 'coaches' for each startup in order to increase skills in staffing cases together and in developing common client centered plans. The executive team added a recommendation that DSHS develop and maintain web-based training materials.

### INFORMATION TECHNOLOGY TO IMPROVE COMMUNICATION

The information technology team recommended flexible, short-term solutions for the immediate startups: off-the-shelf software, providing a secure, Internet-based, e-communications "space" that supported document storage (such as the consent form and the common service plan) and threaded conversations for each client team. In the longer term a custom application might be developed if the startup experience warranted the effort and funds were available. This application would communicate with existing program-specific case management systems so as to avoid "double entry" of key information by staff.

### A COMMON SCREENING TOOL FOR MULTIPLE NEED CLIENTS/FAMILIES

In the short-term, the screening team recommended the use of Client Registry information on past service utilization, augmented by some program specific criteria.

The screening team also drafted a common referral form. In the long term, the team recommended that a common screening tool should be developed to assess and screen clients for multiple DSHS services when they were first served. To be useful, that tool would need to be acceptable to the various program areas and enhance cross-program referral validity.

### FLEXIBLE FUNDING ACROSS PROGRAM AREAS

The Budget Director proposed a three-step process to resolve funding difficulties. In the short-term, if such flexible funding was needed for specific clients and the authority was not available locally, teams would consult with their fiscal and program management. The Budget Division agreed to serve as the ultimate decision-maker, to resolve disagreements between those managers. In the long-term, waiver requests and/or requests for changes in state law might be necessary, after some experience had accumulated identifying areas where flexibility was needed and impossible due to legal constraints.

## RECOMMENDATIONS FOR THE NO WRONG DOOR-CASE COORDINATION STARTUPS

The executive team considered the five constraints and made the following practical, short-term recommendations for start up projects beginning in January 2002.

### NUMBER OF STARTUPS AND SITES

Six to twelve sites, at least one per region would be selected. Each type of shared client would have at least one urban and one rural site. Co-location was not required, but a single coordinating supervisor was recommended for each startup.

### SELECTION OF PERSONS/FAMILIES TO SERVE

RDA would provide startups with lists of the appropriate shared clients/families who in the prior year had been served by multiple DSHS programs in the particular site in the prior year. Additional criteria could be used by startups to narrow down those lists (such as difficult-to-serve, in crisis or in sanction).

### COMPOSITION OF MULTI-DISCIPLINARY TEAMS

Teams would involve the client and/or their chosen family members and advocates, all the DSHS case managers or providers serving these clients, and (if they agreed) community providers not funded by DSHS but also serving that client.

### CLIENT ROLE

Clients or their guardians would agree to participate on their teams if possible. Some client training was recommended, so that clients would know how to provide input in the plan. Clients would sign a consent form allowing most of their service information to be shared across the programs and among the community providers serving them.

### LEAD FOR THE MULTI-DISCIPLINARY TEAM

The lead might change over the anticipated two years service period, moving from one DSHS program to another or to a community agency, hopefully with active participation by the clients themselves. The executive team assumed that among the group with multiple disabilities, the mental health caseworker would lead, if mental health was involved, then aging and adult services, and finally developmental disabilities. For the troubled children and youth group, the lead case manager would be from CA or JRA. For long-term TANF families, the TANF case manager would lead.

### TEAM TASK

A client-centered service plan would be developed jointly at team meetings, based on client strengths and client input. Outreach and home visits might be useful. No new services would be developed.

### COMMUNICATION E-SPACE

Each team member would have access to a shared Internet-based communication space for that client. The common service plan would be posted there. Each team member would be able to easily post comments and actions taken on behalf of that client in that space, and to participate in threaded "e-conversations".

### LENGTH OF SERVICE IN NO WRONG DOOR

The executive team decided that it was likely that client teams would meet periodically for two years on average, more intensely the first year, less intensely the second year.

### FUNDING

Funding for services would be based on each participating program's restrictions. If the teams wanted to do something for a client that could not be done within existing funding constraints, they would raise the problem with their supervisors. If the supervisors could not find a solution, they would bring the problem to the fiscal managers in the program areas and ultimately to the Budget Division to find a solution.

### PROCESS EVALUATION AND MONITORING

A process evaluation was recommended, particularly in the first year of implementation in order to inform both local sites and central planners. An evaluator would visit each site regularly, observe operations and interview staff and clients, and write brief reports on how each site was implementing the model and what problems the site was encountering.

## OUTCOME EVALUATION

An *outcome* evaluation was also recommended. Outcome (performance) measures would be determined, the outcomes for startup clients would be compared to a group of similar clients from other places of similar urban or rural density but lacking startups. Outcomes would include client satisfaction, post-treatment usage, outcomes appropriate to each type of shared client, and cost of key DSHS and external services.

# PURPOSE OF THE NO WRONG DOOR CASE COORDINATION PROJECT

The Department of Social and Health Services (DSHS) Cabinet created the No Wrong Door – Case Coordination Project in November 2000 in order to develop case coordination models for shared clients.

Some DSHS clients and families have very complex problems and need assistance from different programs in DSHS and community agencies. For example, in FY99:

### PERSONS WITH MULTIPLE DISABILITIES

24,913 people received services from two or more of the following DSHS programs: mental health, aging and adult services, alcohol and substance abuse, and developmental disabilities.

### TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES

92,733 people were in families where a child or youth was involved with child welfare and/or juvenile rehabilitation services, while someone in that child's immediate family (this could be the child or it could be another family member) received other DSHS services. These other services were a disability grant or vocational rehabilitation services, or services from mental health, aging and adult services, alcohol and substance abuse, or developmental disabilities.

### LONG-TERM TANF FAMILIES

8,758 people were in families that received Temporary Assistance to Needy Families (TANF) for 36 continuous months, while someone in the household also received a disability grant or was served by vocational rehabilitation, was served by mental health, aging and adult services, alcohol and substance abuse, or developmental disabilities.

The 120,165 persons involved in these three types of shared services represented only about ten percent of the 1.2 million people who were DSHS clients in FY99; however, they needed many more services and support than the average client. The DSHS Cabinet believed that its separate programs, while serving the clients with one need reasonably well, were not serving multiple-needs clients, or "shared clients," effectively.

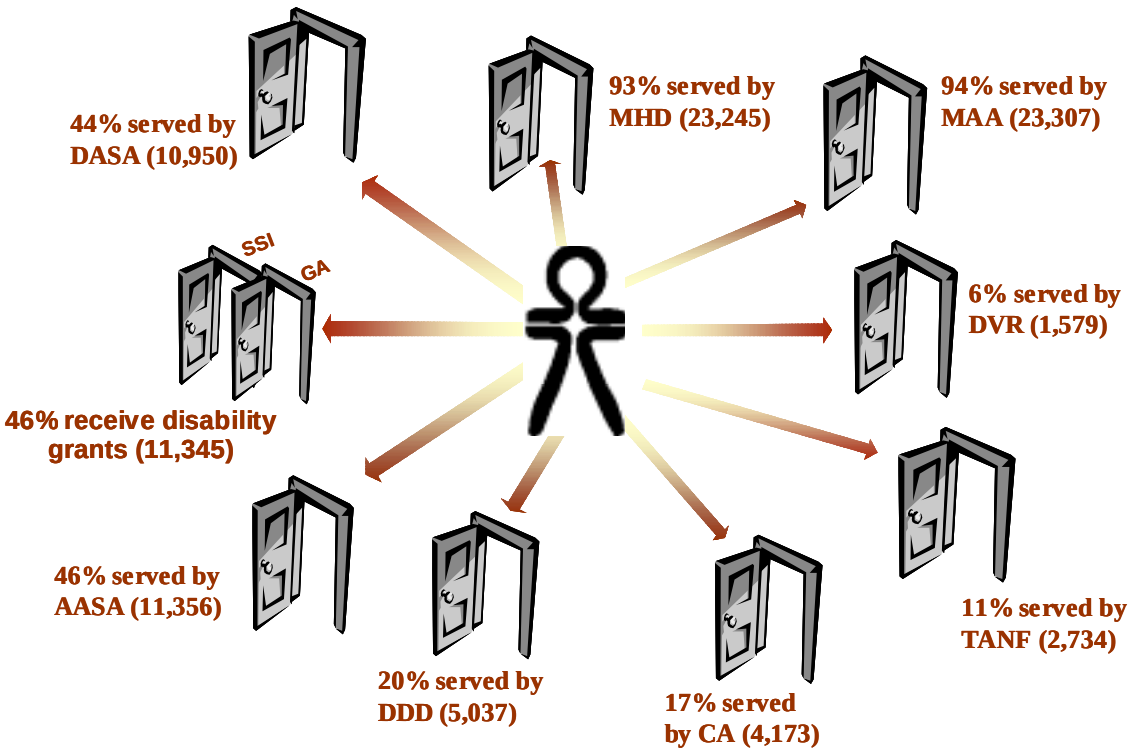
Therefore, in November of 2000, the DSHS Cabinet authorized a six-month project to design case coordination models to better serve the three types of shared clients mentioned above.

The project was housed in the DSHS Research and Data Analysis (RDA) Division. It was both a research project (using research data, rigorous information gathering and a search of relevant innovations implemented in Washington and other states) and a quality improvement project (using experienced frontline staff, experts in particular areas, professional facilitators and executive staff to design improvements). There were three design teams, five issue resolution teams, and an overall executive team of top managers.

The proposed models had two basic purposes:

- To improve the effectiveness and cost-effectiveness of services for shared clients.
- To improve client satisfaction with DSHS services.

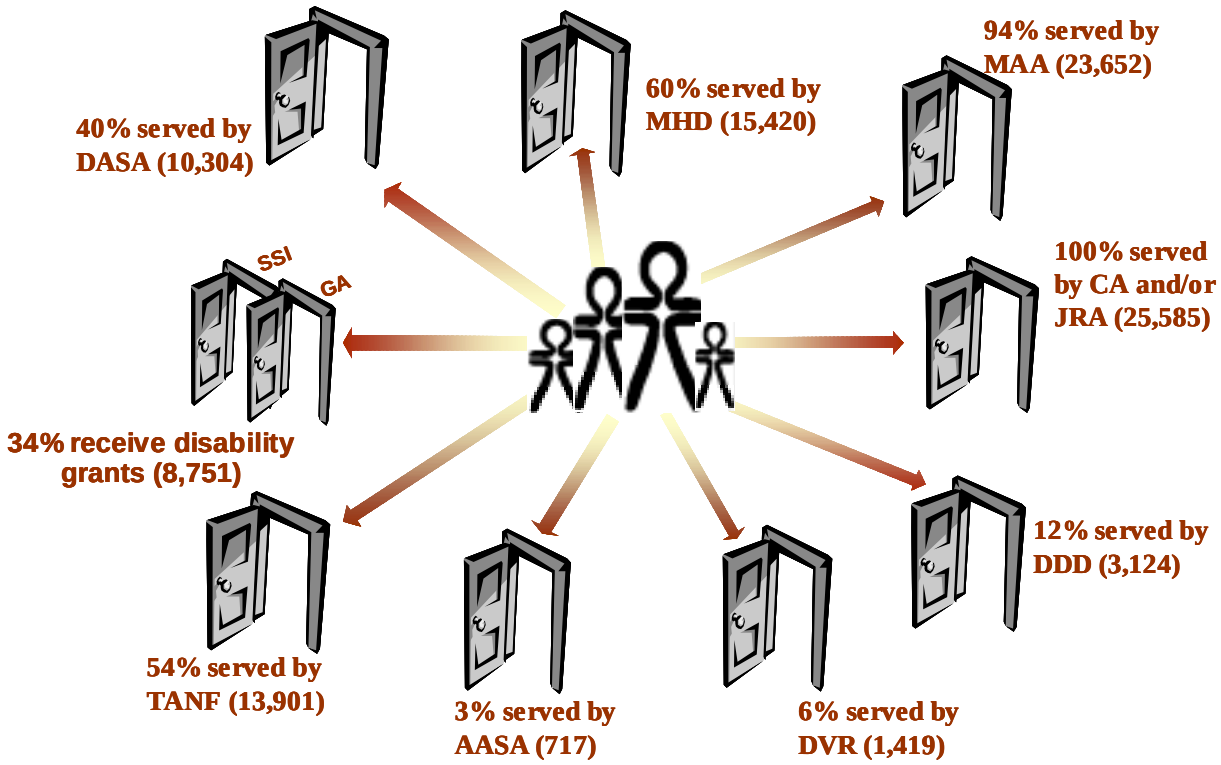
## Type 1: Persons with Multiple Disabilities (24,913 clients)




For Persons with Multiple Disabilities the services being accessed the most were:

- 94% medical assistance (MAA)
- 93% mental health services (MHD)
- 46% disability grants (SSI, GA)
- 46% aging and adult services (AASA)
- 44% alcohol and substance abuse treatment (DASA)

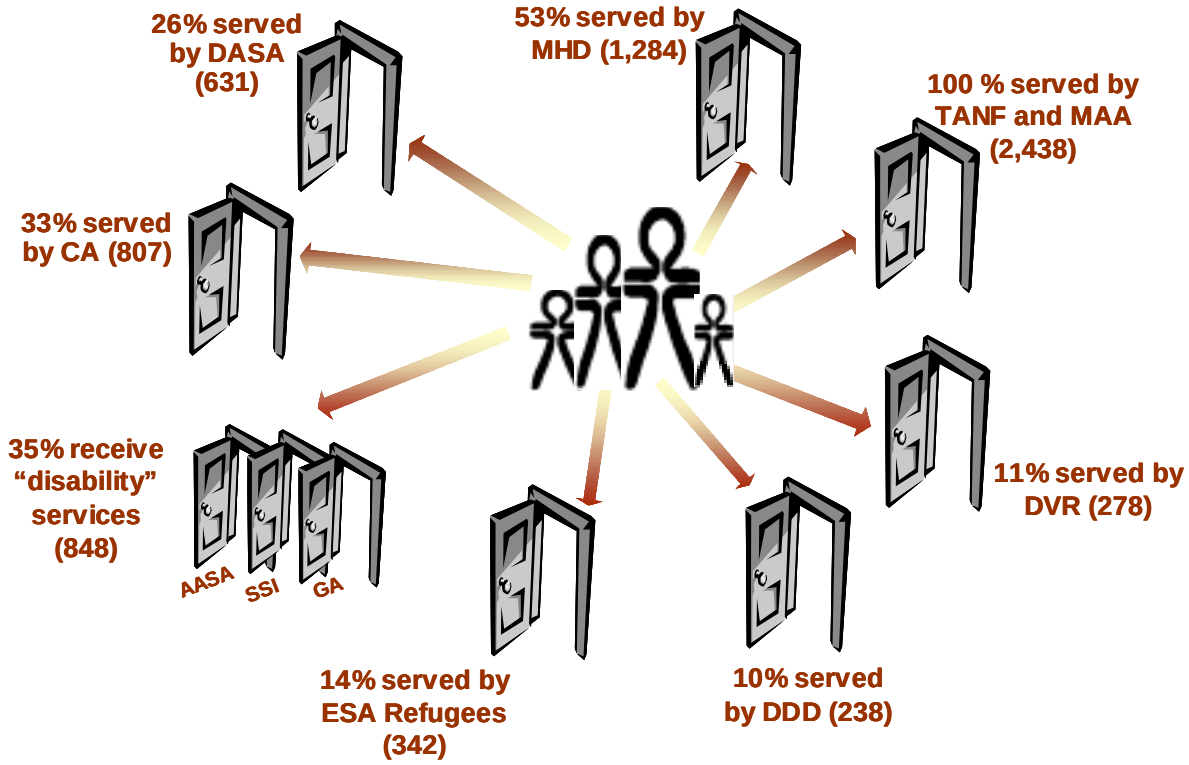
## Type 2: Troubled Children, Youth and Their Families (25,585 cases involving 92,733 persons)




Among Troubled Children, Youth and Their Families the services most received by one or more of the family members or individual youth were:

- 100% children's (CA) or juvenile rehabilitation (JRA)
- 94% medical assistance (MAA)
- 60% mental health services (MHD)
- 54% temporary assistance for needy families (TANF)
- 40% alcohol and substance abuse (DASA)
- 34% disability grants (SSI, GA)

## Type 3: Long-term TANF Families
## (2,438 "assistance units" involving 8,758 persons)




Among Long-Term TANF Families (families on assistance for 3 years or more) the other services one or more household members received were:

- 100% medical assistance (MAA) along with TANF
- 53% mental health services (MHD)
- 33% disability related services (SSI, GA, AASA)
- 33% children's services (CA)
- 26 % alcohol and substance abuse treatment (DASA)

# WHAT RECOMMENDATIONS WERE MADE TO THE DSHS CABINET?

## KEY ELEMENTS FOR NO WRONG DOOR STARTUPS

Agreement was reached on the essential characteristics that all No Wrong Door models should include in the long run. All but the last two were also recommended for the startups. The key elements of the long-term case coordination model were:

- ***A multi-disciplinary team*** comprised of appropriate DSHS program staff members, local community organizations, natural supports to the customer/family, and the client or advocate when possible, to develop an integrated service plan.
- ***A client-centered integrated service plan*** based on the client's strengths, risks, service desires and service needs.
- ***Cross training*** among the multi-disciplinary team to insure a general understanding of each other's services and processes.
- ***A service broker/coordinator**** to coordinate the joint planning and coordinated delivery of services for the customer. *(*Note: a lead case manager may provide this function.)*
- ***Information technology applications*** that are secure and easy-to-use, to help the team communicate with each other about each shared client.
- ***Monitoring and evaluation*** of the service plan, services and outcomes to allow the team to make model changes, when appropriate, and to allow RDA to accurately evaluate the impacts of the startups.
- ***Flexible use of funding*** among the multi-disciplinary team to insure that the client receives services for which he/she is eligible.
- ***Co-location*** of the team to make it easier for the shared client to obtain services and to allow the multi-disciplinary team to learn to work well together. If co-location is not possible, the out-stationing of some service providers and the nearby office location of others could be tried.

The design teams also created a common set of values, a flow chart for coordinated services, and a narrative on ideal models of case coordination. See the last section of this report.

## STRUCTURE OF THE STARTUPS

### HOW MANY STARTUPS, HOW MANY CASES AND GEOGRAPHIC DISTRIBUTIONS?

There would be at least six, and up to twelve, startups of the No Wrong Door-Case Coordination models. Half would be in rural sites, with 50 new cases per year, and half in urban sites, with 100 new cases per year. Each shared client group (Persons with Multiple Disabilities, Troubled Children, Youth and Their Families, and Long-term TANF Families) would have at least one rural and one urban startup site. There should be at least one startup per region.

Existing coordination efforts (e.g., the A-Team or the Dangerous Mentally Ill Offenders collaboration) may be enhanced to include all the No Wrong Door essential elements.

### WHEN WOULD THE STARTUPS BEGIN, AND HOW LONG WOULD CLIENTS BE SERVED?

Startup implementation would begin January 2002, and run continuously for the next three and a half years. Evaluation and monitoring would be ongoing, with reports on client outcomes at the end of each year of startup operation, so that modification, expansion, or contraction decisions could be made each year.

On average, clients would be served intensely for the first year, less intensely for the second year. Each year a new cohort of clients would be added.

### HOW WOULD CLIENTS BE SELECTED FOR STARTUP PARTICIPATION?

All clients or members of their families would have recently or currently used services from selected parts of DSHS. Client Registry will provide potential client names to the startup sites. The startup sites would choose the clients they would serve from that list. Startup sites might use additional screening criteria (such as difficult-to-serve, resistant, has multiple issues, in crisis or in sanction status) to help determine which customers to serve.

- ***Long-term TANF Families:*** Focus parents would have used TANF continuously for 36 months. During the past year, some member of the parent's household would have used services from AASA, DDD, MHD, DASA, or DVR, or would be on SSI or GAU or GA-X. *Additional criteria might include the suspected presence of multiple issues, sanction status, and difficulty in engaging the client.*
- ***Troubled Children, Youth and Their Families:*** Focus children or youth would have used CA or JRA services. During the past year, some member of the child's household would have used services from AASA, CA, JRA, DDD, MHD, DASA, or DVR, or would be on SSI or GAU or GA-X. Additional criteria for CA clients might be multiple issues; chronic neglect criteria; recommendations from Child Protection Team. *Additional criteria for JRA clients might include limited parole periods, multiple barriers, being a parent or on TANF, and being over 18.*
- ***Persons with Multiple Disabilities:*** Focus customers would have used services from at least two of the following programs during the past year: AASA, DDD, MHD, and DASA.

### WOULD IT BE POSSIBLE TO ACHIEVE CO-LOCATION AND SEPARATE NO WRONG DOOR SUPERVISION?

All the design teams agreed that co-location was ideal, but not required. The Long-Term TANF Families design team added that the startup site should have flexible hours, so that clients could go to work and still work with their teams. The Troubled Children, Youth and Their Families design team said, that the site should be warm and inviting, and felt that the startup site should have a single coordinating supervisor.

## "MULTI-DISCIPLINARY" SERVICE TEAMS FOR SHARED CLIENTS

### WHAT WOULD CLIENTS NEED TO DO?

Clients or their guardians would need to agree to participate on their teams, and sign a client consent form allowing their data to be shared across most programs and community agencies serving them. The recommendation was to contract for an hour and a half of training for these clients, to help them learn to "manage" DSHS program and other agency staff!

### WHO WOULD PARTICIPATE IN THE MULTI-DISCIPLINARY SERVICE TEAMS?

Teams would be composes of clients, their families, advocates, or their "natural supports." All DSHS program areas, with case managers or providers serving these clients, would be expected to participate. Community service providers, not funded by DSHS but also serving that client (or needed by that client if that need is revealed through initial screening or on going work with the clients), would be invited and encouraged to participate. These might include Community Action Centers, shelters, housing agencies, public health nurses, school nurses or counselors, domestic violence agencies, city and private social services, faith-based counseling or social services.

### WHO WOULD CONVENE AND LEAD THE MULTI-DISCIPLINARY SERVICE TEAMS?

The lead might change over the two-years the client is participating, moving from one DSHS program to another, or to a community agency, hopefully with active participation by the client themselves. The Persons with Multiple Disabilities design team pointed out that leading the teams might be a service DSHS could contract out, rather than asking an existing case manager to do it. The assumption for lead was:

- ***Clients with Multiple Disabilities:*** If mental health were involved, their providers would be the lead; if not, first a case manager from aging and adult services, and then from developmental disability services.
- ***Troubled Children and Youth and Their Families****:* The case manager for children's services or a juvenile rehabilitation staff would lead.
- ***Long-term TANF Families:*** *The* TANF case manager would lead.

### WHAT TRAINING WOULD BE NEEDED?

The recommendation was that each startup site would have a quarter-time coach available to help the teams learn to work together. This was going to be a culture change, and it would best be learned in the doing. Initial training was also recommended for team members. The training would be held at regional sites where short sessions would occur periodically in order to deal with staff turnover and at the beginning of new startups.

### WOULD OUTREACH AND HOME VISITS BE RECOMMENDED?

The Long-term TANF Families design team was so concerned about outreach that they specified that the lead case manager and at least one team member would visit the client at home.

### WHAT WOULD THE TEAMS DO AND HOW WOULD THEY DO IT?

A client-centered service plan would be developed jointly at team meetings. Services provided would be those already available through the participating programs and agencies. On average, each client's team would meet eight times during the first year of client service, and four times during the second year.

### HOW WOULD SERVICES PROVIDED BE FUNDED

Funding would be based on each participating program's restrictions. If the team wanted to do something for a client that they could not find a way to do within existing funding constraints, they would raise the problem to their supervisors. If the supervisors could not find a solution, they would bring the problem to the program fiscal managers and the Budget Division to see if they could find a solution.

### HOW WOULD MULTI-DISCIPLINARY TEAM MEMBERS COMMUNICATE WITH EACH OTHER AND DOCUMENT THE SERVICE PLAN AND ACTIONS TAKEN?

Each team member would have access to a shared Internet-based communication space for that client (e.g.,"JohnSFamily.com"). The service plan would be posted on that space. Each team member would be able to easily post comments and actions taken on behalf of that client in that space, and to participate in threaded "e-conversations" between meetings.

## EVALUATION AND MONITORING OF STARTUPS

### IS MONITORING AND PROCESS EVALUATION USEFUL?

A process evaluation was recommended particularly in the first couple of years of program implementation. The evaluator (a researcher or administrator) would visit each site regularly, observe operations and interview staff and clients, and write brief reports on how each site was implementing the model and what problems the site was encountering.

**WHAT OUTCOMES WOULD BE EVALUATED?**

The outcomes for startup clients would be determined and compared to a group of similar clients from other, areas of similar urban or rural density. The outcome evaluation design would be a treatment comparison, pre-post design. The treatment and comparison groups would be similar in their pre-treatment service usage across DSHS. During and after startup participation, the groups would be compared as to their satisfaction, post-treatment usage, and outcomes appropriate to each type of shared clients and cost of key DSHS and external services.

Key outcomes, other than client satisfaction with services and life generally, would differ for each shared client type. Likely outcomes include the following:

- ***Long-term TANF Families:*** Increase in employment hours and wages, DASA treatment completion, employment retention, and family income. Reduction in returns to TANF, welfare payments, children's service usage, juvenile rehabilitation service usage, re-arrests and convictions.
- ***Troubled Children, Youth and Their Families:*** For family members as well as focus child, increases in alcohol and drug abuse treatment completion rates and employment participation, and reduced arrests and convictions. For focus child, reduction in time in out-of-home placements, re-referrals, parole revocations, re-arrests or re-convictions.
- ***Persons with Multiple Disabilities:*** Increased stable placements, alcohol and drug abuse treatment completion rates, and client employment rates. Reduced failed placements, days in nursing homes, mental hospitals, arrests; days incarcerated; costs of other DSHS services.

Each year the Division of Research and Data Analysis would produce outcome reports, analyzing differences between treatment and comparison groups for all outcomes. Some outcomes will occur infrequently and will need two or three years of data to assess. Others (including DSHS service and costs of DSHS services) can be evaluated after Year 1. Some outcomes, particularly those that are program based, will occur quickly enough to permit reporting back to each site every quarter.

Specific funding recommendations were made to support training, software development and evaluation requirements included in the above recommendations (see Appendix 10).

# HOW WERE THESE RECOMMENDATIONS GENERATED?

There were ten steps to developing these recommendations.

## STEP ONE: DATA ON SHARED CLIENTS WAS PRESENTED TO CABINET.

RDA assembled information on the number of DSHS clients who had been served by many different programs in the previous fiscal year, 1999. Three types of DSHS clients emerged as being most multiply served and yet largely distinct from one another.

- Persons with Multiple Disabilities,
- Troubled Children, Youth and Their Families,
- Long-term TANF Families.

Almost all these clients received services from at least three program areas, one of them being almost always medical assistance. The patterns of services are depicted in the figures on the following three pages.

For a more detailed presentation of data on how the three types of clients are distinct and how large of a proportion these multiple need clients are of the total number of clients served by DSHS programs see Appendix 1.

## STEP TWO: THE NO WRONG DOOR-CASE COORDINATION PROJECT PROPOSAL WAS APPROVED.

The DSHS Cabinet approved the six-month No Wrong Door-Case Coordination Project to develop models of case coordination for the three types of shared clients. (See Appendix 2 for the actual text of the Proposal and the Project Monitoring chart.)

Half of the proposed work of the project was "research." It involved collecting input from:

- The experiences of the shared clients themselves and the caregivers.
- The frustrations and successes of front line staff involved in trying to coordinate services.
- DSHS regional staff and stakeholders about past barriers to coordination efforts and interesting local innovations.
- Outside professionals or program experts in other states, who had already accumulated experience in coordinating services for multi-need clients.

The research part of the project summarized data, so that the design teams would have current, accurate information. It was designed to show the design teams not to "re-invent the wheel," and to provide inspiration by examining successful practices both in Washington and in other states.

The other half of the proposed project was "quality process improvement." It consisted in garnering expertise from all parts of the agency – experienced and innovative line staff serving clients, key executive staff in all DSHS programs, and experts in resolving barriers in confidentiality, training, information technology support, screening, funding, and evaluation.

A major conference and a structured set of meetings were proposed with the help of professional facilitators. This was designed to make it possible to reach design and policy consensus in a relatively brief time.

### STEP THREE: SHARED CLIENTS AND THEIR CAREGIVERS WERE GATHERED IN FOCUS GROUPS TO DISCUSS THEIR EXPERIENCES RECEIVING DIFFERENT DSHS SERVICES.

They included 70 clients or their caregivers (47 female and 23 male) drawn from RDA lists of the three types of shared clients. The clients and caregivers met in 12 focus groups, held in February and March 2001, in Seattle, Spokane, and Mt. Vernon.

The clients and caregivers had been invited to come for a two-hour session by an independent contractor, Gilmore Research Group. The participants were asked to talk about their own experiences receiving services and then to discuss various aspects of access and coordination with different forms, offices, timing of services, and service providers. They were also asked to make suggestions for improvements.

There were six common themes that came out of the focus groups. Shared clients wanted:

- Better access to information about DSHS's services and eligibility.

  "…if you don't know the right question, you don't find out what services are available."

- Improvement in ways to communicate with DSHS.

  "It's difficult to get DSHS by phone."

- To be heard, respected, and included in decisions about services.

  "Just see that we are people, not pieces of paper."

- Not to have to repeat the same information many times. (A common database was suggested so that different case managers would have access to the same client information.)

  "Why can't they just give the information to one another?"

- A team to plan and to provide their services in a coordinated manner.

  "I just think it would be nice if everyone was on the same page."

- Services in one place (co-location).

  "You have to run the paper work from one agency to another one and to another one."

This material may be seen in greater detail in Appendix 3, which is the final report Gilmore Research prepared summarizing the focus group findings.

## STEP FOUR: CASE MANAGERS WERE INTERVIEWED ABOUT THEIR DIFFICULTIES IN COORDINATING SERVICES FOR SHARED CLIENTS.

Seventeen case coordination stories from Seattle, Spokane, and Mt. Vernon were selected to serve as case studies for detailed analysis. These cases were chosen to exemplify successful, or unsuccessful, case coordination experiences among front line staff, case managers and other service planners, over the past two years.

Frontline workers in DSHS and in community partner agencies were interviewed about these shared clients to gain information from the service planners and providers' point of view. Each of the three design teams received their own set of case stories to serve as common reference points, and "food for thought" as they worked on creating better case coordination models.

Analysis of these case studies revealed a number of trends:

- There was much turnover in service professionals, even in the short term.
- For some clients there were large numbers of service professionals involved, which was difficult for some clients.
- The primary case manager changed frequently. Twelve of the 17 clients had had the same case manager for less than one year, ranging from two weeks to ten months.
- Service styles ranged widely from parallel efforts to thorough teamwork. Some caseworkers were highly involved with clients and communicated consistently with other professionals on the case, while others were not highly involved.
- There were great differences among case managers in their effort and involvement. Some were much more committed to clients than others.
- There was a wide range in client ability to use services. Some knew how to work with teams and follow through. Some clients were very difficult to work with, to the point of harassment. The most troublesome clients were sometimes the most troubled and the most difficult to work with.
- Client eligibility for services varied widely.

The three sets of case histories are confidential, and the design team members signed a confidentiality oath before they read them. This information is not being included to preserve privacy. (See Appendix 4, for the process of interviewing front line staff, the sampling design of the cases, and the interview schedule used for the case histories.)

## STEP FIVE: REGIONAL COORDINATING COUNCILS (RCC) AND REGIONAL ADVISORY COMMITTEES (RAC) DISCUSSED BARRIERS AND MADE RECOMMENDATIONS.

No Wrong Door Project staff and facilitator, Dave Whitling, met with each of the six Regional Coordinating Councils and Regional Advisory Committees (RCCs/RACs). The RCC/RAC members were asked for their perceptions in three areas: What is DSHS doing well? What are the constraints? What are short-term and long-term recommendations?

In terms of what DSHS was doing well, the RCCs/RACs identified several successes, and found more than 100 examples of successful practices in case coordination.

The members reported many constraints to serving shared clients well, and these included:

- Separate cultures of DSHS programs.
- Confidentiality that limited communication about a client between program areas.
- Restriction on blending or sharing funds.
- Lack of a common database.
- Different e-mail systems.

There were six general short-term recommendations that were made in the meetings:

- Use a single intake process.
- Share confidentiality across programs.
- Provide more cross-program training.
- Authorize flexible use of funds.
- Implement a client registry.
- Provide an 800 number as a "front door" to DSHS services.

See Appendix 5 for further detail from each meeting, including long-term recommendations.

## STEP SIX: A NO WRONG DOOR RESOURCE MANUAL WAS CREATED.

The Resource Manual contains examples of consent forms, and narrative descriptions of case coordination for 15 programs in Oregon, Massachusetts, Florida, and Washington. There are examples of forms used for screening and planning services, technology applications, and a discussion of barriers to case coordination and how to overcome such barriers. Selected research material and annotated bibliographies were also available

See an index of the Resource Manual, the research conclusions and model from Oregon, and a research bibliography in Appendix 6. Several copies of the Resource Manual are available upon request in RDA. Please contact Nora Ellsworth (360) 902-0701.

## STEP SEVEN: A ONE-DAY CONFERENCE ON CASE COORDINATION WAS HELD.

RDA hosted a No Wrong Door conference in April, 2001. Ten expert presenters, from Oregon, Massachusetts, and Washington were invited to speak. The main purpose of the conference was to inform the 37 front line staff, representing nine DSHS program areas in different parts of the state, who came together for the first time to prepare for their week of work. The invited guests included Assistant Secretaries, the chair of each of the six RCC/RACs, and members of three design teams (see number 8 below).

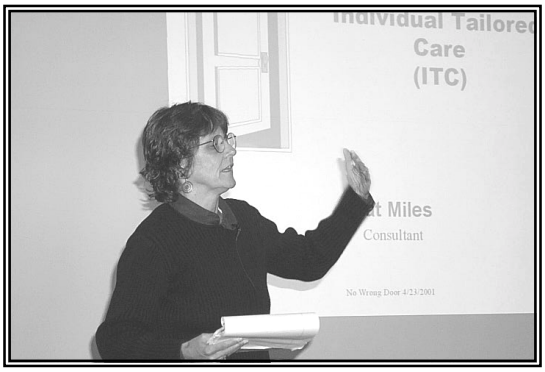
Liz Dunbar, the Deputy Secretary and the No Wrong Door project sponsor, opened the conference with a charge to the design team members. She asked them to listen to ideas for improvement from the speakers and to adapt the ideas into models for case coordination and service integration. She said this was not only an internal change in how DSHS worked with multiple needs clients, but how it worked with community partners to serve the shared clients.

The keynote speaker, **MaryAnn Murphy**, Director of Casey Family Partners Program in Spokane, discussed core beliefs of a coordination model. She proposed three main principles for 'turning the system around':

- Put the client in the center of what we are doing.
- See clients as a resource. "They bring strengths that enable them to survive, and that is what we will build on."
- Recognize the importance of the client's extended family, neighborhood, and churches. Welcome this informal support system and wrap the client with the necessary services.

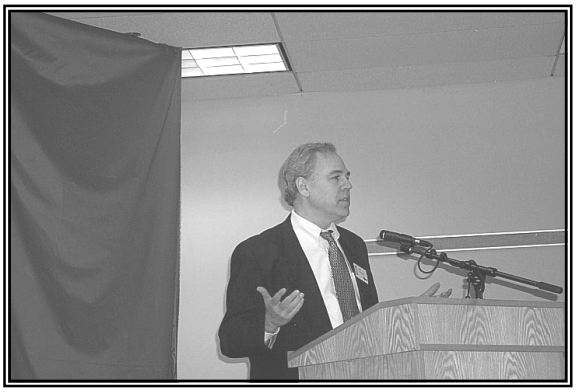
**Patricia Miles**, a national consultant, warned about pitfalls in efforts to change ways we coordinate services for multi-need clients:

- "Interagency teams can make far worse decisions than any single individual when they don't include the client in their decision-making."
- "Getting a lot of services doesn't necessarily mean you are getting your needs met—and the biggest unmet need is loneliness."
- "It's harder to institutionalize new ideas in the system than to institutionalize people."
- "People need us to spend time with them, not necessarily to spend money on them."



**Jeff Kielson**, a Regional Director of the Department of Mental Retardation in Massachusetts, identified the key characteristics of success in systemic change:

- There is recognition of a problem.
- There is a firm commitment to finding solutions.
- Nothing is sacred in terms of existing programs.
- The outcome for the individual is the most important factor.
- Empowering the individual and the family is critical.
- Funding responsibility is worked out before collaboration begins.
- There is a single point of case management responsibility and authority.



Seven other speakers from Washington, Oregon and other states presented their experiences in dealing with coordinating services with different types of clients with multiple needs. These included: troubled families, families on welfare, persons with co-occurring disorders (chemical dependency and mental health problems), older persons with multiple disabilities, and multi-need youth involved with the juvenile justice system.

While the settings and approaches varied widely, a number of common themes emerged regarding the best practices for coordinating services for shared clients:

- A more humane, client-centered orientation.
- Clients deemed "hard to serve" are those with the most complex needs.
- Staff must listen to, and learn from, clients.
- The client's family and community are important resources.
- We must build a community of support around the client.
- Relationships are at the core of social services.
- Reducing the size of caseloads is an important goal.
- A shift in values and skills on the part of service workers is needed.
- A strong commitment to change is necessary to overcome inertia and fear.
- There are important cultural differences between services and systems.
- Cultural change is needed within social and health service organizations.

In the afternoon of the conference, the three design teams had the opportunity to question the guest speakers on their practical experiences. They discussed how to do coordinated planning and integrated service delivery *with* clients, their families and "natural supports," and with community partners. (See Appendix 7 for the conference agenda and a full report of the contributions from each of the speakers)

## STEP EIGHT: THREE DESIGN TEAMS CONSISTING OF INNOVATIVE AND EXPERIENCED FIELD STAFF WORKED TOGETHER FOR A WEEK.

There were three design teams, of 10 to 14 members each, corresponding to the three shared client groups. The teams contained one or more front line staff, from different areas in the state, representing nine different DSHS program areas. Each was appointed from his/her program area. (Note: See names of representatives of each team on following page.)

