DOCUMENT RESUME

ED 404 335 SP 037 170

TITLE	Integrated Services for Children & Families. Improving Outcomes in the Midwest Region. Policy Report No. 2.
INSTITUTION	North Central Regional Educational Lab., Oak Brook, IL.
PUB DATE	96
NOTE	41p.; This report is a sequel to "Policy Briefs" (Report No. 1, 1996), "Human Services Coordination: Who Cares?"
AVAILABLE FROM	North Central Regional Educational Laboratory, 1900 Spring Road, Suite 300, Oak Brook, IL 60521-1480.
PUB TYPE	Reports - Descriptive (141) -- Collected Works - Serials (022)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Elementary Secondary Education; Family Programs; *Human Services; *Integrated Services; Profiles; Public Schools; *Social Services; State Programs
IDENTIFIERS	Illinois; Indiana; Iowa; Michigan; Minnesota; Ohio; Wisconsin

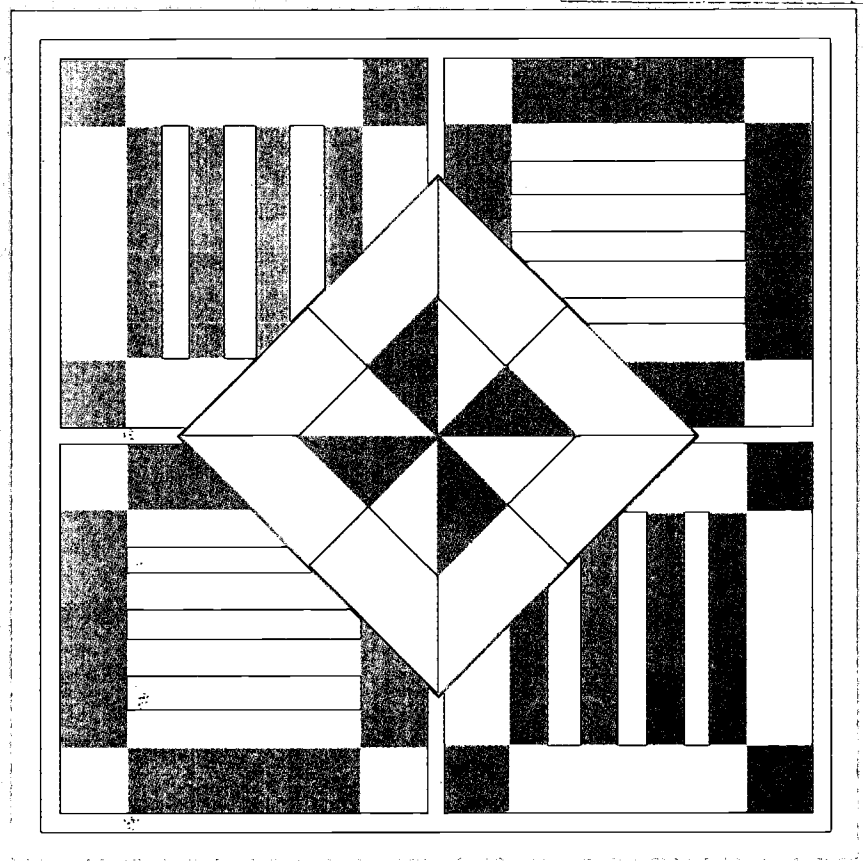
ABSTRACT

This report highlights the North Central Regional Educational Laboratory (NCREL) states' efforts in integrated services and provides commentaries by experts on their experiences in the field. Steven Preister's "Overview" from Report No. 1 serves as the framework for the report, describing NCREL states' current and future agendas, exploring key concepts of human services, and providing information on specific issues that still need to be addressed by the states. State profiles are provided for Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, and Wisconsin. Also included are brief articles: "Reforming Human Services Delivery for Outcomes Accountability" (Robin LaSota of NCREL); "Human Services Reform in Illinois: Turning Rhetoric to Reality" (Beverly Walker, Assistant to the Governor of Illinois for the Governor's Task Force on Human Services Reform); "An Interview with Cheryl Sullivan, Secretary of the Indiana Family and Social Services Administration"; "The Mancelona Family Resource Center: A Microcosm of Change in Michigan" (Gary Knapp); and "Ohio Family & Children First Initiative: A Record of Results of School Readiness" excerpted from a briefing from the Office of the Governor. References are included at end of articles and profiles. (ND)

Policy Report

Report No. 2, 1996

Integrated Services for Children & Families



Improving Outcomes

NCREL

Often external factors are the determinants of academic success or failure. Wise educators and community-friendly schools have known this for years. Education has a vested interest in participating in conversations about how better to restructure and deliver the human services children and their families need.

Editor's Note: *by Judy Caplan, Program Coordinator, Center for School and Community Development, NCREL*

This *Policy Report* was developed as a sequel to *Policy Briefs,* Report No. 1, 1996, "Human Services Coordination: Who Cares?!" We wanted to highlight NCREL states' efforts in integrated services and to bring the reader additional "Commentaries" by experts on their experiences in the field. Steven Preister's "Overview" from the original document acts as the framework for the paper. NCREL states' current and future agendas are described. In Steven Preister's excellent background about human services, key concepts are explored. The reader who is interested in how these concepts take form from state to state will find the state profiles especially rich and useful. Also included are an article by Robin LaSota of NCREL on "Reforming Human Services Delivery for Outcomes Accountability"; "Commentaries" by Beverly (B.J.) Walker, Assistant to the Governor of Illinois for the Governor's Task Force on Human Services Reform, and Gary Knapp, Community Development Coordinator of the Mancelona Family Resource Center in Mancelona Michigan; along with an interview of Cheryl Sullivan of the Indiana Family and Social Services Administration and an excerpt from a briefing from Ohio's Governor on the Ohio Family & Child First Initiative.

Why is a Regional Educational Laboratory publishing a monograph on integrated services for children and families? Where is the connection with schools and learning? Clearly the experiences of children before 8:00 a.m. and after 2:30 p.m. have a profound effect on what happens in the classroom and on all learning. Often external factors are the determinants of academic success or failure. Wise educators and community-friendly schools have known this for years. Education has a vested interest in participating in conversations about how better to restructure and deliver the human services children and their families need.

School administrators, classroom teachers, and educational support staff know the impact of health, social, and environmental conditions on education. The student fearing harassment on the walk home, the child wincing in pain from a sore tooth, the teen missing school to serve as a translator for parents, a child with Attention Deficit Disorder (ADD), the youngster who has moved three times in the third grade—these children come to school worried, preoccupied, distracted, unable to actively

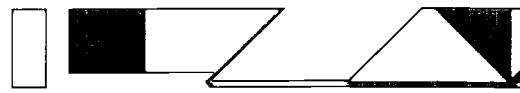
engage in learning and do their best. The children we are most concerned about, the children in need of extra support, often have also come to the attention of some other professional—a nurse at the health clinic, the beat patrol officer, an outreach from a social service agency. Each understands a part of what is needed and, lacking a total picture, can only offer assistance that is often fragmented, ill-timed, and hard to access.

Education is not being asked to meet all the social, health, and emotional needs of young children. Instead, education is *invited* to sit at a community table with human services professionals, parents, local business, religious leaders, and its neighbors to grapple with the challenges facing young people. Everyone must be willing to try new solutions, to change, to define new modes of accountability.

The success of such a partnership depends on the forging of new relationships, agreeing on a common language, understanding each other's organizational cultures, and the development of common goals. Is this work easy? We know it is not. But this collaborative work holds the best promise for providing effective services that are flexible, holistic, family centered, and accountable.

NCREL has worked hard to construct bridges between education and its community neighbors. Sometimes this takes the form of creating environments for idea sharing and information exchanges. Other times the Lab has brokered relationships between the educational and the human services communities. In Illinois, through Project Success—a school-community partnership initiative—NCREL provides training and technical assistance designed to promote community conversation and planning. Laboratory staff work with key community individuals on facilitation techniques, group dynamics, and planning skills. These NCREL-trained Project Coordinators then lead local partnerships through a planning process designed to identify community needs and develop a responsive action plan. In our work, we strive to involve all the stakeholders and ensure that they are full participants.

NCREL hopes this *Policy Report* initiates conversation between educators and human service professionals about possible approaches for working together to realize the best outcomes for our children. We also hope you find this expanded version of the original document interesting and useful. Your comments are always appreciated. Our goal is to give you the most current and accurate information in a very reader-friendly style.



Education is not being asked to meet all the social, health, and emotional needs of young children. Instead, education is invited to sit at a community table with human services professionals, parents, local business, religious leaders, and its neighbors to grapple with the challenges facing young people.

Community Human Services Coordination

Overview

by Steven Preister, Consultant

Why is this issue so important, especially now?

If there is one thing that almost everyone agrees about today, it is that the way we now deliver public human services doesn't work well. Politicians from both parties, policymakers, consumers, human services providers, advocates, and program managers—each from their own perspective—know that even with the best of intentions, the basic design and organization of the human services system is ineffective and needs reform. And children and families who are poor or who have multiple needs suffer the most. As the National Commission on Children reported, "The present system of services and supports is totally inadequate" (National Commission on Children, 1991, p. 312). What is wrong with the way citizens receive human services, particularly in the public sector? The Center for the Study of Social Policy (Center for the Study, 1995, p. 1) and Kunesh and Farley (1993) have succinctly summarized the problems with current services[1]:

- The current system is not focused on *results* (for example, getting a job, reducing family stress, eliminating child abuse) but on procedure and maintenance (for example, qualifying for welfare, maintaining benefits, meeting required criteria).
- The social welfare system *divides the problems of children and families into rigid and distinct categories* that fail to reflect interrelated causes and solutions. Therefore, the current system treats problems or concerns as isolated and individually based rather than viewing them holistically and in the context of family, neighborhood, and community.
- As a result, specialized agencies have difficulty *crafting comprehensive solutions to complex problems*. In addition, multiple programs, funding sources, and accounting rules generate wasteful duplication of services and administrative expenses.
- *Funding for human services is also fragmented and categorized,* making it difficult to pool resources to help solve a problem in a coordinated, comprehensive, and integrated fashion.
- Most services are *crisis oriented,* rather than prevention oriented. Expensive, "back-end" services are emphasized at the expense of long-term prevention programs necessary to change results.
- The current system is too "top down," *not allowing communities the flexibility to determine their own needs and not fostering consumer participation in seeking solutions to improve outcomes.*

[1] *The author has blended and expanded on the descriptions contained in these two sources.*

◇ *Functional communication is lacking* between and among public and private sector agencies.

What do these characteristics of the current human services delivery system mean concretely for families, especially the most vulnerable? Ooms and Owen (1991 a, pp. 3-4) provide some examples:

◇ It is not uncommon for "at-risk" families with several children to have between 4-8 workers assigned to them from different agencies—the AFDC worker, the visiting nurse, the probation officer, the drug abuse counselor, the child protective services worker, the truant officer. This does not include the family's contact with regular "providers" such as teachers, clergy, and health care workers. Each one of these is only concerned with a segment of what they see as a "dysfunctional family." The workers seldom communicate with each other and none of them have the responsibility to assess the family's needs or strengths or work with the family's well-being as a whole.

◇ Typically, a poor parent will have to go to several different offices to establish that she is poor and eligible for services, and she will have to do this several times, filling out different forms each time. Each program has different definitions of who qualifies for assistance and rules about how to count and document income and assets.

◇ Poor families seldom have access to convenient transportation, which makes it harder for them to get to services. They are also more likely to face problems dealing with their environment such as their housing and neighborhood issues like safety.

◇ Poor families typically have no source of regular, preventive medical care and usually only seek health care in crisis at an emergency room or public health clinic where they are unlikely to see the same professional each time.

◇ Families with children with special service needs face the fact that rules governing funding often only pay for the most institutional, expensive type of service for their child which is not usually what the child requires. Outpatient or home-based services typically are not covered. Many of these services are only available to the diagnosed child, not the family. Services that provide parents with the information, education, counseling, and ongoing home-based support needed to care for children with special needs are usually not reimbursable to providers. Too often, a family has to try to squeeze its needs into predefined categories of existing services rather than the services that will meet its needs.

In this time of tight fiscal resources at both the federal, state, and community levels, human services are increasingly coming under scrutiny by policymakers, the media, and consumers. As Ooms and Owen (1991a, p. 5) remarked:

> Faced with this litany of barriers and problems, is it any surprise that taxpayers are concerned that the services they fund are not meeting families' needs and thereby so often fail to achieve their goals? The miracle is that some families do become adept at negotiating these system mazes and do manage to get the benefits ... and use them to improve their children's and families' lives.

Just as there is consensus on the nature of the human services delivery problems, there is also an emerging consensus on a new model of delivery. In shorthand, we call the new model "community human services coordination," and it is based on pilots and experiments conducted across the country. This NCREL *Policy Report* is an introduction to community human services coordination. By community human services coordination, we are referring to a nationwide movement to change the way that public human services are delivered so that they are community-based, flexible and holistic, family centered, and accountable.

Background History[2]

Awareness of these human services delivery problems has existed for a very long time. The settlement house movement at the turn of the century was an attempt to bring together a wide range of services needed by the poor in a neighborhood location. The problems of the system intensified, ironically, with the best of motivations. The social programs initiated in the 1960s and 1970s to address urgent and specific social problems, in fact, increased categorization, and the complex eligibility rules and program regulations prevented states and communities from using the funding and programs flexibly.

As early as the beginning of the 1970s, Elliott Richardson, Secretary of the then U.S. Department of Health, Education, and Welfare (DHEW), launched his agenda to promote services integration including research and demonstration projects, technical assistance efforts, and internal departmental reforms through the Allied Services Act, but the bill never received congressional approval. There were subsequent efforts in the Department to begin changes in the public human services delivery system. In 1974, DHEW established Project SHARE, a national clearinghouse to help improve the management of human services, and, in 1979, the Office of Human Development Services in the Department of Health and Human Services (DHHS) funded the National Network for Coordinating Human Services to develop and maintain linkages between individuals and organizations interested in coordinating

[2] section draws on Ooms and Owen (1991a) and Kinney, et al., 1994.

services that cross categorical boundaries, government jurisdictions, and public and private services. In the early 1980s, the network funded two national conferences. Attention shifted in the late 1970s to welfare reform and national health service. Initiatives continued, however, at state and local levels, energized in part by the enactment of block grants in 1975 and 1981, which gave the states greater flexibility in their use of funds. However, the budget cuts of the 1980s curtailed many of these reform efforts. In the 1990s, this reform effort has spread nationwide and is now represented at some level in most states. It is in states and local communities that the real action is taking place today.

While these developments took place in the world of *social services,* there were parallel developments in almost every other field of human services. These include *child abuse* (National Committee for Prevention of Child Abuse, n.d.), *child care* (Ooms & Herendeen, 1990), *children's mental health and seriously emotionally disturbed children and adolescents* (Knitzer, 1989; Stroul & Friedman, 1986), *child welfare* (VanDenBerg, as cited in Kinney, Strand, Hagerup, & Bruner, 1994, p. 35), *disabilities* (United Cerebral Palsy Associations, 1992/93), *early childhood* (Galinsky, Subilla, Willer, Levine, & Daniel, 1994), *education* (Melaville & Blank, 1991), *employment, training, and public assistance* (Jennings & Zank, 1992), *family preservation and family support* (Family Resource Coalition, 1994), *health care services for infants and toddlers with special health needs* (National Maternal and Child Health Resource Center, n.d.), *pregnant women, mothers, infants, and young children* (National Commission to Prevent Infant Mortality, 1991), *primary health care* (Institute of Medicine, 1982), *school-community collaboration and school-linked services* (Gerry, 1993; National Consensus Building Conference on School-Linked Integrated Service Systems, 1994), *and youth development* (Gambone, as cited in Kinney et al., 1994).

Definition of Terms

There are four core terms that are used to define community human services coordination, and each term has a number of key elements. While each of the four are necessary, none is sufficient by itself to make a reformed delivery system. Woven together, they describe a new design for supporting families and communities in fulfilling their own responsibilities:

1. Human services must be *community based*. This term, describing a core characteristic of a reformed delivery system, has two key elements:
   - ◇ Services need to be *accessible*. They must be based in the community in locations that people use in the community—for example, community centers, schools, shopping areas. They must also be accessible, culturally and linguistically.
   - ◇ Service needs must be *defined* by the local *community, and the defined services planned and monitored by a broad-based group* of community representatives with the authority and responsibility for meeting the community's human services needs. Increasingly, experts are recommending that for community human services coordination to be successful, they must be led by some local governance entity (LGE).
2. Services need to be *flexible and holistic*. Current services are categorical—one agency delivers one kind of service for one problem. If a client comes in the "door" of that agency, she will receive the service whether this is what is needed or not. Clearly, this is not what clients need. The human services delivery system needs to be able to be flexible in a way that allows services to be designed that

best meet the client's needs and, at the same time, holistically addresses these needs including prevention of problems. Different terms that are used to describe this service characteristic include *coordination of services, integration of services, comprehensive services, wraparound services, and prevention-focused services* instead of the current crisis-oriented approach.

3. Services need to be *family centered*. Family-centered services, another core characteristic of effective community services coordination, also has two key elements:

   ◇ *Regardless of which family member seeks or needs services or what agency the individual seeks help from (for example, public aid, child welfare, substance abuse), the holistic approach that community human services coordination takes requires that the services and support provided be family centered.* Services must be tailored to help the individual in the context of her family and community (Ooms and Preister, 1987, p. 11).

   ◇ *Community human services coordination is built on client strengths* rather than client pathology, and uses those strengths and resources in problem solving. *Families and human services staff join as partners* in a collaborative problem-solving effort, with *the family as the senior partner* in defining its own desired needs, goals, supports, and changes (Kinney et al., 1994, pp 7, 13). Services should support and supplement family functioning rather than substitute for family functioning (Ooms & Preister, 1987, p. 10).

4. The program and all persons involved in community human services need to be *accountable*. All the partners in the service effort—the program, the workers, and the family—should be required to demonstrate that they have delivered what each has agreed to:

   ◇ *Program accountability: outcomes.* Currently, human services programs are held accountable for processes—for example, eligibility has been determined, or the client meets the income requirements of the program. In effective community human services coordination, programs are required to meet a different standard. For each client who seeks help, *the program must specify what will be the outcomes the services provided will achieve.* Program effectiveness, then, is measured not in terms of how many clients are "processed" or "not processed," but whether the program actually assists the client in an incremental movement toward self-sufficiency or toward being able to better manage the family problem or need.