The members of the design teams had attended the No Wrong Door conference on Monday, April 23, 2001, met with the experts for their own shared-client group, and then spent the rest of the week, "sequestered" in University Place. Office of Opportunity Employee Develop (OOED) professional staff facilitated their meetings.

Although the three design teams met separately, they agreed upon a common set of values, key elements of case coordination models and a flow chart to show their long term vision of a No Wrong Door system. After working on these long term solutions, they also developed three conceptual startup designs.

On Friday, April 27, 2001 the design teams made oral presentations to DSHS Secretary Dennis Braddock and handed him their written report. (See the final Design Teams' written report in Appendix 8.)

### PERSONS WITH MULTIPLE DISABILITIES DESIGN TEAM:

Ken Johnson (AASA), Carol Clarke (CA) John Taylor (DASA), Bill Siesseger (DASA contractor), Mary Tryon (DDD), Eileen Fielding (DVR), Terry Redmon (DVR), Olga Jouravleva (ESA), Darleen Yuna (ESA), Pam Colyar (MAA), Leann Amstutz (MAA) Jere LaFollette (MHD contractor)

**TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES DESIGN TEAM:**

Annette Olson (CA), Tim Dyck (CA), Kasey Cote (CA), Ruth Leonard (DASA), Melissa Laws (DASA contractor), John Albert (DDD), Tim Cress (DDD), Malcolm Poole (ESA) Jeff Patnode (JRA), Dan Schaub (JRA), Ann Egerton (MAA), Marty Driggs (MHD RSN), Mary Stone Smith (MHD and CA contractor)

**LONG-TERM TANF DESIGN TEAM:**

Marjorie Fitzgerald-Rinehart (CA), RoseMary Micheli (DASA), Ken Guza (DASA), Emilio Vela (DASA), Mike Ahern (DDD), Cathy Monroe (DVR), Stacey Fleming (ESA), Perlitta Matta (ESA), John Culhane (MAA), Janet Clingaman (MHD contractor), Steve Ironhill (MHD and DASA contractor)

## STEP NINE: DSHS CABINET APPOINTED EXPERT STAFF TO BE MEMBERS OF ISSUE RESOLUTION TEAMS.

They tackled five constraints identified by the design teams.

**LACK OF A SHARED CONSENT FORM.**

The Deputy Secretary of DSHS requested that an existing DSHS committee, working on policies to disclose client information work on developing a No Wrong Door shared client consent form. This committee developed a form, which was finalized by the executive team, approved by the Assistant Attorney General, and became a DSHS official form.

See Appendix 9A for the form on Consent to Exchange Confidential Information for Services Coordination.

### LACK OF CROSS-PROGRAM KNOWLEDGE AND EXPERIENCE WORKING IN MULTI-DISCIPLINARY TEAMS ON CLIENT-CENTERED PLANS

The training team recommended periodic trainings in regional sites for each of the core multi-disciplinary teams in each of the startup sites. It also recommended part time 'coaches' for each startup in order to increase skills in staffing cases together and in developing common client centered plans.

See Appendix 9B for the Cross-Training Issue Resolution Team's Recommendations.

### LACK OF TECHNOLOGICAL APPLICATIONS TO FACILITATE COMMUNICATIONS AMONG MULTI-DISCIPLINARY TEAM MEMBERS

The Information Technology (IT) team recommended a flexible short-term solution for immediate implementation of startups: 'off the shelf' software, involving Internet based, but secure, e-communications space supporting document storage and treaded conversations for each team. They also recommended adding an IT support person to monitor startup service needs.

In the long term a custom application could be developed if the start up experience warranted the effort and funds were available. This application would communicate with existing program-specific case management systems to avoid "double entry" of information by case management staff (once in the shared space and once in the program system).

See Appendix 9C for the Technology (IT) Applications Issue Team's Recommendations.

### LACK OF A COMMON SCREENING TOOL FOR MULTIPLE NEED CLIENTS/FAMILIES

In the short term the screening team recommended the use of Client Registry information on past service utilization, augmented by some program specific criteria. The screening team also drafted a common referral form.

In the long term a common screening tool could be developed to assess and screen clients for multiple DSHS services when they were first served. To be useful, this tool would need to be acceptable to the various programs and make cross-program referrals more likely to result in services.

See Appendix 9D for the Client Screening Issues Resolution Team Recommendations.

### LACK OF FLEXIBLE FUNDING ACROSS PROGRAM AREAS

The Budget Director proposed a three-step process to resolve funding difficulties. In the short term, if such flexible funding was needed by startups for specific clients and was not available locally, startups would consult with fiscal managers across programs, and with the Budget Division.

In the long term, waiver requests and/or requests for changes in state law might be necessary, after some experience had accumulated identifying areas of more need for flexible funding.

See Appendix 9E for the Flexible Funding Issue Resolution Team's Recommendations.

Specific funding recommendations were made to support the short-term training, software development and evaluation requirements (See the budget in Appendix 10.

## STEP TEN: AN EXECUTIVE TEAM WAS APPOINTED BY DSHS CABINET TO REVIEW AND FINALIZE STARTUP RECOMMENDATIONS.

The executive team first met on May 7th . Deputy Secretary, Liz Dunbar, gave them their charge, and they heard presentations of the design work accomplished from representatives of each of the three design teams.

On May 22nd the executives presented to each other the case coordination activities that were already occurring in their own program areas and administrations.

From May 31st through June 27th the team met weekly to review and refined three "straw man" startup descriptions, and to review and modify the recommendations from the issues resolution teams.

On June 27th the team discussed estimated central costs to implement startups: training, IT off-the-shelf software, and evaluation. (See Appendix 10)

In early July, the team reviewed estimated program area costs and staff time required for implementing six startups. They were responsible for briefing their own Assistant Secretaries regarding No Wrong Door recommendations and cost estimates. (See Appendix 10)

On Friday, July 13th, the executive team presented their recommendations to the DSHS Cabinet.

Executive team members are named in the Acknowledgements.

## WHAT RECOMMENDATIONS WERE MADE ABOUT THE LONG-TERM MODEL FOR CASE COORDINATION?

The three design teams, even though working separately on different types of shared clients, created a common set of values and a common long-term ideal flow chart for case coordination.

- They concurred on the values that should drive case coordination.
- They concurred on a flow chart and narrative depicting an ideal model of the main steps for case coordination.

The design teams believed that the values and the long-term, model should guide the development of short-term startup designs. They thought that by keeping long-term goals in mind it would help build short-term startups, and gradually resolve barriers standing in the way of case coordination.

The common set of values and the ideal flow chart and narrative for case coordination are presented in the following pages.

## NO WRONG DOOR VALUES

**Accountability:** We are accountable to many stakeholders by:

1. Providing timely and comprehensive services
2. Serving customers efficiently
3. Serving customers effectively and measuring our outcomes
4. Measuring customer satisfactions
5. Using a comprehensive management information system

**Respectful Environment:** We provide a welcoming and supportive environment by:

1. Acknowledging and honoring the diversity of our customers and our staff
2. Responding quickly to customers' inquiries
3. Recognizing that quality services can be provided in uniquely different settings
4. Supporting our staff in their decisions to serve our customers well

**Customer-centered Services:** We will provide consumer-driven, flexible services that respond to the unique needs of each individual and family by:

1. Respecting our customer's choices
2. Providing cultural relevant services
3. Emphasizing holistic and strength-based services

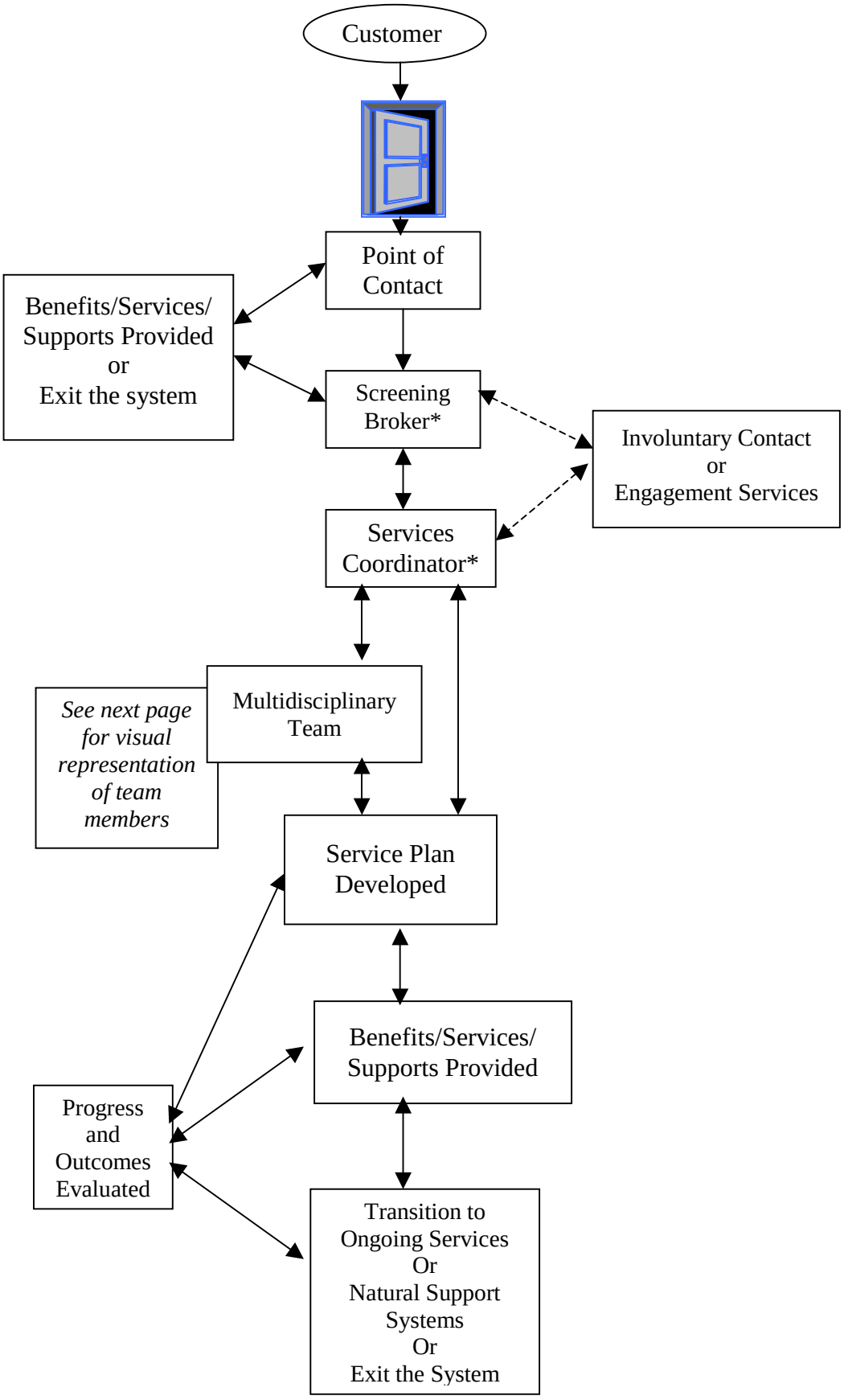
**Partnerships:** We maximize state and community resources by:

1. Knowing DSHS and community resources available to our customers
2. Working in multi-system teams
3. Combining both natural and professional supports
4. Using the broadest definition of family and community
5. Respecting and supporting our partners (suggested by DSHS Secretary Dennis Braddock)

**Quality Workforce:** We are the workforce that is:

1. Respectful to customers
2. Knowledgeable about program services in all divisions
3. Diverse
4. Supportive of our colleagues
5. Using quality principles to work toward a positive change

## NO WRONG DOOR: IDEAL FLOW CHART FOR CASE COORDINATION



# MULTI-DISCIPLINARY TEAM

**COMMUNITY PARTNERS**

HOSPITALS

UNIVERSITIES

HEAD START

PARKS & RECS & YMCA

PARENT TO PARENT CONSUMER NETWORKS

PUBLIC HEALTH

SCHOOLS

BUSINESSES

**NATURAL SUPPORTS**

FRIENDS

NEIGHBORS CHURCH

EXTENDED FAMILY

**DSHS PROGRAM AREAS**

CHILD CARE

JUVENILE JUSTICE

CHILD WELFARE

HEALTH CARE

SUPPORTS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

HOME & COMMUNITY SERVICES

JOB SKILLS TRAINING

CHEMICAL DEPENDENCY TREATMENT

MENTAL HEALTH

JOB DEVELOPMENT

## NARRATIVE FOR THE IDEAL FLOW CHART OF CASE COORDINATION

### CUSTOMER

An individual and/or family actively involved in decisions concerning needed services that depend on the timeliness, accuracy, and quality of another's work.

### *POINT OF CONTACT

Contact may occur on the customer or advocate's initiative, community referrals, or involuntarily (as in cases involving abuse, neglect, or criminal justice system). Initial contact may take place in a variety of ways including: person-to-person, telephone, Internet, or other technological interface.

### *SCREENING BROKER

An experienced worker familiar with all DSHS services as well as community resources and partners. The broker is cross-trained to assess the holistic needs and make referrals to the appropriate services or Services Coordinator. The Screening Broker identifies the needed service(s) with the customer. In the case of a single service, the Screening Broker makes the referral and/or provides the service. A referral to a Services Coordinator is made for complex cases. Each agency will have a designated Screening Broker, available during business hours, responsible for making or receiving referrals.

Single Service:

- Make a referral to the designated Screening Broker at the appropriate agency
- Arrange the service if it is the target agency where the service exists

Multiple Service:

- Make the referral to the appropriate Services Coordinator as determined by the universal screen that identifies the primary service need via that agency's Screening Broker. (Referrals are made from Screening Broker to Screening Broker)
- This function must be supported by adequate and accessible data as well as information systems.

### INVOLUNTARY CONTACT OR ENGAGEMENT SERVICES

These customers may have multiple or single needs and enter the system differently, often through a crisis or the justice system. They may be in denial, resistant, and/or hostile. These customers will have access to a Services Coordinator and the same services as the voluntary customer. Engagement services may also include outreach activities. (This mode of entry is represented by a dashed line to represent an alternative method of access to services)

***SERVICES COORDINATOR**

A DSHS staff member or contracted service provider who is identified as most appropriate to address the customer's primary need. This person, with expert program knowledge, performs or coordinates such tasks as a comprehensive assessment, eligibility determination if required, and the provision or arranging of services.

If multiple needs are identified, the Services Coordinator is then responsible for ensuring the development of a holistic and integrated service plan. The Services Coordinator is also responsible, in collaboration with the customer and others, for maintaining, evaluating, revising, transitioning or terminating the plan. When necessary, the Services Coordinator will also be responsible for convening and facilitating a multi-disciplinary team. Whenever possible the customer will choose the members of the team. The Services Coordinator may change over time, depending on the predominant issue facing the customer or family with an adequate transition plan.

**MULTI-DISCIPLINARY TEAM (AS NEEDED)**

The multi-disciplinary team is a diverse and culturally competent team utilized to develop an integrated service plan and provide services to support desirable outcomes for the customer.

**SERVICE PLAN DEVELOPED**

The customer service plan, based on customer strengths, will serve as a guide or contract that leads to the desired outcomes of self-sufficiency, health, and safety for the customer. When possible, the plan should be driven by the customer, advocate, and/or family. The development of the plan should occur in partnership with the relevant service providers, courts, and community supports.

**BENEFITS, SERVICES, AND SUPPORTS PROVIDED**

Benefits, services, and supports include the identified or contracted goods and services originating from the service plan.

**PROGRESS AND OUTCOMES EVALUATED**

Recognizing that service needs of a customer may change, revision of services is an ongoing process through review and evaluation.

**TRANSITION TO ONGOING SERVICES, A NATURAL SUPPORT SYSTEM, OR EXIT THE SYSTEM**

A transition could be a change in service and/or coordinator, or the termination of service.

The transition will consist of a plan that will continue the goal of self-sufficiency, health, and safety, and provide assistance in building natural or community supports. The complete customer history and documentation should follow the customer when appropriate.

# APPENDIX 1

# DATA ON THREE TYPES OF SHARED CLIENTS: PROPORTIONS SERVED BY DIFFERENT PROGRAM AREAS

# No Wrong Door -- Case Coordination Project

Washington State Department of Social & Health Services

July 2001

# No Wrong Door -- Case Coordination Project

**Who are the clients who receive many different services from DSHS ?**

Washington State Department of Social & Health Services

# Three Types of Shared Clients

***Type 1: Persons with multiple disabilities***. These clients often have challenging behaviors and are receiving services from two or more of these program areas: AASA, MHD, DASA, and DDD.

*In FY '99 there were **24,913** people (21,829 adults, 3,084 youth under 18.)*

***Type 2: Troubled children, youth and their families***. These children are either served by JRA while also served by MHD, DASA or DDD, or they are members of a CAMIS "family case" in which one or more persons are receiving DSHS services from MHD, DASA, and DDD.

*In FY '99 there were **92,733** people (39,936 adults, 44,396 children or youth under 18, and 8,401 where we didn't have age data) in a total of 25,585 cases.*

***Type 3: Long-term TANF families.*** These clients (persons in the ACES "assistance unit") have received TANF for 36 months and are also receiving services from MHD, DASA, and DDD.

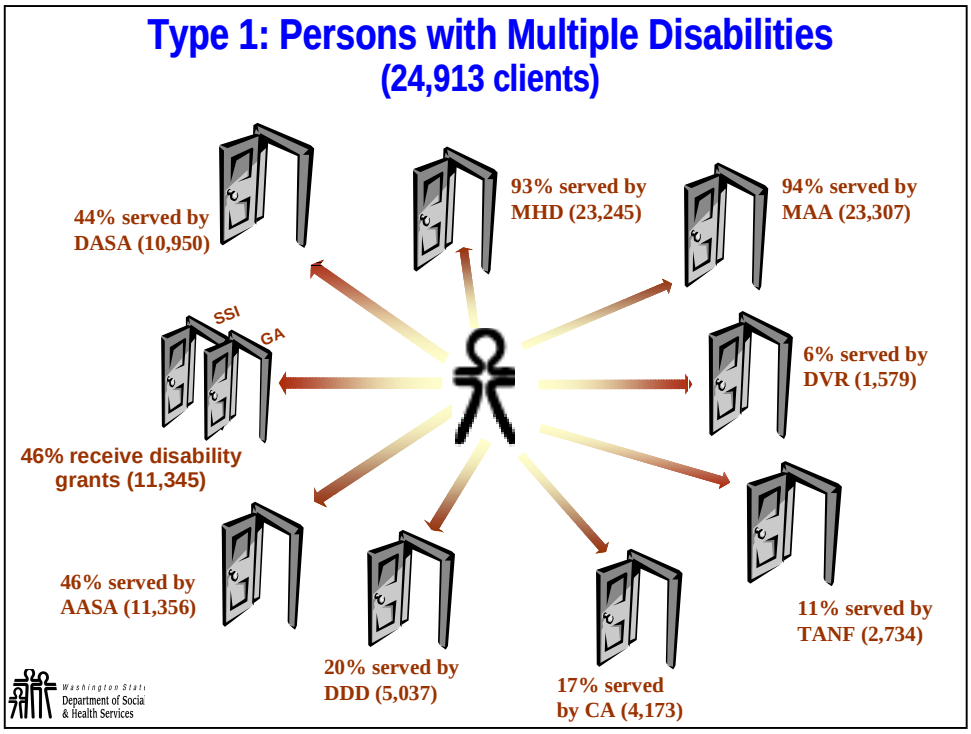
*In FY '99 there were **8,758** people (3,130 adults, 5,628 youth under 18) in 2,438 "assistance units".*

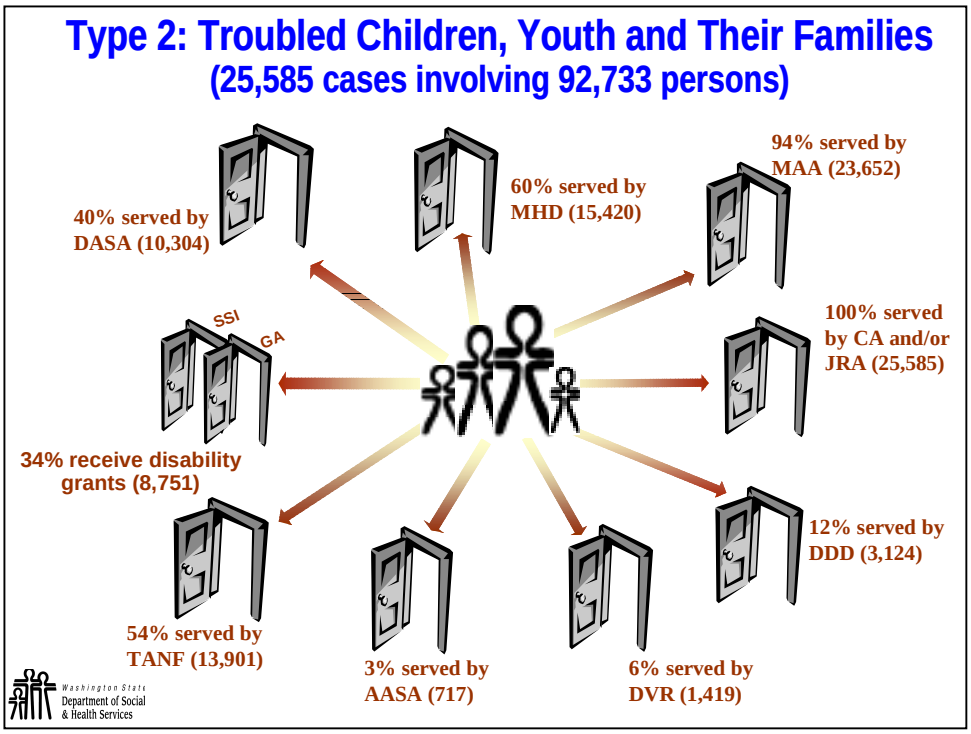
Washington State Department of Social & Health Services

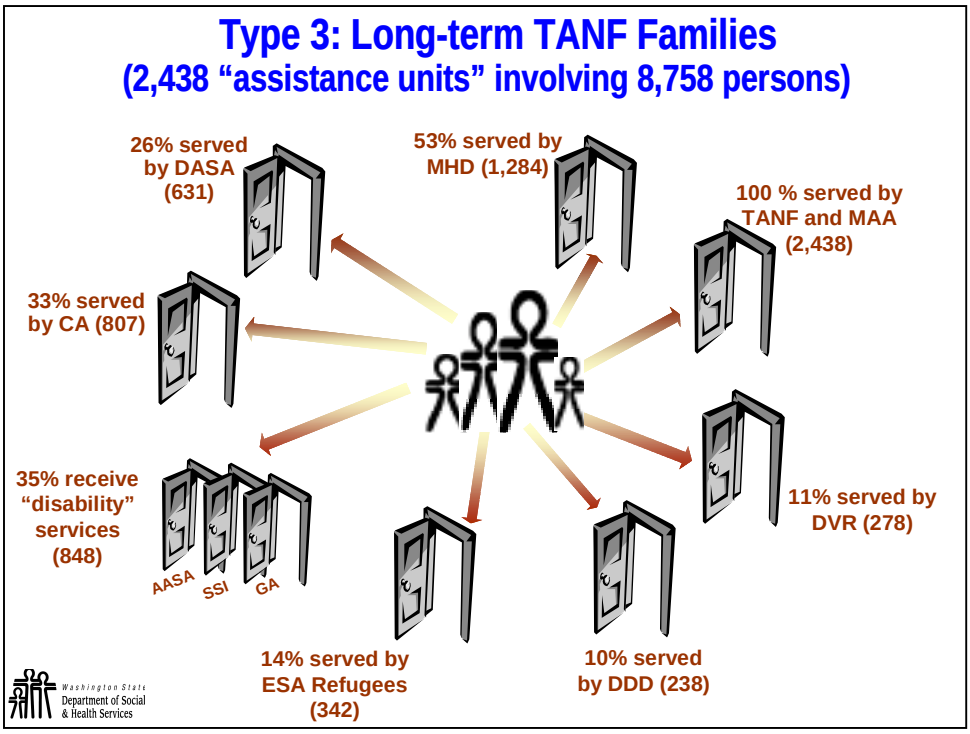
**What programs do these shared clients use ?**

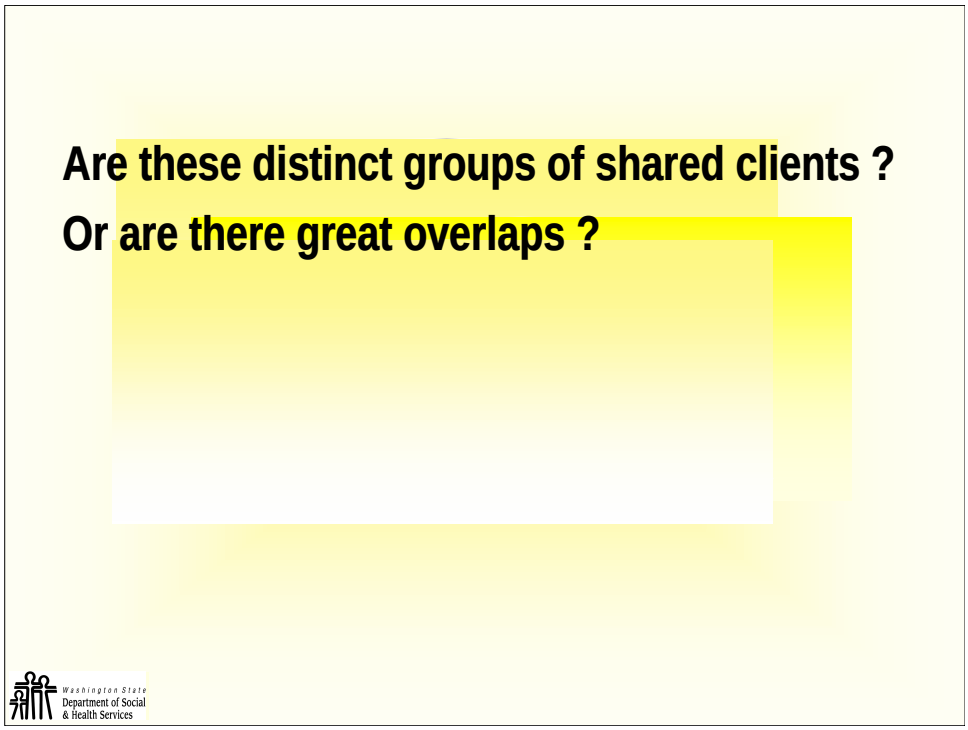
**What doors do they go through ?**

Washington State Department of Social & Health Services

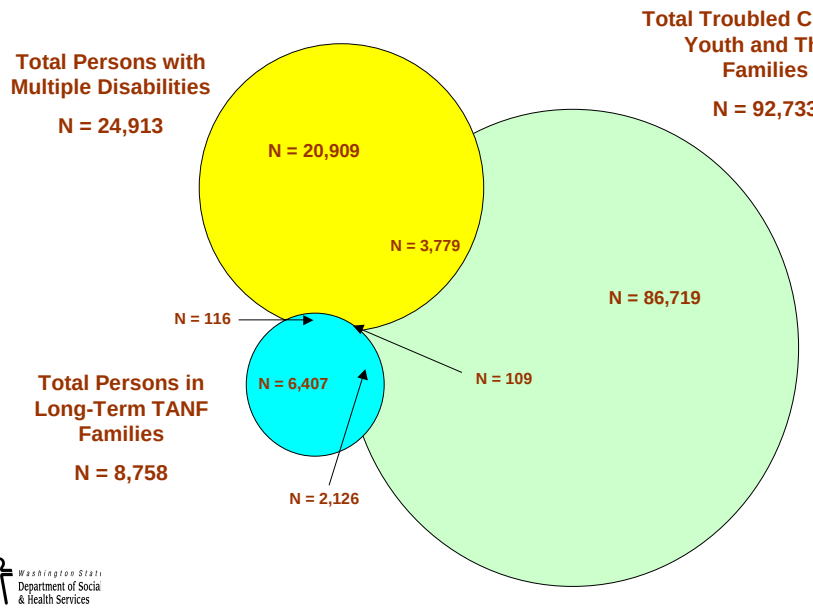

Type 1: Persons with Multiple Disabilities
(24,913 clients)
44% served by DASA (10,950)
93% served by MHD (23,245)
94% served by MAA (23,307)
SSI
GA
6% served by DVR (1,579)
46% receive disability grants (11,345)
46% served by AASA (11,356)
20% served by DDD (5,037)
17% served by CA (4,173)
11% served by TANF (2,734)
Washington State Department of Social & Health Services


Type 2: Troubled Children, Youth and Their Families
(25,585 cases involving 92,733 persons)
40% served by DASA (10,304)
60% served by MHD (15,420)
94% served by MAA (23,652)
SSI
GA
100% served by CA and/or JRA (25,585)
34% receive disability grants (8,751)
12% served by DDD (3,124)
54% served by TANF (13,901)
3% served by AASA (717)
6% served by DVR (1,419)
Washington State Department of Social & Health Services


Type 3: Long-term TANF Families
(2,438 "assistance units" involving 8,758 persons)
26% served by DASA (631)
53% served by MHD (1,284)
100 % served by TANF and MAA (2,438)
33% served by CA (807)
35% receive "disability" services (848)
AASA
SSI
GA
11% served by DVR (278)
14% served by ESA Refugees (342)
10% served by DDD (238)
Washington State Department of Social & Health Services


Are these distinct groups of shared clients ?
Or are there great overlaps ?
Washington State Department of Social & Health Services

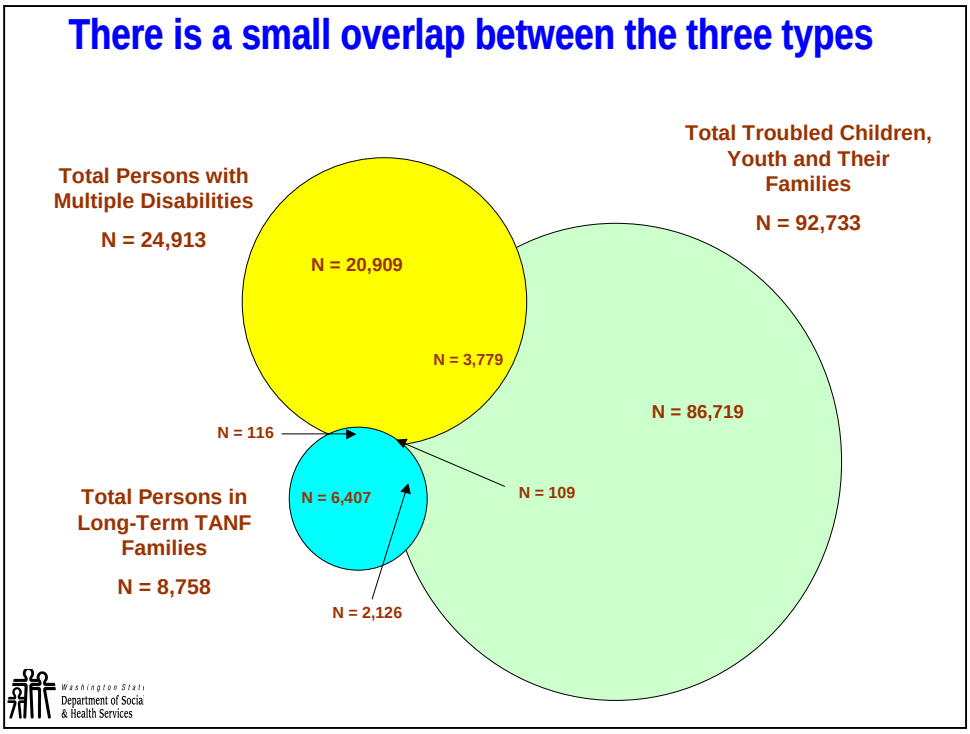
## There is a small overlap between the three types

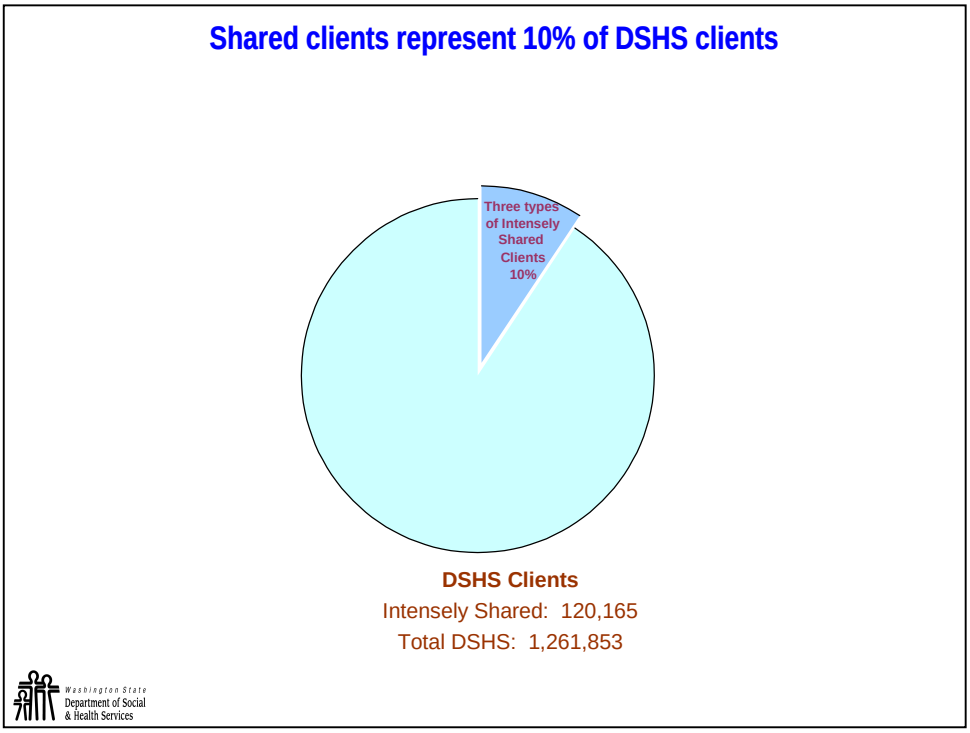



Washington State Department of Social & Health Services

## Do these shared clients represent a large proportion of all clients served by DSHS programs ?

Washington State Department of Social & Health Services

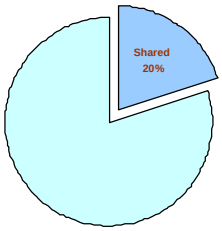

There is a small overlap between the three types
Total Persons with Multiple Disabilities
N = 24,913
Total Troubled Children, Youth and Their Families
N = 92,733
N = 20,909
N = 3,779
N = 86,719
N = 116
N = 109
Total Persons in Long-Term TANF Families
N = 8,758
N = 6,407
N = 2,126
Washington State Department of Social & Health Services


Shared clients represent 10% of DSHS clients
Three types of Intensely Shared Clients 10%
DSHS Clients
Intensely Shared: 120,165
Total DSHS: 1,261,853
Washington State Department of Social & Health Services

## Type 1 (Persons with Multiple Disabilities) represents between 16% and 21% of the total clients served by these DSHS programs

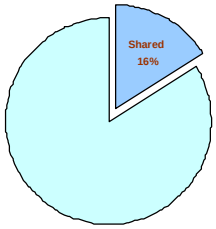
**AASA**

Shared: 11,356
Total: 57,340



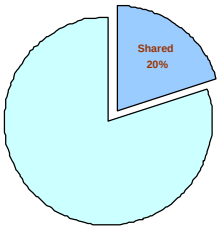

**DDD**

Shared: 5,037
Total: 31,587



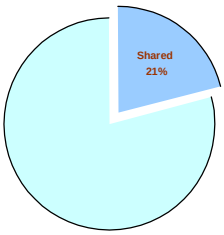

**DASA**

Shared: 10,950
Total: 55,425



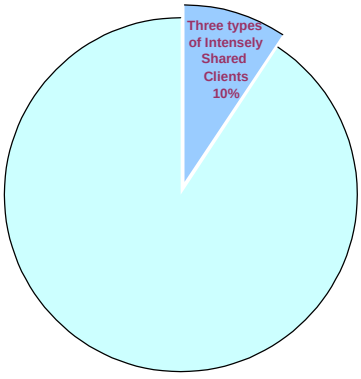

**MHD**

Shared: 23,245
Total: 108,911




Washington State Department of Social & Health Services

## Shared clients represent 10% of DSHS clients

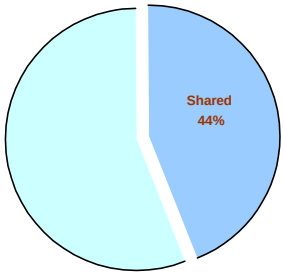



**DSHS Clients**

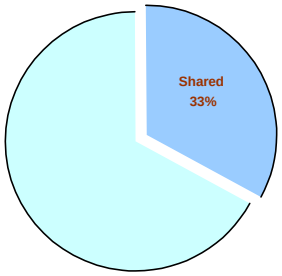
Intensely Shared: 120,165
Total DSHS: 1,261,853

Washington State Department of Social & Health Services

## Type 2 (Troubled Children, Youth and Families), represents a high proportion of CA and JRA cases




**CA "CAMIS cases**
Shared: 24,165
Total: 54,930




**JRA Cases**
Shared: 1,420
Total: 4,349

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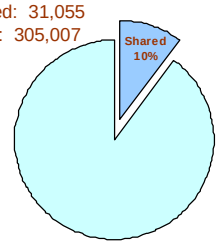
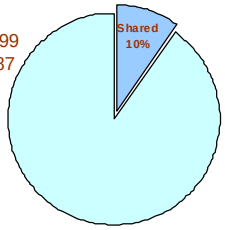
## Type 2 (Troubled Children, Youth and Their Families), represents between 6% and 18% of these DSHS programs

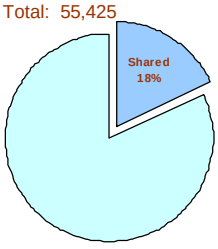
**TANF**
Shared: 31,055
Total: 305,007



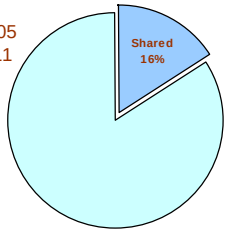

**DDD**
Shared: 3,099
Total: 31,587



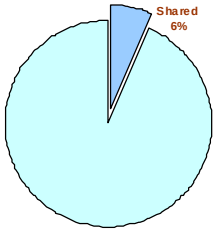

**DASA**
Shared: 10,007
Total: 55,425




**MHD**
Shared: 17,505
Total: 108,911

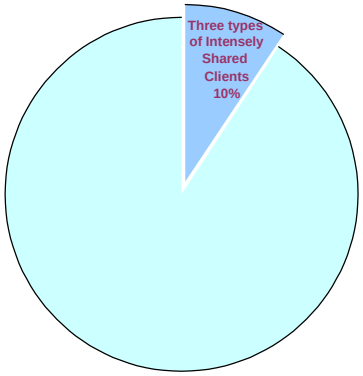



**SSI or GA**
Shared: 9,116
Total: 140,752




Washington State Department of Social & Health Services

## Shared clients represent 10% of DSHS clients



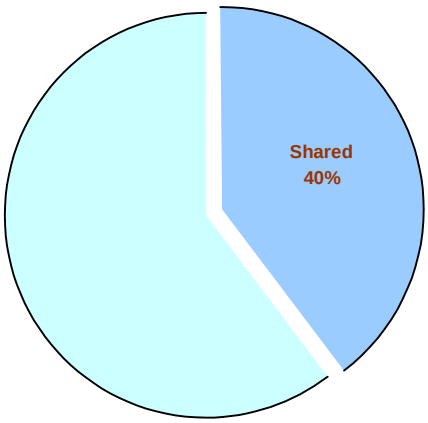

**DSHS Clients**

Intensely Shared: 120,165

Total DSHS: 1,261,853

Washington State Department of Social & Health Services

## Type 3 (Long Term TANF and Their Families), represents 40% of the total cases rceiving TANF for 36 months or more




**Long-term TANF**

Shared: 2,438 (involving 8,758 persons)

Total: 6,069 (involving 21,728 persons)

Washington State Department of Social & Health Services

# APPENDIX 2

# PROPOSAL ACCEPTED BY CABINET

**PURPOSE**

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.

**PRODUCT**

Proposed pilots testing innovative models of case planning and coordination will be designed and presented to Cabinet in this project. Cabinet will then decide whether and how to test these pilots.

**TIMEFRAME**

Seven months (starting from the time of Cabinet decision on types of shared clients).

**EXECUTIVE SPONSOR**

Liz Dunbar, Deputy Secretary.

**STEERING COMMITTEE**

Cabinet (E-Steering Committee).

**METHOD**

This project proposes to design pilots for several different types of shared clients. These client types would be chosen by Cabinet, based on data presented by RDA, prior to the start of this project. RDA proposes the following types of shared clients; others could be modeled based on Cabinet discussion.

- Clients with multiple disabilities and/or challenging behaviors, for whom there are often safety and placement crises and concerns. These clients would be receiving services from two or more of the following program areas: aging, mental health, substance abuse, and developmental disabilities.
- Troubled children and their families. These children would be served by child welfare (CA) or juvenile rehabilitation (JRA). Either the children would be moving between CA and JRA, or any child and/or adult in the CAMIS "family case" would also be receiving DSHS assistance based on disabilities (from DDD, AASA or DVR or on SSI or GA U/X grants), or mental health or substance abuse issues.
- Disabled or substance abusing families on long-term TANF assistance or returning on TANF assistance, where the persons who live in the family (the ACES "assistance unit") would also be receiving DSHS assistance based on disabilities, or mental health or substance abuse issues.

## PROJECT STRATEGY

The project design is based on eight premises, which then shape the major project components:

1. The clients themselves, and their families, will provide information on their experiences in accessing and receiving multiple services from DSHS. **Focus groups** of clients and/or families shared across program areas will be conducted for each type of shared clients.
2. **Historical case studies,** six cases for each type of shared client, will be generated from interviews with case managers and field staff, providing concrete examples of system coordination problems to guide the work of developing new models of case coordination.
3. Groups of staff and stakeholders from the **RCCs** and **RACs** will participate in facilitated group discussions about past regional efforts to serve these shared clients, the barriers those efforts encountered, and their successes.
4. The new case coordination models will be designed by working teams of field staff from all the affected programs who have worked with these types of complex clients. A **design team** (8-10 case managers or field staff) will be formed for each type of shared client. Results from the focus groups and the case studies will help to stimulate effective and efficient innovations.
5. Inspiration helps stimulate creative thinking beyond 'traditional boxes'. **Outside experts** and the **RCC/RAC discussions** will present promising innovations and resolution of constraints to all the teams.
6. Good facilitation helps to overcome traditional 'turf' value differences and miscommunications in order to reach a consensus on innovations. All teams will have **professional facilitators**.
7. Ways to remove existing system constraints to these new case coordination models (such as confidentiality, federal accountability, and union rules) will be designed by innovative top managers from the affected program areas. An **executive constraint resolution team** of top managers, assisted by task groups of experts, will meet to resolve constraints to the proposed pilots.
8. While this project is organizational rather than technologically driven, e-technology (such as private chat rooms, bulletin boards, and e-mail notifications) may help with these new case coordination models. **E-technology representatives** will research software and propose supports.

## DSHS STAFF COMMITMENTS

**Each Assistant Secretary** will agree to select people for the design teams, for the executive team, and for the expert task groups. The case managers or field staff on the design teams and the designated experts on the task groups will need to devote about 60 hours over a period of three months in the spring of 2001.

- Case managers (or other field staff) who have experience serving shared clients and who are committed to finding new models of case planning and coordination.

These people will serve on the design teams that are professionally facilitated. They will spend a concentrated period of time in order to develop one or more models of case coordination (a conference day, one full week for design, and one day for review, in the months of March and April if the project is to be finished in FY 2000).

- Top managers and experts who are innovators and have experience as policy developers, with state and federal regulations, risk management, legal issues, fiscal issues, or information systems. Task groups of designated experts will propose alternate solutions. Top managers, as members of the executive team, will meet six times, sometimes for a full day. They will choose experts for the task groups, participate in the major events of the conference day, review existing promising models and the ones proposed by the design teams, choose among alternate solutions to barriers in implementing the proposed models, and review the description of the proposed pilots in the final report.
- RDA will contribute 50% of the project manager's time, and four weeks of time developing data for the design teams.

## TASKS AND RESPONSIBILITIES OF PROJECT STAFF AND CONTRACTORS

- **RDA Project Director** (full-time) will develop materials for teams, coordinate work of facilitators and outside experts, identify clients for focus groups, direct case history data collection, attend all team meetings, write up their proposals and final report.
- **RDA Special Assistant** (full time) will help with recruitment of all team members, manage scheduling, meeting logistics, and draft minutes and briefings.
- **RDA Technical Assistant** will develop materials and chair expert task groups dealing with system constraints (1/4 time) and with E-solutions (1/4 time).
- **An independent contractor** will conduct focus groups and report data on needs and experiences of different types of shared clients (and their parents or guardians).
- **An independent contractor** will interview case managers or field staff and draft summaries for each of six case histories for each type of shared client.
- **Outside experts** (contracted from Washington and other states) will provide written and oral presentations of existing examples of successful or promising approaches to case planning and coordination, including potential effectiveness and cost review.
- **Independent facilitators** will be contracted to facilitate the work of the teams and to lead the RCC/RAC discussions.
- **Project Manager:** Dario Longhi, Senior Research Manager, RDA (1/2 time)

## BUDGET

Project staff would handle the project coordination and reporting. Contractor costs vary since they depend on the number of client types addressed and the number of design teams. The RDA 'no cost' contribution (project manager and data development for the teams) is $70,000. The agency contribution of case managers, top managers and experts for the teams is clearly considerable. The overall budget needed for staffing and contractors, for three types of shared clients, is:

If this fiscal year: FY2000 $210,000 & 16.5 per person months.

## PROJECT MONITORING OVERVIEW

| **Gather Data**<br><br>*(January-March 2001)* | **Explore Innovations**<br><br>*(April 23, 2001)* | **Develop Case Coordination Model(s)**<br><br>*(April 24-26, 2001)* |
|---|---|---|
| *Research the Issue*<br>• Conduct focus groups with clients to understand their experience with receiving different services.<br>• Develop case studies of clients, which point to system coordination challenges.<br>• Solicit RCC/RAC input on current or past efforts to serve shared clients (successes and failures.)<br>• Speak with outside experts to learn "best practices." | *Conference*<br>Deputy Secretary's Comments:<br>• What's the problem we are here to address?<br>• Why is this a problem?<br>• What will happen if we don't address it?<br>Presentations on "best practices."<br>Summary of results from focus groups and case studies.<br>Summary of RCC/RAC experiences and input.<br>Suggestions from outside experts.<br>*Conference will be at the Labor and Industries Auditorium In Tumwater* | *Develop Model(s)*<br>Three Design Teams:<br>• Multiple Disabilities<br>• Troubled Children and their families<br>• Long term TANF<br>Each Design Team develops and shares the "Vision" (concept) of their model with the other teams.<br>Next, the teams develop and share the "How To's" (the practice) of their model with the other teams. |

| | | |
|---|---|---|
| | | *Finally, the teams identify and share the constraints (what's blocking them) that must be resolved for their model to be applied.*<br><br>Each Design Team shares results with the Executive Committee and receives their feedback. |

| **Executive Review**<br><br>*(May-June 2001)* | **Refine and Select the Final Model(s)**<br><br>*(July-August 2001)* |
|---|---|
| **REVIEW MODELS**<br>**Review**<br>• Design Team leaders present their model(s) to RCC's, Executive Team, and Cabinet.<br>**Problem Solve**<br>• Issues Resolution Team analyzes the constraints and proposes solutions to RCC's, Executive Team, and Cabinet.<br>**Advise**<br>• Executive Team provides advice to the Project Staff and Cabinet. | **REFINE THE MODEL(S)**<br>• Design Teams reconvene for one day to refine their model (s).<br>• Models are presented to RCC/RAC's, Executive Team and Cabinet.<br>• Cabinet selects model(s).<br>• Cabinet decides next steps for pilot testing the model(s). |
| **<u>Product</u>: Executive Team provides advice to Project Staff and Cabinet.** | **<u>Product</u>: A report that describes the best model(s) to test.** |

# APPENDIX 3

# GILMORE RESEARCH GROUP FINAL REPORT

# EXECUTIVE SUMMARY

## PURPOSE OF THE RESEARCH

The No Wrong Door—Case Coordination Project is establishing Design Teams to assess current barriers to the use of DSHS services, by clients and prospective clients, who need a variety of services simultaneously. The teams will develop model(s) for ways that DSHS could operate smoothly, effectively and efficiently for three different client types with multiple service needs.

The focus groups addressed the overall experiences and service coordination of three different client types:

1. Persons with multiple disabilities and/or challenging behaviors, for whom there are often safety and placement crises and concerns. These clients are receiving services from two or more program areas: e.g., aging, mental health, substance abuse, and developmental disabilities.
2. Troubled children, youth and their families. These are children served by Children's Administration or Juvenile Rehabilitation Administration, or any child and/or adult in the CAMIS "family case" also receiving DSHS services (from DDD, AASA, DVR, ESA, MHD or DASA, or from SSI).
3. Long-term TANF households. These are persons in the family in the ACES assistance unit, who received DSHS assistance based on disabilities, mental health, or substance abuse issues.

## RECOMMENDATIONS

1. Provide a print or electronic source of information about what services are available to clients under various circumstances so that the distribution of knowledge will be more equitable and less selective.
2. Set or follow standards for returning phone calls and wait time in the offices so that clients learn mutual respect for their caseworkers and for themselves. Direct paperwork to its correct destination.
3. Offer caseworkers training in the positive ways to interact with clients so that they will be encouraged to progress into an independent setting. Enable caseworkers to offer all of the services available that may solve the underlying client issues and not only those services that are simply stopgap measures.
4. Develop a database of information that may be accessed by any of the agencies working under the auspices of DSHS to provide client service. Access could be limited, based on a client-signed release of information form with a security code for each particular client.
5. Test the team model within a region or a specific client type to ascertain whether it is feasible to gather the various service representatives dealing with a particular client and to assess how well clients respond to that team setting.

- Use this team to plan services initially at the outset of a client program
- Reconvene the team on an annual basis to review progress and make any changes necessary
- Weigh the alternative model of assigning one main caseworker or social worker that would be more responsible for the client, almost like a primary care provider, so that this worker would coordinate referral of the client to other services.

6. Consider moving some of the agencies that work together into the same building so that there is a district service center for each part of the region where a reasonable number of clients reside.

## PROFILE OF FOCUS GROUP RESPONDENTS/GROUP COMPOSITION

### Persons with Multiple Disabilities

| Location | | Total |
|---|---|---|
| Seattle Group I= | 1 female, 1 male | 2 |
| Seattle Group II = | 7 female, 2 male | 9 |
| Mount Vernon = | 5 female, 5 male | 10 |
| Spokane = | 4 female, 4 male | 8 |
| **Totals** = | 17 female,12 male | 29 |

Respondents in the Mt. Vernon group had been dealing with DSHS for one year to 36 years. Most clients in the Spokane group had been involved with the system anywhere from six to 20+ years. One respondent, who had a sister with Downs's syndrome, has worked with developmentally disabled for 50 years.

### Troubled Children, Youth, and their Families:

| Location | | Total |
|---|---|---|
| Seattle Group I = | 1 female, 3 male | 4 |
| Seattle Group II = | 4 female, 3 male | 7 |
| Mount Vernon = | 6 female, 2 male | 8 |
| Spokane = | 2 female, 1 male | 3 |
| **Totals** = | 13 female, 9 male | 22 |

Respondents included several JRA clients, several caretakers, adoptive or foster parents, and parents with children who needed additional support.

Respondents reported that they had been on DSHS services from a few months (this time) to thirty years.

**LONG-TERM TANF:**

| Location | | Total |
|---|---|---|
| Seattle Group I = | 2 female | 2 |
| Seattle Group II= | 4 female, 1 male | 5 |
| Mount Vernon= | 4 female | 4 |
| Spokane = | 7 female, 1 male | 8 |
| **Totals** = | 17 female, 2 male | 19 |

The amount of time respondents had been on or on-and-off "welfare" among the TANF respondents ranged from seven years to about 38 years with an average of about 15 years. The number of children they had in the home was anywhere from one to seven. It seemed the majority had two children at home. Several respondents mentioned that one older child had already left the home. One male respondent said he had a wife and one female said she had a husband in the household. The remaining 17 respondents claimed to be single parents.

**Methodology**

This qualitative research study consisted of twelve focus groups:

- 6 in Seattle, 3 in Mount Vernon and 3 in Spokane
- Conducted from February 21 through March 23, 2001.
- 4 among persons with multiple disabilities, 4 among troubled children, youth, and their families, and 4 among long-term TANF clients.

Gilmore Research Group used lists of clients provided from the DSHS to contact, screen, and recruit the respondents. Originally nine groups were planned with three of each type in total and one per city. Due to the paucity of phone numbers and addresses on the initial lists provided, there was considerable difficulty in recruiting 14 respondents per group. Even when that was possible, less than 50% of recruited clients actually came to the sessions. Thus, three extra groups, one of each type were recruited for Seattle. Some of the sessions were held 2:00 or 3:30 in the afternoon, while others were held in the evening at 5:30 and 7:30 pm. Each discussion lasted about two hours.

The moderator covered the topics mentioned above as well as some general issues related to DSHS services. A copy of the discussion guide is included in the Appendix of this report.

The focus groups in Seattle and Spokane were conducted in focus group facilities, which allow viewing through a one-way mirror. The Mount Vernon focus groups were conducted in a hotel meeting room. DSHS observers were present for one afternoon session.

Each session was audio-recorded, and the Spokane and latter three Seattle groups were videotaped. Copies of these tapes were made available to clients following the sessions. The following report details the findings and provides analysis in the summary and conclusions.

## SUMMARY OF FINDINGS AND CONCLUSIONS

### AVAILABILITY OF INFORMATION ABOUT SERVICES

1. The majority of respondents in all three categories of clients said that the caseworkers or other DSHS employees seem reluctant to tell clients about all of the resources available to them for fear that the clients will take advantage of these assets and in some way jeopardize the employees' jobs.
2. Clients would like a resource for finding the information about available services. They suggested a resource book, an 800-number, or an advocate as aids to awareness.

### CLIENT COMMUNICATION WITH DSHS AND RELATED SERVICES

1. Telephone communication with the DSHS workers is described as difficult in many cases.
    - Respondents of all types mentioned that it is practically impossible to get through to their caseworkers by phone and that they rarely received return calls when they left messages.
    - Several praised the few case or social workers that do answer their phones or return their calls.
2. Mail works as a means of communication for some clients, but for quite a few others, the mail does not seem satisfactory in that it does not reach the intended destination.
    - Some of the respondents with stable addresses that had simple transactions or regular form updates find it convenient to carry out business with DSHS by mail.
    - However, quite a few respondents mentioned that when they have mailed in forms, they might get lost somewhere in the DSHS offices.
    - In some instances, respondents reported not receiving mail or not receiving it on time, due either to an incorrect or incomplete address or a late posting of the mail. If the mail from DSHS is not received, an appointment may be missed or the respondent may lose eligibility for some services.
3. Most non-disabled and non-caretaker clients said they go into the DSHS offices to take care of their affairs because they are more likely to get the matters taken care of in person.
    - Nevertheless, the office visit usually entails a large chunk of time, both in getting to the office and in waiting to see the caseworker after one arrives.

- Clients feel that they are required to be prompt, but that the workers do not respect their time commitments.
- Many clients believe that their paperwork is less likely to be lost if they put it directly in the hands of a DSHS employee.

4. Respondents in adoptive or foster care settings frequently have the caseworkers come out to visit them at home. The caseworker may be conducting a review or monitoring the situation of one of the clients. In most cases, respondents said that they welcome these visits by DSHS personnel and said that they find them useful.
5. Most respondents say that they do not have a computer, but many thought that it might be convenient to correspond with DSHS through the Internet or by e-mail.
    - A few talked about a computer in the waiting area of the DSHS offices that could be used to exchange information with the agency.
    - Other clients were skeptical about their own abilities to operate the system or send email correctly, and one person thought that the caseworkers would be no more likely to respond by email than they do on the telephone.
    - Several clients had computers but may not have had email.

**COORDINATION OF SERVICES**

1. Clients in almost every group referred to the fact that "the right hand does not know what the left hand is doing," meaning that the various agencies and services that comprise the DSHS organization do not always communicate well with each other.
    - One client had to deal with her son's repeat of former abusive behavior in a foster home because DSHS and CPS did not share information about his previous sex offenses.
2. Loss of critical pieces of information may have devastating results. Respondents in all groups indicated that they often receive termination notices due to mishandled paperwork. These notices cause distress for clients when they believe that they have fulfilled the requirements. In addition, they are perceived as a threat that they will be without necessary funds for a period of time.
3. The repetitiveness of forms was viewed as a waste of paper and an unnecessary effort by a number of respondents who were involved in a variety of services either for themselves or for a family member.
    - Some clients report that they have to turn in the regular economic services review paperwork every month to every three months, while those who have been clients longer maybe repeat the process every six to 12 months.
    - There are often similar sets of forms that must be completed for the other services such as mental health, daycare, DDD or DVR.

4. The fact that clients must visit multiple offices for various services was considered inconvenient, to some extent a waste of time, and an enormous effort for the disabled or for single parents.
    - Many clients said that they have had to visit two or three geographically distanced offices for the different services that they receive.
    - These trips are often made more arduous if they cannot drive, must take public transportation, and have to bring along young children.
5. A common database of information was suggested so that various offices and caseworkers could share the same client files, with permission of course. This method was expected to cut down on the number of different forms that a client might have to complete and reduce the loss of information when transferred from one office to another.

### CONFLICT OF REQUIREMENTS FOR DIFFERENT SERVICES

1. Some agency regulations reportedly preclude the client doing the things one needs to do to be successful or to get permanent disability status.
    - TANF clients seem to want to get on SSI as a permanent solution to the need to get off TANF after five years of receiving funds from that source. There seemed to be issues surrounding whether one must be looking for work through Work First at the same time one is trying to show one's disability.
    - Mental health visits are reportedly not paid for when one is on GAU, although they may be on GAX. One office said that the client was on GAU, while another recorded the same client as on GAX.
2. Receiving further education through one of the other DSHS-related rehabilitation programs might be more valuable than completing the ESA's Work First program according to some who would prefer to spend time in college courses that train them for better jobs.

### SINGLE CASEWORKER VS. TEAM APPROACH

1. The majority of clients expressed interest in the team approach to dealing with a client that uses multiple services, although they saw both the pros and cons of such a model.
    - Respondents felt that it would be more efficient and speed up the process to have all of the services "on the same page" and planning the client's options in a coordinated way.
    - Some believed that the team approach might balance out those caseworkers or social workers that had a positive attitude toward the client with those who seemed to have a negative attitude toward the same client.
    - The main drawback for some was that facing a group seemed a bit intimidating.

2. Those who were hesitant to face a group of professionals or favored one-on-one interaction would prefer one or the two following options:
    - See one caseworker that coordinated all of their other services
    - Have the team meet separately without the client present and then have one representative convey the results.
3. There was some skepticism on the part of clients about DSHS' ability to get all of the representatives together for a team meeting. Thus, it was assumed that such team gatherings would take place only at the outset of a program or if there was a crisis to address.

## PERSONS WITH MULTIPLE DISABILITIES

### OVERALL EXPERIENCE

**Variety of Programs Clients are On/In:**

- Home health care
- Food stamps
- DDD
- COPES
- Medical coupons
- SSDI
- SSI/SSA
- TANF
- GAU
- Work First (FIP – in past)
- CPS
- CAP

**Challenges:**

- Being told that one's services would be discontinued, being terminated, in part related to lost paperwork or lack of competent workers.

*"So I get this letter that I'm cut off, so I go in there to talk to them. In the letter down at the bottom, it said, 'and/or,' and this person that didn't speak English could not grasp. She thought—she says, 'Oh, that means you've got to do both things.' It's like 'No—and/OR!'…I'm all for giving somebody a job, but…you should have somebody that doesn't have an attitude problem, you know, and can understand the language." (Mt. Vernon)*

- It is a challenge just getting information on what is available– lack of accessibility.

*"I mean we've been everywhere, we've called, we've spent lots of hours on the phone trying to find out what services are out there. But there is just nobody that's going to give you the answers, so it's a lot of networking with people you know and finding out how did they get that." (Seattle 1)*

*"It's like if you don't know the right questions, you don't find out [what services are available]." (Seattle 2)*

*"For me, it's they don't tell you anything." (Spokane)*

*"You have to be willing, initially, to commit a couple of days of just sitting in that office to work through the maze…" (Mt. Vernon)*

- Various DSHS offices seem to have different attitudes and different levels of customer service. In Spokane, the west side office is perceived as being more responsive to client needs. In Seattle, there was differentiation as well:
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- "I think they (DSHS staff) are prejudiced. I think the poor people don't get nothing, and they give more stuff…more money to the people in the better districts." (Seattle 2)
- 
- "You're the lowest thing on the totem pole." (Mt. Vernon)
- 
- Turnover of caseworkers is difficult for clients: they do not always know who it is or what to expect and they have to reacquaint the caseworker with the case.
- Clients perceive that there is an unnecessary amount and repetition of paperwork:

*"Why do you have to, you know, keep filling the forms out every month? They have so much paperwork to do. It seems like they create if for themselves, you know" (Seattle 2)*

- There is no transition between receiving benefits and becoming independent once one is working.

*"I think they need to help the next level of people, because they give you all kinds of services when you are not working… but then as soon as you start working, they cut you off for cash, they cut off your food stamps…" (Spokane)*

*"They need to give you more help in those first steps when you are trying to help yourself."*

- Clients frequently must wait a long time to see a caseworker when they go into an office.

*"[I use] Phone and mail. Going in and talking to them and sitting in their office for hours." (Mt. Vernon)*

- It is difficult to maintain services when one moves from one address to another.

- Burnout of chore workers due to poor pay and working conditions.

**Positive Experiences:**

- Case manager is very helpful and works well with chore manager.
- Some great case managers with DDD but they don't stay long. 2-3 months, 6 or 7 at the longest.
- The following are examples of caseworkers who are helpful:

*"Well, I'm satisfied with my worker because he has offered me different programs and encouraged me to stay in for my treatment." (Seattle 2)*

*"My caseworker helps me manage my money." (Seattle 2)*

*"I have a good worker…even from her own house she'll call me and say, 'Did you get that paper? Did someone read that paper to you.'" (Seattle 2)*

*"I've never had any problem in the system at all; it went just as smooth for me as it could…I ended up in the hospital in Mt. Vernon with a dislocated shoulder, and a social worker came to see me and said, 'You need to have these services' and the next thing I know I am getting SSI." (Mount Vernon)*

*"They gave me a phone and answering machine – clothes and stuff." (Spokane)*

*"They had someone there to help me get through the social security red tape." (Spokane)*

- One respondent had the impression that degreed caseworkers were better – better listeners, better at personal interactions.
- Some reported that they appreciated the good services they have received:

***"****Every time I need to go to treatment, they're there for you to help foot the bill, and it's not cheap to go to treatment." (Mt. Vernon)*

*"We've been on medical coupons for quite a while, and my youngest son had bad teeth…His teeth were so bad that he [got an infection in his] tongue. He couldn't eat. But for the next two years, he went to the dentist [DSHS paid]." (Mt. Vernon)*

**INTERACTION**

**By Phone:**

- **80%** is by phone, but it is frustrating.
- Some still prefer the phone because it is difficult for them to go into the offices.
- One respondent has been with DSHS for 3 or 4 years and has had five caseworkers, so when he calls he is never sure he is asking for the correct person (not notified of changes).
- A Spokane respondent had the perception that DDD is better on phone messages than DSHS.
- Others have problems with phones that are always busy or not picked up:

*"Well, my mother's experience has been that when she calls in she usually gets an answering machine, and sometimes it's several days before they get around to returning the call, even if she calls in 2 or 3 times." (Spokane)*

*"I've had the same worker for the last six months, and I have never heard from her, and I have called her numerous times over different things." (Spokane)*

**In Person:**

- Some say they go in person every three months to once a year.
- Clients go in person when necessary, like when the caseworkers have misplaced their paperwork.
- One respondent indicated that about 20% of the time, the DSHS workers come out for visits.

**By Mail:**

- These respondents interact frequently by mail.
- Some get paperwork and return it by mail.
- Paperwork mailed in often gets lost or buried.
- Some get notices in the mail for appointments that take place that day and it is too late to make arrangements to get there.

*"I like it when they call you up and say you missed your appointment, and we sent you two letters, and it (the letter) doesn't show up." (Spokane)*

**By Computer:**

- One person said that DSHS had some computers available to clients for a specific purpose:
- "They've got computers in there, but that's for the Work First program." (Mt. Vernon)
- One respondent has a computer but never considered email as an option.
- A couple respondents in two of the groups said they would like to do email with DSHS if it was made easy.
- A few Spokane respondents had access to a computer, but said they probably wouldn't use email or wouldn't know how. One thought that if they don't return phone messages, why would email be any different?

**Other Means:**

- One respondent said a "protective payee" picks up things and handles them for the client.

**ASPECTS OF SERVICE COORDINATION**

**Different Forms/Repetitive Paperwork:**

- Forms for food stamps are considered the worst and some clients need help to fill them out:

*"I think we all need to take a course. There needs to be a college course on forms for food stamps." (Seattle 1)*

*"Every time we had to fill out forms for my mother, well it's about 8 or 10 pages, and maybe it was only supposed to be for food stamps, but you gotta give her life history and everything else…and they just got the information 6 months before." (Spokane)*

- There are many different kinds of forms to fill out and some information might be shared:

*"I got forms for food stamps. I got forms for Medicaid. I got forms for I go to private counseling and therapy…." (Seattle 1)*

*"My caseworker has the same information my daycare worker needs. Well, why can't they just get off their butts and walk over there to the desk and get the information?" (Spokane)*

"I have to fill out all kinds of forms. It's every three months, and when I go to mental health, I've got to go through their thing and have their evaluation and then it's go back to DSHS, and I got to fill out their paperwork and stuff too. There's a lot of paperwork, and it's every three months that I got to do it." (Mt. Vernon)

**Different Offices for Different Services:**

- Food stamp worker in one office – SSI in another.
- Lots of different offices.

**Services Coordination:**

- It is difficult because…

*"Every service has different rules…"*

*"The right hand doesn't know what the left hand is doing."*

*"It doesn't even necessarily mean the case manager would have to do it, but the case manager can coordinate things." (All above from Seattle 1)*

*"The mental health system is not getting paid anything when you're on the GAU, and so they kind of look down at you. The counselors don't seem to want to dig deeper and help. …And I can't go and see Dr. Backmann until I get that GAX coupon. So I talked to the supervisor over there at mental health, and she told me I have to go in there AGAIN, and this will be the second time that I've went in to DSHS. It's not right." (Mt. Vernon)*

- It would make life easier for clients if they did not have to do the coordinating.

*"I'd like to see them get their act together a little bit better to where you get stirred in the right direction to begin with instead of going back and forth and back and forth to different people." (Mt. Vernon)*

**Single Case Manager vs. Multiple Case Workers:**

- A few clients said they would prefer to have a single case manager because they had concerns about the team approach.
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- " I really like it when you get a good case manager that's there." (Seattle 1)

*"Well, I have two, and then I'm always getting confused with – actually have three…and trying to keep track of which one do I talk to…" (Seattle 1)*

*"I don't think the team would benefit me because both my workers suck." (Spokane)*

*"I'd rather deal with one person than a group." (Why?) "Get too much lost in the team."*

*"It's a lot more comfortable to try to talk to one person about your personal problems than it is to talk to a big group of people." (Mt. Vernon)*

- A number of respondents indicated they would like a team meeting approach – perhaps once per year.

*"I think a team would be a lot better because then you would have four different perspectives." (Spokane)*

*"CPS. I got a team. We all get together for staffings and figure out next what we can do for me…I got to tell them what I need, and that's the hard thing you know." (Spokane)*

*"I imagine, if I was connected with a lot of the different services all at once that I'd probably want all of my different people talking with one another to make sure that everybody knew what was going on so they can better serve my interests." (Spokane)*

*"It wouldn't take you as long. I mean, as …you can get things done quicker if it's a team of people…the more people the better, you know." (Spokane)*

*"I just think it would be nice if everyone was on the same page." (Mt. Vernon)*

- Others said the various people involved in your case should communicate with each other – perhaps have a meeting to develop a plan for your services…but without the client present.
- There were a few types of workers that some clients would not want on their team. One respondent said that he might not want DOC on his team, but that it would depend on the individual worker, because there are good ones that he would want on his team.
- Most said they would like to have more time with their caseworkers. Some thought maybe an hour every 90 days would be nice.

**Suggestions for Ways to Improve Service:**

- Clients would like to be treated as more than a statistic or a piece of paper

*"Just see that these are people, not pieces of paper." (Seattle 1)*

- Clients need resources so that they can discover what services are available to them.

*"I think the reference book is awesome. There needs to be something where those services are listed…and all of the services listed." (Seattle 1)*

*"Well, I think they need somebody that would explain what is available to you, to us."*

*"Some sort of orientation thing when you first walked in the door." "Maybe more TV ads, radio ads, just through mailings or whatever to let the general population know what kind of services are available to the individuals that just need those type of services." (Spokane)*

*"Just have like a network computer or something up in the front waiting room or whatever, where you can access…what you need help with, and then it tells you all the services provided…what you need to do." (Spokane)*

*"How about an 1-800 number that we would call and have a phone option thing for maybe new services…like a menu that would say, like, …medical could be one, finances, housing." (Spokane)*

*"A client advocate? They used to have those about ten years ago." (Mount Vernon)*

- Offer release of information forms so that various people a client sees within the system could share the information
- Clients would like to have the paperwork and office visit procedures simplified:

*"One office visit (once a year) and it would take care of the whole thing." (Spokane)*

*"Put them all in the same building." (Mt. Vernon)*

- Provide outreach to prevent people from falling through the net.

## TROUBLED CHILDREN, YOUTH, AND THEIR FAMILIES

### OVERALL EXPERIENCE

**Other Services besides Welfare:**

- CPS
- Mental health
- Work First
- DVR
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**Challenges:**

- One does not always know what services are available under various circumstances.

*"It's been kind of a complicated journey in finding out what the children are eligible for, what services are available…I still keep kind of piecing things together. I had the kids for two years before someone said, 'Oh, yeah, we should be paying your daycare.' So there were kind of some issues there after I spend $15,000 out of pocket." (Mount Vernon)*

*"I've been dealing with DSHS and their lovely little plans here for 11 years, and up until two years ago I didn't even know there was a DVR program. There's a lot of programs that they have that they don't tell you about, and that can be really frustrating when you do find out about it…You know, for 9 years you guys could've told me I could've done this, and now I can't do it? You know, when it could've already been out of the way. And I wouldn't even have to deal with you guys anymore, I'd have a job, you know. So there are services that they do have that unless you hear about it from somebody else, they won't offer to tell you about it. And that's been my experience through a lot of the services. I mean I've had workers come up to me, 'Where did you hear about that?'" (Seattle 2)*

**Positive Experiences:**

- Caregivers and foster parents usually find DSHS caseworkers cooperative and willing to call on them at home.

*"I've had really good rapport with DSHS caseworkers. I have four different boys, I have four different caseworkers, and I call any of them, and they're right there…If I want them to come out, they come out, or we discuss something over the phone and we do that." (Seattle 1)*

**INTERACTION**

**In Person:**

- Clients who are caring for problem children in their homes are likely to receive frequent visits from DSHS caseworkers.
- Clients who go to the offices may have to wait a long time to see a caseworker.

*"He's got me here, tell me to come in at 9:30. I got there at 9:00, and…I was there 'til 2:00 in the afternoon, you know? Hours and hours and hours…I'm not the only person, and, you know, a lot of people are sitting in there, and, you know, the same caseworker made them all appointments, and he wasn't going to be there. And he knew it. It was a planned vacation." (Seattle 1)*

**By Phone:**

- Some seem to have relatively simple transactions and established relationships so that they can conduct business over the phone.

*"All mine's been over the phone. Everything."*

**By Mail:**

- For some clients, including at least one adoptive parent, most of the arrangements could be carried out by mail.
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*"I really didn't do a lot of running around to offices, and when we set up the adoption support it was all through the mail and over the phone." (Seattle 2)*

**By Computer:**

- Several respondents indicated that they would like to access services or update forms by computer or on the Internet.

**ASPECTS OF SERVICE COORDINATION**

- Different Forms/Repetitive Paperwork:
- Same information has to be supplied repeatedly to various agencies within the DSHS system:

*"I did fax her a copy of the paperwork I got from the CSO office, and then now I have to get all the information from the schools again, and it would be so much easier if the caseworker would just send them copies of what I gave her." (Seattle 2)*

*"You have to run the paperwork from one agency to another one and to another one. And then, when they get to court, if the paperwork don't jive from one to another, you have to do it again." (Seattle 2)*

**DIFFERENT OFFICES FOR DIFFERENT SERVICES**

- Some of the respondents seemed minimally involved with other offices besides the main DSHS office. However, those that were visiting more than one would find it more convenient to have them co-located.

*"Half my family is on DSHS on TANF, and the other half is on SSI. Well, my DSHS office is in West Seattle, but my SSI office is all the way in Burien. So, it's quite a travel…it was in West Seattle. They just decided to move their SSI office down to Burien." (Seattle 2)*

*"When I was having problems with Support Enforcement and CPS, because the CPS worker was there with a Support Enforcement officer at one point in my home, so I wound up bouncing between DSHS, Support Enforcement and the CPS work. So, I had to hit three different offices, all within three days—a couple of different times to each office." (Seattle 2)*

**Services Coordination:**

- There is a lack of communication between different service offices.

*"I'm dealing with three different agencies…I have DSHS, I have CPS, and DOSE. And they don't interact…They don't communicate with each other, and you have to end up repeating the same steps over and over…They don't talk amongst themselves to end any of the confusion to speed up anything." (Seattle 2)*

- One solution suggested was a common database.

*"They would go back to like if they did the main database thing where they input your file. The computer would automatically read it and there'd be red flags on it that would say, okay, he's qualified for this and this and this and this. You know, then your caseworker wouldn't have, you know, you wouldn't have to be running around, well, do I qualify, do I qualify, fill out this form, fill out this form." (Seattle 2)*

**SINGLE CASE WORKER VS. TEAM APPROACH**

- Some clients would like to have their main caseworker do all of the coordinating for them, so that they do not have to run around or do repetitive paperwork.

*"I think it would be better if they had one caseworker that coordinated everything." (Seattle 2)*

*"It'd be easier, more personal, that you could deal with that person. They could, you know, …help you, assist you to fill out what you needed to do instead of going and coming back another day to see the one for medical or daycare, childcare." (Seattle 2)*

- Other clients thought that the one caseworker might not be familiar with all of the different related agencies and services, especially if that caseworker were new on the job.
- A few of the clients had experience with the team approach and found that it worked very well. Many in at least one group liked the concept.

*"Seattle Mental Health – in the children's department, when the kids are with them, if it's a severe enough case they will form what's called an IST, an interagency staffing team, where they get everybody that works on that case – CPS, DSHS, you name it, they're there – and you all sit down, you all talk about the different – okay, DSHS will say it will – in our area this is what's going on. CPS will say in our area this is what's going on. And by the time you get around the room, you know where everybody is, what page they're on, and then you form this plan, you know. And you down, okay, and then they talk to the parent and they say, okay, well, what services do you think you need, you know? And that way everybody gets involved…so if they did something like that, I think that would be good." (Seattle 2)*

*"If you feel uncomfortable with a certain worker that shows up in that group, you can voice that in there and you feel supported by the other workers that are working with you that are positive with you…In a group atmosphere, no matter whether that person likes it or not, they're going to behave themselves because there's other people around." (Seattle 2)*

- Some would find a team intimidating and would prefer to work with a counselor or caseworker one-on-one. One client said that the workers could meet as a group without him present, and that one caseworker conveying the information to him.