   ◇ *Worker accountability: empowerment and support skills.* In effective community human services coordination, workers are held accountable not for how many clients they "process," but for *their ability to engage clients in a trusting, working relationship, to facilitate the family's definition of its own goals, to tailor services so they fit the real needs of the family, and for monitoring the family's successes and obstacles and helping the family overcome problems* (Kinney et al., 1994, pp. 21, 16, 19).

   ◇ *Family/client accountability: goal setting and achievement.* In effective community human services coordination, families are not passive clients whose only responsibility is to demonstrate eligibility. Instead, a family works in partnership with a case manager to *define very specific, short-term, measurable goals it wants to achieve to solve the problem or address the need.* Then the family works with the case manager to achieve those goals, celebrating successes and working to overcome obstacles that get in the way of goal achievement (Kinney et al., 1994, p. 19; Ooms, Hara, & Owen, 1992).

These four core terms are used to describe a reformed delivery system for any of the traditional domains of human services—for example, the child welfare system, the health care delivery system, the educational system, the juvenile justice system, and so forth. Other terms that are commonly used in relation to community human services—such as *school-linked programs or school-community collaboration*—are used to name or describe strategies or processes employed to help achieve a reformed system.

Some Relevant Research in Brief

There is a growing body of data resulting from research conducted on programs in the various human services areas—in child welfare, health care, education, and so on—that have attempted to change their delivery systems to reflect the four characteristics described in the previous section. This research has consisted largely of case studies of human services reform efforts at the community or state level. In the arena of human services coordination, community-based initiatives that have been evaluated include the Walbridge Caring Community Program (St. Louis), the Family Opportunity Program (Denver), New Beginnings (San Diego), and New Futures (Savannah) (Ooms & Owen, 1991).

Evaluating the effectiveness of large-scale systems reform is more difficult because these systems are so complex. For example, the Annie E. Casey Foundation has provided funds to support large-scale human services reform in seven states. Illinois is one of these states, and its initiative is known as the Governor's Task Force on Human Services Reform. Core elements of

this initiative include a state-level collaborative and decision-making body (the Task Force), five pilot community demonstration projects—each with a local governance entity and mandated collaboration between the site and local providers of seven state human services departments, and a reorganization of seven of Illinois' departments into one department of human services. Other states attempting statewide reform include Idaho, Iowa, Maryland, Tennessee, and Virginia (Ooms & Owen, 1992). But technologies to evaluate such large-scale initiatives are only beginning to emerge. They include microsimulation, experimentation and quasi-experimentation, qualitative evaluation, and case studies (Cohen & Ooms, 1993).

Specific Issues States Need to Address

The current human services delivery system was created over many decades in a piecemeal fashion. To create community human services coordination, states will have to adopt a holistic approach that deals with four core issues:

1. *Outcomes-Based Services*. The most fundamental change that states wanting to reform the human services delivery system must make is to change the nature of program accountability. State, county, and community public human services agencies and their nonprofit provider contractors have to shift from recording and rewarding programs for processing clients, measuring what kinds of services are provided to whom, and how much money was spent on clients to *rewarding programs for achieving defined, desired results*. This is a major challenge that requires a shift in the culture of the agency and also requires a great deal of work in defining, in measurable terms, the client outcomes for which the agency has responsibility. The arena of defining outcomes in behavioral human services is still in its beginning stages, but a beginning has been made (Schorr, Farrow, Hornbeck, & Watson, 1995).

A corollary issue that states will be required to address is *developing and implementing effective management information systems* (MIS) that provide policymakers and administrators with the outcome data needed to make policy and program decisions, provide supervisors with the information they need to make appropriate case loads, and provide front-line workers with the technology to reduce paperwork while simultaneously facilitating community human services coordination.

2. *Structures That Support Community Human Services Coordination*. The current structures that exist for monitoring, implementing, and providing human services will not work for a reformed system. New systems will need to be put in place:

   - *New legislative structures*. In a categorically defined human services system, state legislatures monitor programs similarly—categorically. *But these legislative structures do not promote systems reform*. According to a survey by the National Conference of State Legislatures, *many state legislatures have taken steps in recent years to improve their organizational ability to promote the coordination of, and gain greater visibility for, children and family issues*. By 1990, 20 states had set up standing committees and 8 had established select committees that consider children, youth, and family issues. Tennessee created a Select Joint Committee on Children and Youth that includes, as members, the chairperson of each relevant standing committee as well as the finance committee leaders (Ooms & Owen, 1991b, p. 4).
   - *New executive branch structures*. In an effort to promote coordination and integration of human services, *states have been experimenting with new executive branch structures to see if these can be more effective than the traditional separate, multiagency approach*. A few states are attempting to consolidate agencies and services for children and families *under a single cabinet level department* (Connecticut, Delaware, Rhode Island). Two states have folded these departments into a consolidated division of an *umbrella human services/resources department* (Arkansas, Idaho). An increasing number of states (at least 14) are setting up commissions on children and youth, or children and families, either by law or through governors' executive action. These commissions are intended to promote more coordinated and broader examination of children and families' needs. And some states are experimenting with *interagency planning councils and task forces* (Ooms & Owen, 1991b, pp. 4-6).
   - *Local governance entities* (LGEs). Earlier, we discussed that community human services coordination requires some local governance entity. Just as the states are saying to the federal government that they need flexibility in designing policies and programs that fit their unique state environment, *communities are telling states that programs designed at the state level may not be effective for each community*—in other words, one size does not fit all. Since the problems and burdens of service fragmentation are experienced by families and service providers at the local level, it is here at this level that the leadership must be found to craft more effective solutions (Ooms & Owen, 1991b, p. 6). As the Center for the Study of Social Policy (1991, p. 1) has postulated:

Creating this new leadership is not a simple task. It requires rethinking the mechanisms through which states and localities have governed services in the past. It also entails negotiating new roles among service agencies and implementing more collaborative decision making among previously autonomous public and private funders and providers. Perhaps most important, it requires that a local community make a commitment to a continual reexamination of service operations while also adjusting and retooling them as necessary to make services more effective.

These entities vary in the power they have, but they play a crucial role in the success of any community service reform. Typically, they have four functions: agenda setting and strategy development; developing new service strategies; coordinating fiscal strategies; and monitoring, supporting, and reassessing these activities and maintaining accountability for child and family outcomes. Experience has shown that for LGEs to be successful they need to develop a common philosophy and vision; they need a lengthy planning period; they need to design service packages that combine at least some educational, health and social services usually in a single location; they must change the service delivery system; and they must have provider participation and commitment (Ooms & Owen, 199lb; Center for the Study of Social Policy, 1991).

3. *Financing* (Ooms & Owen, 1991b, pp. 8-10). In order to fund a reformed human services delivery system, *states will need to adopt a variety of financing strategies*. They will need to combine sufficient funds from different sources to be able to sustain comprehensive, integrated services over the long run. And they will need to develop funding that is flexible and can meet service needs that do not fit into preformed categorical packages. They will also need to *redirect funding from crisis-oriented, institution-based, high-cost services into prevention-oriented, home-based, lower-cost services*.

Funding strategies that states have experimented with include *general state revenues* (to fund start up, planning, staffing, and administrative activities that are otherwise not reimbursable from existing sources of categorical funding; *increased federal financial participation* (maximizing federal entitlement reimbursements to the state to provide a more stable financial base for reform programs); *redeployment and refinancing* (redeploying funds used for high-cost, institution-based programs to community-based, family-centered programs; redeploying staff from traditional programs into the new programs; and reinvesting the additional maximized federal funding into these services); *pooled, flexible dollars* (by state legislation or interagency agreements, pool funds from different agencies and use them flexibly to fund integrated service delivery); *private foundation and federal grants* (seeking start-up grants to cover expenditures involved in the time-consuming process of planning community human services coordination).

4. *Training, Technical Assistance, New Technologies, and Service/Program Evaluation*. Community human services coordination cannot be achieved without an investment by the state in training, technical assistance, new technologies, and service/program evaluation. Yet these are areas that traditionally have had a low priority in state funding.

   ◇ *Training*. The current public human services workforce cannot be expected to move from a system that stresses eligibility and maintenance to one that focuses on outcomes and empowerment without training and support. Training will need to be provided statewide. Training requirements range from generalist skills (strengths-based approaches to working with client families; basic skills of engaging client families in a partnership process that results in goal setting and attainment) to more advanced skills such as case management (Cohen & Ooms, 1993a).

   ◇ *Technical assistance*. States will need to provide both state agencies and local governance entities (LGES) with the technical assistance necessary to plan and implement community human services coordination. Specific areas of technical assistance that need to be provided to LGEs for planning and implementing community human services collaboration include at least the following: LGE formation, membership/participation, governance structures and processes; LGE strategic planning; LGE's promotion of collaboration between the community state agencies, and local providers; mechanisms for delivery of reformed services (personnel, financing, contracts, and so on); and training for and implementation of family-centered frontline practice (Cohen & Ooms, 1993a).