#### SUGGESTIONS FOR WAYS TO IMPROVE SERVICE

- Clients would like some flexibility in scheduling review appointments so that they can accommodate their children's or their own schedules.

*"I think one of my biggest problems with them is like when I go in for my review, I have a five year old. She only goes to school half a day. And not having transportation, I have to catch the bus everywhere. And when they give you an appointment at 9:00 in the morning and your child has to be at school at 8:30 and you have to catch the bus –it's kind of hard, because then your child ends up missing a whole day of school just so you can go to an appointment." (Seattle 2)*

- Send out completed paperwork and ask for changes rather than asking the client to rewrite the forms quarterly.
- Have one common database for the whole DSHS system and better communication between agencies and services.

*" That they just worked off the same base network file system. I think it would eliminate a whole lot of problems." (Seattle 2)*

## LONG-TERM TANF

#### OVERALL EXPERIENCE

**Other Services besides TANF:**

- An amputee, went to DVR
- SSI, some in each focus group, or applying for it
- Service Alternatives (can work at a non-profit and get paid, while on grant money)
- Took care of aging Mom on Copes
- CPS
- Spokane Counseling and Networking (SCAN)
- ADATSA (program for those addicted to alcohol and chemicals)

**Challenges:**

- Inability to get/keep a job

*"Without addressing some underlying problems, you can throw all the money that you want at somebody and it's not going to change their basic abilities. …My housing was never addressed, and my emotional state was never addressed. They gave me money to go to school, but I couldn't maintain housing or emotional stability to maintain school. They did what the rules said they could do, but they didn't look outside the box as far as what was really causing me to not be able to function well enough to support myself and get through a quarter." (Seattle 1)*

- Caseworkers do not always tell clients what resources are available to them.

*"They act like it's coming out of their pocket." (Spokane)*

*"There have been numerous times when I have not been offered that, and I didn't know it existed." "Yeah, lack of knowledge, and they weren't going to tell you what was available." (Seattle 1)*

- Client lack of self-esteem.

*"I felt that I'm not worth being helped. I'm not worth getting any education. I'm not worth nothing but a welfare recipient. And I tried to be optimistic and I tried to have a positive outlook. But it seems that nothing changes. And I know it was a tactic to get me off the welfare system by taking away the child support, but when they did that they took away a lot of the quality of life." (Mt. Vernon)*

*"The overall is low esteem which keeps me from going out there saying, I can – I'm a good person, I'm just as smart as you, and I can work this job and be a part of this society, you know? A productive part, right? That's – that's where the part down here with the Welfare check coming in is the low self-esteem."*

- Client inability to get disability:

*"I'm stuck between a rock and a hard place where they want me to work, but SSI doesn't want me to work. But if I don't work, then I don't get money, if and I do work, then I don't get money [through SSI]. So they're going to make it so I can't get SSI, the DSHS." (Mt. Vernon)*

- Number of different caseworkers:

*"I have five different social workers that I had, and one didn't know what the other one was doing. And so finally it just finally got straightened out where Norinda—He was a social worker, because I had like social worker and a caseworker and a Work First worker, and a couple other ones, I don't remember their names…Anyway, so one didn't know what the other one did, and…Norinda finally said, 'Do what I tell you. Forget about what other people are telling you.'*

*So I finally got used to him, and then he left. And now…start all over again. You gotta do the same hoops." (Mt. Vernon)*

*"I've had five different workers in the last seven months. Five different workers." "I've had the same one for like five years." "Oh, you're lucky." (Spokane)*

*"I've probably had 30 caseworkers in the last 10 years." (Seattle 2)*

- Inability to get to see worker:

*"You go to this one up here, the one on Francis, and there's no walk-ins. So they won't accept your phone calls, and then you can't come in and get help. What's up with that?" (Spokane)*

*"I left my caseworker messages for like three weeks, and he still never called me back. I went down there and stood down there for over two hours, and I never got to see him…. He was there but he was seeing other clients that had come in before me, and I'd gotten there at 2:30, and their walk-in hours are between 2 and 3, and he just didn't have enough time to see me." (Spokane)*

**Positive Experiences:**

*"There is a person at the office that I go to who's changed my life by being available on the phone, by remembering me, by seeing me at the drop of a hat…at Welfare…She's a social worker." (Seattle 1)*

*"Lake City has a community—— they have a workforce there that has been there for awhile. There's a core of women there. The supervisor that – one of the head supervisors is this phenomenal woman, and they have an esprit de corp. there. They care. They care. And they express their concern; they express their love. They are not riding your tails, looking at you judgmentally…that has been one of the major things that has helped change my life. I've been there I think a couple – maybe going on three years, and my life has just been steadily, steadily, steadily improving, and I've developed relationships with the people at the office there, and I feel safe. I don't feel like I have to hide, or that I'm a rat scurrying in for my crumbs, you know, which I don't deserve. I feel like a human being that they care about. I tell you, and they're not stingy. They're not trying to cover – hide resources. All the other offices, they're not going to tell you what they – they could give you. In fact, one – one lady even told me if I didn't find a place to live, because I was being evicted, that she was going to make sure my assistance was cut." (Seattle 1)*

*"I have my son working with a DVD specialist, and she comes out and she's really wonderful. She's about the nicest person I've ever met that works with the DSHS services." (Spokane)*

*"Some of them try to be pretty helpful…like your electricity's turned off, you know, and you go to them, and you actually get a hold of them. You know, there's some things that they can do that's helpful. And in other organizations, like the SNAP program, I think that's one of the best programs around here…Spokane Neighborhood Action Program. I mean, they've done all kinds of things for me…(Related to DSHS?) It must be, because Spokane Works comes off of it. They work with Spokane Works, and Spokane Works is tied in with both of them." (Spokane)*

*"My social worker is wonderful…she came out to the house and she got it set up so he was getting daycare, and they paid for two months of an old bill that I had with the college at the daycare. And then my landlord was trying to evict me the same month I got the check, and she said use that to help pay your rent off…plus she's trying to help us find a behavioral counselor, you know, for him. And she helped me get somebody to come out to the house and watch him and get that all set up, you know." (Spokane)*

**INTERACTION**

**In Person:**

- Go in for eligibility review every 3-6 months for food stamps, welfare; 1 time a year for supplement, and just now applying for DVR.
- Clients often say that they have to go in to an office more frequently at first and then the time interval between reviews becomes longer.

*"When you get on DVR, you get a regular counselor that kind of works with you." (Seattle 1)*

*"They usually have a monthly check-in, eligibility check-in. Now, it's every six months. It varies." (Mt. Vernon)*

*"First I have to go to –every 30 – every 90 days I have to go in for a new evaluation, and…Then I go from there to mental health. Mental health I have one, two times a week I speak with my counselor…Then three days a week I go to see MICA – mental illness, chemical addiction." (Mt. Vernon)*

- Some go into the office to deliver paperwork so that they have proof that it was delivered:

*"I've learned to keep my copies of turning in of the papers. Keep a copy of it. If you don't, [they say] you haven't did (sic) this…They stamp it and they have to sign it and it's your proof that you did turn in the paperwork." (Seattle 2)*

- One usually has to wait for some time when one visits the DSHS offices:

*"I go in like everybody else—really, just sit and go in there and wait and wait and wait, and see somebody, maybe two or three years [hours]. Same question that they ask you every time you go….It's really just going in like that's part of their job. As long as there's somebody sitting in there waitin', it look like they're doing some work…You might be in there two, three hours, and they barely call a name or two. And nobody's working that hard." (Seattle 2)*

**By Phone:**

- Clients try to use the phone, but often give up and go into the office.

*"Your can't get through on the phone, no way hardly." (Seattle 1)*

*"I don't do the phone call thing, ' cause if they get the message or not, or you get the answering machine, or if they're going to call you…I always go there." (Seattle 2)*

*"I usually do it over the phone, but lately it's been in person, because…they don't call you back at all." (Spokane)*

*"I start with the phone, but I have a lot of problems getting through, too, so a lot of times, I just give up and go down there. And then I'm told she's not there…" (Spokane)*

*"This one I got—they just changed me last week—and I got her on the phone. I didn't get an answering machine." (Spokane)*

**By Mail:**

- They have experiences with lost paperwork:

*"You can mail it in, but that's about as far as it goes…They send me a return envelope with postage paid…I filled it out, I'd send them in, they'd say they never received them…I kept a copy, so I just sent another one." (Mt. Vernon)*

**By Computer:**

- Very few have computers, and some may have been hesitant to say they did.

*"I have a 7-year-old son that knows more about a computer…Well, I have one…[but] I'm scared to let them know I have one." (Seattle 2)*

- Some said they would like that method if they had access to a computer.
- One or two said they had seen a computer for client use in one of the DSHS offices. Some others thought there would just be a line up at the computer.

**ASPECTS OF SERVICE COORDINATION**

## Coordination with CPS

- A number of the respondents in the TANF as well as other groups were currently or had been involved with CPS. In a number of cases, the parent had to give up the children during a type of treatment for drugs or alcohol abuse. In some cases, CPS referred them to other agencies:

*"I was CPS involved, and they referred me to…SCAN, and SCAN was supposed to do all this stuff for me, and they just didn't do any—they were supposed to come visit once a week…but they never—they didn't come visit me like they were supposed to." (Spokane)*
*"Casey Family Partners is hooked up with Child Protective Services. And they're kind of—they kind of get around in a group and tell you basically what you need to do and what you're not doing. And usually when you come out of a meeting from them you feel about this tall." "That really depends on who you get on your team. I know when I first got involved I was also CPS involved, and I had Sue on my side, though. She really stuck up for me." (Spokane)*

## How out-of-state situations are handled:

*"The state of Washington will not maintain a person on methadone. There's nothing – no place that the coupons will pay for, …but the state of Washington will pay Oregon. They paid the bill in Oregon for me to go across the border to a hospital there, psychiatric hospital that the state of Oregon says, okay, maintain her on methadone, it's okay. And Washington State will pay them. That's – those are strange things that need addressing." (Seattle 1)*

*"We made a deal before I moved to California for my son to get his heart transplant. They were going to cover the transplant, they were going to give us medical and food stamps and a check while we were there. As soon as we left the state of Washington they dropped everything they said.*

*We lived in California for 8 months with no money, no help from anybody. A week before we came back to Spokane, then they said, oh, I'm sorry, we said that we were going to do this, and we're supposed to do this, and then they sent us a check and food stamps and a medical coupon that we couldn't even use in the state of California anyhow." (Spokane)*

## Other lack of Coordination of Services:

*"I've been waiting for two weeks now for my bus pass to my job…and still haven't got it…They expect me to continue to keep my job, yet they're always late, and I let them know a week before the first I need a bus pass. I'll get off work half an hour early just to go get it, but I don't hear anything back. And then I go in there and nobody's in there." (Spokane)*

*"They don't treat you like they're joined establishments. You've got to go through the hassle of dealing with them all." (Seattle 1)*

**Positives When Coordination Works:**

*"One big package. I got my schooling, my treatment, and my counseling, all in one building, so I was like, cool, I can handle this." (Spokane)*

**SUGGESTIONS FOR WAYS TO IMPROVE SERVICE**

- Clients would like to feel comfortable rather than fearful when they enter the DSHS offices.

*"Like she said, she's able to operate in confidence….as where I'm still operating in fear." (Seattle 1)*

- Respondents would like a collaborative rather than adversarial relationship with their workers.
- It would be preferable to clients to provide all of the DSHS services in one location:

*"What I was thinking, though, is that if they had a system that kind of umbrella'd a lot of services where people didn't have to run around for their mental health care, for their substance abuse care, and stuff like that, and had it all under one roof, I think that would be –[good]. (Client was interrupted by another client)." (Seattle 1)*

- One social worker directs the client to all of the various services needed or available:

*"The social worker. She's a human being with a brain who's looking at the big picture. And she knows about – she knows all the services, and she has my best interests at heart, and …she's helping me identify what I need and what's out there, because she's looking at me as a whole person."*

*Some would prefer to have the whole team together once or twice a year.*

*Others would rather have only one main worker and referrals to the other services.*

*"I like the autonomy, because I can choose if I want them to communicate, to better provide support services… you put all those people together, it's kind of like a judge and a jury, you know. They're going to kind of get a consensus going. They're going to kind of make a flat decision about you. Whereas when you have it decentralized like this, I think there's some competition among the agencies." (Seattle 1)*

# DSHS SERVICES COORDINATION

**DISCUSSION GUIDE**

**Introduction of procedures, topic and each participant—15 min**

Thank you for agreeing to take part in this research project on services that are provided by DSHS staff or through various agencies in the community under the direction of DSHS. We are interested in getting feedback about your experiences in using some of these services,

DSHS wants to provide the best possible services, so they are trying to learn how they might improve the way that their services are coordinated and to find out what your preferences would be. This is just one of nine such groups that we are doing around the state over several weeks. DSHS is also interviewing case managers around the state, to get their ideas about service coordination and improvement. Then, DSHS will take the information from these focus groups and from the interviews to put together a proposal for improving services.

Before we begin I want to tell you that we are audio/videotaping this session. This is because I will be writing up the findings of all the groups and it is impossible for me to take enough notes to remember all the interesting and important things that are said across nine groups. The tapes will be used for research purposes only.

There will be no identifiers other than first names used on the tapes. In the final report, no names will be used and the findings of all the group discussions will be combined. We don't quote people, only ideas. The information we gain here goes directly to my company, Gilmore Research Group, which is an independent research company. We will protect your identity and we guarantee that your name is not associated with any of the information you provide. You may refuse to answer any question and you don't need to bring up anything that you might be uncomfortable sharing with the other people here.

<u>Your participation in this group will have no impact on any government services you may be receiving now or in the future. No one will know what you individually said tonight.</u>

IF MIRROR FACILITY: You may also have noticed the mirror. There are several viewers on the other side of that mirror. They are people who are working with me on this project and are also interested in what we are learning in these group discussions. Having them in the room can be distracting, so that is why we hold these discussions in this type of facility where they can watch and listen without influencing the discussion.

IF NON-MIRROR FACILITY: You may also have noticed that several people are (one other person is) here in the room with us. These are people who are (She is) working with me on this project and also interested in what we are learning in these group discussions. I have asked them (her) to sit to the side so they (she) can watch and listen, but they (she) will not be part of the group discussion.

If, for any reason, you feel uncomfortable being taped or viewed and wish to exclude yourself from the group, you may do so.

IF ANYONE VOICES CONCERN AND WISHES TO BE EXCUSED, TAKE THAT PERSON OUTSIDE ROOM, THEN PAY THE INCENTIVE FEE, THANK AND EXCUSE THE PERSON.

*Great, let's get started. A final few ground rules are:*

- We'll all try to be sure that everyone has an opportunity to express their opinions and just so that we are sure to hear, please speak up at same level as I am.
- Only one person speaking at a time.
- No right or wrong answers, want your honest opinions and suggestions.
- Feel free to help yourselves to refreshments at any time.
- Please keep what is said in the group to the group

**RESPONDENT INTRODUCTIONS**

First name?
What town or part of town you live in?
How many in your household?
How long you have been working with the various DSHS programs, to get access to services you need, or someone you care for needs? Here is a list of those services, and the DSHS program areas that administer them (REFER TO LIST OF SERVICE TO SEE WHICH ONES WE ARE TALKING ABOUT.)

**OVERALL EXPERIENCE-15 MIN**

Do you mostly find out about DSHS services yourself, working with DSHS case managers or workers, or does someone else – a lawyer, a worker in some other organization, a client group – help you find out about and apply for DSHS services?

Think of the ways that you interact with the people who provide some of the services through DSHS. (Is it by phone, in person, by mail, by email?)

- Which ways do you prefer and why?
- Would you prefer to contact these people by email? Easier or more difficult?
- Do you have a computer? Is one accessible to you? In what way?

What are the positive things about the way you interact with the workers that oversee or provide the services, such as the ones listed here? What makes that a good experience for you?

What difficulties, if any, do you have in getting the services you need? What makes that difficult?

(Jot down any notes you would like, so that you remember them when we come to you?)

**ASPECTS OF SERVICE COORDINATION-30 MIN**

Over half of people who use DSHS services use services from more than one DSHS program. Or sometimes, the families use services from several programs. These next questions ask you about your experiences with using multiple services administered by several different programs.

Access

Do you need to fill out many different forms? How is that?
Do you need to go to many different offices? How is that?

Coordinated

How is it fitting the various services together?
Dealing with different people for different services?
Figuring out what you are eligible for?

# APPENDIX 4

# CASE STUDIES FROM INTERVIEWS OF FRONT LINE STAFF

## NO WRONG DOOR – CASE COORDINATION PROJECT
## CASE HISTORIES

**CASE HISTORY MANAGER: JUDY OLMSTEAD, (360) 902-0728,**
OLMSTJV@DSHS.WA.GOV
**PROJECT MANAGER: CAROL WEBSTER, (360) 902-0714, WEBSCA@DSJS.WA.GOV**

During the data gathering phase of the project, case histories of 18 clients will be developed which will point to system coordination challenges.

All the case managers involved with the selected 18 clients will be interviewed; thus, if a client has received services from DASA, DDD, the RSN, and DCFS, four case managers would be interviewed. The client will not be interviewed. Client perspectives were gathered in focus groups conducted by Gilmore Research. The geographic areas used both for the client case histories and for the focus groups are in Regions 1, 3, and 4.

From each of the three geographic areas, six case histories will be collected, two each from each type of shared clients:

1. Persons with Multiple Disabilities
2. Troubled Children, Youth, and their Families
3. Long-term TANF Families

The four interviewers are Virginia Frost, Judy Olmstead, JoAnn Ray, and Carol Webster.

**What does this mean for program staff in each geographic area chosen?**

- Project staff from Research & Data Analysis will contact the appropriate administrators in each area to make sure they have heard of the study, and will observe the notification procedures each administrator deems appropriate. Thus, in one region the Regional Administrator may delegate all direct work with the project to other levels of staff, but request a voice mail notification about each client selected to be the focus of interviews. As appropriate, field services administrators, county coordinators, and others will then be contacted by the interviewer.
- In the specific office or treatment center, the head administrator will be notified of the study, and of the needed staff involvement. Again, that administrator will direct the interviewer regarding whom to contact next, and how.
- One type of staff involvement is straightforward: the interviewer will have the name of a client and his/her case manager, and will want to interview that case manager. The interview takes approximately an hour and a half.
- A second type of staff involvement is more complex: The office or treatment center may first be asked to help choose the client from a list of clients. Depending on the specific program, the method for making this choice will vary, and will have to be worked out with the Research & Data Analysis interviewer involved. After the client is chosen, the relevant case managers will be contacted and interviews will take place.

Please contact Judy Olmstead, who is in charge of the case histories, or Carol Webster, overall project manager, with any questions. We appreciate your help.

## SAMPLING FOR CASE STUDIES

*Cases were selected from lists of shared clients provided by Client Registry in three regions: one in Eastern Washington (DSHS Region 1), one in an urban area (DSHS Region 4) and one in a more rural area in Western Washington (small town in Region 3). Final selection was made with the input of front line staff from various program areas. The specific programs which would provide input was chosen based on the proportion of shared clients served by that program. Regardless of initial input, on average 3 to 5 interviews were conducted with all front line staff, from various programs, who had served the shared client.*

### PERSONS WITH MULTIPLE DISABILITIES

| | |
|---|---|
| Region 1 | 1 – MHD |
| | 1 – DDD |
| Region 3 | 1 – MHD |
| | 1 – DASA |
| Region 4 | 1 – AASA |
| | 1 – DASA |

### TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES

| | |
|---|---|
| Region 1 | 1 – DASA |
| Region 3 | 1 – DDD |
| | 1 – CA |
| Region 4 | 1 – CA |
| | 1 – MHD |
| Western WA | 1 – JRA |

### LONG-TERM TANF FAMILIES

| | |
|---|---|
| Region 1 | 1 – MHD |
| | 1 – ESA (TANF) |
| Region 3 | 1 – DCFS |
| | 1 – ESA(TANF) |
| Region 4 | 1 – DASA |
| | 1 – ESA (TANF) |

**CASE STUDIES QUESTIONNAIRE**

In Advance:

- If you wish, substitute a name for XXX with search & replace
- If you will need names & phone #s & other contact information about other case managers involved with XXX, page down to item 48 and make notes to yourself there.
- Fill in information at the top of the page
- Fill in the client name of the sampled client (may also need other family members' names at the start of the interview)
- Fill in the name & identifying information for the CM being interviewed;
- **Be sure to get CM email address**

==========

1. Interviewer __Virginia Frost __Judy Olmstead __Carol Webster __JoAnn Ray
2. Date
3. Client location __1 __3 __4 ___Preliminary interview
4. Time Interview Started: _____

==========

5. CM interviewed Office/agency Phone #

6. CM **email address**

==========

7. Identifying information about the person(s) who are the focus of the interview

| Name | Age | Sex | Relationship | Race & Ethnicity/culture |
|---|---|---|---|---|

#1

8. Can you tell me who else is in the family?

#2

#3

==========

9. Did you receive the project description and confidentiality form?
{If yes} Do you have any questions?

{If no} I'd like to take a moment and share these with you over the phone, and answer any questions you have. I'll also make sure you are sent copies by email. Do you have any questions?

==========

10. First I have a few questions about your work situation. How many years have you worked in _____?

{DCFS, DDD, ESA, etc. /this MH agency /this substance abuse treatment agency}

---

11. What is your current title?

==========

12. How long have you been in this position?

==========

13. What unit is used to describe your caseload – family, individual teenager, etc?

==========

14. How many of this unit do you have on your caseload?

==========

15. About how many {of this unit—family, teenager, adult} do you work with, or make contacts on behalf of, in a typical week?

==========16. Now I'll switch the focus to XXX. Who referred XXX to you?

{Get & record detail: unit, section, division}

==========

17. Why was XXX referred to you?

==========

18. When did you first start working with XXX?

==========

19. Please draw me a verbal picture of XXX at the time you first knew them.

==========

20.What was XXX's personal and family situation when you first knew them?

==========

21. I'm going to start now by asking a big picture question. Then I'll move into more detail. To start, I'd like you to think over the whole time period you've worked with XXX, and give me a very broad, brief summary of what has been happening.

==========

22. Now I'd like to ask for more detail. Please think of the last two years only, starting in March 1999. I'd like you to tell me the story of what's been happening with XXX during this time. Because our project is about case coordination, I'm particularly interested in:

(a) What other professionals joined you in serving XXX?

(b) How well do you think you all worked together on behalf of XXX?

==========

23. What other professionals, if any, would you have liked to have worked with on behalf of XXX?

==========

24. I have a checklist of items here about the past two years of work with XXX. Some of them you may already have answered, and if so, we'll skip them or discuss them briefly.

{Interviewers: cut and paste a COPY of all relevant information from the narrative above}

During the past two years, did you conduct one or more formal assessments of XXX? If yes, please give details, and indicate any joint assessments with other professionals.

==========

25. Which divisions within DSHS, other state agencies, community agencies, and contracted providers were involved over the past two years?
{Spell out acronyms}

==========26. Which agency, if any, had the lead?

==========

27. Did the agencies share common goals/outcome measures/ expectations for XXX? Please describe.

==========

28. Did the agencies have a common plan for XXX? If so, what was it?

==========

29. How did the professionals communicate with one another ( face to face & 1 on 1, joint meetings, email, Fax, phone)

==========

30. How often did the professionals communicate?

==========

31. Communication WITHIN your organization: Did you have case staffing meetings within your organization about XXX that included XXX? __yes __ no

IF YES: How often did you hold such meetings, and how useful were they?

==========

32. Did you have case staffing meetings within your organization about XXX that *DID NOT* include XXX? __yes __ no

IF YES: How often did you hold such meetings, and how useful were they?

==========

33. Communication ACROSS organizations: Did you have joint meetings with other service providers that included XXX? ___yes ___no

*IF YES* with whom, how often, and usefulness?

==========

34. Did you have joint meetings with other service providers that *DID NOT* include XXX? ___yes ___no

*IF YES* with whom, how often, and usefulness?

==========

35. ***Now I'd like to ask about XXX's choices. Which of the services available to them did XXX actively seek out, and what were the reasons XXX gave for doing this?

36. ***Which of the services available to them ***didn't*** XXX actively seek out, and what were the reasons XXX gave for doing this?

37. ***What was the impact of XXX's service-use behavior on the networking/ linking among the professionals working with XXX?

==========

38. What sources of data did you use in coordinating services for XXX?

{Case notes, conversations with other professionals, conversations with family members, community collateral contacts, ACES, CAMIS, Client Registry, JAS, Target, MH data system, STARS, SSI, Other--specify}

==========

39. What contracts or interagency agreements did you use, if any, and how did they work?

==========

40. Was there anything about the funding for XXX that either helped or placed limits on what you could do for them? Please explain.

==========

41. I'm going to ask a few questions where I'd like you to give me a rating. "1" equals very low and "5" equals very high.
How highly do you value the approach of working together as a collaborative team with a variety of professionals serving one client?
{rate from 1 to 5}

How often do you get to use this approach?
{rate from 1 to 5}

How highly do you believe your direct supervisor values this approach?
{rate from 1 to 5}

==========

42. What about other levels of management: which ones do you feel support the idea of working in a collaborative way?

==========

43. To summarize these past two years, please tell me about any key elements related to case coordination you see that led to successes with XXX.

==========

44. Now please tell me about any key elements that led to a lack of progress.

==========

45. I have two final questions. In order to understand the challenges and successes of case management coordination for XXX, is there anything I should have asked you and didn't? Please explain.

==========

46. If you could say just one thing to the Cabinet of DSHS about case coordination, what would it be?

==========

47. As I transcribe and summarize this interview, is it OK with you if I or another member of our research team check back with you about a detail I don't understand?

==========

48. Optional Question: If you need to find other case managers linked to XXX so that you can interview them, this is the place to ask about names and phone numbers.

==========

49. Now for a final task. Before I complete this interview, I want to report out this information using a fake name for XXX and a fake name for you. I will pick the pseuodnym for XXX. If you want, you can pick your own fake names.

Name(s) chosen by interviewer for XXX:

Name for the case manager/therapist:

{Note to interviewers:
substitute fake names in your summary reports ONLY,
not here in the original document.}

==========

50. If you wish to see how this information had been used, we will send you a copy of the design team recommendations to the DSHS Cabinet which have been based on these interviews. Do you want a copy? ___Yes ___No

If yes: I'll have it sent to your email unless you want to give me a different address:

==========

51. Thank you very much for your time and help. If you have any questions as you think back over the interview, or want to add anything, my name again is…….and my phone number is……..

==========

52. Time Interview Ended:

==========

# APPENDIX 5

# BARRIERS TO CASE COORDINATED SERVICES AND RECOMMENDATIONS TO IDENTIFIED BY DSHS

## REGION 1 MEETING SUMMARY

### BACKGROUND

On February 7, 2001, from 1-3 p.m., the DSHS Region 1 Regional Coordinating Council members met in Spokane to hear a presentation on the **No Wrong Door – Case Coordination Project**, and to provide input to the project team.

### RCC Members Present:

| Name | Organization | E-mail | Phone |
|---|---|---|---|
| Larry Buckner | IPSS | Larry@dshs.wa.gov | 509 533-2126 |
| Pao Vue | AASA | VueP@dshs.wa.gov | 509 323-9404 |
| Don Read | OOED/ESD | ReadD@dshs.wa.gov | 509 456-3079 |
| Shirlee Steiner | AASA | Steinsk@dshs.wa.gov | 509 456-2478 |
| Aaron Powell | DCS | Apowell@dshs.wa.gov | 509 363-5055 |
| Dario Longhi | RDA | longhde@dshs.wa.gov | 360 902-0734 |
| Carol Webster | RDA | webstca@dshs.wa.gov | 360 902-0714 |
| Dave Whitling | OOED/ESD | whitldl@dshs.wa.gov | 253 566-5760 |
| Sharon Storer | PO/ESD | StoreSK@dshs.wa.gov | 509 456-3910 |
| Charlene Spilker | PO/ESD | SpilkCL@dshs.wa.gov | 509 456-3910 |
| Jana Matthews | DAEO | MatthJL2@dshs.wa.gov | 509 456-6119 |
| Judy Maginnis | MAA | Maginja@dshs.wa.gov | 360 725-1320 |
| Carl McMinimy | CSD | Mcminco@dshs.wa.gov | 509 685-5600 |
| Marty Butkovich | DJR | Butkomj@dshs.wa.gov | 509 625-5206 |

### Project Background:

Carol Webster, Project Director, welcomed participants, reviewed the agenda and stated the purpose of the project. Key points:

- The issue has been referred to by many names such as “shared clients,” “multi-need clients,” etc. For ease of understanding, the project is being called, “No Wrong Door – Case Coordination Project”. The goal is to improve the service to clients who are served by multiple programs within DSHS. The purpose is to propose one or more case coordination models that can be piloted in the next fiscal year.
- The Cabinet funded the project and the Executive sponsor is Liz Dunbar, Deputy Secretary.
- Carol then introduced Dario Longhi, the Project Manager.

Dario provided a detailed project overview via a Power Point presentation.

**Facilitated Discussion:**

Dave Whitling and Don Read led a facilitated discussion of the bolded questions below. Following each question is the participant's responses.

**WHAT ARE YOUR SUCCESSES AND BARRIERS TO SERVING MULTI-CASE CLIENTS?**

| Successes | Barriers that limit coordination |
|---|---|
| • The RSN (MH) and DASA have started to work together to provide a Community Emergency Response system (ERS). They brought in an expert from Massachusetts, HUD (feds). DASA received 3 beds (in patient) for referrals from the ERS.<br>• Spokane County is hiring one FTE to coordinate services for clients with mental health and substance abuse issues. The RSN wrote a grant and received 562 K.<br>• DASA has out-stationed a DASA worker in the CSO to help with TANF clients that have substance abuse issues. | • Federal confidentiality statutes that pertain to child support and chemical dependency (CFR 42-2 and WAC's).<br>• Information systems don't communicate well with each other (JR with County Courts).<br>• Unions speak out when programs try to coordinate. It is misperceived as potential loss of jobs.<br>• Every agency has different goals and performance measures.<br>• There are different email systems and this makes communication difficult. |
| **SUCCESSES**<br>• Aging is establishing an "Adult Team" in each region to staff shared/difficult cases. The team consists of (HCS, DDD, MH and RSN).<br>• Spokane MH, DCFS, RSN, Casey and the Juvenile Court are working together to treat families (court ordered treatment and chemical dependency clients).<br>• Spokane County Public Health, CSD & MAA have a contract with Public Health Districts for assessment and on-going services to TANF families.<br>➢ Monthly meetings of field staff (DDD, HCS, RCS and RSN) to discuss the status of Boarding Homes and Adult Homes. | **BARRIERS**<br>• There are restrictions on funds and how they are used.<br>• The regulations change at a pace that does not permit a transition period to train staff and stabilize the change before the next wave of change.<br>• Resources are stripped to the bone, so how does one free up time and resources to plan when present requirements are overwhelming. |

| | |
|---|---|
| • Monthly meetings with HCS, Elder Services and Community Mental Health to address system issues (technical and human).<br>• Quarterly Quality Improvement meeting where providers meet with HCS, RCS and DDD. The meeting is educational and discusses problems/concerns.<br>• MAA has a quarterly managed care meeting throughout the state on how to access MH services.<br>• Children's Administration is starting a new program entitled "Break Through". It's a meeting with service providers to share information about services.<br><br>**SUCCESSES**<br><br>• Informal shifting of dollars within CSD. Contracts are funded for TANF, County Agencies, MH, etc.<br>• Mental Health Center has a contract with Indian Child Welfare to provide services to the tribes.<br>• The Spokane MH Center is providing a central intake and referral service for MH clients. | |

**Next Steps**

Carol Webster closed the meeting by thanking participants for their participation and input. She said there would be a typed summary sent to each participant. She also asked for exemplary coordination projects or programs in Region 1 that could be featured as "Poster Presentations" for the April 23 conference in Olympia.

> *Note: If you find content corrections or add specific examples, please forward them to Dave Whitling, email – whitidl@dshs.wa.gov. or phone (253) 566-5760. Thank you.*

## REGION 2 MEETING SUMMARY

### BACKGROUND

On April 12, 2001, 2-3 pm, Region Two RCC/RAC members met at the Pasco CSO to hear a presentation on the "No Wrong Door" project.

**Members Present:**

| Name | Organization | Email | Phone |
|---|---|---|---|
| Judy Cook | MAA | Cookjr@dshs.wa.gov | 360 725-1324 |
| Bev Casey | RAC | bcasey@cbc2.org | 509 547-0511 |
| Kris Marsh | RAC | krism@columbiaindusties.com | 509 582-4142 |
| Andres Aguire | DVR | aguira@dshs.wa.gov | 509 527-4398 |
| Rey Pascua | CA | | 509 575-2646 |
| Barb Myers | RAC | admissions@sundown.org | 509 457-0990 |
| Cristina Klatousky | RAC | claltousky@wsnconune.org | 509 839-9762 |
| Pleas Green | JRA | greenpj@dshs.wa.gov | 509 575-2646 |
| Randy Kimbler | JRA | kimblrl@dshs.wa.gov | 509 968-3924 |
| Ken Start | DASA | stark@dshs.wa.gov | |
| Tomes Villenueva | ESA | tomes@dshs.wa.gov | 509 945-2203 |
| Virginia Almeida | DASA | almeivi@dshs.wa.gov | 509 225-6196 |
| Julie Selbo | HCS | Selboj2@dshs.wa.gov | 509 527-4482 |
| Paul Reynolds | DDD | reynopa@dshs.wa.gov | 509 945-2203 |
| Kathy Murray | RAC | murrayd@elltel.net | 509 968-4011 |
| Yvonne Frailey | RCC/Coord. | frailym@dshs.wa.gov | 509 225-7988 |
| Carol Webster | RDA | Webster@dshs.wa.gov | 360 902-0714 |
| Suzanne Noble | RAC | snoble@cwcmh.org | 509 968-3126 |
| Lorry Perkins | RAC | lperkins@cwcmh.org | 509 547-0511 |
| Stella Vasquez | DSHS | vasqusd@dshs.wa.gov | 509 225-7918 |
| Dave Whitling | ESD | whitldl@dshs.wa.gov | 253 566-5760 |

**PROJECT BACKGROUND**

Carol Webster, Project Director, welcomed participants, reviewed the agenda and stated the purpose of the project. Key points:

- The No Wrong Door – Case Coordination Project purpose is to improve the service to clients who are served by multiple programs within DSHS.
- The Cabinet funded the project and the Executive sponsor is Liz Dunbar, Deputy Secretary.

Carol handed out a PowerPoint presentation of the No Wrong Door – Case Coordination Project and gave a project overview.

**Facilitated Discussion:**

Dave Whitling led a facilitated discussion of the three questions.

- What are your innovative practices/successes in serving shared clients?
- What barriers limit coordination/collaboration?
- What recommendations do you have to improve service?

**Below is a summary of RCC/RAC input.**

| Successes | Barriers that limit coordination |
|---|---|
| • **WorkSource** of mid Columbia. Private and public employers helping unemployed find jobs. One stop concept to help the unemployed.<br>• **Harvest Council** seeks to provide emergency housing for migrant workers. Many community & state agencies participate. It now has a clinic, food bank and DSHS Office.<br>• **Adult Service team** (DD, MH, DVR, County) meets to coordinate issues related to mutual clients.<br>• **Hispanic Children's Intensive Project** (CPS, MH and other agencies) provides services for children.<br>• **Synergy** (CHMH, CD, MH, JRA, | • Funds are difficult to share because they come with strings attached.<br>• Confidentiality.<br>• Territorialism.<br>• Time and funds to do what needs to be done.<br>• Language and cultural gaps. WAC's are insensitive to the different cultural needs.<br>• Serving clients in the rural areas – great distances.<br>• Facilities are not ADA equipped.<br>• Size of DSHS.<br>• Our hours of operation often make it difficult for the client to access services. |

| | |
|---|---|
| Foster Parents). Screens clients with coexisting disorders and develops/services tools to help clients.<br>• **HASAP** (HIV/AIDS, Substance Abuse Program).<br><br>**SUCCESSES**<br><br>• **CIO's are co-locating** staff with other service agencies with emphasis on WorkFirst clients.<br>• **Transition Advisory Group.** Disability service providers, DD, school districts help DD clients (age 14) with transition issues.<br>• **E-JAS**. ESA database with access to records if serving shared clients, and ability to type in notes. | • Inadequate screening and case managers lack knowledge of other programs.<br><br>**BARRIERS** |

**WHAT ARE PRACTICAL THINGS WE CAN DO TO IMPROVE SERVICES TO SHARED CLIENTS?**

| Short term solutions | Long term solutions |
|---|---|
| • Improve access via a single telephone number: 1 800 DSHS.<br>• Better initial screening once they gain access.<br>• Common reception areas with greeters, event calendars, maps, etc.<br>• Shared staff & cross training of staff.<br>• Quick referral guide of programs and services.<br>• Get cross agency buy-in for this effort. | • Form Community Coalition of social services. Become familiar with who has expertise in different areas.<br>• Centralize location –specific to community needs for critical services.<br>• Cross training.<br>• Sophisticated information sharing system.<br>• Buildings that house multiple programs.<br>• Create an Ombudsman to resolve issues between divisions. |

**Next Steps**

Carol Webster thanked RCC/RAC members for their participation and input. Also, she solicited ideas for Region 2's Poster Presentation for the No Wrong Door Conference on Monday, April 23rd.

## REGION 3 MEETING SUMMARY

### BACKGROUND

On February 26, 2001, 12-1:30 PM, Region 3ee RCC/RAC members met in Arlington to hear a presentation on the "No Wrong Door – Case Coordination " project and provide input to the project team.