   ◇ *New technologies and service/program evaluation*. States will need to invest in new and emerging technologies that will support and enhance community human services coordination. These include management information systems (already discussed), public access networks designed to give clients direct, private, and anonymous access to information about social services, education, jobs, and training, and the technologies of

About the Author

Steven Preister, DSW, is the Executive Director of the National Association of Family-Based Services. In the past two years, he has provided consultation, policy analysis, large-scale case studies, and production of training manuals in child welfare and human services reform, managed care of human services, and family-based work in Head Start for the Illinois Governor's Task Force on Human Services Reform, the Annie E. Casey Foundation, the Family Impact Seminar, the Center for the Study of Social Policy, Catholic Charities USA, the Head Start Bureau, the National Alliance for Business, and the Center for the Support of Families. He has written and published extensively in the area of family policy, child welfare, and human services. Previously, he served as the Deputy Executive Director of the American Association for Marriage and Family Therapy, taught graduate social work at The Catholic University of America, directed a family service agency, a university family research center, and a family policy and education foundation. He served as a foster parent of two special needs infants and now is their adoptive father.

managed care, which can be used to support the objectives of cost-effective, efficient, community-based, family-centered human services. Finally, states need to invest in service and program evaluation (Cohen & Ooms, 1993b).

Conclusion: Needs and Summary

This NCREL *Policy Report* summarizes the problems of the current human services delivery system. Despite the best of intentions, the basic design and organization of the human services system is ineffective and is particularly difficult for poor and multiple needs children and their families. There is a clear consensus that the system needs to be reformed.

Through experiments over the last 20 years, we are learning that there is a more effective and humane way of delivering human services. We call this new model *community human services coordination*—human services delivered in such a way that they are community-based, flexible and holistic, family centered, and accountable. This model is being used increasingly by almost all areas of human services. Case studies indicate that while difficult to implement, community human services coordination can be effective and successful in empowering client families and their communities.

States that decide they want an alternative way of delivering human services will need to undertake a challenging and difficult initiative that will require a major investment of time and resources. They will have to address at least four specific issues to be able to ensure a successful reformation. First, state, county, and community public human services agencies and their nonprofit provider contractors will have to shift from recording and rewarding programs for processing clients, measuring what kinds of services are provided to whom, and how much money was spent on clients to *rewarding programs for achieving defined, desired client results or outcomes*. They will also have to invest in management information systems to support outcomes-based services and measure their effectiveness. Second, *states will need to reinvent governance structures so they will support community human services coordination*. These include new legislative and executive branch structures and, most important, local governance entities to plan and oversee community human services coordination. Third, *they will need to adopt funding strategies to finance the reform effort and to capitalize new and reformed services*. Finally, *they will need to commit themselves to a major and ongoing investment in training, technical assistance, new technologies, and program evaluation* that are essential for the success of the reform initiative.

Finally, drawing on the experience of states and communities that have been struggling with such efforts, it must be noted that a reform initiative such as community human services coordination is a challenging and lengthy undertaking that involves critical tasks and processes. Certain tasks need to be accomplished (for example, dealing with the four issues described in the previous paragraph) if the initiative is to be successful. But reforming the human services delivery system is also a *human* process: time and energy needs to be invested to involve all stakeholders and ensure that they are full participants. It takes time for this to happen and to bring about the consensus needed to drive the reform and to sustain it through implementation. As a human process, this cannot be bypassed or hurried. This reform takes place one person at a time. And so those undertaking this reform initiative will need to commit themselves to a lengthy process that will require patience and tenacity.

References and Resources

The Center for the Study of Social Policy, The Child and Family Policy Center, the Center for Youth Development and Policy Research, and the Family Resource Coalition. (1995). *A working paper on Reforming Human Services and the Personal Responsibility Act*. Washington, DC. The paper appeared on HandsNet, an on-line information system for human services professionals on July 12, 1995 on the Children, Youth, and Families Forum.

Center for the Study of Social Policy. (1991). *Building a community agenda: Developing local governance entities*. Washington, DC: Author.

Cohen, E., & Ooms, T. (1993a). *Training and technical assistance to support family-centered, integrated services reform*. Washington, DC: The Family Impact Seminar.

Cohen, E., & Ooms, T. (1993b). *Data integration and evaluation: Essential components of family-centered systems reform*. Washington, DC: The Family Impact Seminar.

Family Resource Coalition. (1994). *Best practices in family support*. Chicago: Author.

Galinsky, E., Subilla, L., Willer, B., Levine, J., & Daniel, J. (1994). State and community planning for early childhood systems. *Young Children*, 49(2), 54-57.

Gerry, M. (1993). *A joint enterprise with America's families to ensure school success*. Washington, DC: Council of Chief State School Officers.

Institute of Medicine. (1982). *Health services integration: Lessons for the 1980s*. A Report of the Committee on Services Integration: Washington, DC: Author.

Jennings, E.T., & Zank, N. (Eds.). (1992). *Coordinating public assistance programs: Integrated approaches for federal, state and local governments*. Westport, CT: Greenwood Press.

Kinney, J., Strand, K., Hagerup, M., & Bruner, C. (1994). *Beyond the buzzwords: Key principles in effective frontline practice*. Falls Church, VA, and Chicago, IL: National Center for Service Integration (Falls Church) and the National Resource Center for Family Support Programs (Chicago). Published in conjunction with Mathtech, the Child and Family Policy Center, the National Governor's Association, Policy Studies Associates, and the Yale University Bush Center.

Knitzer, J. (1989). *Collaborations between child welfare and mental health: Emerging patterns and challenges*. Paper prepared for the Changing Services for Children Project: New York: Bank Street College of Education.

Kunesh, L., & Farley, J. (1993). Integrating community services for young children and their families. *Policy Briefs*, Report 3. Oak Brook, IL: North Central Regional Educational Laboratory.

Melaville, A.I., & Blank, M. (1991). *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services*. Washington, DC: Education and Human Services Consortium. Available from the Institute for Educational Leadership.

National Commission on Children. (1991). *Beyond rhetoric: A new American agenda for children and families*. Filial Report. Washington, DC: Author.

National Commission to Prevent Infant Mortality. (1991). *One-stop shopping: The road to healthy mothers and children*. Washington, DC: Author.

National Committee for Prevention of Child Abuse. (n.d.) *Long-range plan, National Committee for the Prevention of Child Abuse: Its mission and activities*. Chicago: Author.

National Consensus Building Conference on School-Linked Integrated Service Systems. (1994). *Principles to link by. Integrating education, health, and human services for children, youth and families: Integrated service systems that are community-based and school-linked*. Washington DC: American Academy of Pediatrics.

National Maternal and Child Health Resource Center. (n.d.) *A national goal: Building service delivery systems for children with special health care needs and their families*. Washington, DC: Author.

Ooms, T., & Binder, H. (1992). *Keeping troubled families together: Promising programs and statewide reform*. Washington, DC: The Family Impact Seminar.

Ooms, T., & Herendeen, L. (1990). *Implementing child care in the Family Support Act*. Washington, DC: The Family Impact Seminar.

Ooms, T., & Owen, T. (1991a, September). *Coordination, collaboration, integration: Strategies for serving families more effectively. Part one. The federal role*. Washington, DC: The Family Impact Seminar.

Ooms, T., & Owen, T. (1991b, December). *Coordination, collaboration, integration: Strategies for serving families more effectively. Part two. State and local initiatives*. Washington, DC: The Family Impact Seminar.

Ooms, T., & Owen, T. (1992). *Promoting adolescent health and well-being through school-linked, multi-service, family-friendly programs*. Washington, DC: The Family Impact Seminar.

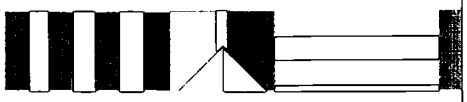
Ooms, T., Hara, S., & Owen, T. (1992, December). *Service integration and coordination at the family/client level. Is case management the answer?* Washington, DC: The Family Impact Seminar.

Ooms, T., & Preister, S. (1987). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. A Report of the Family Criteria Task Force. Washington, DC: The Family Impact Seminar.

Schorr, L., Farrow, F., Hornbeck, D., & Watson, S. (1995). *The case for shifting to results-based accountability with a start-up list of outcome measures*. Washington, DC: The Center for the Study of Social Policy.

Stroul, B.A., & Friedman, R.M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Georgetown University Child Development Center.

United Cerebral Palsy Associations. (1992/93, Winter). Family support: States set the stage for federal legislation. *Family Support Bulletin*.



Project Success challenges community leaders, educators, parents, and state and local social service agencies to work together in identifying problems facing school-aged children and to develop community-based solutions for those problems.

Editor's Note: *The states in NCREL's region—Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, and Wisconsin—were asked to describe their current initiatives in human services coordination and their future plans and to indicate several key contact persons. Their efforts follow.*

Illinois

The enormity of social problems facing children and their families today is historically unprecedented—poverty, homelessness, child abuse and neglect, lack of adequate medical care, substance abuse, crime. These demands have placed tremendous stress on families and communities nationwide. Illinois continues a commitment to meeting these needs through the development of a responsive, collaborative human services delivery system.

Among Illinois's most successful initiatives is Project Success, a community-based model created in 1991 that focuses on school-linked human services as a means to improve delivery of health and social services for all children and families. The project responds to the reality that a child who comes to school hungry, abused, or neglected will not be able to concentrate when he or she arrives in the classroom. Bringing those services to the school will improve access for all children and families in need of services.

Project Success challenges community leaders, educators, parents, and state and local social service agencies to work together in identifying problems facing school-aged children and to develop community-based solutions for those problems. Each Project Success community embraces six core service components required for healthy families and communities.

- Prevention and primary health care
- Proper nutrition and nutrition education
- Preventive and rehabilitative mental health services
- Services that protect and promote family stability
- Substance abuse prevention, intervention, and treatment
- Positive family social activities

Project Success communities use these components in planning and implementing activities during their initial program year. These activities include health fairs with free immunizations and physicals, school breakfast and summer lunch programs, counseling and dental services in the schools, parent advocacy groups to strengthen skills and involvement, volunteer retirees to mentor students through the Illinois READS program, the distribution of school supplies, recreational opportunities, drug prevention programs, antigang initiatives, parent-child dances, book fairs, and field trips. Such activities have not only benefited children and their families but have significantly improved relationships between schools, parents, social service organizations, health care providers, and other community members.

To be eligible, communities must demonstrate that 20 percent of the students served are economically disadvantaged. They must also be willing to develop a new process to provide services to children and their families, and have a not-for-profit organization willing to serve as the administrative agent for Project Success. Communities are then eligible to receive a one-time start-up grant of up to $15,000

to create and begin implementation of a community plan for service integration. Currently, 162 Project Success communities provide services through approximately 600 elementary and middle schools. A fundamental strength of Project Success is found in its individual application within each community. Just as each child and family present unique strengths and needs, so, too, do individual collaborative models. No one model for local collaboration will work for every Illinois community.

The Governor appointed the Governor's Task Force on Human Services Reform in 1993 to improve service delivery. The task force was charged with examining the Illinois health and human services delivery system and recommending innovative management strategies for the then $8 billion (now over $11 billion) human services budget. The task force report convinced the Governor that fundamental changes would be necessary to create a responsive, efficient services delivery system. His goal was to ensure that the state's financial investment in human services was achieving all desired outcomes.

The recommendations of the task force led Illinois to embark on additional efforts in community involvement. Pilot "federations" currently exist in five Illinois communities. Each federation has proposed projects that create opportunities for the community and state government to work together to meet local needs. Common themes have emerged in the projects of each federation: family self-sufficiency, integrated/noncategorical services, and coordinated intake and assessment. Still, each federation has developed its own vision of how that particular community hopes to achieve its goals. The formation of broad-based community federations has resulted in ideas from the local level being included in the task force's decisions.

Most recently, after years of input from communities, advocacy groups, state employees, and service providers, the Governor signed landmark legislation on July 3, 1996 (House Bill 2632 and H.B. 22), creating a new Department of Human Services (DHS) by reorganizing services currently provided in six separate state agencies. The new Department will include the current Departments of Mental Health and Developmental Disabilities, Rehabilitation Services, and Alcoholism and Substance Abuse, as well as many programs from the Departments of Public Aid, Children and Family Services, and Public Health. The DHS consolidation becomes effective on July 1, 1997. Transition planning has already begun in earnest. Reorganization planning and transition committees went to work shortly after the Governor announced his intention to consolidate human service agencies early in 1996. The newly created Task Force on Human Service Consolidation, made up of legislators and cabinet officials, held its first meeting August 23 and will continue to meet periodically throughout the planning process. In addition, advisory panels and work groups composed of agency directors and staff, private service providers, advocacy groups, and consumers are addressing critical reorganization issues such as program consolidation and service delivery redesign.

Human services reorganization is indeed a daunting task due to the fragmented delivery system that has evolved over the course of many years. However, the anticipated benefits hold much promise. Reorganization will allow the state to offer "one-stop" services for clients, eliminate costly and confusing service duplication, and reduce administrative paperwork and multiple agency contracts.

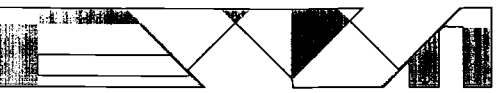
Illinois' efforts toward better human service collaboration are far from over. Additional communities statewide continue to enthusiastically embrace the Project Success model. Existing projects are expanding their initial ideas through innovative applications of the collaborative philosophy. Continued planning, careful initiation, and rigorous evaluation will be critical during the months leading to and following implementation of the new Department of Human Services. Opportunities to gather input from community members, state agency members, and other interest groups will continue throughout this process.

Key Contact Persons:

Lori Williams
Assistant to the Governor for Project Success
2 1/2 State House
Springfield, IL 62707
(217) 782-1446

Theresa Wyatt
Assistant to the Governor for Human Services Reform
2 1/2 State House
Springfield, IL 62707
(217) 524-1578

Beverly (B.J.) Walker
Assistant to the Governor for Human Services Reform
James R. Thompson Center
100 West Randolph, Suite 6-200
Chicago, IL 60601
(312) 814-4166



Human Services Reform in Illinois:

Turning Rhetoric to Reality

by Beverly (B.J.) Walker, Assistant to the Governor, Governor's Task Force on Human Services Reform, Chicago, Illinois

In America, the rhetoric of reform has typically been easy—the reality has not. In fact, there is great consensus about what we need in human services reform among the country's writers and policymakers. Whether in government or the not-for-profit sector, we all seem to agree on the kinds of services that work. They should be community-based, integrated, family-focused, preventive, and comprehensive. And we seem to recognize the need for public-private partnerships and the importance of family cohesion and eliminating disincentives to work. Most important, we all agree that outcomes should drive program design and delivery.

With so much agreement, why is there so little progress? Why do we see these themes reflected in discrete, local programming (both inside and outside the public sector), but not across large-scale public systems, and *not* as part of widespread comprehensive and collaborative neighborhood systems? Why is the rhetoric so hard to make real?

In Illinois, about three years ago, the Governor appointed a Task Force on Human Services Reform to examine this gap between rhetoric and reality. And for the past year, I have been serving as Assistant to the Governor on the reform issues uncovered as part of that Task Force process. The work is hard and confusing. Oftentimes, in reform efforts, we are accustomed to seeing tangible, relatively short-term outcomes for our work. We write a report with recommendations (for someone else to implement), or we develop a new program and find the funding to get it started. Unfortunately, bridging the kind of gap we see between rhetoric and reality in human services reform will require a greater focus on *"how,"* not just on *"what."* In an outcomes-based environment, we find ourselves in the awkward position of advocating the process. (This does not feel good!)

Unfortunately, if the answer to human services reform were a simple prescription for retooling programs, we would already have many of those programs. (There is no lack of these skills in the current environment.) The reality is that there is no prescription. Each state, each county, each community has a different set of needs and strengths. It is, therefore, engagement among these various communities, with their various stakeholders, that must be regarded as the very first "product" (outcome, as it were) of reform. And, most importantly, we must engage key players both at the "top" (state government) and the "bottom" (community leaders and representatives.)

A focus on engagement requires a shift of perspective. It requires a *long-term vision*—not a short-term one. It requires a facilitative, rather than a prescriptive approach. The goal is to bring the right people to the table and then to create a forum seductive enough to make them want to stick around long enough to negotiate reform.

At its heart, this reform process is really about creating demand. To effect real change, both the people responsible for delivering services and the people using (and paying for) those services have to want to change; both have to want to be engaged. If the top is not interested in change, only a huge and potent groundswell of grassroots effort will move public officials to make meaningful reform. And if the people at the bottom do not see the benefit in reforms created by the top, no amount of far-sighted leadership from elected or other officials will enable the buy-in necessary to make those reforms effective. Demand must be stimulated at both ends and those of us leading and facilitating those efforts must find the kinds of strategies that engage both the top and the bottom.

In Illinois, the Task Force, along with the Governor and his executive staff, has created a great deal of demand from the top. In addition, the changing relationship between the federal government and state governments, the prospect of scaled-back block grants for many human services, and the likelihood of more stringent work requirements for Aid to Families with Dependent Children (AFDC) recipients are also contributing to the desire of state officials (and not just in Illinois) to reconsider human services delivery systems.

To stimulate demand from the bottom, five field trial sites or federations, representing five diverse communities, are working to mobilize local engagement in restructuring human services in Illinois. The federations were asked to recommend changes in state policies, procedures, and practices. To sustain the community's engagement, we asked them to take on a real and urgent local human services problem, an authentic task, one that was important to the community and that might have concrete, visible results. We asked them to design a pilot project around this problem and use the pilot to learn more about what changes need to be made at the systems level. Although the federation activities are focused on tangible changes in services delivery, the long-term goal here is really about building demand for change and keeping the local community engaged in efforts to reform human services in Illinois.

To build a bridge between state government and communities, we are using a process of negotiation. One of the most difficult tasks of systems reform is getting government and community to agree on what needs changing and how. In Illinois, we are asking both sides to meet and discuss proposals from the community. We ask them to negotiate the hard issues until they reach consensus. The ultimate goal here is pretty straightforward—both sides must own the direction of change and be willing to work together on behalf of it. Typically, government and community have been suspicious of one another; this negotiation strategy intends to break down some of this mistrust. Although every attempt is made to find ways to operationalize or make real the federations' ideas, the only promise made is good faith and a willingness to keep talking. All else must be negotiated.

When I came to state government, I feared that if I attempted to lead some kind of change effort, no one would follow. (It's the old "suppose I gave a party and no one came?" story.) In fact, I have learned that one does not begin leading until people are engaged, and through their own engagement take up their leadership. What we have found is that when people become engaged in reform activities—when they sit at the negotiation table—they become leaders of reform. The task engages them. They have a stake in the ultimate outcome, and they work to make it successful. It is that process which will ultimately get us beyond rhetoric in human services reform.