**Members Present:**

| Name | Organization | E-mail | Phone |
|---|---|---|---|
| Judy Abbott | DVR | abbotj@dshs.wa.gov | 425 339-4868 |
| Deborah Wright | RAC | debwright@wamedes.com | 425 355-3761 |
| Dave Fiorini | ESD | fioridm@dshs.wa.gov | 206 361-3581 |
| Nancy Wolke | CSD | wolkene@dshs.wa.gov | 360 658-6888 |
| Bob McClintock | RCS | mcclir@dshs.wa.gov | 360 428-5893 |
| Jim Hardin | RAC | None | 425 334-4987 |
| Carol Webster | RDA | webstca@dshs.wa.gov | 360 902-0714 |
| Dave Whitling | OOED/ESD | whitldl@dshs.wa.gov | 253 566-5760 |
| Chuck Benjamin | NSRSN | executivedirector@nsrsn.org | 360 416-7013 |
| Margaret Zander | RAC | miz@emailmsn.com | 360 653-1343 |
| Cheryl Stephani | JRA | stephcs@dshs.wa.gov | 360 902-7804 |
| Linda Cummings | DDD | cummili@dshs.wa.gov | 425 339-4833 |
| Kathy Ellington | DCS | kellingt@dshs.wa.gov | 425 438-4848 |
| Merrilea Mount | RAC | mountmjjk@msn.com | 425 259-9052 |
| Bob Cockburn | RAC | None | None |
| Earl Long | DASA | longea@dshs.wa.gov | 360 658-6893 |
| Charlene Wagner | RCC/RAC | wagnecd@dshs.wa.gov | 360 658-6892 |
| Pam Shot well | JRA | shotwpa@dshs.wa.gov | 425 339-1842 |
| Patricia | MAA | armstpa@dshs.wa.gov | 360 725-1725 |
| Armstrong | ESD | burdech@dshs.wa.gov | 206 361-4762 |
| Cheryl Burdett | HCS | marketj@dshs.wa.gov | 360 416-7409 |
| Terry Marker | RDS | sugarda@dshs.wa.gov | 360 902-7869 |
| Dave Sugarman | | | |

**Agenda:**

12:00 Introductions

12:05-12:25 Project Overview

1225-1:30 Group Discussions

- What are your experiences serving shared clients (Successes and Barriers)?
- What are ways to improve service to shared clients?
- Next steps and adjourn

**Project Background:**

Carol Webster, Project Director, reviewed the purpose of the project. Key points:

- The goal of the No Wrong Door- Case Coordination Project is to improve the service to clients who are served by multiple programs within DSHS.
- The Cabinet funded the project and the Executive sponsor is Liz Dunbar, Deputy Secretary. My June 30, 2001, the No Wrong Door – Case Coordination Project will submit to the Cabinet one or more models for case coordination that can be piloted in the next fiscal year.

  Dave Sugarman provided a detailed project overview via a Power Point Presentation that showed the number and percentage of clients who were multiply served.

**Facilitated Discussion:**

Dave Whitling led a facilitated discussion of the bolded questions below. Following each question is the participant's responses.

**WHAT ARE YOUR SUCCESSES AND BARRIERS TO SERVING MULTI-CASE CLIENTS?**

| Successes | Barriers that limit coordination |
|---|---|
| • DASA: Clearing House developing a web site that includes an inpatient bed monitoring for placement.<br>• Triage coordination on a local level between DASA, MH and probation providers. | • Lack of program knowledge between programs ( i.e., health districts and DSHS (first steps)<br>• Federal and State funds have strings tied to them, therefore cannot be flexibly used. |

- Snohomish County WorkSource center in Everett, Lynnwood and Sky Valley outstation are working with Region 3 and Snohomish County Prosecutors Office to identify non-custodial parents participating in job training and counseling. Web site developed (by Wenatchee DCS) is being used to share data. The aim is to renegotiate lower child support payments pending client's completion of work source programs.

**SUCCESSES**

- Snohomish County ADATSA pilot – streamlining of ADATSA referral process.
- Coordinating team efforts around problem families – DDD, RSN, DASA and Snohomish County Human Services.
- JRA/DCFS case planning meetings to place joint clients. Program manager and above level meet once a month. *Contact: Debbie Gome, DCFS, and Linda Beal, JRA.*
- Community Action Teams – Sno. Co. DD, RSN, AAA case managers, DOC, HCS, DCS meet to plan case coordination for most difficult clients. Meet every other week. Contact: *Gov's blue book A-Team project (James Mead)*
- JRA co-occurring disorders pilot in 3 regions. Multi Systemic Therapy (MST) is a nationally researched model of systemic intervention. *Contact: Jeannie D'Amato in JRA Headquarters and Monica McAlister from Region 3 JRA.*

- Program goals are not always aligned. For example DCS may be attempting to collect from a TANF client who's trying to get on his/her feet.
- Non-coordinated computer systems require reentry of client data.
- Confidentiality (HIPPA)

**BARRIERS THAT LIMIT COORDINATION**

- Difficulty connecting the intervention system and the prevention system for MH and DASA.

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|---|---|
| • AASA, RSN, HCS Coordination Meetings for protocol development for former WSH clients and sex offenders on parole who are in need of long term adult care. Activities include: staff orientation, 14- day holding for assessment prior to placement, funding and case responsibilities. *Contact: Diana Stryslin RSN and James Mead HCS)*<br>• Grant to hire school district MSW.<br>• Children's policy advisory group in Region 3 (DDD, ESD, MH, DCFS) to determine how to meet the needs of high-risk children. Local meetings in the counties.<br><br>**SUCCESSES**<br>• MH collaborative work plans to develop cross system training, planning and staffing.<br>• Region 3 brown bag lunches monthly to share information and network with the Human Services agencies.<br>• TANF and DSFS conduct cross-agency case staffing on known cases. There's no useable data available to identify all the shared clients.<br>• CICP (Council for Integrated Children's Programs) meets monthly meets monthly to determine projects in Snohomish County to work on collaboratively.<br>• Community Teams (Sno. Co and DSHS) Adults #1 and Children's & Families #2 meet to problem solve cases. Includes TANF, HCS, DDD, MH, DCFS and others groups based on client needs.<br>• DVR's independent living program coordinates with other DSHS program case managers to facilitate service delivery. May include group home managers, AAS, TANF, DDD and others. | |

| | |
|---|---|
| • Group homes funded through DSHS practice collaboration to manage the details of resident's lives and activities. | |

## WHAT ARE PRACTICAL THINGS WE CAN DO TO IMPROVE SERVICES TO SHARED CLIENTS?

| SHORT TERM SOLUTIONS | LONG TERM SOLUTIONS |
|---|---|
| • Continue to collaborate by including vendors and community partners.<br>• Increase interagency case staffing to improve collaborative efforts.<br>• Regional Human Services website for cross – communication. Up to date information, contact names, phone numbers, etc.<br>• Learn who our counterparts are and use email better.<br>• Create a Regional Directory | • Common computerized interagency data system.<br>• Make the computer systems communicate so we can identify shared clients more easily.<br>• Fix computer systems so they can talk to each other.<br>• Cross system collaboration and identifying a single case manager.<br>• Cross training of staff.<br>• Flexible funding that's non categorical and has redeemable coupons. |

**Next Steps**

Carol Webster closed the meeting by thanking participants for their participation and input. She said the No Wrong Door Project team would send a summary of the meeting. Also, she solicited ideas for Poster Presentations for the April 23rd conference. RCC/RAC members asked if the WorkSource center (Cindy Schaefer) and the Aging multi-agency team (James Mead) could be the poster presentations as well as speakers. Carol said yes.

Note: If you find content corrections or add specific examples, especially of e-government, please forward them to Dave Whitling, email – whitldl@dshs.wa.gov or phone (253) 566-5760. Thank you.

# DSHS REGION 4 COORDINATING COUNCIL MEETING SUMMARY

## BACKGROUND

On March 1, 2001, 10:30-12 noon, Region 4 RCC members met in Seattle, at 400 Mercer Street, to hear a presentation on the "No Wrong Door" project.

**Members Present:**

| Name | Organization | E-mail | Phone |
|---|---|---|---|
| Cheryl Burdett | ESD/OOED | burdech@dshs.wa.gov | 206 361-4762 |
| Dave Fiorini | ESD/OPO | fioridm@dshs.wa.gov | 206 361-3581 |
| Harvey Funai | DASA | funaihm@dshs.wa.gov | 206 272-2156 |
| Greg Heartburg | AASA | heartgc@dshs.wa.gov | 206 341-7610 |
| Pat Jennings | AASA | jennipa@dshs.wa.gov | 206 341-7820 |
| Janet Wallace | DCS | jwallace@dshs.wa.gov | 206 341-7445 |
| Marybeth Poch | DDD | pochmb@dshs.wa.gov | 206 720-3038 |
| Dave Whitling | ESD/OOED | whitldl@dshs.wa.gov | 253 566-5760 |
| Asha Singh | DDD | singhas@dshs.wa.gov | 206 361-3033 |
| Carol Webster | RDA | webstca@dshs.wa.gov | 360 902-0714 |
| Susan Worthy | RCC | sworthy@dshs.wa.gov | 206 720-3189 |

**Agenda:**

10:30 Introductions

10:05-10:25 Project Overview by Carol Webster, RDA

10:25-11:50 Facilitated Discussion

- What are your experiences serving shared clients (Successes and Barriers)?
- What are ways to improve service to shared clients?

11:50-12:00 Next steps and adjourn

**Project Background:**

Carol Webster, Project Manager, welcomed participants, reviewed the agenda and stated the purpose of the project. Key points:

- The goal of No Wrong Door – Case Coordination Project is to improve the service to clients who are served by multiple programs within DSHS.
- The Cabinet funded the project and the Executive sponsor is Liz Dunbar, Deputy Secretary. By June 30, the project will give the Cabinet one or more models to pilot test in the next fiscal year.

- Carol provided the group with handouts that covered the who, what, when, where and why for the project. In addition, she clarified RCC/RAC's role in the conference. Each RCC and RAC chair and the coordinator will be invited to the April 23rd conference. Each RCC/RAC is invited to present, via a poster booth, one (or a maximum of two) of their most noteworthy coordination initiatives.

**Facilitated Discussion:**

Dave Whitling led a facilitated discussion of the bolded questions below. Following each question is the participant's responses.

## WHAT ARE SUCCESSES AND BARRIERS TO SERVING MULTI-CASE CLIENTS?

| SUCCESSES | BARRIERS THAT LIMIT COORDINATION |
|---|---|
| • King East CSO and DCS are conducting videoconferences with clients. This saves clients from making two trips, and means staffs are not placed in a position to interview for other programs.<br>• There's a monthly coexisting disorder (COD) meeting with DASA and MH is conducted to coordinate services to COD clients. Contact Cindy Bergh 206 296-0616 for more information.<br>• There is a Systems Integration Advisory Committee that meets monthly (DASA, MH and | • MH not sitting at RCC/RAC table in King County. MH contract with United Behavior Health. Sub contracting to MH providers is difficult – hard to place or find the best services.<br>• Too much paperwork and high caseloads.<br>• Hiring and retention of staff and providers in high cost of living areas (Seattle) is a problem.<br>• State mental health has no presence in King County. |
| **SUCCESSES**<br>• System Integrators) to resolve systemic issues and attempt to resolve them. *Contact Patrick Vars (206) 296-0615 for more information.*<br>• TANF Outstation: DASA has out stationed staff in CSO's to serve TANF clients. *Contact Rose Soo Hoo for more information.* | **BARRIERS THAT LIMIT COORDINATION**<br>• Confidentiality limits coordination.<br>• A lot of staff time is spent on trying to get funds for clients on waiting lists or making referrals for clients who are not eligible for DSHS services.<br>• Email systems are different. We have no single source (address book) to find someone's email address. |

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|---|---|
| • DCFS Outstation: DASA has out stationed chemical dependency clients at DCFS. *Contact Sharon Toguinto for more information at (206) 296-7626.*<br>• If over 18, clients can dis-enroll from DDD and become AASA clients. Clients may prefer services from AASA to avoid being labeled as DD.<br><br>AASA and DDD work together to determine who is the primary vs. secondary case manager, and this is a jointly funded program.<br>• Adult Family Housing (AFH) placements by separate DSHS divisions can result in mixed populations in 1 home (young adult, DD client, elderly client, etc.). Is this collective mix good?<br>• Group care placement and coordination with multi-system youth (DCFS, MH, DD, JRA, Group Home) is excellent in King County.<br>• WorkSource Centers, as a resource for mutual participants looking for free employment services, is working in Seattle. (DVR)<br>• Quality Assurance case managers and Residential Case Services (RCS) coordinate about AFH households.<br>• DD with RCS (Developmental Disabilities and Licensing). RCS notifies DD staff regarding suspension of adult family home licenses. AASA is also notified if an aging adult is in the household. Local police assist in each instance when the home is notified of its loss of license. | • Our clients have a higher level of dysfunction than in the past. It's hard to find providers who will take difficult clients and if you disclose the truth about the client you can't place them.<br><br>Also, for these difficult clients they may be the one person who spoils or disrupts the group home. |

| | |
|---|---|
| DD and AASA staff works together to remove clients. Before any clients are removed family/guardians are notified and DD staff follows up with the family/guardian after placement.<br>• Fircrest works with Children's Services when the care of a client becomes an issue. Communication has improved through joint meetings to problem solve challenging cases. | |

**WHAT ARE PRACTICAL THINGS WE CAN DO TO IMPROVE SERVICES TO SHARED CLIENTS?**

| SHORT TERM SOLUTIONS | LONG TERM SOLUTIONS |
|---|---|
| • Get MH representation on RCC.<br>• Consistent email system.<br>• RSN manager on RCC.<br>• Establish coordination teams for client services for high profile cases.<br>• Require and enforce participation on RCC.<br>• On confidentiality forms ask clients to grant their consent to share their information to appropriate agencies to facilitate service delivery.<br>• Train for and implement client registry.<br>• Prioritize the more critical clients.<br>• Joint training. | • Establish a pool of better-trained providers to serve multiply-challenged clients.<br>• Co-location of most used services.<br>• Video conferencing equipment.<br>• Establish a shared client database.<br>• Portable funding. Redesign the funding system so the money follows the client.<br>• Increase the budget in King County to increase staff salaries and to enhance recruitment and retention.<br>• Establish a single entry and eligibility determination.<br>Redesign the case management system so the client only has to work with one case manager. "One Stop Shopping".<br>• Educate the public and the legislature on what it actually costs for services. |

**Next Steps**

Carol Webster closed the meeting by thanking participants for their participation and input. She said the No Wrong Door Project Team would send a typed summary to the participants. Also, she asked for Region 4's ideas for an exemplary project for the Poster Presentation at the April 23rd Conference.

**Note: Please review the content for accuracy. If you have corrections or additional ideas, especially as they reflect Information Technology (IT) web based applications that improve service, please pass them along to Dave Whitling, 253 566-5760 – email whitldl@dshs.wa.gov. Thanks.**

# DSHS REGION 5

## NO WRONG DOOR RCC/RAC MEETING SUMMARY

### Background

On March 8, 2001, 10:30-12 noon, Region 5 RCC/RAC members met in Bremerton at the DVR Office to hear a presentation on the "No Wrong Door" project.

### Members Present:

| Name | Organization | E-mail | Phone |
|---|---|---|---|
| Mary Beth Quinsey | RCC/RAC | Quma300@dshs.wa.gov | 253 566-5760 |
| A. Delight | DDD | deligaj@dshs.wa.gov | 253 983-6284 |
| Mary Lafond | CSTP | lafonma@dshs.wa.gov | 253 593-2820 |
| Nancy Sutton | DCFS | Sutn300@dshs.wa.gov | 253 756-2375 |
| Jim Friedman | DASA | friedjr@dshs.wa.gov | 253 983-6066 |
| Ralph Mercado | CSD | mercara.wa.gov | 253 476-7035 |
| Roger Ward | DVR | wardr@dshs.wa.gov | 253 983-6535 |
| Dave Whitling | ESD/OOED | whitldl@dshs.wa.gov | 253 566-5760 |
| Elaine Odom | RCS | odomer@dshs.wa.gov | 253 983-3848 |
| Carol Webster | RDA | webstca@dshs.wa.gov | 360 902-0714 |
| Edith Owen | RRC | eoweninwa@juno.com | 253 565-4484 |
| Teckna Riley | WSH | rileytm@dshs.wa.gov | 253 756-2931 |
| Barb Austin | DCS | baustin@dshs.wa.gov | 253 476-7676 |
| Peggy Hanson | RN | pegsterhrn@msn.com | 253 761-1272 |
| Mary Beth Ingram | MAA | ingramb@dshs.wa.gov | 360 725-1327 |
| Sherrie Cowan | OESD | scowan@oesd.wednet.edu | 360 405-5807 |
| Ann Mumford | CMLT | amumford@compmh.org | 253 396-5901 |
| Dan Schaub | JRA | schaudl@dshs.wa.gov | 253-476-7129 |
| Arvan Reese | RAC | arvan@home.com | 360 377-8295 |
| Lee Trujillo | RAC | luminanio@hotmail.com | 360 871-5408 |
| Phil Wilson | ESD | wilsoph@dshs.wa.gov | 253 476-7067 |
| Jackie Stenger | RAC | jstenger@aol.com | 253 627-3064 |
| Eileen Seeley | RAC | 1503 Sunset Dr. S<br>Tacoma 98465 | 253 565-0670 |
| Edwin Torgenson | TUL | | 253 383-2007 |
| Chris Emov | RAC | chrisea@tacid.org | 253 565-9000 |
| Lily Viray | RAC | lilyb@ccsww.org | 253 305-0836 |
| Stan Neff | AASA | neffsa@dshs.wa.gov | 253 476-7224 |
| Frances Bailey | DASA | bailefe@dshs.wa.gov | 253 476-7076 |

**Agenda:**

| | |
|---|---|
| 9:30-10:00 | Project Overview by Carol Webster, RDA |
| 10:00-1130 | Facilitated Discussion |

What are your experiences serving shared clients (Successes and Barriers)?

- What are ways to improve service to shared clients?

**Project Background:**

Carol Webster, Project Manager, reviewed the agenda and stated the purpose of the project. Key points:

- The goal of the "No Wrong Door- Case Coordination Project" is to improve the service to clients who are served by multiple programs within DSHS. The Project will submit to the Cabinet one or more models for case coordination by June 30, 2001.
- The Cabinet funded the project, and the Executive sponsor is Liz Dunbar, Deputy Secretary.
- Carol provided the group with two overviews of the project. In addition, she said that each RCC and RAC chair, and the coordinator, will be invited to the April conference, and each region is invited to present, via a poster booth, their one (or a maximum of two) exemplary case coordination program or project.

**Facilitated Discussion:**

Dave Whitling led a facilitated discussion of the bolded questions below. Following each question is the participants' responses.

## WHAT ARE SUCCESSES AND BARRIERS TO SERVING MULTI-CASE CLIENTS?

| SUCCESSES | BARRIERS THAT LIMIT COORDINATION |
|---|---|
| • Wrap around services meeting with AASA to coordinate discharge, placement and follow up care from WSH to AASA. Attendees include RSN, MH, WSH, family members, financial specialist and AASA.<br>• RSN sponsors meetings (Older Adult Group – HARK Housing Group) to help nursing homes meet the needs of clients with behavior issues – to explore a hybrid setting to blend legal issues. It includes HCS and RSN contract staff. | • Duplicated application of client information (client has to repeat their story several times.)<br>• Duplicated services – the same services are provided by different agencies.<br>• Confidentiality laws – tension between preventing discrimination and improving services. Federal and State laws for adult family homes create barriers for discharge. |

- Meetings with RSN and WSH to place difficult adult clients.
- MAA, ESA and AASA are working on a simplified application process to make application easier for the client. *Contact: Mary Beth Ingram (360) 725-1327.*
- RCS and Investigator work together to provide a comprehensive review and assessment of abuse/neglect complaints. *Contact: Elaine Odom (253) 993-3848.*
- Shared Children Team, using a clinical team to review applications and coordinate services. This group also reviews treatment of the most complex children for either in-patient or community placement. It involves DCFS, DCA, RSN, JRA, DDD, and School Districts. *Contact: Lin Patton (253) 756-2735*.
- Bimonthly meeting of DASA and Community Services Division to coordinate and resolve adult treatment issues. *Contact: Sherry Byers (253) 798-6105.*
- MICA meetings to improve access and better coordinate services. Pierce RSN & DASA providers. *Contact: Jim Jackson and Sherry Byers (253) 798-6105.*
- DVR and County DD meetings to coordinate services and address system issues and funding. Pierce County DVR staff meets with County DD staff and contractors. *Contact: Roger Ward (253) 983-6535*

- King County doesn't work on Pierce County's application process or placement plan. They require the client to start all over again.
- The more people that are involved in coordination, the more time it takes. Often this isn't in the client's best interest.
- Inflexible use of funding/resources limits regional ability to effectively serve clients.
- Funding is seen as the driver, which can lead to losing sight of client's needs.
- Show casing projects doesn't support the community or a collective effort.
- Each office has guidelines and procedures, which are not aligned and often serve as barriers to coordinated service. Often there are conflicting missions (i.e., DASA = chemically free while CA = improve the safety of children.)
- Tend to focus on process and procedure, not on client service outcome.
- Staff turnover limits building a culture of collaboration. It takes time to build relationships to support collaboration.

| | |
|---|---|
| • Pierce County Parent Coalition meeting meets quarterly to address system issues and coordinate services to DD students. Parents, DVR, DDD, Special Ed. Staff, County DSD and County transition staff attend. *Contact: Tracey Van Derwall.*<br>• "Rent-a-Friend" Project. Its purpose is to coordinate community organizations and RSN for high needs and multiple needs children and young adults so there is someone in the community that can develop a more informed relationship with clients.<br>• Vancouver RSN and Catholic Community Services of Pierce County use videoconference to conduct the meetings.<br>• Madigan Hospital and DDD created a single application so Madigan and DDD contractors could use the same application and reduce bureaucracy and have families only tell their story one time. *Contact: Dave Langford (253) 597-3617.*<br>• Funded positions for dual diagnosed Children. DASA funded an FTE at CSTC for dually diagnosed children (MH and CD). DASA, Child Study and Treatment Center and Horizon Treatment services participate. *Contact: Mary Lafond (253) 756-2735.*<br>• State mandated child protective teams have been established to address safety and reunification issues. DASA, Criminal Justice, DASA contractors, RSN, and MH participate. | |

| | |
|---|---|
| • A collaborative agreement has been established between MH and DD that requires "mandatory" collaboration of DD/MH diagnosed adults. RSN, DDD, MH and County DD participate.<br>• Interagency Coordinating Council meets to coordinate services for children birth to 6. Schools, providers and parents participate. *Contact: Child Care Resource Referral (360) 405-5807.*<br>• MH coordinator in JRA Region 4 & 5 offices to coordinate services to JRA clients. Greater Lakes, CMH and Good Sam participate. Contact: Dan Schaub (253) 476-7129.<br>• DASA and Sex Offender Coordinator. Currently one in each region.<br>• Dependency Attorneys coordinate legal services (Becca Bill). An attorney, social work and investigator participate. *Contact: Lee Trujillo or Sharon Gill at (253) 520-6509.* | |

## WHAT ARE PRACTICAL THINGS WE CAN DO TO IMPROVE SERVICES TO SHARED CLIENTS?

| SHORT TERM SOLUTIONS | LONG TERM SOLUTIONS |
|---|---|
| • Reevaluate state laws reference contracting out services.<br>• Use multidisciplinary teams region wide (e.g., shared children's team).<br>• Develop simplified shared confidentiality form that involves clients and agency services.<br>• Review confidentiality policies.<br>• Provide advanced coordinated placement knowledge to facilitate client transition. | • Provide client advocates.<br>• Ensure the dollars follow the client, not piecemealed and put into categorical programs.<br>• A single application and database system.<br>• A universal database.<br>• A central reference point for DSHS – One contact for client who is then directly connected to the relevant service (s) via the phone and web. |

| | |
|---|---|
| • Develop a standardized client intake form.<br>• Better train managers to support staff to deal with the human side ("manage with the heart"). The attitude transfers to the client.<br>• Provide a coordinator/facilitator of client services for the client – to coordinate all services needed by the client and tackle the bureaucracy.<br>• Gather client demographics only once – gather specific client information one time and put it into the system.<br>• Have greeters in each complex/bldg – the Wal-Mart model, to direct clients to where they need to be.<br>• Place more emphasis on staff retention and development. | • A simple phone numbers, such as: 1-800-DSHS<br>• Shared client data (automated).<br>• Agencies cross training.<br>• Client-initiated choice of services (e.g., child care or free training.)<br>• A common toll free access # with trained staff.<br>• Adequate funding.<br>• One, integrated statewide department with local offices. |

**Next Steps**

Carol Webster closed the meeting by thanking participants for their participation and input. She said the Project team would send a typed summary. Also, she solicited ideas for a Poster Presentation of current innovative practices that's result in better service to shared clients. Note: Members suggested the Shared Children's Team.

**Please review the content for accuracy. If you have corrections or additional ideas, especially as they reflect Information Technology (IT) and web based applications that improve service, please pass them along to Dave Whitling at (253) 566-5760 – email whitldl@dshs.wa.gov. Thank you.**

## REGION 6 MEETING SUMMARY

### BACKGROUND

On January 10, 2001, 10-12 noon, Region Six RCC/RAC members met at the Lacey Government Center to hear a presentation on the "No Wrong Door" project.

**Members Present:**

| Name | Organization | E-mail | Phone |
|---|---|---|---|
| Melissa Phillips | DCS | Mphillip@dshs.wa.gov | 360 664-6997 |
| Don Mitchell | RAC, Lewis Co. | dajr@quik.com | 360 330-2645 |
| Mary Sarno | MHD | sarnomx@dshs.wa.gov | 360 902-0796 |
| Bobbe Andersen | RAC, Thurs. Co. | Bobbedeano@home.com | 360 357-5610 |
| Dean Uribe | JRA | | 360 484-3223 |
| Hazel Eichner | RAC, Pacific Co. | | 360 942-5975 |
| Cheryl Flynn | RAC/RRC Staff | Flynnc1@dshs.wa.gov | 360 725-1824 |
| Bob Marley | RAC | bobksdc@gorge.net | 509 493-2662 |
| Sonja Bogan | DAEO | bogans@dshs.wa.gov | 360 586 –7052 |
| Chris Toombs | HCS | Toombca@dshs.wa.gov | 360 664-7595 |
| Ryan Pinto | JRA | | 360 407-7250 |
| Trudy Marcellay | IPPS | | 360 664-0322 |
| Becky Neal | DCFS | near300@dshs.wa.gov | 360 413-3418 |
| Teresa East | DDD | eastta@dshs.wa.gov | 360 586-5728 |
| Betty Newson | DVR | newsob@dshs.wa.gov | 360 407-0624 |
| Phil Wilson | ESD | wilsoph@dshs.wa.gov | 253 476-7067 |
| Dana Taylor | RAC | | 360 577-8858 |
| Judy Duff | RAC | Jduff@longview.k12.wa.us | 360 575-7437 |
| Dario Longhi | RDA | longhde@dshs.wa.gov | 360 902-0734 |
| Carol Webster | RDA | webstca@dshs.wa.gov | 360 902-0714 |
| Tonia Frasier | OOED/ESD | frasitm@dshs.wa.gov | 253 566-5760 |
| Dave Whitling | OOED/ESD | whitldl@dshs.wa.gov | 253 566-5760 |

**Agenda:**

10:00 Introductions

10:05-10:25 Project Overview

10:25-11:50 Group Discussion

- What are your experiences serving shared clients (Successes and Barriers)?
- What are ways to improve service to shared clients?

11:50 12:00 Next steps and adjourn

**Project Background:**

Carol Webster, Project Director, welcomed participants, reviewed the agenda and stated the purpose of the project. Key points:

- The project has been referred to by many names such as shared clients, multi-case clients, etc. For ease of understanding the program is being called, “No Wrong Door”. The aim is to improve the service to clients who are served by multiple programs within DSHS.

- The Cabinet funded the project and the Executive sponsor is Liz Dunbar, Deputy Secretary.
- Carol then introduced Dario Longhi, the Project Manager.

Dario provided a detailed project overview via a Power Point presentation. Participants were provided a copy of the Power Point slides.

**Facilitated Discussion:**

Dave Whitling and Tonia Frasier led a facilitated discussion of the bolded questions below. Following each question is the participant's responses.

## WHAT ARE YOUR EXPERIENCES SERVING SHARED CLIENTS?

- A recent case was shared where a homeless youth, who had multiple needs, was unable to access the system. It was estimated there were 165 phone calls before access was achieved.
- In Vancouver JRA and DCFS have joint meetings on how to help youth. A DSHS used to provide a family resource coordinator in a school in Olympia. This was a very successful program but it was discontinued. The school saw the value and continued the position.
- Serving foster care children is a challenge because each program has different licensing requirements.
- The Cowlitz facility has multiple program staff housed in one building. Co-location of facilities has improved coordination.

## NEXT RAC/RCC MEMBERS WERE ASKED TO SHARE SUCCESSES AND BARRIERS TO SERVING MULTI-CASE CLIENTS.

| SUCCESSES | BARRIERS THAT LIMIT COORDINATION |
|---|---|
| • Co-location of program in a central location, e.g., Cowlitz facility.<br>• Multi disciplined teams that meet to plan client services, i.e., JRA and DCFS meet to discuss clients they both serve.<br>• The Family Resource Coordinator that was once a DSHS position funded in schools was helpful to families and youth. | • There's no central point where clients can access DSHS services, i.e., the homeless youth where 165 phone calls were made.<br>• Often times the client's need is not within the program's scope of services, i.e., JRA youth that's homeless.<br>• We deal well with transactions but not with ongoing/long term support of clients. |

- Good assessment of what the client really needs facilitates effective coordination.
- In some communities a neutral facilitator brings together different program staff to facilitate coordination of shared client services.
- Transition Councils in Grays Harbor help kids in transition from school to community.
- Some case managers seek out the shadow case managers and attempt to provide coordinated services.
- DVR and DDD are working at developing peer relationships to better serve shared clients.
- Some programs coordinate well with community partners. DSHS is not the only one in business to provide social services.

**SUCCESSES**

- 211 information databases is a pilot in Vancouver to develop a shared database so a client's history is available to all social service agencies in that region.
- The RCC/RAC conference held last year identified many of the suggestions raised in this meeting. This report needs to be reviewed for other innovative ideas that can improve service to shared clients.
- Pacific County CSO has a 1-stop resource book for financial workers.
- Vancouver DCS has one person devoted to answering any DSHS related questions and referring the person to the appropriate resource.

- DSHS has a culture and structures that serve a specific need not the holistic needs of a client.
- Confidentiality
- Staff is not trained regarding all the services we provide.
- The way's the WAC's are written funds have strings tied to them. Difficult to use money in a flexible way.
- Incongruent rules. DCS is required to collect child support from a non-custodial TANF client. Another example is that you can't be on TANF with a car but how are you supposed to get work?
- Community Program Managers have been cut. Much of their role was to coordinate community programs.
- Lack of awareness of community or other DSHS programs/services.

**BARRIERS**

- The people we have answering the phones are the lowest paid and often times these are the positions with the highest turnover.
- Case management terms are defined differently in each program.
- A lot of time is wasted figuring out how to stay within the letter of the law and still meet client needs. Much of this is because funds are stove piped and have strings tied to them.
- Because it's difficult to meet the client's needs in a holistic way, caseworkers lose hope and become apathetic.
- Developing peer relationships between programs is not encouraged.

| | |
|---|---|
| • Chelan and Douglas County have a contract written to service shared clients. The contract requires coordination as part of its language. (RSN, DVR, DD, MHD)<br>• Jerry Minaker is training AASA, MH and CA in what JRA does. Some forms have been changed as a result of this effort. | • The client has to repeat their story to each program. No uniform database.<br>• DCFS has separate caseworkers serving the same family. This complicates coordination.<br>• Too much training when an employee is hired (Academy) and they are overwhelmed. Need to spread training out and ensure it's on going. |

## WHAT ARE PRACTICAL THINGS WE CAN DO TO IMPROVE SERVICES TO SHARED CLIENTS?

| SHORT TERM SOLUTIONS | LONG TERM SOLUTIONS |
|---|---|
| • Staff training on different programs.<br>• A DSHS public information call center (with trained staff).<br>• Design and implement training "refresher" courses to follow up on new employee orientation sessions.<br>• Assign CPM duties temporarily to existing staff.<br>• Conduct cross training between divisions and agencies.<br>• On-going cross – divisional training.<br>• Resource manuals.<br>• One identified resource person per office.<br>• Ensure DSHS contracts mandate collaboration.<br><br>**THEMES:**<br>**More Training:** Cross division training. More staff training so they know what other divisions do.<br>**ONE STOP INFO SOURCE:** THERE'S A NEED TO PROVIDE CLIENTS EASIER ACCESS TO INFORMATION AND SERVICES.<br>**Write contracts in language that requires collaboration.** | • Shared applications between programs (databases).<br>• Bring back the Community Resource Program Manager.<br>• Flexible use of funds.<br>• Reduce the size of caseloads.<br>• Buildings that house multiple programs.<br><br>**THEMES:**<br>**Use technology** to share information**.**<br>**Flexible use of funds.**<br>**Design space (buildings, etc.) to support collaboration.**<br>**More staff.** |

### Next Steps

Carol Webster closed the meeting by thanking participants for their participation and input. She advised there would be a typed summary sent to each participant. Also, she solicited ideas for a Poster Presentation of current innovative practices that's resulting in better service to shared clients. Several innovations were identified.

**Meeting Evaluation**

Participants liked the presentation of information and opportunity to provide their input. One disappointment was not all divisions/program areas were present to provide input.

There was a suggestion that this theme be refined and used at the August 2001 RCC/RAC conference. This is a valuable suggestion that will be explored.

**Other Comments:**

1. Suggest RCC coordinators manage the poster displays. Provide the guidelines and space limitations and encourage them to use it as a practice for their August conference.
2. Prepare an "Innovations Form" so good ideas can be captured at the other meetings.
3. Adapt, shorten the Power Point presentation. Take out the who, what, etc., shorten the descriptions of the three client groups, etc.
4. Invite the RCC/RAC Chairs and the Region Coordinator to the April conference.
5. Email the other coordinators and Cabinet liaisons informing them of the importance of the meeting.
6. Continue to provide participants a copy of the slides to take notes on.

# APPENDIX 6

# INDEX OF RESOURCE MANUAL, OREGON RESEARCH AND PLAN, AND PROJECT RESEARCH BIBLIOGRAPHY

# VOLUME I

## NARRATIVE PROGRAM DESCRIPTION

- Worksource of Lynnwood
- Rogue Family Center, Oregon
- Articles about the reorganization of the Oregon Dept. of Human Services
- ITC Individualized and Tailored Care, Pat Miles
- Co-Occurring Disorder Pilot Project, JRA Jeannie D'Amato
- Brokering Assessment Tool for Peer Technical Review
- White Consulting Representative Projects, Debbie White
- Systems Collaboration with Shared Children (Pierce County)
- The 'A'Team
- Juvenile Offender Co-Occurring Disorder Pilot Program (2)
- The "START"/Sovner Center Model, Joan Beasley
- Florida Dept of Children and Families-Developmental Disabilities Program
- 'Personal Planning Guide'
- Coos County Oregon, Developing a One-Stop Career and Opportunity Center (has flow model)
- Conceptualization of Casey's Family Team Process
- Family Support Center, Olympia
- Casey Family Partners: Spokane(2)
- Family Governing Boards, Jeff Keilson, Boston

## APPLICATION FOR SERVICES

- Comprehensive Family Assessment, Oregon
- Self-Sufficiency Scale Rating Definition Guide, Oregon
- Family Centered Assessment and Intervention, Oregon
- Family Self-Sufficiency Scale, Oregon
- Systems Collaboration with Shared Children, Pierce County (application and referral)
- Community Stabilization, Pierce County (release consent and)
- 'A'Team (Client Information for Staffing)
- Assessing Readiness for Coordination, Debbie White
- Specific Questions and Comments to Use with Families, EHS Center (Mental Health)
- DOE/DMR Project Process and Guidelines, Jeff Keilson, Mass.
- Juvenile Offender Co-Occurring Disorder Pilot Program Referral
- START Personal Support Plan, Jeff Keilson, Mass.
- Intent to Commit to the NEWMARK SYSTEM, Coos County, Oregon

  - Application for service partners
  - Authorization for release of information
  - Intake Information
- Brokering A tool for internal assessment of the development and Quality of Brokering Functions and Principles
- Grid Mutual Model for Parent-Child interaction, EHS Center
- Starting Early, Starting Smart, outcome variables and modules

**LIST OF PARTNERS**

Self-Determination brochure, Jeff Keilson, Massachusetts
Casey Family System of Care
Adult and Family Services Division, Oregon Dept of Human Services
Community Team for Adults, 'A'Team, Region 3 Washington

**CONFIDENTIALITY AGREEMENT**

- Authorization for Release of Information, Jackson County, Oregon (twice)
- Authorization to Exchange and/or Release Information, Casey Family Partners
- Authorization to Release Information Work Capacity Assessment, DSHS Workfirst Program
- Release of Confidential Records Consent, JRA DSHS 20-202
- Confidentiality, Restrictions of Data Sharing and the Client Registry
- Consent for the Release of Confidential Information, DVR
- Authorization to Obtain/Release Information DSHS 14-12
- Authorization to Release/Obtain Information DSHS 09-855
- Federal cite for regulations safeguarding information for the financial assistance programs, specifically as it applies to refugees
- DDD Authorization to Obtain/Release Information DSHS 14-12A
- Authorization to Obtain/Release Information DSHS 14-012x
- C.F.R. 42 (Federal regulations regarding confidentiality of alcohol and substance abuse clients
- Summary statements of application of 42 C.F.R. by DASA
- Consent for the Release of Confidential Information DASA
- Oath of Confidentiality (employees of Systems Collaboration with Shared Children)
- Shared Confidentiality Agreement ('A'Team)
- Caregiver Consent Starting Early Starting Smart, Spokane
- Release of Confidential Records Consent JRA DSHS 20-202 (duplicate)
- Establishing a Statewide Database that tracks Alcohol/Drug patients without violating confidentiality Legal Action Center Washington D.C.