The Governor and the brave people of Illinois, both inside state government and out, deserve a great deal of credit for undertaking this effort. In this state, we are learning to work together across the kinds of ideological, cultural, and geographic "divides" that are polarizing people in other parts of the country.

*This article is excerpted from a longer essay, "Getting Engaged: Turning Rhetoric to Reality in Human Services Reform," published in *Lessons Learned 3*, a publication of the Annie E. Casey Foundation, Baltimore, Maryland. Copies of the original essay can be obtained from the Casey Foundation by contacting Linda Berradino at 800-222-1099.

To build a bridge between state government and communities, we are using a process of negotiation. One of the most difficult tasks of systems reform is getting government and community to agree on what needs changing and how. In Illinois, we are asking both sides to meet and discuss proposals from the community.

Indiana

The Step Ahead process is a new approach to service delivery, not another program. Step Ahead facilitates the coordination and development of service delivery systems that provide bridges to connect and fill gaps in services for children and families. This process helps to provide uninterrupted and holistic services for children and families in areas such as health, education, child care, special needs, employment, nutrition, mental health, literacy, and various other areas of need.

Consolidated Agency

An analysis of state government operations resulted in a massive overhaul of the way Indiana delivers its social services. The product of that analysis and reorganization, the Indiana Family and Social Services Administration (FSSA), was established by Public Law 9-1991. With an annual budget of nearly $4 billion, the more than 11,000 employees of FSSA have important work to do in developing, coordinating, and overseeing nearly 175 programs in Indiana.

In the course of launching new initiatives and reexamining existing processes, the agency undertook a yearlong effort to develop a strategic plan. With the completion of that plan, the agency has a common vision, a shared mission, and an ongoing commitment to serving the needs of its clients and the state's taxpayers.

After input from a large number of staff, advocates, and the public, common themes emerged. The agency has expanded upon those themes to define four top priorities: Step Ahead, Information Development for Policy Decisions, Community-Based Services, and Welfare Reform. Strategies are being developed to reach the four goals of accountability, program planning, organizational development, and self-sufficiency.

By bringing together pieces from once separate bureaucracies, FSSA has reached across program, division, and agency boundaries to develop comprehensive systems that address the needs of children and families. By forming partnerships with businesses and communities, FSSA continues to fill in the pieces of the social services puzzle. FSSA is what its mission statement is about: "People helping people help themselves."

Step Ahead

Indiana introduced Step Ahead as a process to recognize parents as a child's first teacher and to address the need in Indiana for a collaborative approach to ensure a seamless service delivery system for families. The state of Indiana has incorporated the Step Ahead initiative as the process to strengthen and enhance the availability of a statewide comprehensive service delivery system. This process provides an effective way to channel resources so that each resource builds on the work accomplished with other resources and is more responsive to the needs of families.

The Indiana General Assembly enacted Step Ahead into law with bipartisan support in 1991. The Step Ahead process is a new approach to service delivery, not another program. Step Ahead facilitates the coordination and development of service delivery systems that provide bridges to connect and fill gaps in services for children and families. This process helps to provide uninterrupted and holistic services for children and families in areas such as health, education, child care, special needs, employment, nutrition, mental health, literacy, and various other areas of need.

Step Ahead has required a creative approach to address the disjointed maze of overlapping programs with confusing and often inconsistent eligibility criteria for families in need of services. By bringing together funding streams and linking them to various programs, Step Ahead has brought cohesiveness to service systems across the state. The Step Ahead Panel was created to implement the Step Ahead legislation and it acts as an advisor for the Step Ahead Councils. Panel members are appointed by the Governor and the Superintendent of Public Instruction.

Step Ahead is community based, planned, and directed. Volunteers in all 92 counties have formed local Step Ahead Councils. Each Council conducted comprehensive needs assessments of existing resources, programs and services and identified service delivery gaps. Each Step Ahead Council then created a Plan of Action to address the needs of families and children. These Plans were built around five primary component areas: family support systems, mental health, nutrition and health, personnel development, and educare.

Although Step Ahead Councils have received only modest discretionary grants from the state, they have mobilized citizens and resources within their communities to implement their Plans of Action. Since 1990, Step Ahead has been able to attract nearly 24 million additional dollars for county allocations to serve children and families. Many of the additional dollars allow for parental choice in the selection and utilization of services. The Indiana General Assembly has appropriated $3.5 million per year for planning, council development, and service development among all 92 Step Ahead Councils. Each county receives a portion of these funds based on the population of single-headed households with children under the age of five.

Leadership of the Councils is shared among the Step Ahead county coordinator, who has administrative responsibilities; the fiscal agent, who receives and administers grants and contracts; and the council members. Approximately 3,000 citizens serve on Step Ahead Councils, applying common sense and real-life experience. These Councils have focused their efforts in several priority areas, which include quality early child care and education (educare); maternal and child health; well-baby and well-child health care; teen pregnancy prevention; and family support, such as parenting education and counseling. Once identified as having the most fragmented social service delivery system for families and children in the country, Step Ahead has made Indiana a leader among states in developing more effective and efficient services for children and families.

Indiana Policy Council for Children and Families

The Indiana Policy Council for Children and Families was established to implement the Indiana Collaboration Project (ICP). The state Policy Council, appointed by the Governor, includes the superintendent of public instruction, the attorney general, the director of the State Budget Agency, the secretary of the Indiana Family and Social Services Administration, and the commissioners of the Department of Administration, Personnel, Correction, Health, Higher Education, and Workforce Development/Employment and Training Services. The Council provides leadership and oversight for the delivery of health, education, and social services to children and families. Meetings are scheduled bimonthly to help ensure that barriers to services provided to children and families by state agencies are removed or avoided.

The Council is overseeing the implementation of the State Consolidated Plan. The Indiana Consolidated Plan was the enabling document that received federal approval for coordination of children and family services across approximately 199 relevant programs funded by the Departments of Education, Health and Human Services, Housing and Urban Development, Labor, Justice, and Agriculture.

The creation of the Indiana Family and Social Services Administration, the development of the Step Ahead process, and the establishment of the Indiana Policy Council for Children and Families have provided structural foundations for meaningful improvements in human services coordination. Specific examples of these improvements, which include Blended Funding, Electronic Network, Common Intake Form, and the Program Review Teams, are as follows:

Blended Funding

The goal of blended funding is to provide seamless service at the local level and to authorize agencies to share appropriate expenses and blend necessary funds to serve children and families. Through the Indiana Collaboration Project, the Blended Funding Subcommittee drafted two proposed agreements to be used to blend funds for services for children and families. Both agreements were adopted by the Policy Council. The county funding agreements are being tested in three pilot locations: Bartholomew, Morgan, and Putnam counties.

The Indiana Family and Social Services Administration fiscal division and the Office of General Counsel worked together to develop a contract mechanism to authorize and track blended funding. At the local level, funds for multiple contracts from numerous state agencies now are blended into a single contract to decrease administrative costs and reduce paperwork.

A blended management fund at the state level pools resources for services, computers for an electronic network, and training across state agencies. For example, the Indiana Family and Social Services Administration Division of Mental Health and Division of Family and Children, the State Department of Health, and the Criminal Justice Institute pooled funds to prevent child abuse and neglect through the Healthy Families Indiana initiative. The Family and Social Services Administration blended state and federal funding to increase the number of school sites that provide school age child care from 56 to 337, serving 13,422 children.

Electronic Network

The Electronic Network is being developed to expand opportunities to access information and improve communications by the Step Ahead Councils and state and

federal agencies. By sharing and being able to access the same information, agencies can be more aware of opportunities to meet the needs of children and families throughout the state.

By sharing and being able to access the same information, agencies can be more aware of opportunities to meet the needs of children and families throughout the state.

Approximately 64 local Step Ahead coordinators involved in the Indiana Collaboration Project received hardware, software, and training to use the electronic network. Agencies represented on the Indiana Policy Council for Children and Families helped implement the electronic network. This network allows County Step Ahead Councils to communicate with their county/state facilitator, a trained state employee; resolve issues and bureaucratic barriers to implement the Council's Plan of Action; access on-line information about potential funding opportunities to enhance services for children and families; and develop partnerships to improve services for children and families.

Common Intake Form

A committee of attorneys and program staff from six state agencies worked together with input from local Step Ahead Councils to develop the Common Intake/Release of Information Form. The Common Intake section of the form is used to minimize the number of times that a family must complete intake information when applying for services. The Release of Information section is used to effectively coordinate services to children and families. Addressing seven different federal and state statutes regarding confidentiality, this form provides the mechanism to allow families to share confidential information if they wish. Within the Indiana Family and Social Services Administration, the Divisions of Family and Children, Disabilities, Aging and Rehabilitative Services, and Mental Health have signed Memoranda of Understanding for the use of the form. Training is being provided at the state level in the use of the form to help strengthen and support efforts at the local level.

Program Review Teams

By sharing and being able to access the same information, agencies can be more aware of opportunities to meet the needs of children and families throughout the state. Program Review Teams are interdisciplinary and interdivisional teams (composed of program, fiscal, legal, and data representatives) serving as vehicles for implementing the agency's Strategic Action Plan. These teams are working to increase coordination across programs and improve community-based service delivery systems for families and children through:

- ◇ Identifying strengths and barriers that impact on agency priorities and goals.
- ◇ Identifying and using essential data for decision making.
- ◇ Developing innovative approaches to create new opportunities, achieve administrative efficiencies, and solve problems.
- ◇ Devising methods of accountability that address outcomes and quality.