- Work-Source Washington Data Sharing Notice (see statement at bottom of page 1) Consent Form
- Authorization to Display Name in DSHS Client Registry (draft of form used by DVR and DASA
- C.F.R. 42
- Instructions Authorization to Release Information DSHS 14-12x
- Authorization to Release Information DSHS 09-242
- Sample Patient Notice C.F.R. DASA
- Participant Consent for DVR to Receive Confidential Information DSHS 09-075x
- Participant Authorization for DVR to Disclose Confidential Information DSHS 09-756x
- DVR/CSD Client Consent DSHS 09-885
- Draft Proposal of DSHS WAC change to consolidate confidentiality requirements
- Old Manual F cites and instructions ??????
- Consent for the release of confidential alcohol or drug treatment information
- Consent for release of information
- Release of Information Form (AGs opinion regarding 90 day release limit)
- Oath of Confidentiality RSN
- Employee Service Agreement
- ADATSA Client Notice and Agreement
- Release of Confidential Information DASA
- Consent for the Release of Confidential Alcohol or Drug Treatment Information
- OSE Manual, Authorization for Release of Records DSHS 17-83?
- Authorization to Represent and to Obtain/Release Information Pierce County
- Confidentiality and Health Care Records (AG's Review)
- RSN Enrolled Consumers Referral for MPC Services (Management Bulletin)
- Disclosure by Substance Abuse Programs (DHHS General Counsel Opinion)

**INTER-AGENCY AGREEMENT**

- Catholic Community Service contract with Pierce County Human Services (RSN)
- JRA Co-Occurring Disorder PROTOCOL
- Agreement between Inland Counseling Network, Children's Home Society of Washington, Elder Mental Health, Walla Walla County Resource Management Services and Walla Walla County Department of Human Services
- Mental Health collaborative protocols proposed for RSN contracts, Richard Onizuka
- DDD/MHD Collaborative Work Plan (DDD/MHD)
- Governor's Juvenile Justice Advisory Committee RFP requiring collaboration
- Client Service Contract WORKFIRST (Statement of Work)
- Inter-local Agreement, JRA co-occurring disorders
- Memorandum of agreement between Western State Hospital and Child Study Treatment Center
- Intra-Agency agreement between employee services division and Mental Health Division
- Interdivisional agreement between the Division of Developmental Disabilities and The Mental Health Division
- Memorandum of understanding between Mental Health Division and the DSHS Finance Division for the Mental Health Psychiatric Hospital billing compliance project
- Policy 4.08 Monitoring and Quality Improvement of Adult Family Home Services (DDD)
- Interagency Agreement between Department of Mental Retardation and Department of Education, Massachusetts
- Interagency Agreement between Timberlands Regional Support Network and DSHS, DDD Region 6
- Memorandum of Understanding between DSHS, DDD and Pierce County Human Services
- Working Agreement between King County RSN and DDD Region 4
- Intra-Agency Agreement between CA and DDD (DRAFT)
- Catholic Community Services contract with Pierce County Human Services (RSN) (1), (2), and (3)
- Interagency Agreement between State of Washington Public Institutions of Higher Education and DSHS and Dept of Services for the Blind (DVR)
- Interagency Agreement between Grays Harbor County and DSHS (DVR)
- Core Provider Agreement DSHS 09-048x (MAA)
- Job description for DCFS Compass Health liaison in Region 3 although there is no formal contract or agreement

# VOLUME II

## DESCRIPTION OF FUNDING SOURCE

- Resource Sharing Agreement Creekside WorkSource Center, Lynnwood
- Braided Funding 'A'Team
- Types of Brokering Arrangements, Debbie White
- Collaboration, Debbie White
- Blended Funding (Proposed Legislation) Family Planning Council
- Sources of Revenue, Casey Family Partners: Spokane
- Program Budget Co-Occurring Disorder Pilot
- Resource Sharing Agreement WorkSource Renton (DVR)

## TECHNOLOGICAL INNOVATIONS

- AWRD Access Washington Resource Directory
- 15 IT Projects to support collaboration Dept of Human Services, Oregon
- Meta Frame (legacy system integration)
- Client Touch (Case Management Software)
- SMART San Mateo Access Resource Tracking system outsourced to Electronic Data Systems (EDS)
- Answer Phone, Phone action line in ESA Region 6
- Provider Gateway Case Tracking software common front end to link existing 'silo' systems
- CalWIN brief news item on replacing old social service system
- NY tries to erase government boundaries news article
- Groove Networks example of group-ware to support team communications
- HELPWORKS self assessment software
- Microsoft Office 2000 has ability for teams to be identified and notified of Team significant communications and documentation
- CASE TRACK
- Meetings Redefined Videoconferencing is nice, but newer technologies use the Net to promote collaboration and sharing of live documents
- One Easy Link New Jersey's coordination of the Dept of Human Services, Labor, and Health and Senior Services
- Microsoft Office 2000 (2)
- Meeting the Challenges Ahead, John Atherton, ESA

Trial Eligibility Computer On-line preliminary self eligibility determination

**OREGON RESEARCH**

# Remaking DHS

## *Reorganizing the Oregon Department of Human Services to better serve Oregonians*

***February 2001, Version 1.0***

Department of Human Services
500 Summer St. NE, E25
Salem, Oregon 97301-1098
(503) 945-5944
(503) 945-6214 (TTY)
www.hr.state.or.us


DHS VISION
Better outcomes
for clients & communities
Through collaboration, integration
and shared responsibility

# Remaking DHS

## Reorganizing the Oregon Department of Human Services to better serve Oregonians

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***Executive summary***

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***The foundation***



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***A new structure for DHS***



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***A look ahead***



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***In summary***

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***Appendices***

# A foundation built on research

**Years of experience in seeking more collaborative approaches to human services formed the foundation of the reorganization effort.**

It was important that the teams planning the agency's restructuring have the benefit of experience gained and lessons learned through years of human service practice. Accordingly, the planning process included research into service integration and restructuring efforts in Oregon and elsewhere.

Members of the research team compared the structure of Oregon's Department of Human Services (DHS) with that of comparable state agencies nationwide. They studied a decade of integration work in Oregon, human services innovations in other states, and the full 30 years of Oregon DHS history. They consulted with people involved in various service integration projects.

Those contacted included the DHS "partnership leaders" in Oregon's four prototype counties — Baker, Coos, Jackson and Polk — where DHS is joining with local partners to build fully integrated, countywide human services systems.

The research defined challenges and revealed insights, summarized here, that helped shape the planning process.

## *A long-standing challenge*

The research provided a reminder that although the benefits of more collaborative work have long been recognized, producing fundamental change has been difficult.

Efforts at collaboration have sometimes been perceived as threats to budgets, programs or organizational identities. In addition, the size and complexity of the agency, with its multiple programs, responsibilities and constituencies, has been an obstacle to change.

## *Listening to clients*

In focus groups, human service clients in several Oregon locations indicate a frustration with the current system. In particular, clients speak of difficulty navigating a system that has separate field offices, caseworkers, case plans and paperwork requirements for each program.

However, those clients receiving supports at integrated sites, such as the Rogue Family Center in Jackson County, describe themselves as better served.

## *A look across the country*

The research team found that Oregon's human services agency is one of the most broadly focused in the country. Only in Montana, North Carolina and Vermont do state human services agencies encompass such a wide range of services. This represents a promising opportunity to bring together, in easily accessible fashion, a wide range of appropriate supports for each Oregon client or family.

## *Some general findings*

Other insights gained from the research team's review of experiences in Oregon and elsewhere:

- There is no single, preferred way to organize human services. States have grouped services in various ways, each with its own benefits and challenges.
- Integration has been instrumental in making human services more accessible and more responsive to client and community needs.

- Ease and timeliness in sharing client information within the system are essential to success in service integration.
- The support of advocacy and advisory groups, counties and other partners is vital. DHS must seek general agreement among these entities before implementing major system changes.
- Service integration sites all use at least three integration approaches, most often coordinated case management, interagency protocols and co-location of staff.

## *View from the field*

The research team interviewed the partnership leaders that DHS has placed in the four prototype counties to work with a broad range of state and local partners. These leaders confirmed the research findings, listing a variety of necessary changes, including:

- Integrated information and case management systems.
- Streamlined contracting systems.
- Non-competitive philosophies and values among DHS divisions.
- "System navigators" or family advocates to help link clients with appropriate services.
- Use of innovative and flexible funding to support the service delivery model, including funding for service coordination.
- Use of multidisciplinary teams, both to improve outcomes for clients and communities, and to effect system change.

# The centerpiece: Integrated service for clients

**The new DHS structure will use teams of specialists to provide services efficiently and comprehensively, in a way that involves clients and families in finding solutions.**

The agency's new structure includes a service delivery model that addresses various levels of client need. It acknowledges that some people seek single or straightforward supports, that some are best served by referral to community partners, and that some have multiple, complex needs.

The chart on page 34 shows how a reorganized DHS will provide coordinated services for a variety of client needs.

The system envisions a "no wrong door" approach. Instead of searching for the "right" office for a given support, clients will be able to access a full range of services by making contact at any of a variety of human services facilities. In keeping with the concept of client self-determination, the system will assist Oregonians in building on their strengths, assessing their needs, and choosing from the range of available services.

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## *Appropriate services*

Depending on the circumstances, a person will be connected with DHS services or will receive an **enhanced community referral.**

The concept of enhanced community referral emphasizes that referral must amount to more than simply giving the individual another agency's address or phone number. Rather, there must be assurance that the referral is appropriate, and that all partners involved continue to work together to provide seamless service.

If DHS services are required, a **resource and service specialist** will assess client needs.

If a person needs a single or relatively simple service, eligibility will be readily determined and the service provided quickly. Examples may include immunizations, food stamp benefits or Oregon Health Plan coverage.

Clients with more complex needs will be linked to a **lead services manager.** This manager will work with the client to develop an integrated service plan, which helps the client address his or her problems. Clients entering the system involuntarily (in child abuse or neglect cases, for instances) will have their first contact at this point.

When appropriate, the lead services manager also will have access to an **integrated service coordinator.** This person will bring together service providers from DHS and its partners to work with the client on an integrated service plan. Over time, the lead service manager may change to reflect the changing needs of the client.

Crisis intervention will be provided as necessary at any point in the process.

While the client receives services, the lead services manager will monitor client needs and progress, adjusting the integrated service plan as required. Transition services will be provided to assist the client in realizing his or her goal.

## *Key role for technology*

The reorganization planners see technology as a vital support in building a system that addresses needs holistically, and that gives clients and families greater control over the services they receive. For instance, eventual technological enhancements could:

- Enable case managers and other staff, with proper confidentiality safeguards, to share information already on file about clients' involvement in the system.
- Allow people to learn readily about available services, and perhaps to provide some information to begin an application process — through home or public library computers, or at electronic kiosks, for example.

- Provide a network for client point of contact, basic screening to determine needed services, and enhanced community referral.
- Help with the storage and carrying of a wide variety of specific client information — such as children's immunization status — through data-storing "smart cards."

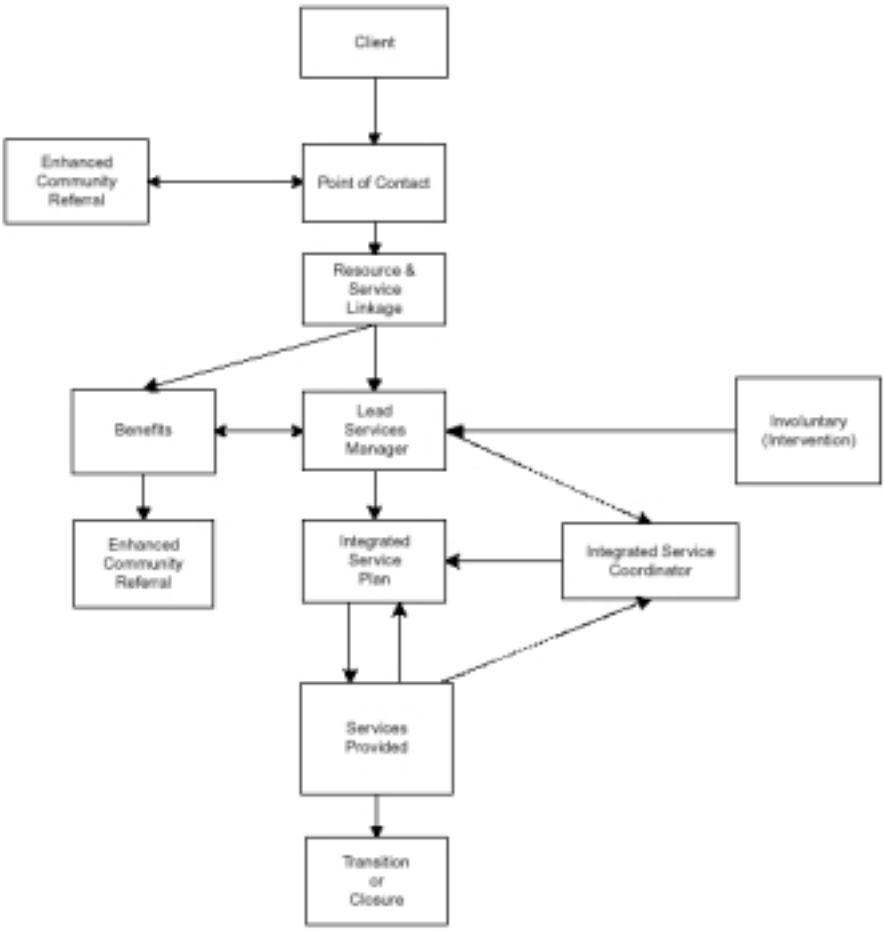
## *The importance of training*

DHS will continue to develop and value specialized expertise in human services disciplines. This knowledge is essential to excellent service.

However, for the new approach to client service to succeed, staff also must receive additional skills and knowledge. Familiarity with the full range of available supports will be necessary. In addition, staff will need skills involving working in teams and creating and carrying out integrated case plans.

The new DHS organization will be geared to provide these tools.

Chart: DHS Service Delivery Model



# Client service delivery model

**Explanation of chart; definition of terms.**

***Client:*** A person actively involved in decisions concerning needed services. Clients may seek single or multiple services or benefits.

***Point of contact:*** Contact may occur on the client's initiative, as a result of a community referral, or involuntarily (as in cases involving child abuse or neglect). Initial contact may take place in a DHS office, at the client's home, in a community partner's office, or through technological interface.

***Enhanced community referral:*** A referral that involves more than just providing a client or family with a list of community supports, or with direction to another agency.

In enhanced community referral, clients are guided through the process of accessing those other agencies, services or supports. The referring staff person ensures that the service or support is currently available, provides basic information on eligibility criteria, may help problem-solve about transportation to the resource, and may contact the resource to ensure that a suitable linkage has been made. Examples include referrals to food banks, support groups, clothing resources, shelter, or other community support.

***Resource and service linkage:*** A conduit for access to DHS services. It involves a thoughtful and purposeful screening conducted with the client in order to determine the primary service or benefit needs. For single or simple service needs, eligibility is determined and benefits issued. For complex needs, the client is connected to a lead services manager. This function must be supported by adequate and accessible data and information systems.

***Benefits and services:*** Benefits help clients and families by providing financial, medical, housing, food, and transportation support. Services may include counseling, access to employment, training, health and residential services, and other specialized programs.

***Lead services manager:*** A DHS staff member or contracted service provider identified as best able to address the client's primary presenting need. This person, with expert program knowledge, performs such tasks as assessment, eligibility determination if required, and the provision or brokering of services and expertise.

If multiple needs are identified, the lead services manager is then responsible for ensuring the development of an integrated service plan. The person is also responsible, in collaboration with the client and others, for maintaining, evaluating, revising, transitioning or terminating the plan. The lead services manager may change over time, depending on the predominant issue facing the client or family.

***Integrated service coordinator:*** A facilitator available to the lead services manager at the local level to help develop a service plan in complicated or particularly difficult cases. The facilitator will not have case management responsibility for an integrated plan, and will be expected to disengage from the process once the plan is successfully developed and is being implemented.

Among skills and services the facilitator may bring to the process:

- Convening multidisciplinary teams and facilitating discussions to reach common outcomes for the client.
- Identifying additional local and state resources and supports that may help in the achievement of goals and outcomes.
- Providing expertise about traditional funding sources, potentially flexible funding sources, and resources within the community external to DHS.

***Integrated service plan:*** A plan consistent with the department's mission to promote independence, health and safety for all Oregonians. To the extent possible, the plan's goals should be driven by the desires and choices of the client and/or family. Plan development should occur in partnership with the client, relevant DHS staff or service providers, courts, and other appropriate community service providers.

Among the plan's key features:

- Major goals for the client or family.
- Clear timelines and expected outcomes.
- Agreement upon and identification of the lead service manager.
- An objective, consistent collaborative approach agreed upon by all participants.
- Identifying additional local and state resources and supports that may help in the achievement of goals and outcomes.
- Inclusion of expertise about traditional funding sources, potentially flexible funding sources, and resources within the community external to DHS.

The plan should be readily available to the client and service providers/case managers throughout its implementation.

***Involuntary services:*** These clients may have multiple or single needs and enter the system differently, often through a crisis. They may be in denial, resistant, and/or hostile. They may receive services more quickly because of the nature of their crisis (e.g., child protective services, court-ordered civil commitment). If ongoing needs are identified, these clients will have access to a lead services manager and an integrated service plan.

***Transition services:*** These include enhanced referrals and all case management activities, resulting either in the client's success in achieving desired outcomes, or in the termination of the service plan for other reasons.

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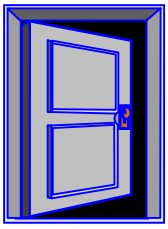
# APPENDIX 7

# NO WRONG DOOR CONFERENCE AGENDA AND REPORT



***Labor and Industries Auditorium***
***Tumwater, Washington***
***April 23, 2001***

**8:30** **Welcome**
**Carol Webster**, Project Director
No Wrong Door – Case Coordination Project

**8:35** **The Problem and Our Opportunity**
**Liz Dunbar**, Deputy Secretary, DSHS

**8:45** **Summary of Data Gathering Activities**

**What Gilmore Research Focus Groups Told Us**
*Carol Webster, Project Director*

**What Case Histories Told Us**
*Judy Olmstead, Contractor*
*No Wrong Door – Case Coordination Project*

**What RCCs/RACs Told Us**
*Dave Whitling, Facilitator OOED, Consultant*
*No Wrong Door – Case Coordination Project*

**9:15** **Keynote: Mary Ann Murphy, Director**
*Casey Family Partners, Spokane*

**9:35** **B r e a k**

**9:45** **Panel I: Best Practices in Case Coordination**

**Pat Miles**, *Consultant*
*Individual Tailored Care (ITC)*

**Jeff Keilson**, *Consultant*
*Massachusetts Department of Mental Retardation*

**James Mead**, *Social and Health Services Program Manager*
*Home and Community Services, Region 3*

**Shirley Iverson**, *Acting Director*
*Adult and Family Services, Oregon Department of Human Services*

**Joan Beasley**, *Consultant*
*Massachusetts*

**10:35** **Panel II: Best Practices in Case Coordination**

**Cyndi Schaeffer**, *Administrator*
*Alderwood Community Service Office*

**Sharon Saffer**, *Director, and* **Shelly Ray**, *Adult Resources Manager*
*Walla Walla Human Services*

**Jeannie D'Amato**, *Substance Abuse Program Administrator*
*Juvenile Rehabilitation Administration*

**Debbie White**, *Consultant*
*Oregon*

**11:15** **Q & A**

**11:25** **"Walkabout" (Visit to Poster Presentation Booths)**
*Visit with local exemplary case coordination projects*

**12:15** **Box Lunch, Continue Walkabout, Free Time**

**1:00** **Design Teams Workshops**
*(RCC/RAC members and Executive Team members may sit in on the Design Team of their choice)*

*More Time to ask Expert Presenters About How To:*

- *Agree on goals, values, model and outcomes with partners*
- *Agree to form multi-agency teams & reward staff for collaboration*
- *Obtain supervisory support & agency management support*
- *Agree upon shared confidentiality agreements*
- *Agree to screen, assess, and plan together for shared clients*
- *Write & use contracts to support case coordination*
- *Braid funding streams to support case coordination*
- *Co-locate staff*
- *Report outcomes & evaluate to suit all partners*
- *Find & use IT to support case coordination*

**3:45** **B r e a k**

**4:00** **Reconvene to Review Common Principles We Heard in the Morning and the Afternoon Workshops**
*Wally Vlasak and Dave Whitling, Facilitators, OOED*

**4:15** **Closing Comments and Charge to the Design Team**
*Liz Dunbar*

**Q & A**

**4:35** **Design Teams Plan for the Week and Adjournment**
*Carol Webster*

# NO WRONG DOOR CONFERENCE REPORT

*The No Wrong Door Conference, on April 23, 2001, featured research results and 10 expert speakers who addressed the needs of shared clients. This is a summary of the conference report that was written by writer-editor Roberta Wilkes*

## CONFERENCE PRESENTATIONS

### Liz Dunbar, Deputy Secretary, DSHS

### The Problem and Our Opportunity

In her opening remarks, the Deputy Secretary described the evolution of the No Wrong Door approach out of an e-government initiative intended to exploit technology for the support of DSHS operations. Technology is still an important element of support, but it is not driving the design of integration and coordination of services.

What are we trying to accomplish? Dunbar said that DSHS is committed to service integration and coordination of assessment, planning and services for multi-need clients. Planners want to address key problems in the most effective and promising ways possible. Feedback and ideas for improvement were collected from multi-needs clients and families, from frontline case managers and providers, and from guest experts who have been involved in case coordination and service integration in Washington and other states.

The challenge is to creatively adapt those ideas to the Department's needs and to develop models that can be realistically implemented in the next couple of years, given the available resources. The models are expected to serve as a foundation for continuous quality improvement in the future. Local coordination is crucial, both internally and with partners and other providers, in areas such as housing, education, employment and training, and legal assistance.

### Carol Webster, No Wrong Door Project Director, RDA

### What Gilmore Research Focus Groups Told Us

In her presentation, the Project Director reported on the 12 focus groups that were held in February and March 2001. Six were held in Seattle, three in Spokane, and three in Mt. Vernon. They included 70 shared clients or their caretakers (47 female and 23 male) from the three target groups: Long-term TANF Families, Troubled Children, Youth and Their Families, and Persons with Multiple Disabilities. There were six common themes.

1. Information about services and eligibility

- Clients want access to information about DSHS's services.

  "…if you don't know the right questions, you don't find out what services are available."

  "It's been a complicated journey finding out what these children are eligible for, what services are available."

  "All those services should be listed in one place."

  "How about an 800 number that we could call?"

2. Improve Communications

- It's difficult to get DSHS by phone. *(80% of clients in focus groups communicate with DSHS by phone, but have difficulty doing so.)*
- Mail gets lost in DSHS.

3. Hear Me, Respect Me, Include Me

- Caretakers and clients want clients to be seen as human beings, not statistics.
- Clients want to be respected and to be included in planning for appropriate services.

  "Just see that these are people, not pieces of paper."

4. A common Client Database

  "My caseworker has the same information that my daycare worker needs. Why can't they just give the information to one another?"

  "…if they just worked off the same network file system, I think it would eliminate a whole lot of problems."

5. A Team to Plan and Provide Services

  "I just think it would be nice if everyone was on the same page."

  "They don't treat you like they are joined establishments. You've got to go through the hassle of dealing with them all."

6. Services in One Place (co-location)

  "You have to run the paper work from one agency to another one and to another one."

  "It's one big package; I got my schooling, my treatment, and my counseling all in one building. So I was like, 'Cool, I can handle this.'"

**Judy Olmstead, Independent Researcher, RDA Contractor**

**What Case Histories Told Us**

Seventeen case coordination stories from three different geographic areas in Washington were selected to serve as case studies for detailed analysis. These cases were chosen to exemplify successful or unsuccessful case coordination experiences over the past two years. Frontline workers from DSHS and community partners were interviewed about these cases to gain information from the service providers' point of view. Each project design team received a different set of these case stories to serve as examples, as common reference points, and as "food for thought" during creation of new models.

Clients represented in these cases included:

- One 3-year-old released for adoption
- Three teenagers with minimal family
- One two-parent family
- Seven single mothers
- Three single adults with minimal family
- Two single adults with no family

Analysis of these cases revealed a number of trends:

- There was much turnover in service professionals, even in the short term.
- For some clients there were large numbers of service professionals involved, which was difficult for some clients.
- The primary case manager changed frequently. Twelve of the 17 clients had had the same case manager for less than one year, ranging from two weeks to ten months.
- Service styles ranged widely from parallel efforts to thorough teamwork. Some caseworkers were highly involved with clients and communicated consistently with other professionals on the case, while others were not highly involved.
- There were great differences among case managers in their effort and involvement. Some were much more committed to clients than others.
- There was a wide range in client ability to use services. Some knew how to work with teams and follow through. Some were very trying to work with, to the point of harassment. The most troublesome clients were sometimes the most troubled and the most difficult to work with.
- Client eligibility for services varied widely.

The process of collecting input from case managers was itself a valuable source of information, as project interviewers experienced the system as "clients." They reported much difficulty gaining access to respondents, having to go through many administrative layers to reach frontline staff. Some interview requests were denied, although most frontline staff was quite cooperative.

**Dave Whitling, OOED Senior Consultant**

**What RCCs/RACs Told Us**

Whitling reported on the input gained from the regional administrators and advisors from all six Regional Coordinating Councils and Regional Advisory Committees (RCCs/RACs). Members were asked for their perceptions in three areas: What are we doing well? What are the constraints? What are short-term and long-term recommendations?

Successes

There is clearly much strong innovation occurring in the field throughout Washington. Respondents submitted more than 100 examples of successful practices in case coordination.

Constraints

- Confidentiality requirements limit communications between agencies.
- There are restrictions on the blending or sharing of funds between programs.
- There is no common client database.
- There is a lack of knowledge of other programs, both within and external to DSHS.
- Different e-mail systems present an obstacle to smooth communications.
- Within each program there are separate cultures, languages, and definitions, as well as different goals and ways of measuring them. Programs sometimes operate at cross-purposes.
- DSHS is structured programmatically, not holistically.

Short-term Recommendations

- Use a single intake process.
- Share confidentiality across programs.
- Provide more cross-program training.
- Authorize flexible use of funds.
- Implement a client registry.
- Provide an 800 number as a "front door" to DSHS services.

Long-term Recommendations

- Co-locate programs that serve shared clients.
- Establish portable funding that follows the client.
- Provide an 800 number for eligibility inquiries.
- Create a common database.

**Mary Ann Murphy, Keynoter**

**Director, Casey Family Partners—Spokane**

Mary Ann Murphy said the murder of a teenage client in 1994 stimulated an intense reexamination of the social services system in Spokane. She described the community's acknowledgment of its "non-system of care" in the face of this tragedy and its dedication to changing the system. The Casey Family Foundation was recruited to help create a new way of serving clients' needs.

The goal was: "Every door will open to a comprehensive array of services." Part of the problem, said Murphy, is that many clients do not know how many doors there are. Another issue is that those who fall through the cracks in the system are often labeled "difficult to engage" or "borderline." She invoked several important principles for turning the system around:

- Put the client in the center of what we are doing.
- See clients as a resource. "They bring strengths that enable them to survive, and that is what we will build on."
- Recognize the importance of the client's extended family, neighborhood, and churches. Welcome this informal support system and wrap the client with the necessary services.

Using a medical analogy in which patients are often treated as organs or diseases, Murphy urged the group to treat clients as whole persons and in a family context. She emphasized the importance of changes in values that must occur if we are to engineer a service change: "Every person in the system must accept responsibility. Secondly, we must all listen to and learn from others, even subordinates. The whole system needs to change to address the whole person."

A shift of skills, as well as values, is needed. The challenge of the skill change is to become a learner and change agent. To be effective, this process has to occur at every level—front line, supervisors, and executives.

Casey Family Partners is running a program to strengthen parent-child relationships and avoid child neglect. One element of the program is videotaping and analysis of parent-child interactions. Murphy presented videotape showing a client and a social worker discussing the client's interactions with her children. The lesson, however, lay in the style of client-social worker interaction, in which the latter assumed the role of listener/learner as the client taught her about the child's development.

"The parent-child relationship," said Murphy, "is at the core of our work." She presented another videotape showing a father interacting with his infant to illustrate the importance of their relationship and, in particular, the face-to-face communication that is crucial to a child's development.

### BEST PRACTICES IN CASE COORDINATION

Nine other speakers, representing social service programs in three states, described their experiences with case coordination. While the settings and approaches varied widely, a number of common themes emerged across these programs about what is needed to effect change:

- Everyone desires a more humane, client-centered orientation.
- The client's family and community are important resources.
- Relationships are at the core of social services.
- A shift in values and skills on the part of service workers is needed.
- A strong commitment to change is necessary to overcome inertia and fear.
- We must build a community of support around the client.
- Cultural change is needed within organizations.
- Staff must listen to and learn from clients.
- There are important cultural differences between services and systems.
- Reducing the size of caseloads is an important goal.
- Clients deemed "hard to serve" are those with the most complex needs.

**Patricia Miles**

**Consultant, Individualized and Tailored Care, Oregon**

Loneliness is the greatest need

Miles told a "cautionary tale" about a child growing up in the mental health system whose life story illustrates what can go wrong. "Dennis" was being raised by his grandmother—his only family member—but experienced a series of placements elsewhere, including foster care and mental health facilities. A team of caseworkers oversaw his care. His condition worsened as he was separated from his grandmother, he experienced great isolation, and "people talked about his label and forgot to talk about him."

Miles drew attention to several lessons from this case:

- "Interagency teams can make far worse decisions than any single individual when they don't include the client in their decision-making."
- "Getting a lot of services doesn't necessarily mean you are getting your needs met—and the biggest unmet need is loneliness."
- "It's harder to institutionalize new ideas in the system than to institutionalize people."
- "People need us to spend time with them, not necessarily to spend money on them."

**Jeff Keilson**

**Regional Director, Department of Mental Retardation, Massachusetts**

Community-based self-determination for clients

Keilson believes that the challenge of case coordination lies less in the design than in the implementation of sustainable programs. He cited three obstacles: Giving up power is difficult. The environment does not reward risk-taking. There is great resistance to change.

One successful program in Massachusetts has been an agreement by which the Department of Mental Retardation transferred $35,000 per patient to community organizations to support 250 patients during their transition from mental hospitals into the community after eight years of hospitalization. This money was matched with federal funds. The arrangement has been very successful for 13 years.

In a similar arrangement, the Department of Education has taken money that was being used to support children in residential facilities and transferred it to programs that return them to the community. More than 200 children have benefited, including some who would have been placed in residential treatment but were able to avoid it.

A third approach in Massachusetts involves a more fundamental cultural change in service delivery. A Robert Wood Johnson Foundation grant supports a program of self-determination for people with disabilities and their families. It has moved decision-making authority and control of resources from state agencies to community governing boards composed of individuals and families.

Clients and families defined their own communities—Latino, Haitian, African-American, families with children with autism, and others—and formed a powerful multicultural alliance. Participants elect governing boards, which then become linked to "natural" community agencies—in many cases a neighborhood health center. State and city agencies provide support as defined by families, who hire and direct their own case managers. More than 700 families are involved, most never having had access to appropriate support or been linked to others with similar problems before.

A good example of the problems addressed is that of a pregnant woman with mental retardation in the Haitian community. Ordinarily, the baby would have been placed elsewhere and the mother moved to a group home. In this case, seeking to keep this family together in a culturally appropriate way, the governing board used state money to hire an aunt to live with the mother, her child, and her grandmother.

This program, said Keilson, "forces state agencies to respond to clients. Having governing boards controlling resources changes the traditional roles of state and provider agencies. We make one decision—what resources are available—and they take decisions from there. We become technical assistants rather than decision-makers. We need to be comfortable with that role and excited by it. Change can happen."

Keilson identified several characteristics of success in systemic change:

- There is recognition of a problem.
- There is a firm commitment to finding solutions.
- Nothing is sacred in terms of existing programs.
- The outcome for the individual is the most important factor.
- Empowering the individual and the family is critical.
- Funding responsibility is worked out before collaboration begins.
- There is a single point of case management responsibility and authority.

**James Mead**

**Program Manager, Home and Community Services, DSHS, Snohomish County**

Teaming to support the most complex needs

Snohomish County sought to design a system to serve clients with complex needs, who often were not receiving the services they needed and for whom fragmented approaches were not working. The clients included those needing services for mental health, nursing care, rehabilitation, substance abuse, developmental disabilities, and sexual offense.

The "A" Team's goals were:

- Reduce recidivism rates and costs
- Provide the appropriate array of services for clients
- Reduce the costs of resources
- Reduce the risk to clients and the public of inappropriate placements
- Reduce the human costs to clients

Several community agencies in Snohomish County were invited to identify problems and to form teams with DSHS units. Partners in The "A" Team include: DSHS Home and Community Services, Division of Developmental Disabilities, Department of Corrections, Compass Health, Inc., Snohomish County Corrections, Snohomish County Human Services Mental Health Regional Support Network, Area Agency on Aging, County Involuntary Treatment Program, County Alcohol and Other Drugs Department, and Associated Provider Network.

The "A" Team is an organizational change only; there is no special funding. Services are provided directly by each participating agency. Directed by two co-chairs, the team meets monthly and is prepared with pre-meeting information. Sponsoring agencies present each client to the group, and assignments ("Action Plans") are distributed to team members according to the client's needs.

At each meeting the team revisits the cases staffed at the previous meeting to check on progress. There is a shared confidentiality agreement and client information staffing form.

Among the challenges have been the effort needed to get everyone to the same table; focusing on the needs of the client, not the needs of the particular agency; and understanding each other's roles, capabilities, and limitations.

In many cases the team has been able to assemble services necessary to stabilize clients, keeping them out of more restrictive environments, and saving money. Specific successes include:

- Inpatient hospitalization was reduced by 134 days for 67 clients, saving $67,938.
- Psychiatric hospitalization for 12 clients was reduced by 9 days, saving $97,200.
- Reduced recidivism eliminated the need for emergency mental health treatment for 8 clients, saving $26,865.
- Clients received appropriate care, staying within their communities, and experienced improved mental and physical health.
- Total savings during the first two years of the "A" Team project were $525,266.

**Shirley Iverson**

**Acting Director, Adult and Family Services, Department of Human Services, Oregon**

"No pass without a receiver"

For the past decade, Oregon has focused on building a "circle of support" for families receiving TANF. This means assembling an extensive group of partners in teams to provide the necessary services to keep families self-sufficient. Some partners are purchased through community contracts, while others come from public agencies.

"We have tried to put a different face on our human services system," said Iverson. To achieve this, she is bringing together culturally different agencies that often have had little communication for years, even within DHS. There is much fear of change in organizations—fear of giving up comfortable ways of working. Working in welfare systems can be isolating work, and people who do it can become insular and territorial. It is sometimes necessary to give up "ownership" in order to become a broader team to support families. Iverson advised, "Pick which bridge you are going to cross today and which bridge to burn. Both will have to be done to be successful."

The most innovative program in Oregon is the Rogue Family Center in Jackson County, which has adopted a holistic approach to serve each family. Twenty-one community, county, and state agencies are co-located at the center, and staff have been cross-trained. Lobbies are used as resource rooms, where a client waiting is considered "a client wasting time." Greeters and "system navigators" help clients find their way around. A team of co-located staff serves clients. In recent years, the region that is served by the center has seen greatly reduced rates of welfare, food stamps, crime, and teen pregnancies.

"There is a world out there in client services that we have not seen yet," said Iverson. "We are reconnecting to our passion about service to clients."

**Joan B. Beasley**

**Consultant, Massachusetts**

Creating successful cross-systems linkages

Beasley discussed broader aspects of change in social service delivery. What makes service systems effective includes each person in the system taking responsibility for what is happening. This includes accountability, linkage, and affiliation agreements; cross-systems collaboration, and accountability to the humanity of the people we serve. Public policy change is a complex process with many practical and societal aspects, but what is really needed is change in belief systems.

In mental health-developmental disabilities dual diagnosis, for example, multiple systems must be recruited to serve clients with multiple needs, including service planning, cross-systems/interdisciplinary training, outpatient, inpatient, and respite care, crisis intervention, family support, and others. Beasley emphasized that variable prototypes of coordinated care are needed, and that a linkage model must be appropriate to the community. An effective model can be a traditional case-management plan, an integrated approach, or cross-systems linkage. An example of a cross-systems approach is a Massachusetts crisis-prevention plan to keep people out of emergency rooms and psychiatric hospitals.

Characteristics of a successful systems linkage plan include:

- Avoid additional strain to a strained system.
- Ask for additional funding if it is necessary and there is accountability.
- Resources should be allocated where needed to fill in service gaps.
- Linkage agreements should be implemented at all levels, from direct care to state level.
- Don’t lose the individual needs of the client in planning services.

Service linkage difficulties include:

- It is important to hear from more people involved directly in delivering services, including private service providers.
- There are numerous cultural barriers between systems, and cultural change is slow.
- Conflict often arises between services used at different points in a client's life cycle, generated by real or perceived inequalities of importance and resources.

"The stigma surrounding disability is probably the biggest barrier to giving the people we serve a voice in their care."

**Cyndi Schaeffer**

**Administrator, WorkSource of Snohomish County**

Multiple supports for job seekers under one roof

WorkSource serves a "universal population" of job-seeking clients with many different needs through a highly integrated, co-located set of services that braid resources. Participating agencies include: DSHS, Employment Security Department, Edmonds Community College, Snohomish County Housing Authority, TRAC, Job Corps, YWCA, Refugee Forum, and others.

The agencies all rent space in the WorkSource building in Lynwood and must commit to being integrated in the program. Each receives 300 hours of cross-program training. Service to clients is seamless and agency divisions are transparent. All agencies provide case management and link to other agencies as appropriate for each client. Schaeffer is the facility manager, and each program has supervisors on site. An oversight team meets twice a month to review policies and decisions. The lobby is a resource area open to all clients, with computers, telephones, copiers, and other equipment.

Blended services and resources include:

- Job search assistance
- Job counseling, referral and placement
- Occupational skill training
- On-the-job training
- Adult education classes
- Unemployment insurance

Schaeffer reported that each agency's separate culture initially presented barriers, and overcoming territoriality was a challenge. Service integration is achieved through collaborative case staffing for all clients, with interagency representation. Other practices that have fostered unity between partners include: joint service planning, continuous quality improvement processes, and co-enrollment of clients.

Benefits to TANF clients under the WorkSource system include:

- Flexibility and choice of services through extended and weekend hours
- Adequate staffing to avoid getting lost in the cracks of the system
- Increased access to employers through shared resources
- Training to support advancement on the job
- A variety of educational and training opportunities

**Shelly Ray**

**Adult and Children's Resource Manager, Department of Human Services**

Teaming to prevent psychiatric hospitalizations

Walla Walla appointed four cross-trained Community Stabilization Specialists to work across systems and across ages to avert unnecessary mental health hospitalizations. Co-located at various agencies, these specialists work as a team with families. Because the community psychiatric hospital is closing, this approach represents a new way of operating that is likely to continue. Families drive the process, and the team builds on their strengths. High-demand clients can burn out caseworkers, but "in teaming, you are not there alone," said Ray. Team members do not carry caseloads. After families are stabilized, they are passed to caseworkers

Ray presented the example of a single, immigrant mother with three children. The family has experienced six to eight hospitalizations in the past year, Children's Home Society placements, adult mental health, DCFS, CPS, the legal system, school difficulties, and a history of abuse. The mother's hospitalizations were threatening the children's stability. A team was formed to work with family and help them identify their needs and strengths. The family is now living in its own home, with increased stability and no hospitalizations for the past four months. The effort has been collaborative and driven by the family's needs, in particular preventing the children's placement outside the home.

There has been no formal evaluation of the program, but Ray believes the team has been able to reduce hospitalizations in this population. She emphasized, "Families are what matters; not policy. People need professionals to stick with them no matter what."

**Jeannie D'Amato**

**Substance Abuse Program Administrator, Juvenile Rehabilitation Administration**

Helping families to help their youth

D'Amato implemented the Juvenile Offender Co-Occurring Disorder Pilot Program, a new program serving youth in King, Snohomish, Kitsap and Pierce Counties. It offers integrated post-release treatment for juvenile offenders with co-occurring mental health and substance abuse disorders. These represent the most needy youth in JRA system.

Eligibility criteria include: age 17½ years, with any substance abuse or dependence disorder and any AXIS II disorder, *or* currently prescribed psychotropic medications, o*r* suicidal status within the past six months. Currently, 29 youth have been referred, with the ultimate goal of enrolling 90 families per year. The cost is $7,100 per family.

The goal of the program is to empower parents to make positive decisions once the youth is out of the system, help them understand needs of their child, and find assistance. The therapeutic model is Family Integrated Treatment (F.I.T.), developed by the University of Washington and consisting of Multi-systemic Therapy, Dialectical Behavior Therapy, and Motivational Enhancement Therapy. Key aspects of the model are:

- Small caseloads, averaging 4 to 7 families
- Therapists on call 24 hours a day, 7 days a week, to deal with crises
- Services begin during the last 2 months in the institution
- Services continue in the home for 4 to 6 months during parole
- Therapists work closely with JRA and other agencies on youth and family issues, planning for transition to the community, and sanctions while the youth is on parole
- Therapists consult weekly with UW staff on adhering to the treatment model

Collaboration with other agencies ensures that the youth and family's needs are, including medical coupons. Because some participating youth are under the jurisdiction of Division of Children and Family Services (DCFS), a DCFS representative was added to the design team, and DCSF caseworkers begin to participate as soon as a youth is referred to the program. The next steps for the program will be continuing education of JRA staff, other agencies, and local communities using an intranet site, as well as developing additional therapist to support more families in the program.

**Debbie White**

**Consultant, Oregon**

"I am, I can, I will."

Debbie White reminded the group that in collaboration, what is most important is "relationships, relationships, relationships." Change and reform in organizations often evoke reactions such as "Too much work!" "They don't pay me enough!" "Stupid policy!" and "We don't do it that way!" White's response is the affirmative one of, "I am, I can, I will" and her message is: "You can have an impact and you will make a difference."

## QUESTIONS AND ANSWERS

**Q**: What should have been done in the case of "Dennis?"

**Patricia Miles**: I would have made sure that everyone was included in planning, to create a culture in which we constantly ask, "Is what we are doing healthy?" and where no one has to feel defensive about what they did. There were no culprits in that story, just situations that brought people to the table without the right tools.

**Q**: What kind of training is effective in helping frontline workers become respectful learners and family-centered practitioners?

**Mary Ann Murphy**: Joint training of people from different disciplines hearing the same message and cross-training in which they walk in each other's shoes. We don't have to do it exactly the way it's done elsewhere. We work with a consulting psychologist, who serves as a model learner rather than imposing a structure on us.

**Q**: What is the relative effectiveness of defining a community geographically as opposed to culturally?

**Jeff Keilson**: It is important for the individual or family to define his or her own natural community. Some have defined themselves culturally, while others define their communities according to the needs of their children. We played no role in defining them. The separate communities also connect with each other for mutual support.

**Q**: How have you mitigated the loss of program-by-program constituencies that help retain funds for vulnerable populations?

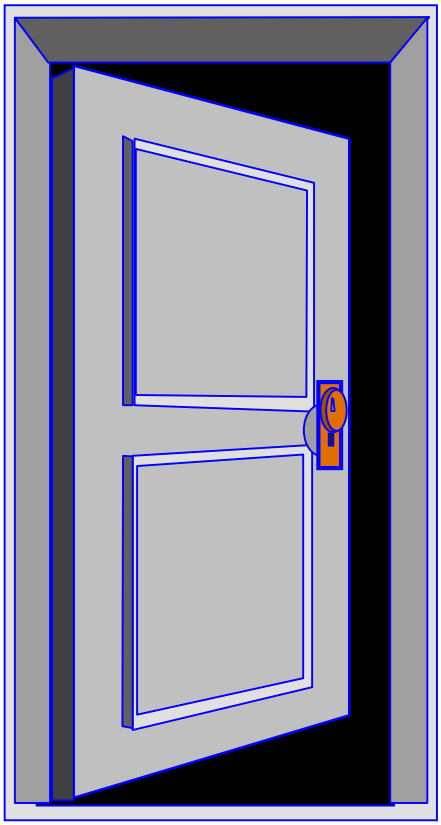
**Shirley Iverson***:* In Oregon we have brought together a group of stakeholders to focus on needs of vulnerable populations. They have always seen the overlap and the need to integrate services—disabled children within TANF households and elders with TANF children, for example.

**Jeff Keilson***:* We are aware of the need to ensure that reforms will continue when our grant is over. We have trained individuals and families to be in control and hold authority. It will be very hard in the future to ignore such a diverse group of so many families that are united. However, it is an ongoing concern.

**Joan Beasley***:* We have not always been successful in Massachusetts, but loss of funding cannot take away what we have learned from the process. You need to find a common language so that basic cultural changes and cross-system movement can remain intact, even in times of scarcity. But this is a challenge. One of the most important developments in mental health in our state has been the "Alliance for the Mentally Ill." In state government we sometimes feel threatened by self-advocacy groups, but they are the best hope for people with disabilities.

# APPENDIX 8

# NO WRONG DOOR DESIGN TEAMS REPORT



# No Wrong Door

## Design Teams' Report

***Developed by the No Wrong Door Design Teams***

***and presented to***

DSHS Secretary Dennis Braddock

*on*

**April 27, 2001**

**No Wrong Door Design Teams' Members**

***500 Years of Experience***

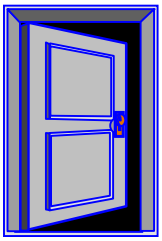
***University Place, April 26, 2001***

**PERSONS WITH MULTIPLE DISABILITIES DESIGN TEAM:**
Ken Johnson (AASA), Carol Clarke (CA) John Taylor (DASA), Bill Siesseger (DASA contractor), Mary Tryon (DDD), Eileen Fielding (DVR), Terry Redmon (DVR), Olga Jouravleva (ESA), Darleen Yuna (ESA), Pam Colyar (MAA), Leann Amstutz (MAA) Jere LaFollette (MHD contractor)

**TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES DESIGN TEAM:**
Annette Olson (CA), Tim Dyck (CA), Kasey Cote (CA), Ruth Leonard (DASA), Melissa Laws (DASA contractor), John Albert (DDD), Tim Cress (DDD), Malcolm Poole (ESA) Jeff Patnode (JRA), Dan Schaub (JRA), Ann Egerton (MAA), Marty Driggs (MHD RSN), Mary Stone Smith (MHD and CA contractor)

**LONG-TERM TANF DESIGN TEAM:**
Marjorie Fitzgerald-Rinehart (CA), RoseMary Micheli (DASA), Ken Guza (DASA), Emilio Vela (DASA), Mike Ahern (DDD), Cathy Monroe (DVR), Stacey Fleming (ESA), Perlitta Matta (ESA), John Culhane (MAA), Janet Clingaman (MHD contractor), Steve Ironhill (MHD and DASA contractor)

**STAFF:**
Dario Longhi, Carol Webster, Dave Sugarman, Judy Olmstead (RDA), Dave Whitling, Wally Vlasak, Tonia Frasier, Ellen Andrews (OOED)



**No Wrong Door – Case Coordination Project**

## EXECUTIVE SUMMARY

### Background

The No Wrong Door – Case Coordination Project was created by the DSHS Cabinet in late 2000, and managed and conducted by the Research and Data Analysis Division (RDA).

The purpose of the project is to develop case coordination models for the Cabinet by June 30, 2001 that can be pilot tested in the next fiscal year. The Cabinet directed RDA to work on case coordination models for three specific types of shared clients:

1. Persons with Multiple Disabilities
2. Troubled Children, Youth, and Their Families
3. Long-term TANF Families

### PHASES OF NO WRONG DOOR PROJECT

To carry out the project, RDA presented its plans and received approval by the Cabinet in meetings in January and February 2001. The project has four phases:

**1. Gather data**

Gilmore Research, an independent contractor, **conducted focus groups** of shared clients and their caregivers in three areas of the state.

Judy Olmstead, Ph.D., under contract to RDA, **wrote case coordination studies** of 17 shared clients. Several DSHS case managers and case managers from local social service agencies were interviewed for each client.

Dave Whitling, an OOED facilitator, **summarized the input of joint RCC/RAC meetings** about current or past successful efforts to serve shared clients and input on constraints.

JoAnn Ray, Ph.D., Eastern Washington University, **identified experts in case coordination** throughout the country for different types of shared clients.

RDA staff **made site visits to Jackson County and Coos County, Oregon** and met with Oregon's Department of Human Services staff about their plans to enhance case coordination throughout their department.

2. **Discuss Innovations at a Conference**

On April 23, 2001, RDA held a No Wrong Door conference, for Design Team and Executive Team members, to present experts and to question them in depth.

3. **Design Teams Develop Coordination Models**

On April 24th through the morning of April 27th, 36 Design Team members worked together to design an ideal concept of coordinated service delivery. They then addressed specific short- term recommendations that could help DSHS pilot the concept of coordinated services within the next fiscal year.

### EXECUTIVE REVIEW

The Executive Team is scheduled to meet for the first time on May 7th to begin their review of the draft models created by the Design Teams.

### WHAT'S INCLUDED IN THIS SUMMARY

This Executive Summary represents the initial work of the first three phases. The Design Teams have developed a statement of values for providing services to shared clients, a case coordination concept (model), raised issues to address, and made recommendations.

1. **Values**

   The three Design Teams concurred on the values that should drive case coordination.
2. **Concept**

   The three Design Teams concurred on a concept (model) of providing services to shared clients. A flow chart diagram (see page 4) and a narrative (see page 6) explain this concept.
3. **Issues and Recommendations**

   The three Design Teams worked separately to identify and prioritize the issues that they could discuss and make recommendations about, for the short term and the long term.
   a. Persons with Multiple Disabilities
   b. Troubled Children, Youth and Their Families
   c. Long-term TANF families

### NEXT STEPS IN THE NO WRONG DOOR PROJECT

The next steps in the project will be to present the report of the Design Team's work to the Executive Team. The Executive Team will review the concept and recommendations in May and June 2001. They will convene technical experts (Issues Resolution Team) to work on constraints that stand in the way of achieving the concept.

## No Wrong Door Values

**Accountability:** We are accountable to many stakeholders by:

1. Providing timely and comprehensive services
2. Serving customers efficiently
3. Serving customers effectively and measuring our outcomes
4. Measuring customer satisfactions
5. Using a comprehensive management information system

**Respectful Environment:** We provide a welcoming and supportive environment by:

1. Acknowledging and honoring the diversity of our customers and our staff
2. Responding quickly to customers' inquiries
3. Recognizing that quality services can be provided in uniquely different settings
4. Supporting our staff in their decisions to serve our customers well

**Customer-centered Services:** We will provide consumer-driven, flexible services that respond to the unique needs of each individual and family by:

1. Respecting our customer's choices
2. Providing cultural relevant services
3. Emphasizing holistic and strength-based services

**Partnerships:** We maximize state and community resources by:

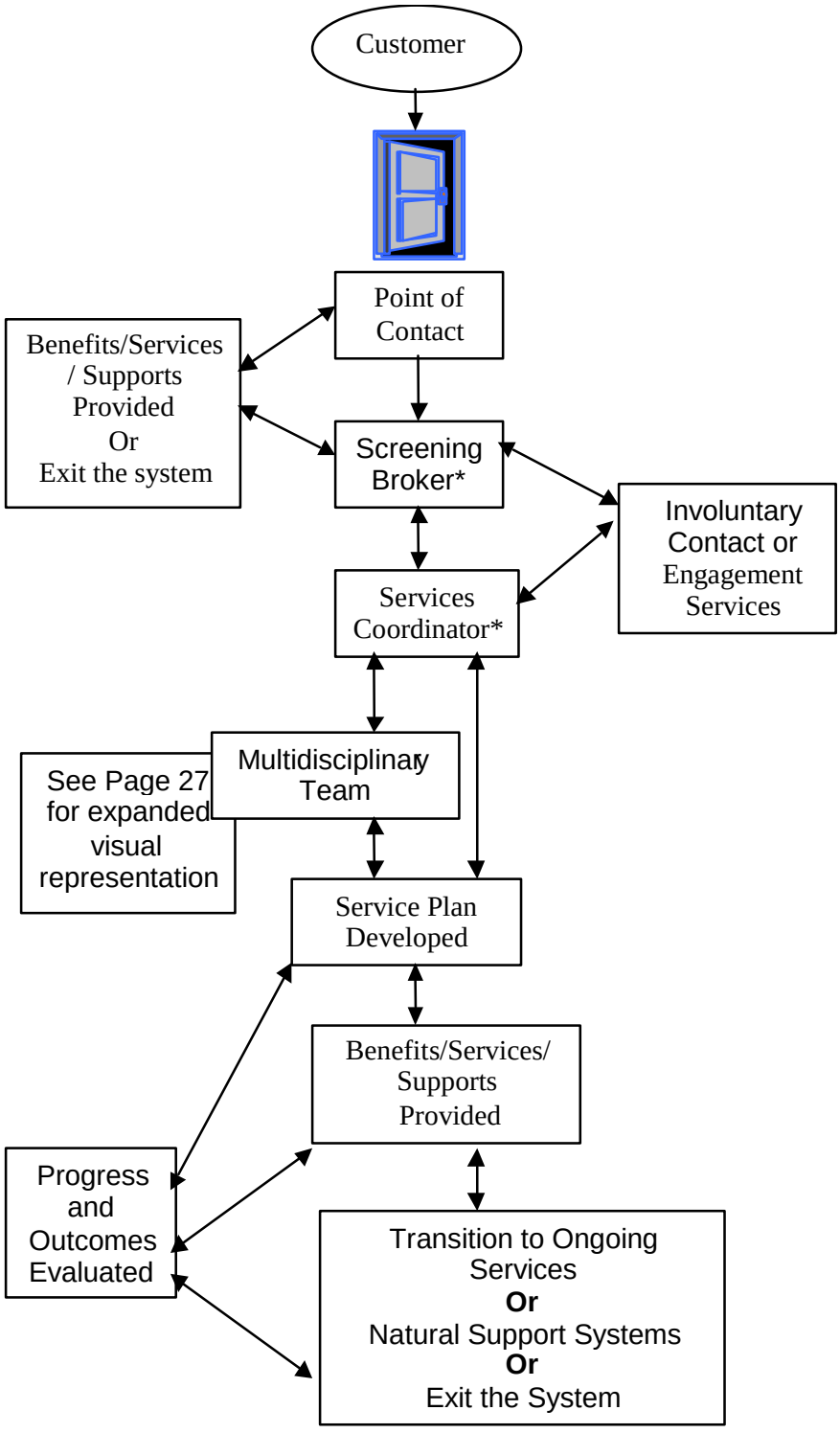
1. Knowing DSHS and community resources available to our customers
2. Working in multi-system teams
3. Combining both natural and professional supports
4. Using the broadest definition of family and community
5. Respecting and supporting our partners *(suggested by DSHS Secretary Dennis Braddock)*

**QUALITY WORKFORCE: WE ARE A WORKFORCE THAT IS:**

1. Respectful to customers
2. Knowledgeable about program services in all divisions
3. Diverse
4. Supportive of our colleagues
5. Using quality principles to work toward a positive change

**No Wrong Door Case Coordination**

**Service Delivery Concept**



# MULTIDISCIPLINARY TEAM

## COMMUNITY PARTNERS

HOSPITALS

UNIVERSITIES

HEAD START

PARKS & RECS & YMCA

PARENT TO PARENT CONSUMER NETWORKS

PUBLIC HEALTH

SCHOOLS

BUSINESSES

## NATURAL SUPPORTS

FRIENDS

NEIGHBORS

CHURCH

EXTENDED FAMILY

## DSHS PROGRAM AREAS

CHILD CARE

JUVENILE JUSTICE

CHILD WELFARE

HEALTH CARE

SUPPORTS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

HOME & COMMUNITY SERVICES

JOB SKILLS TRAINING

CHEMICAL DEPENDENCY TREATMENT

MENTAL HEALTH

JOB DEVELOPMENT

## NO WRONG DOOR CASE COORDINATION

### SERVICE DELIVERY CONCEPT NARRATIVE

**Customer:** An individual and/or family actively involved in decisions concerning needed services that depend on the timeliness, accuracy, and quality of another's work.

***Point of Contact:** Contact may occur on the customer or advocate's initiative, community referrals, or involuntarily (as in cases involving abuse, neglect, or criminal justice system). Initial contact may take place in a variety of ways including: person-to-person, telephone, Internet, or other technological interface.[1]

***Screening Broker:** An experienced worker familiar with all DSHS services as well as community resources and partners. The broker is cross-trained to assess the holistic needs and make referrals to the appropriate services or Services Coordinator. The Screening Broker identifies the needed service(s) with the customer. In the case of a single service, the Screening Broker makes the referral and/or provides the service. A referral to a Services Coordinator is made for complex cases. Each agency will have a designated Screening Broker, available during business hours, responsible for making or receiving referrals.

**SINGLE SERVICE:**

- Make a referral to the designated Screening Broker at the appropriate agency
- Arrange the service if it is the target agency where the service exists

**MULTIPLE SERVICE:**

- Make the referral to the appropriate Services Coordinator as determined by the universal screen that identifies the primary service need via that agency's Screening Broker. (Referrals are made from Screening Broker to Screening Broker)
- This function must be supported by adequate and accessible data as well as information systems.

**Involuntary Contact or Engagement Services:** These customers may have multiple or single needs and enter the system differently, often through a crisis or the justice system. They may be in denial, resistant, and/or hostile. These customers will have access to a Services Coordinator and the same services as the voluntary customer. Engagement services may also include outreach activities. (This mode of entry is represented by a dashed line to represent an alternative method of access to services)

[1] This may be the same person.

***Services Coordinator:** A DSHS staff member or contracted service provider who is identified as most appropriate to address the customer's primary need. This person, with expert program knowledge, performs or coordinates such tasks as a comprehensive assessment, eligibility determination if required, and the provision or arranging of services.[2]

If multiple needs are identified, the Services Coordinator is then responsible for ensuring the development of a holistic and integrated service plan. The Services Coordinator is also responsible, in collaboration with the customer and others, for maintaining, evaluating, revising, transitioning or terminating the plan. When necessary, the Services Coordinator will also be responsible for convening and facilitating a multidisciplinary team. Whenever possible the customer chooses the members of the team. The Services Coordinator may change over time, depending on the predominant issue facing the customer or family with an adequate transition plan.

**Multidisciplinary Team (as needed):** The multidisciplinary team is a diverse and culturally competent team utilized to develop an integrated service plan and provide services to support desirable outcomes for the customer.

**Service Plan Developed:** The customer service plan based on customer strengths will serve as a guide or contract that leads to the desired outcomes of self-sufficiency, health, and safety for the customer. When possible, the plan should be driven by the customer, advocate, and/or family. The development of the plan should occur in partnership with the relevant service providers, courts, and community supports.

**Benefits, Services, and Supports Provided:** Benefits, services, and supports include the identified or contracted goods and services originating from the service plan.

**Progress and Outcomes Evaluated:** Recognizing that service needs of a customer may change, revision of services is an ongoing process through review and evaluation.

**Transition to Ongoing Services, a Natural Support System, or Exit the System:** A transition could be a change in service and/or coordinator, or the termination of service.

The transition will consist of a plan that will continue the goal of self-sufficiency, health, and safety. Also providing assistance in building natural or community supports. Complete customer history and documentation should follow the customer when appropriate.

[2] This may be the same person.

## SUMMARY

### FOR TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES

**Key Short Term Recommendations:**

1. **Create an oversight mechanism:** Secretary Braddock creates a mechanism at Executive level to provide on-going direction and oversight to the No Wrong Door Initiative.
2. **No Wrong Door = Quality Improvement:** Tie the No Wrong Door Project to the Quality Improvement Initiative.
3. **Form the Issues Resolution Group**: The Executive Team assigns cross program experts to:
   - Develop an Agency consent form (to address confidentiality)
   - Find ways to blend funds
   - Increase cross program training
4. **Conduct Troubled Children, Youth and Families pilot studies:** Conduct 3-5 pilot projects statewide aimed at Children and Families with complex, high needs served by three or more programs. (See below for details)

### PROPOSED PILOT FOR CHILDREN, YOUTH & FAMILIES

1. **Population and timeframe**
   - High needs/complex cases served by at least 3 programs
   - New referrals by JRA, DCFS and TANF so you can evaluate outcomes
   - Two biennia – first year start up and implement for 3 years

2. **Where to conduct the pilots**
   - Three to five locations
   - Rural, suburb and urban

3. **Key Players**
   - DCFS, JRA, DDD, TANF, MH, DASA, MAA
   - Community partners, family members and natural supports

4. **Recommended caseload**
   - 25 to 50 families served at each pilot site

5. **Composition**
   - One or two staff (carefully recruited) from appropriate divisions
   - A researcher to set up the research plan and help evaluate outcomes

- Central office, customers and community partners

**6. Training Needs**

- Recommend State Office develop and conduct training for pilot staff
- Someone like Pat Miles (consultant) to help develop curricula
- Training should be incremental and on-going

**7. Evaluation**

- The effectiveness of multi-disciplinary teams and Service Brokers
- Customer satisfaction (what was needed and was it provided?)
- Cost effectiveness: Catholic Community Services has some outcome measures that could be used to develop baseline measurements

**8. Physical Set-up**

- Easy access and comfortable environment for the customer
- Team either co-located or located so they could easily meet and have access to each other

**9. Other Considerations**

- Need a Central Office team to support the pilots
- Each pilot site would have a coordinating supervisor
- The underlying service values are client centered – "Hear Me, Respect Me and Partner with Me"

## SUMMARY

### FOR LONG-TERM TANF FAMILIES DESIGN TEAM

### Key Short Term Recommendations:

1. Secretary Braddock issues an all staff memo in support of a **No Wrong Door initiative** to serve shared clients. The memo:
    a. sets forth a common vision for all staff and all contractors
    b. emphasizes collaboration between divisions
    c. requires a collaboration clause in all DSHS Requests for Proposals (RFPs) and contracts to encourage case coordination for shared clients.
2. Secretary Braddock holds Assistant Secretaries accountable for case coordination for shared clients through their performance agreements.
3. Secretary Braddock and the Cabinet establish a timeline for implementation of one or more No Wrong Door pilot projects for long-term TANF customers.
4. DSHS (ESA) pilot tests the short-term recommendations of the Long-term TANF design team in several CSOs through an RFP.
5. The RFP includes the following activities:
    a. Prioritize (triage) long-term TANF families by level of care required.
    b. Assign some highly effective case managers fewer, but more difficult cases.
    c. Assign other case managers more, but less difficult cases.
    d. Offer flexible hours of operation in the CSO (e.g., 6:00 a.m. to 8:00 p.m. on weekdays and some Saturday hours).
    e. Require home visits for all long-term TANF cases at 36 months.
    f. Make appropriate technology (laptops with remote access to ACES and cell phones) available to case managers for home visits.
    g. Use a simple, effective multi-need-screening tool for TANF customers.
    h. Uses a shared confidentiality form.
    i. Establish a contact person from other divisions/programs who TANF case managers in the CSO can call or e-mail with questions about services for TANF families.
    j. Create multi-system staff willing to serve on multi-system case staffing teams.
    k. Hold frontline, cross-staff meetings.
    l. Ask local DASA and MHD-RSN contractors and CA staff to come into the CSO to cross-train all TANF staff.
    m. Put job search materials in the CSO lobby.
    n. Put a computer in the CSO lobby for customers to use.
6. Publicize the pilots and “best practices” tried elsewhere in the *News Connection*.

7. Evaluate the effectiveness of the pilot test and increase the effort.
8. Other short-term recommendations:
    a. Make sure all policies for TANF customers reflect the values of the No Wrong Door initiative.
    b. Involve frontline staff in writing policies for long-term TANF clients, rather than reviewing draft policies.

## SUMMARY
### FOR PERSONS WITH MULTIPLE DISABILITIES DESIGN TEAM

**Key Short Term Recommendations:**

*High need clients inevitably have multiple disabilities that require multiple system support. DSHS Agencies often fail to collaborate on addressing client needs, which results in poor outcomes.*

## EXECUTIVE LEADERSHIP

Executive management takes an active role in effecting system wide coordination.

**RECOMMENDATIONS: SECRETARY BRADDOCK MANDATES:**

- Collaboration and coordination
- Regional Administrators, without delegation, to regularly meet
- Coordination and collaboration in performance agreements
- Regular progress reports

## COLLABORATION IS REQUIRED

**RECOMMENDATION:**

- Blended or braided funding
- Co-location
- Multi-system teams

## CUSTOMERS NEED EASIER PROCESS TO ACCESS DSHS SERVICES.

**RECOMMENDATION:**

- Universal screening tool
- Statewide toll free number
- Increased collaboration in existing co-located facilities.

## DSHS STAFF NEEDS MORE STREAMLINED PROCESS TO SHARE CUSTOMER INFORMATION

**RECOMMENDATION:**

- Universal consent for release of information
- Universal data base

## THERE IS A LACK OF UNDERSTANDING OF DIFFERENT DSHS AND COMMUNITY SERVICES AND OF HOW TO ACCESS THOSE SERVICES

**RECOMMENDATION:**

- Establish liaisons in local agencies for general referral knowledge
- Cross agency training of employees
- Uniformly accessible DSHS websites

## PROTOTYPE PRINCIPLES FOR SERVING PEOPLE WITH MULTIPLE DISABILITIES

1. Multi-system teams
2. Co-location
3. Outreach
4. Flexible Services and Funding
5. Access

## PILOT PROJECT OR PROTOTYPE

- Develop RFP during first year
- Two projects:  One urban, one rural
- Total of 20 customers served
- Universal screening tool developed
- Universal data base developed
- Cross agency training required for success

## PHASE I

- Identify project manager (DSHS or partner agency resources pooled to hire person who will ensure implementation)
- RFP developed (includes implementation process and evaluation of project)
- Contracts established
- Universal confidentiality form developed
- Universal data problems identified and process in place to ensure resolution
- Training needs identified and provides

## PHASE II

- Multi-disciplinary teams formed
- Outreach provided when needed
- Identified multi-system customers will have a primary contact person (within the contracted agency) who will coordinate other services
- Blended or braided funding used for services
- Collaboration required
- Services provided
- Evaluation on a continuation basis (reports quarterly)
- On-going training for DSHS staff and community partners

## PHASE IV

- DSHS culture has changed
- Collaboration is an expectation
- Co-location of staff is normal
- Barriers to communication has been reduced (data systems in place)
- Multi-disciplinary teams are usual
- All new DSHS staff receive interagency training regarding available services
- Legislature has “brought-in” with funding sources following the customers rather than agency

# ISSUES, DISCUSSION AND RECOMMENDATIONS FOR TROUBLED CHILDREN, YOUTH AND THEIR FAMILIES

## TROUBLED CHILDREN, YOUTH AND FAMILIES RECOMMENDATIONS

### ISSUE: LACK OF COORDINATION ACROSS PROGRAM BOUNDARIES

**Discussion:**

Services are similar between divisions and there is no coordination of those services. In addition, boundaries between divisions are rigid and not easily permeable.

**Examples:**

1. CA worker helping clients find employment and other financial services;
2. Childcare funding being offered by MAA, CA and CSO; and
3. Relatives taking placement of children removed from home seeking financial services through TANF. Some relatives give up because of the process.

Workers do not have the ability to assist clients in accessing services outside their division.

Workers, as evidenced by our own experience at the discussions at the No Wrong Door Summit, have little to no real knowledge of what other divisions do.

Funding sources create rigid eligibility requirements preventing access to services that could lead to better outcomes for clients.

Real services need to available on evenings and weekends. A family can come in after dinner and find the same services that are offered during the day.

Services need to be available as needed over the lifetime and may need to be accessed more than once, especially for the multiple needs families that services from more than one division. Families with serious multiple needs will need to access the same service multiple.

Multi-disciplinary Teams (MDT) needs to have the ability to access funds for services and referrals to services that exist in the community, bypassing the usual the entry points for that service. For example, a referral can be made out of the MDT to DASA for inpatient services without the client having to go through a new entry point.
There is no one intervention or method of service delivery that will be appropriate or effective in every case, i.e., not every family needs a family group conference or a MDT. However, for most cases of multiple needs of families the most effective is with a team approach utilizing both internal DSHS and external community resources and partners.

The Service Broker has to have the ability to authorize team development. There needs to be a process in place so that so that a MDT can be formed quickly and with real bodies and participants. The process needs to be identified by which cases are assigned quickly and a response generated to the client.

**RECOMMENDATIONS**

**Short term:**

1. Select a pilot CSO and DCFS offices to stay open (and staffed) one evening a week.
2. Publicize and use existing ESA Internet system for service access.
3. DCFS/DSHS web list each office and current phone number under each program.
4. Allow customers to access services through email. This should be channeled to the appropriate office.
5. Break down knowledge barriers by cross training.
6. Establish liaison within each DSHS division on a local office basis who meet regularly (can be located offsite). There would have to be an incentive to regularly attend and participate. This could be a forum to staff high needs families who need multiple services.
7. Outstation several high uses program in CSO (i.e. FRS worker spends two days a week in the CSO.) DASA person located in CA office.

**Long Term:**

1. Create MDT's to act as an access point (entry point) for other services.
2. Create a funds broker who can figure out and access funding sources as needed by MDT and/or worker. For example, CA staff uses a different form to access HBS and Psych-psych funds. The CA staff could use one form to request the services and the funds broker would be responsible to find the appropriate pot of money for the service.
3. Create a mechanism to form MDT's quickly and effectively. (The MDT needs to form quickly so as to be responsive to customers.)

## TROUBLED CHILDREN, YOUTH AND FAMILIES RECOMMENDATIONS

### ISSUE: INCREASE THE SERVICE RECIPIENT'S VOICE AND CHOICE

**Discussion:**

- DSHS offices should be inviting and welcoming to the community.
- DSHS offices should be part of the community, accessible and easily located.
- The system often dehumanizes people.
- How DSHS staffs are treated can reflect how service recipients are treated in turn.
- Service recipients often cannot choose who will work with them and how their resources are spent.

### RECOMMENDATIONS

**Short Term:**

1. Make reception areas feel comfortable, welcoming and inviting.
2. Improve lobbies by:
   - Providing water fountains and coffee
   - Clean restrooms
   - Comfortable furniture, tables for paperwork
   - Magazines and coloring books
   - Signs that say "welcome"
   - Suitable decorations
3. Mandate a 5-minute waiting period.
4. When possible, greet service recipient at the door and escort them to workspace.
5. Language is important. How people are described leads to agency philosophy and practice.
6. Develop better/private work place cubicles to accommodate service recipient.
7. Whenever possible, service recipient decides who will be primary worker and who will sit on MDT.
8. Study ways resources can be made flexible and granted for use within set guidelines. I.e., DDD family-support project.
9. Offices should develop staff professional biographies to assist service recipient in choosing primary worker. I.e., University of Washington Counseling program.
10. We often do not measure the effectiveness of our work, and when measured the results do not often make any meaningful changes in policy or practice.
11. Staff and service recipients develop measuring tools locally that ask about recipient satisfaction and service outcomes.
12. Survey information is given to staff and service recipients to make any needed recommendations for change. I.e., DDD VPP Mailer cards.
13. Develop focus groups for ongoing quality control perspective.

14. Contact King County Families In Common Project to view their person centered contract language work (Catherine Follet).
15. Establish a work group to study current policies, forms, and contracts to begin editing them for person-centered language.

**Mid Term:**

1. Expand survey to measure to cover larger scope of services.
2. Invite service recipients to appropriate portion of staff meetings.
3. Invite service recipients to participate in policy development.
4. Make service recipient survey results/ feedback an audit item.
5. Co-locate offices and locate them in community places, i.e., supermarkets, fairs, malls.

**Long Term:**

1. Build DSHS offices in the community that includes other non-human service providers, i.e. banks, grocery stores, and restaurants

**Best Practice Examples:**

Areas of best practice identified as client driven and family centered:

- DDD Person-centered planning
- DSHS Infant Toddler Early Intervention Program "IFSP" (Individual Family Services Plan)
- DCFS Family Group Conferencing

## TROUBLED CHILDREN, YOUTH AND FAMILIES RECOMMENDATIONS

### ISSUE: NEED FOR CULTURE CHANGE WITHIN DSHS

**Discussion:**

- **Collaboration is promoted, not practiced!** Segregation exists amongst divisions regarding vision, mission, values, philosophy and goals.
- Management and Supervisors need to embrace, articulate, operationalize and provide leadership in implementation of "No Wrong Door".
- Work plans are developed and implemented without adequate outcome base and defined timelines. As a result plans and concepts like "No Wrong Door" fade away and are not implemented.
- Shared data is needed for the purpose of analyzing outcomes for system improvement, instead of data being used for punitive consequences.
- Categorical funding and inconsistent RCWs and WACs between Divisions prevent access through any door.
- Line Staff expresses lack of opportunity to voice needs, concerns and provide input into change.

### RECOMMENDATIONS

**Short Term:**

1. Form an oversight mechanism at the Executive level to sustain the work of the Summit.
2. Communicate and adopt the shared vision, mission, values, philosophy and goals developed during the "No Wrong Door" Summit that support the success and implementation of "No Wrong Door" across all DSHS Administrations.
3. Tie No Wrong Door to the Agency Quality Improvement Initiative.
4. Contract with Pat Miles to provide training to management, supervisors and line staff in all DSHS Departments on customer directed strength-based provision of services and team facilitation.
5. Hold monthly meetings including a cross-section of staff from all departments and participate in staff development, cross-training and relationship building activities! (Location-Location-Location/Relationship-Relationship-Relationship)
6. In the Pilot projects, begin immediately to reduce caseloads for line staff working with children and families that have the most complex needs. (No specific number for caseload size recommended will be different in each department and depends on level of involvement in the cases).
7. Immediate Attitude Change: acknowledge and provide incentives to staff for innovative and flexible service delivery.
8. Use data as an accountability measure to promote innovation, flexibility, quality improvements and success.

9. Create mechanisms at mid level to sustain No Wrong Door, i.e., quarterly meetings between supervisors across programs to debrief successes and areas for improvement in implementing No Wrong Door.

**Long Term:**

1. Re-write RCWs and WACS in a manner that promote and support collaboration, information sharing, blended resources (both human and monetary) and access to services no matter what door a customer walks through.
2. Develop orientation for all new department staff specific to "No Wrong Door" mission, values, philosophy, goals and practices.
3. On going training on customer directed and strength base services and team facilitation. Integration happens by repetitive learning.

## TROUBLED CHILDREN, YOUTH AND FAMILIES RECOMMENDATIONS

### ISSUE: STAFF DEVELOPMENT –LACK OF CROSS AGENCY KNOWLEDGE

**Discussion:**

- We have several Academies' that tend to overload new employee with too much information too soon.
- There's little on-going staff development.
- There's little inter-intra cross program training.
- There's no incentive to participate in cross training.
- The employee who gains more cross agency knowledge and increased competency gets more work. (Disincentive)
- Opinions outside your silo are not honored, i.e., "You aren't a Social Worker, how would you know?"

**There are several academies.**

- DASA, JRA and MH have a quarterly case management academy for youth and adults.
- Annual COD conference.
- Annual CD conference.
- Annual Behavioral Health conference.
- Annual Parole conference.

### RECOMMENDATIONS

**Short Term:**

**Cross-program JRA's.**

Job shadowing (spend a few days with a peer from another program).

Division Open House to learn about other programs and network.

Interagency leadership training, i.e., Region 6 has a leadership program that includes the Ropes Course.

**Mid Term:**

Co-locate staff. More out-stationing of staff like DASA does or CA does with their Mental Health provider.

**Long Term:**

DSHS Annual Conferences to address issues that cut across boundaries.

DSHS Academy attended by staff from all programs and from different levels of the Agency.