The mission of these teams is to (1) assist with implementation of management initiatives, (2) identify continuous quality and productivity strategies, and (3) recommend methods to improve services to families. Program Review Teams have helped link performance planning and measurement, budget decision making, and financial reporting in key functional areas.

Key contact person:

Cheryl Sullivan, Secretary
Indiana Family and Social Services Administration
P.O. Box 7082 • Indianapolis, IN 46207-7083
Telephone: (317) 233-4452 • Fax: (317) 233-4693

An Interview With Cheryl Sullivan, Secretary of the Indiana Family and Social Services Administration

On August 1, 1996, Deanna Durrett, NCREL, spoke with Cheryl Sullivan, Secretary, Indiana Family and Social Services Administration (FSSA), to learn about the consolidation of state human service agencies in Indiana. Newly elected Governor Evan Bayh consolidated the agencies in 1991 in response to numerous studies that characterized Indiana's human service delivery system as disjointed and disorganized. Bayh merged the administration of public welfare (AFDC, Medicaid, food stamps), aging and rehabilitation services, child welfare, mental health and developmental disabilities, and addiction services. Sullivan became the administrator in 1993.

Durrett: There are a number of reasons for consolidating human services agencies. What do you view as the most compelling?

Sullivan: It is now possible to base public policy on the needs of the family in the most comprehensive and coordinated way. For example, in the past as we moved people from public assistance into jobs, we would have looked at public assistance as a separate categorical program with a separate funding stream, administered by a separate agency and that program would have been held accountable. [Today] moving the family to economic self-sufficiency is the objective and responsibility of all of our agencies. Now we have one case manager per family as opposed to one case manager per categorical program. The family sees no individual categorical program staff and staff see the walls between programs coming down. Yesterday, on a conference call, we had people from mental health, vocational rehabilitation, workforce development, and commerce all talking about how to blend funding and staff.

Durrett: If I'm that mental health worker on that phone call, what do I do differently now?

Sullivan: The family's problem isn't all your burden. You know you can get others on the phone to solve the problem with all the issues involved in making that family successful. The mental health person could have solved that one problem alone, but now each person looks at what he or she can contribute. Therefore, you don't feel so isolated.

Durrett: This is almost a case management story. Are you suggesting that state people take on the role as case manager for every local problem?

Sullivan: We see ourselves as state employees modeling behavior, giving others—including local people—permission to propose solutions, take risks. Also, my role has changed from regulating and monitoring to facilitation and technical assistance. For example, in the past, we had people who would inspect and close down child care centers that did not meet the standards. Now, because we need quality child care, the role of that inspector is to help rally support in the community to help correct the deficiencies. Our goal is an adequate supply of quality child care. It means you have to invest in the staff—train them to be problem solvers, good communicators and to know how to negotiate and resolve conflicts. We've invested a lot in that training to support our new role.

Durrett: What changes would local agency people cite as evidence that consolidation has made a difference?

Sullivan: They know who to contact—they don't feel so isolated and they have been given permission to solve problems. Local people know there is a problem-solving format.

Durrett: What does "problem-solving format" mean?

Sullivan: It means communities can propose ways they want government to interact with them. A simple example—they can blend funding into a single contract and avoid having to deal with the paperwork involved in individual contracts.

What we want to happen is that these barriers are identified and solutions are proposed at the local level. But, if they cannot be, there is a process for passing the problem along to the level that can. At the county, we have the Step Ahead* Coordinator; at the region, there is a county-state facilitator; at the state, there is a working group; and above the working group is the Policy Council. I'm on that and so is the Superintendent of Public Instruction, the Commissioner of Corrections and other agency heads.

Just because you have a piece of paper creating reorganization doesn't mean it just automatically happens. More work happens after the creation. What matters is what you do when you come in in the morning and take off your coat. If people are just going to go back to the way they did things before, there is no need for the reorganization.

Durrett: You have mentioned Step Ahead. I know that this involves community-level planning and funding for services for young children. But it sounds like the community-based problem solving is now being expanded to issues beyond early childhood.

Sullivan: Yes, communities can identify the issues they want to work on. Step Ahead gave us a structure and a start. The state doesn't say everyone is going to work on infant mortality; communities can choose their priorities, including those which deal with issues in older children or adults. A lot of the emphasis, however, is still on early intervention and prevention for all issues.

In responding to the ideas and needs of local communities, we have blended funding, changed regulations, and obtained federal waivers. In fact, that work will set us up well to respond to the opportunities presented in the new welfare legislation.

Durrett: Indiana was one of the early states to consolidate human services functions at the state level. What kinds of questions do your peers in other states ask you?

Sullivan: They want to know about the overall physical structure . . . about how it was created . . . are corrections included? . . . is health? What are our accomplishments? They ask if we have saved money and reduced staff. The answer to both is absolutely yes. They want to know who our advocates are . . . who hasn't been supportive.

I then throw in a little unsolicited advice. Just because you have a piece of paper creating reorganization doesn't mean it just automatically happens. More work happens after the creation. What matters is what you do when you come in in the morning and take off your coat. If people are just going to go back to the way they did things before, there is no need for the reorganization. In the past, people were looking to the rule, the permission, the memo. The training our staff receives gives them the permission to do something different. It takes time, and you have to address the needs of the staff. We have done a lot of training, not only in procedures, but in staff skills like conflict resolution. And, you have to keep bringing people back to the vision.

Durrett: What are the biggest challenges?

Sullivan: It takes time. . . the importance of patience . . . the importance of addressing the needs of staff . . . reintroducing the vision again and again. Since we no longer give our information by categorical program, we talk about family success and economic self-sufficiency; we reinforce the broader priorities and policies. If the Congress is getting away from categorical separate programs, we need to reorganize our agencies to be able to deal with block grant funding and consolidation of programs. Education agencies are an integral part of this process.

* The Step Ahead initiative is a process (rather than a program) enacted into law with bipartisan support. It facilitates the coordination and development of service delivery systems that provide bridges to connect and fill gaps in services for children and families. More detail on Step Ahead is included in the Indiana state section of this report.

Iowa

In 1993, the Iowa Legislature created the bipartisan Council on Human Investment (CHI) to develop and implement a system of performance management for state government in Iowa. The cornerstone for this initiative is human services coordination as state government agencies, the Iowa Legislature, and the citizens of Iowa determine priorities to be used for policymaking and resource allocation. Benchmarks are determined and budgeting models are developed to tie resource allocation to results and to the people's priorities. The current focus areas are: Strategies for Strong Families, Economic Development, Workforce Development, Healthy Iowans, and Strong Communities.

Each state department identified staff to work on each focus area and as is evident from the areas chosen, human service coordination is the dynamic result from much of this work. State agencies share skills, expertise, and eventually resources to accomplish common goals for the families of Iowa.

This initiative is closely aligned with State Government's Strategic Plan and this year's Governor's Year of the Family initiative. State agency directors are involved in weekly planning meetings chaired by the Lt. Governor and bimonthly community forums. These forums will be held each month until December. They are facilitated by the Governor and Lt. Governor and are held in communities across the state from 7 to 9 p.m. The purpose of the forum is to hear from community members about their concerns and to initiate or expand human services coordination in communities to assist them in developing their capacity to support families.

For Iowa, collaboration efforts between the Departments of Health, Human Services, Economic Development, Employment Services, and Education are not new. In 1993, these five agency directors formed The Family Strategies Work Group and developed "A Working Policy Blueprint for Iowa's Families." This document illustrated some of the existing ongoing internal coordination efforts that focused specifically on families. State strategies for future planning and future initiatives were also identified. The group's purpose was and is to promote coordination efforts between state agencies and encourage greater communication with and between other state, community, public, and private agencies. In actuality, we now believe that we are in need of a collaboration of collaborations and have begun to focus our efforts to this end.

In Iowa, we have been fortunate to obtain funding from several foundations, such as Casey and Danforth, to assist us in broad-based community development efforts. Many communities in Iowa are working together to support the needs of families.

Specific state efforts in Human Services Coordination can be found in "A Working Policy Blueprint for Iowa's Families." Of special note would be our Decategorization/Child Welfare project, the Family Development and Self Sufficiency initiative, Family Resource Centers, School-Based Youth Services programs, and Healthy Iowans' project as well as all state at-risk programs. Each of these involves broad support from state and community agencies, both public and private, and includes parents and families as partners. Caring Iowans are working together to support our families.

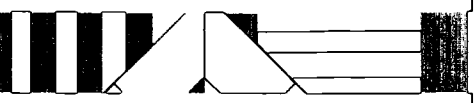
Our state Legislature this past session passed an "Innovation Zones" bill. This bill will enable local jurisdictions to establish community partnerships to redirect existing public funds to achieve improved outcomes for children and their families. The state and local jurisdictions shall negotiate new relationships in the decategorization of funding appropriated and available to local jurisdictions that share the risk related to and responsible for achieving improved outcomes.

An innovation zone board is created within the Council of Human Investment. The Board is staffed by the Human Investment Council, and its membership is composed of the directors or their designees of the Departments of Human Services, Human Rights, Education, Public Health, Employment Services, and Management. Four members of the Legislature will serve as ex officio, nonvoting members.