## TROUBLED CHILDREN, YOUTH AND FAMILIES RECOMMENDATIONS

### ISSUE: STANDARDIZED OPERATIONS

**Discussion:**

- Customers and staff are currently faced with duplicating effort because of multiple application forms, policies, consent forms and information systems.
- Customers have limited access to information to help them navigate the system.
- Caseworkers are not aware of other services the client is being provided.
- Standardized consent forms, application, intake and screening forms will reduce time, effort, and frustration of customers as well as staff
- Improving caseworker access to common client information will minimize duplicating services and improve coordination.

### RECOMMENDATIONS

Standardize Client Application, Intake, and Screening

1. Conduct a pilot study in Clark County to standardize client application, intake, and screening forms. As part of the pilot review and consolidate information provided to clients. (Build upon and existing initiative in Clark County Alcohol and Drug with Child Protective Services).
2. Based on the results of the Clark County pilot, further this effort (statewide or other pilots).

### MINIMIZE THE CONFIDENTIALITY BARRIER

1. Recommend the executive team review existing DSHS and other confidentiality forms and recommend a common consent form to pilot.
2. Based on the results of the pilots, further this effort (statewide or other pilots)

### INCREASE ACCESS TO CUSTOMER INFORMATION (CLIENT REGISTRY)

1. Conduct more client registry training (especially for pilot projects).
2. Require caseworkers to access client registry at intake to determine if client is being served by other programs.
3. Re-establish the client registry team and up grade client registry. (Fund the e-mail option to notify case workers when a client accesses additional services)

# ISSUES, DISCUSSION AND RECOMMENDATIONS FOR LONG-TERM TANF FAMILIES

## LONG-TERM TANF FAMILIES RECOMMENDATIONS

### ISSUE: COMMITMENT BY EXECUTIVE MANAGEMENT

**Discussion:**

- Top Management must support/encourage collaboration for it to be taken seriously.
- Agency managers are held accountable for collaboration in their performance agreements.

### RECOMMENDATIONS

**Short term:**

1. Secretary sends out an all staff memo in support of the No Wrong Door initiative that:
   - Emphasizes collaboration between divisions
   - Holds Asst. Secretaries accountable through their performance agreements
   - Lays out a common vision/goal for all staff and all contractors.
   - Calls for a clause emphasizing collaboration in all relevant DSHS RFPs and contracts.
2. Assistant Secretaries and Directors make unannounced joint visits to CSOs to emphasize collaboration.
3. Establish a timeline for implementation of pilots.
4. Publicize attempts at collaboration
5. Promote "best practices."

**Long term:**

1. Continue to show support for the No Wrong Door initiative.
2. On-going evaluation of outcomes of pilot sites.

# LONG-TERM TANF FAMILIES RECOMMENDATIONS

## ISSUE: EXECUTIVE LEADERSHIP

DSHS executive management needs to take an active role in effecting system wide coordination of services.

### Discussion:

- Currently there is very little collaboration and coordination between divisions leading to less than optimal service delivery.
- More coordination and collaboration needs to occur to effectively deliver services.
- Top management can model collaboration and coordination between and among divisions.
- Without top management direction and modeling no changes between divisions will occur.

## RECOMMENDATIONS

### Short term:

1. Secretary Braddock meets with, Assistant Secretaries, Division Directors, and regional Administrators to mandate collaboration and coordination of departmental services.
2. Secretary Braddock requires all Regional Administrators, without delegation, to regularly meet for the purpose of coordinating services between and among all department divisions. The efforts shall include but not necessarily be limited to the following:
    a. Implementing cross training,
    b. Development of a universal confidentiality form, and
    c. Co-location of service delivery and blending funding streams for service delivery.
3. Secretary Braddock requires that all performance agreements for Assistant Secretary, Directors, and Regional Administrators/Managers shall include the requirement for coordination and collaboration between and among all department divisions.
4. Regional Administrators shall regularly report to the division directors on their progress toward coordination of all services between and among all divisions.

**Long term:**

1. Establish a team to outline incentives for collaboration and coordination between and among divisions.
2. Establish policies to measure savings as a result of the collaboration and coordination.
3. Return any savings to fund the multi-disciplinary teams rather than be returned to the general fund.

## LONG-TERM TANF FAMILIES RECOMMENDATIONS

### ISSUE: CASELOADS

**Discussion:**

- High caseloads (generally 90 families) make it impossible for effective case management of long-term TANF customers.
- Hard-to-serve cases should stay with specialized, competent case managers.
  - No flexibility in caseload management (home visits, actively involved with customers and their needs).
- Current long-term TANF families have become increasingly difficult to serve because they have (some times unidentified) multiple service needs.
- No incentive for experienced case managers to work with long-term TANF customers.
- We should consider piloting a maximum of 30 long-term families. This is the caseload of non-profit agencies working on similar cases.

### RECOMMENDATIONS

**Short term:**

1. Pilot one or more CSOs to reduce long-term TANF caseloads with long-term TANF customers, by triaging caseloads.
2. Prioritize (triage) caseload by level of care. Some case managers will have more cases, but they need a lower level of care. Some case managers will have fewer cases that need a higher level of care.
   - Empower case managers to have flexibility in case management.
   - Reduce administrative barriers to effective case management
3. Pilot a knowledgeable "connector/navigator/service coordinator" to screen/assess a client's multi-system needs.
4. Pilot an effective multi-need-screening tool.

**Long Term:**

Recommend that the Executive Team review existing DSHS and federal client confidentiality laws and regulations.

## LONG-TERM TANF FAMILIES RECOMMENDATIONS

### ISSUE: IMPROVE COMMUNICATION

**Discussion:**

- Clients have to give their demographics and tell their "stories" again and again.
- No universal application for services.
- Minimal communication between MIS systems in DSHS and between DSHS and community service organizations.
- Lack of timely response to customers and colleagues due to caseload size.
- Inconsistencies between CSOs in what we tell our clients about what services we offer.
- Improve communication by focusing on customer's needs to come to a common consensus (client and case managers).
- Oral and written communication (and the process itself for receiving TANF services) are complicated.
- Current technology doesn't support intra-department communication and collaboration (e.g., there is no ability to share case notes between different divisions who serve the same client).
- Communication needs to be human and respectful to different cultures.

### RECOMMENDATIONS

**Short term:**

Standardize a universal e-mail system.

**Long term:**

## LONG-TERM TANF FAMILIES RECOMMENDATIONS

### ISSUE: POLICY

**Discussion:**

- Frequent policy changes create worker confusion, ineffective service (such as incorrect payments) and leads to worker dissatisfaction.
- Current policies do not reflect No Wrong Door initiative (no shared confidentiality agreement or shared application)
- Policies should be written in clear, concise English.
- Policy is not always focused on unique customer needs

### RECOMMENDATIONS

**Short term:**

1. Evaluate those policies that have a lot of "exception to policy" to see what was happening and if the policy is still appropriate.
2. New policies should be customer-focused and avoid crisis management.
3. Make sure new policies reflect values of the No Wrong Door initiative.
4. Have frontline staff involved in developing policies, rather than only at the review stage.

## LONG-TERM TANF FAMILIES RECOMMENDATIONS

### ISSUE: COMPETENCY TRAINING

**Discussion:**

- Some ongoing training is not relevant and wastes time.
- No cross-divisional training for TANF staff to understand other programs, their resources, their eligibility requirements, and their services available to Long-term TANF clients.
- Needs to be a consumer voice reflected in training.
- Cross training will lead to more effective and efficient services provided to TANF clients.
- Cross training results in more knowledgeable TANF staff and other agency staff.
- Relevant training could increase staff retention (reduces turnover).
- Technology is not being maximized within the DSHS, and we cannot contact our community partners.

**RECOMMENDATIONS**

**Short term:**

1. Have local DASA, MHD/RSN contractors, CA and DDD staff come into local CSO to cross-train with TANF staff.
2. Establish a contact person from other division/programs that TANF case managers at each CSO can call or email.

**Long term:**

1. Create a case manager academy so that TANF staff can be well cross-trained.
2. Create a DSHS academy.

## LONG-TERM TANF FAMILIES RECOMMENDATIONS

**ISSUE: WORK ENVIRONMENT**

**Discussion:**

- Limited engagement of Long-term TANF clients are minimally engaged in TANF, and it is difficult to assist clients achieve self-sufficiency.
- We should conduct home visits (at 36 months). At the home visit TANF case managers could determine multi-system needs and provide services, such as transportation to doctor and other necessary appointments.
- TANF case managers have limited flexibility to give each unique client the specific, appropriate services they need.
- We need to empower the TANF case managers to make customer-focused decisions to help TANF customer achieve self-sufficiency. Case managers' decisions are questioned.
- All relevant services and resources are not together in one place.
- Funds are not attached to or do not "follow" the TANF customer
  - Institutionalized divisional barriers do not allow us to most effectively and adequately serve the long-term TANF customers. (It is often difficult to work with DSHS staff in other divisions.
  - Many CSO lobbies are cold and unwelcoming toward the customer and don't provide relevant resources (such as materials for job search, Basic Health Plan, etc.)

**RECOMMENDATIONS**

**Short term:**

1. Establish more flexible hours at a pilot CSO (for example, 6:00 a.m. to 8:00 p.m. weekdays and open on Saturdays.)

2. Put job search materials in CSO lobbies.
3. Identify current CSO leases to determine how office space can be co-located in the future.

**Long term:**

1. Determine current CSO leases so that future services could be co-located.
2. Future office leases should be able to have enough space to accommodate co-location.
3. Offer technology/computer access in lobbies with links to other DSHS divisions, state agencies and local community agencies.
4. Make appropriate technology available for TANF case managers to take laptops with them when they make home visits.
5. Identify administrative barriers (policy and funding constraints) to serving TANF clients in a more flexible manner.

# ISSUES, DISCUSSION AND RECOMMENDATIONS FOR PERSONS WITH MULTIPLE DISABILITIES

## PERSONS WITH MULTIPLE DISABILITIES RECOMMENDATIONS

### ISSUE: COLLABORATION

**Discussion:**

- High need clients inevitably have multiple disabilities and require multiple systems support
- Case managers are not always informed by the client of other system involvement resulting in:
  - Duplication of care
  - Contradictory service plan approaches
- Service documentation often duplicates information from other systems resulting in:
  - Wasted worker time and reduced satisfaction
  - Client frustration/exhaustion
- A holistic service approach:
  - Supports better client outcomes
  - Reduces overall effort of all involved
  - Reduces duplication of services
  - Creates greater client and worker satisfaction
  - Identifies all critical areas requiring intervention

### RECOMMENDATIONS

**DSHS support for multi-system approaches to serving high need clients at all levels of the organization by:**

1. Development of models for blending funding
2. Support for inter-system training
3. Establishment of policies to prioritize inter-system collaboration of frontline workers

**Short term:**

1. Development of local multidisciplinary case coordination teams (e.g., "A" Team, Joint Crisis Response Team for Children in Snohomish County)
2. Develop procedures to:
   a. Identify other agencies providing services to shared client
   b. Prioritize participation in collaborative case coordination meetings
   c. Identify gaps in services which may require flexible funding

**Long term:**

1. Ongoing support for collaboration using blended and flexible funding.
2. Electronic Multiple Tracking System.

## PERSONS WITH MULTIPLE DISABILITIES RECOMMENDATIONS

### ISSUE: CUSTOMER ACCESS TO SERVICES

**Discussion:**

- Customers need easier process in order to access DSHS services
- Current methods of points of contact are not being fully utilized-in person, phone, e-mail, Internet
- Current forms duplicate information impeding customer ability to comprehend and access
- Customer/service provider is often unaware of services available from other agencies

### RECOMMENDATIONS

**Short term:**

1. Forms committee to design a universal screening tool available in multiple formats and levels of customer ability to comprehend
   a. Example: Rogue Family Center form: Comprehensive Family Assessment
2. Statewide 1-800 number available for customer to speak to live person in order to provide access to DSHS service
3. Encourage increased collaboration and effectiveness of current co-located facilities (pilot?)
4. All DSHS workers have access to services database of all divisions and agencies

**Long term:**

1. Co-location of services within DSHS on a larger scale

## PERSONS WITH MULTIPLE DISABILITIES RECOMMENDATIONS

### ISSUE: CUSTOMER INFORMATION SHARING WITHIN DSHS

**Discussion:**

- Current release forms are too self-limiting
- Customer signs too many consent forms in too many offices
- Customer does not know who he/she works with
- Customer does not know why information is needed and who will see it
- Duplicate information requested by many divisions/agencies
- Current release forms are too self-limiting
- Customer signs too many consent forms in too many offices
- Customer does not know who he/she works with
- Customer does not know why information is needed and who will see it
- Duplicate information requested by many divisions/agencies

#### RECOMMENDATIONS

**Short term:**

1. A team is designated to design a universal consent for release of information form
   a. Example: Jackson Co. OR – Comprehensive Shared Confidentiality Agreement
2. Agencies must agree to share information
3. Form should be acceptable to outside agencies

#### CONSTRAINTS

- Territorialism
- WACs do not have consistent requirements for confidentiality

## PERSONS WITH MULTIPLE DISABILITIES RECOMMENDATIONS

### ISSUE: TRAINING

**Discussion:**

- Employees do not have knowledge of other programs/services available
- Causes frustration to customers and unnecessary shuffling
- Inaccurate information is being disseminated
- Training among partners will allow customers to access appropriate services timely and effectively
  - Increased customer awareness and choice and location of services available
  - Increased trust and confidence in the system
  - Increased communication between partners and customers

### RECOMMENDATIONS

**Short term:**

1. Establish liaison within local agencies for general referral knowledge
   a. e.g., DDD worker wants to refer customer for vocational services at DVR. This would allow the worker to call a contact person at DVR in order to provide accurate referral location to customer. Allows for cross-pollination at the local level.
2. Establish focus groups which includes local area trainers to survey partners regarding current level of knowledge of other programs
   a. e.g., WorkSource Northwest has developed focus groups to gain information about program services
3. Assemble training groups using existing training and front line staff within local areas who will create a training curriculum based on the focus group survey
   a. e.g., WorkSource Northwest is currently engaged in such a project
4. Web Reference guide with ability to cross-reference services
   a. e.g., The WorkSource Northwest website has the ability to link by services as well as agency
5. Convene a group to evaluate current information available on all DSHS websites
6. Establish a consistent format for service information to be posted on a main DSHS web page
   a. e.g., the current DSHS web page needs to be modified to reflect consistency and ease of use.
7. Webmaster(s) update sites based on local input.

**Long term:**

1. Develop employee knowledge for “one stop shopping”

a. e.g., working toward co-location of services with representatives of various agencies in one area ( WorkSource-Alderwood)

2. Talking Kiosk
3. Move toward e-training (e.g., web-based training, Interactive Video Technology, Net Meeting

**Constraints**

- Employee training time ( WorkSource example took 300 hours per employee to become cross-trained)
- Adding additional duties to existing training staff

# APPENDIX 9-A

# CONFIDENTIALITY ISSUE RESOLUTION RECOMMENDATION CONSENT FORM

Washington State Department of Social & Health Services

# CONSENT TO EXCHANGE CONFIDENTIAL INFORMATION FOR SERVICES COORDINATION

The Department of Social and Health Services (DSHS) can help you better if we are able to work with all the other agencies and professionals that know you and your family. By signing this consent form, you are giving permission for the agencies and individuals listed below to share information about you and your situation with us. DSHS will not share confidential information with anyone else without your consent.

| CUSTOMER'S NAME | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|
| ADDRESS | CITY | STATE |

## Authorization

I authorize the following agencies or individuals that I have indicated below to exchange information about me in order to better plan and coordinate services for my family and me. I understand that information may be provided verbally or by computer data transfer, mail, fax, or hand delivery. Please initial all that apply and specify division, program, name, or part of agency authorized to exchange records).

_____ All parts of the Department of Social and Health Services; or the following:

_____ Community Services Division (benefit programs)
_____ Home and Community Services Division
_____ Division of Vocational Rehabilitation (DVR)
_____ Medical Assistance Administration
_____ Division of Developmental Disabilities
_____ Children's Administration
_____ Juvenile Rehabilitation Administration
_____ Division of Alcohol and Substance Abuse
Mental Health, including state hospitals
Other:

_____ Health care providers: _____
_____ Mental health care providers: _____
_____ Chemical dependency service providers: _____
_____ Housing services: _____
_____ School districts: _____
_____ Community and technical colleges: _____
_____ Department of Corrections: _____
_____ Employment Security Department and its employment partners: _____
_____ Other:

I authorize the following records to be exchanged or shared (initial all that apply):

_____ All DSHS records
_____ Birth control/abortion services records
_____ Family /social history
_____ Mental health records
_____ School/education records
_____ Health care records
_____ HIV/AIDS and STD test results, diagnosis or treatment records
_____ Chemical Dependency (CD) records including the following:
_____ Assessment
_____ Treatment Status Reports
_____
_____ Treatment Plan
_____ Discharge Summary
_____
_____ Specific information (list):

**This consent is good for up to one (1) year or until _____ (whichever comes first).**

**I understand and agree to the exchange of information authorized in this form. I understand I may revoke this consent at any time, but I understand that revocation will not affect any information that was already exchanged. A copy of this form is valid to give my permission to share records.**

| CUSTOMER'S SIGNATURE | DATE | AGENCY CONTACT/ WITNESS SIGNATURE | TELEPHONE |
|---|---|---|---|
| PARENT OR LEGAL GUARDIAN'S SIGNATURE (IF APPLICABLE) | PRINT NAME | TELEPHONE | DATE |

☐ Parent ☐ Legal Guardian (attach court order) ☐ Other:

To those receiving information under this authorization**: Federal and state law and regulations protect the information disclosed to you. You may not release it to any other agency or person without specific written consent. You are subject to the same standards and laws of confidentiality as the originating holder of the records.**

## INSTRUCTIONS FOR COMPLETION OF CONSENT FORM

**Purpose:** Use this form when you need to share information within DSHS or with other agencies to coordinate services for a customer (anyone receiving services or benefits from DSHS).

**Use:** Fill out this form for customer electronically if possible for ease of reading, using appropriate and necessary fields. A separate form must be completed for each person requesting or receiving services or benefits, including children.

**Parts of Form:**

IDENTIFICATION:

>Name: List name of one customer only on the form. Include any former names that customer may have used when receiving services.

>Date of Birth: Required to identify individual from those with similar names.

>Social Security Number: Advised to assist in identifying records and tracking history and services received.

>Address: Additional information that will help in locating and identifying the customer.

AUTHORIZATION:

>Agencies or persons exchanging records: Customer must initial all agencies that will be sharing records. Fill in any others that are not specifically listed. In blanks after non-DSHS agencies, provide identifying information about the program, such as specific name, address or location.

>Information exchanged: Customers must indicate all types of records that they agree to have shared. They can indicate all DSHS records but, if these records will include information relating to mental health (RCW 71.05.390 and 71.34.200), HIV/AIDS or STD testing or treatment (RCW 70.24.105), or drug and alcohol services (42 CFR 2.31(a)(5)), the customer must initial these items specifically to clarify their permission. Please note that authorization for sharing of psychotherapy notes may not be combined with other the consent to share information for any other purpose and must use a separate form under 42 CFR 164.508(b)(3).

>Duration: Customers must reauthorize their consent at least annually. Provide an earlier ending date if it will serve program purposes or is warranted by the circumstances. For health care records under RCW 70.02.030(6), a health care provider may not release information if the consent is more than 90 days old.

>Understanding: Be sure the customer understands what permission is being granted and explain how and why information will be shared. Use a translated form and interpreter if needed or read the form aloud to a customer who has difficulty in reading.

SIGNATURES:

>Customer: Have customer or child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for all other health care) sign this box and insert the date the form was signed. If the customer cannot write, the customer may substitute a mark in this box that you witness.

>Agency Contact or Witness: You will sign in this box if you are the one presenting and

explaining the form to the customer. Please list your telephone number for purposes of contacting you. If the customer will be signing the form away from a business site, instruct the customer to have a witness sign the consent in this block and provide the telephone number of the witness.

>Parent or Legal Guardian: If the customer is a child younger than the age of consent, a parent or guardian must sign instead of the child. If the customer has been declared legally incompetent, the court appointed guardian must sign the consent. A guardian must provide a copy of the order of appointment from the court. If someone is signing in another capacity (such as the personal representative of an estate), please mark "other" and provide a copy of the authority to act. Parents or guardians or others must provide date their signature and provide their telephone number. You should sign as the agency contact or have a witness sign the form.

**NOTICE WHEN EXCHANGING INFORMATION:**

Please note that the information shared to others and that DSHS receives is subject to the same confidentiality protections as it was at the original agency. If you need to share information with someone not listed on this form when signed, you must obtain an additional consent form from the customer. If you are providing information regarding drug or alcohol abuse by the customer under this consent form, you must include the following statement when exchanging information as required by 42 CFR 2.32:

> *This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

# APPENDIX 9-B

# CROSS TRAINING ISSUE RESOLUTION TEAM RECOMMENDATIONS

### WHO

- Multi-disciplinary team members (DSHS front line staff, contracted providers, main local community partners)

  Assumption: The pilot site selects a core group of persons, a few from each primary DSHS program area involved in the pilot, and a few from the main community partners, who will form the core of the pilot site. Others may be trained, as needed, as they join the multi-disciplinary team, or if they create new multi-disciplinary teams. The core group can be used to "set the culture" or expectations for a multi-disciplinary team, and they can serve as initial trainers.

- Coach (an expert trainer, team facilitator, and mediator, who support the team with objective insight)

  Assumption: The coach would not be a member of the multi-disciplinary team, but rather serve as an independent coach. Coaches could be drawn from existing facilitators or quality coordinators. Coaches could be hired by DSHS headquarters, on contract, to serve several No Wrong Door pilot sites, or could be local facilitators who can coach the multi-disciplinary team regularly and on a consultation basis. The coach will already have team facilitation skills and may have skills in integrated social services for particular shared-client groups.

- Customer (i.e., clients/families) and 'natural support' members

  Assumption: The customer, his or her family and the customer's natural supports (friends, relatives, etc.), needs some training to know what to expect at a No Wrong Door pilot and how to actively participate with a multi-disciplinary team.

## WHAT (NEED FOR TRAINING AND TRAINING CONTENT)

### MULTI-DISCIPLINARY TEAM MEMBERS WILL NEED TWO TYPES OF TRAINING:

General orientation to the mission, values, concepts, services and processes that each members' program area brings to the team; the legal requirements of some program areas; how to monitor customer outcomes as the coordinated service plan is implemented; and how to use the technology applications in the pilots.

This short-term training for understanding the basic services and processes used by other DSHS team members would be done online initially, by accessing information from various program websites. In the longer-term, a No Wrong Door website would contain comparable and appropriate information from each of the DSHS program areas.)

Orientation to community partners' services and processes would be done in-person by community partners, unless the partners also have websites. Training on outcome monitoring would be done by team members themselves or by the DSHS programs' regional or research staff. Technology applications training would be done by Client Registry staff or DSHS IT staff.

2. **Team training** about how to work as a team, how to work from a customer-centered and strength-based perspective to create a coordinate service plan, how to provide coordinated and integrated services; and how to communicate effectively about services and outcomes.

   This training, and all DSHS trainers on the team agreed, occurs most efficiently through role-playing, and dealing with real shared-client cases. Two to three days, with a skilled facilitator, would be required. The training would present team members with a few multi-needs cases. The pilot team would attempt to resolve the needs of the multi-needs case. This type of hands-on experiential training would also be appropriate for community partners. This training is intended to confer practical skills on how to function as a team, manage conflicts, build trust in each other's skills, as well as provide a customer-centered, strength-based way of planning and providing services. OOED staff, Pat Miles, Debbie White, could provide this training or comparable trainer/facilitators with program area knowledge. The No Wrong Door case coordination histories might be used in this training.

- **Coaches** need skills in team building, conflict resolution and facilitation. The coaches will need to have appreciation for the diverse professional cultures that will be brought together in the multi-disciplinary team.
- **Coach Training**. Coaches may need the general orientation to No Wrong Door available to multi-disciplinary team members. Additionally, less-well trained coaches may need to take a course(s) offered by OOED and DOP in the mechanics of helping teams to function well. (See attached list of courses)
- **Customer (i.e., clients/families)** needs to have some training to be able to effectively participate in the multi-disciplinary team. The customer needs to be involved in helping to form the team, as well as participating as a member of the team in planning services, completing the planned services, and achieving the agreed upon goals. This training could be simple or more extensive, depending on the type of DSHS shared-client group and customer skills (e.g., it may be more in-depth for DVR and DDD, and less in-depth for JRA or Long-term TANF).
- **Customer Training**. There are several existing examples of the type of training. The PEP program helped train DVR participants to be involved with their own plans and outcomes. AASA uses a 12-minute video to educate customers on 'Options'. People to People have some training that prepares people to 'sit on boards'. Drawing from these examples, short-term training guidelines could be developed. In the long-term, a video could be created.

**WHERE**

- **Local/on-site.** Training would be done on-site, at each pilot site, to minimize travel and training costs.

**HOW**

- **Initial and ongoing.** The training would be done initially at each pilot site, but would need to be ongoing, because new team members may need to be trained as core members change (both among community partners and DSHS front line staff).
- **Available coaches/trainers/facilitators.** Experts/facilitators could be obtained, on contract, through OOED, through known experts (e.g., Pat Miles and Debbie White may be able to serve as coaches, or trainers for coaches) through community partners' resources, or through local universities.

**Rough Estimate for Hours for Training in a Year**

| TEAM (8 – 24 HOURS) | COACH (0-8 HOURS) | CUSTOMER (4-5 HOURS) |
|---|---|---|
| **CORE TEAM NEEDS:**<br>**TEAMWORK**<br>• Integrated service planning and delivery (ITC)<br>• Customer-center, strength-based approach<br>• General orientation of others' services and cultures | **ALL COACHES**<br>• No Wrong Door history and concepts<br>• General orientation of others' services and cultures | **ALL:**<br>• No Wrong Door team expectations<br>• Rights and responsibilities |
| **ALL TEAM MEMBERS NEED:**<br>• No Wrong Door history and concepts<br>• How to use technology applications<br>• General orientation of others' services and cultures<br>• How to use technology applications<br>• Flexible funding procedures<br>• How to make a technical assistance request. | **AS NECESSARY:**<br>• Group process<br>• Facilitation<br>• Conflict resolution<br>• Planning | **AS NEEDED:**<br>• Goal setting<br>• Decision making<br>• How to articulate needs<br>• How to prioritize<br>• How to compromise |

| | Small Need | Medium Need | High Need |
|---|---|---|---|
| Long Term TANF | Coach<br>8 hours for team<br>.5 hour for customer | Coach<br>16 hours for team<br>2 hours for customer | Coach<br>24 hours for team<br>4 hours for customer |
| Troubled Children, Youth and their Families | Coach<br>8 hours for team<br>.5 hour for customer | Coach<br>16 hours for team<br>2 hours for customer | Coach<br>24 hours for team<br>4 hours for customer |
| Persons with Multiple Disabilities | Coach<br>8 hours for team<br>.5 hour for customer | Coach<br>16 hours for team<br>2 hours for customer | Coach<br>24 hours for team<br>4 hours for customer |

Coach: Could be one or two persons, from the list of trained facilitators and quality coordinators. The coach(es) could be contracted through DSHS headquarters, and visit each pilot site to provide training, coaching, team facilitation.

Small need: Staff already has had training in providing integrated services. Pilot site area already has culture of trust and multi-disciplinary teams already operate.

Medium need: Staff already has had some training in providing integrated services. Area is beginning to build a culture of trust and multi-disciplinary teams.

High need: No training in providing integrated services. No culture of trust and multi-disciplinary teams. Services provided through "silos" or sequentially.

# APPENDIX 9-C

# TECHNOLOGY (IT) APPLICATIONS ISSUE TEAM RECOMMENDATION

## TECHNOLOGY NEEDED

Technology applications were reviewed to support three functions in the No Wrong Door pilots:

*Clients* need to be relieved from having to provide the same information to more than one program of the department.
*The screening broker* function needs technology support to identify customers who will be referred to the multi-disciplinary team.
The *multi-disciplinary team* needs technology support in order to share consent forms, screening information, plans, and actions *(i.e., case notes).* The support needs to be easy enough for a case manager to create a group that has exclusive rights to read and edit any documentation that the members create.

The software needs to be capable of automatically notifying members of the group, by email, when any of the documentation within the space reserved for the group members is added to or edited. The software must allow both the creation of documents from within the group, and importing documents from without. The software must be capable of creating and keeping threaded discussions. The software must be web browser accessible, and Macintosh compatible, to meet needs of the least technical environments of community partners.

Some community partners *may* require DSHS-supplied computer equipment to be able to participate on a multi-disciplinary team.

## SOLUTIONS IDENTIFIED

A **card** technology application could provide the DSHS shared client a card with all the identifying information required by all DSHS programs. Once name and other identifiers, as well as family members, address and other basic data were recorded, offices could 'read' the card and transfer the information to existing systems, which currently support each program area. The card could also carry the information and a unique signature that could be read into a template to create a paper copy of a shared consent form, as needed. The team agreed that a card technology could **not** be ready in January. However, the idea has merit for all clients who use more than one service from us in a year. We recommend that DSHS create a separate project to investigate this idea further, and develop a proposal with costs and identified benefits to the department.

**Client Registry** information, combined with family member information carried in the Client Services Data Base from ACES and CAMIS, can be used to identify DSHS clients and families who warrant a referral to a No Wrong Door pilot project. This could be ready in time for the pilot sites in January.

Four **commercial collaboration software packages** were found which could provide the communication support to a multi-disciplinary team. Each has strengths and weaknesses, and the IT team will continue to test them. They are

- Groove
- QuickPlace
- eRoom, and
- InfoWorkSpace

## IMPLEMENTATION CONSIDERATIONS

1. **Client Registry,** with additional information from Barcode and CAMIS, can be configured to support the pilots by identifying DSHS shared clients. *(Additional staffing is needed to accomplish and maintain this).*

*The four **collaboration software packages** need to be further analyzed in order to* define requirements, test the software, and have a hands-on test by case managers. A final selection of the best package can be made by late September, leaving time for implementation at pilot sites by January.

# APPENDIX 9-D

# CLIENT SCREENING ISSUES RESOLUTION TEAM RECOMMENDATIONS

## LONG-TERM RECOMMENDATIONS

- Each program area will have the same key elements in each of their screening tools
- A group will be convened to determine which key elements are necessary in a screening tool in order to identify multiple needs.
- The group will use data from the pilots and review current screening tools used in each division.
- Cabinet needs to decide who will pay to make sure key elements are in place in each division's screening/assessment tools.
- Cabinet needs to decide the funding for implementing changes in divisions' screening tools.
- Need to determine what screening tool to use when clients come in through medical providers, not through a DSHS division.

## SHORT-TERM RECOMMENDATIONS

- Direct pilots to use current screening tools in each program area, to fulfill screening criteria for referral to No Wrong Door pilot. *(See following pages).*
- Direct pilots to use the one-page referral tool, and check off boxes, to know who needs to be involved on the multi-disciplinary team. This tool can be used in hard copy initially; however, it should be made available electronically, with drop-down boxes. *(See draft referral tool in the following pages).*
- Need to involve the client in determining whom he/she wants on his/her multi-disciplinary team to serve as his/her natural support.

## PROPOSED SCREENING CRITERIA FOR LONG-TERM TANF CLIENTS AND THEIR FAMILIES FOR REFERRAL TO A MULTI-DISCIPLINARY TEAM

### POTENTIAL CANDIDATES (CLIENT AND FAMILIES) MUST MEET THE FOLLOWING:

**On TANF at least __ months*** and in need of, or currently involved with, **at least one** of the following:

- DDD (or disability-related payment, such as GA-U or SSI)
- MHD
- DASA
- CA

### PLUS ONE OF THE FOLLOWING

Have multiple issues that prevent, or interfere with, WorkFirst participation.
Have been hard-to-engage in or refused to engage in WorkFirst.
Currently in sanction status, or at risk of being sanctioned.

Time limit case staffing indicates that multidisciplinary approach is needed.

* To be determined by Cabinet (e.g., 12, 24 or 36 months).

**PROPOSED SCREENING CRITERIA FOR:**

Persons with Multiple Disabilities for Referral to a Multi-Disciplinary Team

**POTENTIAL CANDIDATES MUST MEET THE FOLLOWING:**

Information obtained through the Client Registry, or other means, indicates that the individual is receiving services, or has received services within the previous year, from **at least two** of the following:

- AASA
- DASA
- DDD (or a disability-related payment, such as GA-U, SSI)
- MHD

*Note: DVR customers would be eligible if they also were involved with two of the program areas above.*

**PLUS THE INDIVIDUAL MEETS THE FOLLOWING CRITERIA:**

1. Has multiple issues that are impacting care planning and goal resolution.
2. Agrees *(either the individual, guardian, power of attorney, or decision-maker)* to participate in the Multi-Disciplinary Team.

**PROPOSED SCREENING CRITERIA FOR:**

Troubled Children, Youth and Their Families for Referral to a Multi-Disciplinary Team

**POTENTIAL FAMILIES MUST MEET THE FOLLOWING:**

**Served by (services open in) Children's Administration,** and in need of, or currently involved with, **at least two** of the following program area services:

DASA (or substance abuse issue, or through chemical dependency providers)

DDD (or disability-related payment, such as GA-U or SSI)

JRA

MHD (or mental health issue)

ESA (TANF/WorkFirst)

**PLUS ONE OF THE FOLLOWING**

1. Have multiple issues that prevent, or interfere with, case resolution.
2. Have been screened in for high standard of investigation based upon "chronic neglect" criteria.
3. Have indicated willingness to sign a voluntary services contract.
4. Child Protection Team staffing indicates that multidisciplinary approach is needed.

**Served by (committed to) Juvenile Rehabilitation Administration,** and in need of, or currently involved with, **at least one** of the following program area services:

CA

DASA (or substance abuse issue)

DDD (or disability -related payment, such as GA-U or SSI)

DVR

MHD (or mental health issue)

**PLUS ONE OF THE FOLLOWING:**

1. Have a limited length of parole supervision (12-24 weeks), requiring other agency involvement for long-term case planning.
2. Have multiple barriers to access of appropriate DSHS services.
3. Have been identified as a multi-systems case, requiring an inter-agency multi-disciplinary team.
4. Have indicated a willingness to participate in the multi-disciplinary team at the pilot site.
5. Be over 18 years old, be parents, and may use TANF.

## NO WRONG DOOR DRAFT REFERRAL FORM

***Date:*** _____

***To:*** _____
NO WRONG DOOR SERVICE COORDINATOR

***From:*** _____
*No Wrong Door Entry Point* Agency

***Staff Person Name:*** _____

***Title:*** _____

***Phone:*** _____

***Fax:*** _____

***Email:*** _____

***Customer Name:*** _____

***Identified Issues:*** _____
_____
_____
_____

### *Current Agency Involvement:*

- ❑ **AASA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **CA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **DASA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **DDD** Contact: _____ P: (_____)_____ Email: _____
- ❑ **DVR** Contact: _____ P: (_____)_____ Email: _____
- ❑ **ESA (other)** Contact: _____ P: (_____)_____ Email: _____
- ❑ **ESA/WF** Contact: _____ P: (_____)_____ Email: _____
- ❑ **JRA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **MAA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **MHD** Contact: _____ P: (_____)_____ Email: _____
- ❑ **AASA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **Other** Contact: _____ P: (_____)_____ Email: _____

**Local Community Partners**

### *Recommendations for Multi-disciplinary Team Members:*

- ❑ **AASA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **CA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **DASA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **DDD** Contact: _____ P: (_____)_____ Email: _____
- ❑ **DVR** Contact: _____ P: (_____)_____ Email: _____
- ❑ **ESA (other)** Contact: _____ P: (_____)_____ Email: _____
- ❑ **ESA/WF** Contact: _____ P: (_____)_____ Email: _____
- ❑ **JRA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **MAA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **MHD** Contact: _____ P: (_____)_____ Email: _____
- ❑ **AASA** Contact: _____ P: (_____)_____ Email: _____
- ❑ **Other** Contact: _____ P: (_____)_____ Email: _____

*Local Community Partners:*

***Comments:***

# APPENDIX 9-E

# FLEXIBLE FUNDING

The primary objective for this committee was to address the obstacles to the operation of the pilots resulting from the various funding sources involved. In addition, the committee felt it should clarify a fundamental assumption about the No Wrong Door pilots and funding.

**Fiscal constraints:**

Allocation of resources to serve common clients will be dealt with at the local level, from within the current level funding base. As pilots are identified, local managers from programs involved will determine resources available to support the selected clients. It is assumed the clients served by the pilots are part of the anticipated caseload of various programs and therefore staffing, support and support services are included in the base budget for each program. Consistent with this assumption is the implicit understanding that per capita costs for clients, in excess of those anticipated in the allotments to serve these clients, will by necessity reduce funding for clients in non-pilot sites.

**Proposed process to overcome perceived funding restrictions:**

1. If it is perceived that funding restrictions are an obstacle to the operation of a pilot, designated local managers are to work with fiscal managers within each program and administration to explore whether such restrictions can be obviated.
2. When necessary, the Budget Division will facilitate a process to explore funding options, within available funds, to support the projects that cannot be resolved at the local or regional level.
3. If funding constraints present intractable obstacles to implementation of No Wrong Door pilots, the Budget Division and the affected administrations will note such instances and seek relief through state law changes or waiver requests. It is expected that intractable funding restraints will be minimal.

**Clarifying assumptions:**

There is no budget enhancement for No Wrong Door pilots within the DSHS budget. In fact, the only resources available to support this initiative are the resources given to us for existing programs. Participants in the pilot must realize that the funding for common clients will come from existing program funding.

To the degree that better coordination allows for a more efficient allocation of resource to meet client needs, funding could be freed up to support the pilots. However, the pilots are not an opportunity to expand services or change eligibility criteria for clients served by the pilot.

# APPENDIX 10

# ESTIMATED ADDED STAFF HOURS AND FTE AND 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).

## 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 | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *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**

| | 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** |
| 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**

| | 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** |
| 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 |


**Research and Data Analysis Division**
**Report Number 11.99**