As an expansion of the family forums, we are developing a state team composed of the Lt. Governor; the directors of Health, Education, and Human Services; the mayor of Waterloo; a city councilwoman; a member of the Board of Health; a chief juvenile court officer; a director of community services; and personnel from a school district. This team will represent Iowa on the Chief State School Officers' Ensuring Student Success Through Collaboration Project. This project will greatly support our community development efforts.

Key contact person:

Susan J. Donielson, Ed.D.
Administrator, Office of Educational Services for Children, Families, and Communities
Department of Education
Grimes State Office Building
Des Moines, IA 50319-0146
Phone: (515) 281-3575 • Fax: (515) 242-6025
sdonjel@max.state.ia.us



The interagency vehicle between and among the human services departments in Michigan is being driven along an interesting path.

Michigan

The interagency vehicle between and among the human services departments in Michigan is being driven along an interesting path. For approximately the last six years, the state directors of the Departments of Social Services (now Family Independence Agency), Mental Health, and Public Health (now Department of Community Health), and the Office of Services to the Aging met monthly to determine interagency policies and direction. Since 1992, the Department of Education has also been part of this group. This state-level human services partnership has generated a significant degree of collaboration in the development of policies and adoption of principles for ongoing work to bridge the gap across agencies, their systems, and clients.

To expand upon and refine this collaboration, the state human services directors and the superintendent of public instruction signed a document in October 1994 entitled "Our Commitment to Systems Reform for Children and Families." This document confirmed their commitment to a collaborative, seamless, locally controlled, family-friendly system of services. It also established the groundwork for systems reform envisioned to focus on "new ways of doing business" to achieve better results for multigenerational families receiving services across multiple human service and educational systems. A Task Force on Systems Reform, composed of state and local leaders, families, and other consumers, was assembled to make recommendations about collaboration.

In February 1995, the Task Force issued its report, "Systems Reform for Children and Their Families: Strategies for Change." From the 55 recommendations contained in the report, 10 were identified as priority:

1. Each locally defined community will have or develop by October 1, 1995, one multipurpose collaborative body (MPCB) as a decision-making body to coordinate human services within the community. (Status: 73 MPCBs representing 81 of 83 counties in place)
2. The MPCB must be used for state-sponsored interagency initiatives involving public agencies. (Status: Ongoing)
3. Each state department will identify a source of funding from current appropriations that may be used locally for flexible financing of collaborative services based on the needs of the child and family. (Status: Complete)
4. An amount (determined annually) will be identified from state human services department lapsed funds to create the Innovation in Systems Reform for Families and Children Grant Fund. (Status: Ongoing)
5. A Barrier Busters Board—composed of the state human services directors and the directors of the Departments of Management and Budget and Civil Service—will be established to review, remove, or alter specific barriers to collaborative service delivery. (Status: Ongoing)
6. On the state level, an audit procedure will be developed for auditing collaborative interagency initiatives. (Status: Nearing completion)
7. A state-level Technical Assistance Work Group will facilitate joint technical assistance among collaborative initiatives and join with local collaboratives in planning and implementing technical assistance activities. (Status: Ongoing)

8. Existing technical assistance resources of the state human services departments and collaborative initiatives will be coordinated by the Technical Assistance Work Group whenever the topics and issues are relevant across systems. (Status: Ongoing)

9. Evaluation of systems reform efforts will consist of a state-defined core set of outcome measures. (Status: Nearing completion)

10. The state will identify select core measures and a standardized methodology to be included in all local consumer satisfaction and evaluation studies measuring community outcomes in order to permit statewide comparability. (Status: Nearing completion)

The intent of this initiative, called Putting It Together With Michigan Families, is to provide a vehicle to facilitate systems reform across agencies.

A retreat with chairs of the original Task Force subcommittees (which included state and local representatives as well as consumers) was held in March 1996 to evaluate the first year's progress and determine direction and focus for the second and subsequent years. It was determined that the overall strategy will be to continue to refine those recommendations from the report not completed in year one (see those above with "ongoing" status) and work to achieve additional recommendations. Specific plans include:

1. At the state level, the human services agencies will continue to strive to model what is being asked of the local communities regarding interagency collaboration.

2. Staff from each agency will continue to dedicate a portion of their time to ensure implementation and provide ongoing technical assistance to local communities.

3. A regional collaborative institute was held in October 1996 for 33 counties on the west side of the state to provide a forum for learning, sharing, and networking. (Note: The first institute was held in Southeast Michigan; the second was for all counties in the Upper Peninsula. Plans are under way for a final institute in 1997 for all northeastern and central counties.)

4. The Innovation Grant Fund will become operational with the 1997 fiscal year as will implementation of the joint audit process.

5. A home page on the World Wide Web is in the design phase and is based on local communities' need for accessible information regarding systems reform at the state and local level.

Key contact persons:

Carol Wolenberg, Deputy Superintendent
Michigan Department of Education
608 West Allegan Street
Hannah Building
P. O. Box 30008
Lansing, MI 48909
517-241-0062
cwolenberg@ed.mde.state.mi.us

Jocelyn Vanda, Executive Assistant to the Director
Family Independence Agency
Grand Tower Building
Suite 31514
P. O. Box 30037
Lansing, MI 48909
517-335-6099
vanda@state.mi.us

Anne Armstrong, Executive Assistant
Department of Community Health
320 South Walnut
Lansing, MI 48913
517-373-3626
armstronga@state.mi.us

Carol Parr, Acting Director
Office of Services to the Aging
P. O. Box 30026
Lansing, MI 48909
517-373-8268
carolparr@state.mi.us

This state-level human services partnership has generated a significant degree of collaboration in the development of policies and adoption of principles for ongoing work to bridge the gap across agencies, their systems, and clients.

The Mancelona Family Resource Center:

A Microcosm of Change in Michigan

by Gary Knapp, Community Development Coordinator, Mancelona Family Resource Center, Mancelona, Michigan

The evolution of the Mancelona Family Resource Center is, in many ways, a microcosm of the change taking place across the country. Strategies for schools, neighborhoods, and public agencies to link services and supports in order to achieve better results for children and families are presenting ever growing challenges and opportunities.

Among these opportunities is "the vision of schools serving as community learning and service centers that deliver a wide array of educational, health, nutritional, day care, and related social services to children, youth, and their families. This service delivery initiative, often called service integration, attempts to integrate delivery of a full scope of educational and human services through collaborations that include schools and major health and social service providers. The process implies fundamental transformation of the mission of both school and community agencies. It is, indeed, no longer business as usual for either" (Bhaerman, 1994).

The uniqueness of the Mancelona Family Resource Center is within the scope of its community-based services, its goal of providing school-linked integrated services tied to educational outcomes, and its role within the broader mission of Project S.H.A.R.E. (School Home Alliance for Restructured Education).

The fact that the Resource Center exists is a statement of tenacity and willpower. Its ability to sustain itself will, most surely, remain a constant challenge, and the vision held by those closest to its creation stands as the true test of its ultimate success. The Resource Center began as an effort to relocate existing service provider agency staff under a single roof, in close proximity to the school(s), in order to respond to identified community/school needs. Operating as a single-point of entry, Resource Center services are built and developed around a client's existing strengths. The services are sensitive and flexible to the needs of not only that client, but his or her family as a whole.

Using a strength-based needs assessment approach, our goals include:

- ◇ Better preparing children for entering and succeeding in school.
- ◇ Ensuring that children feel safe in their homes, schools, and neighborhoods.
- ◇ Promoting healthy lifestyle choices by providing holistic care for children and families.
- ◇ Preparing youth and adults to succeed in the world of work.

Providing relocated staff from the following service agencies, on a school campus, or in an impoverished rural community, represents an important first step in accomplishing these and other related goals:

- ◇ Mancelona Public Schools (early childhood development and teen parent programs)
- ◇ District Health Department #3 (including both health and dental services)
- ◇ Burns Clinic (obstetrics and prenatal care)
- ◇ JOBNET (collaborative job training and employment opportunities)
- ◇ Chip Counseling Services (substance abuse counseling)
- ◇ Probate Court (delinquency prevention services)
- ◇ Women's Resource Center of Northern Michigan (child abuse counseling; domestic abuse counseling)
- ◇ Antrim/Kalkaska Community Mental Health (outpatient therapy; marriage counseling)
- ◇ Antrim County Family Independence Agency (client-specific, family-focused services)
- ◇ Women's Resource Center of Grand Traverse (alternative to violence program for men)

◇ Michigan State University Extension (parenting classes; home-based intervention)

◇ AMERICORPS*VISTA Volunteer
(community and economic development-related services)

Relocated staff from these agencies are connected to children and families through a common intake/multidisciplinary team referral process. A multidisciplinary design team has, over the past two years developed and implemented policies and protocols that link youth and families from within the schools to services provided through the Resource Center. The Resource Center coordinator and a facilitator ensure the coordination of services and are the link between the schools and the relocated staff housed within the resource center. This process is a vital piece of a broader strategy to evolve from side-by-side to integrated, school-linked services tied to educational outcomes. By removing social, behavioral, health, and other barriers to learning, we hope to allow teachers to concentrate on their roles as educators.

The governance of the Resource Center and Project S.H.A.R.E. includes representation from all the participating human service provider agencies, the schools, private sector businesses, and community members. The six stated goals that make up the broader mission of Project S.H.A.R.E. are:

◇ End child abuse in the schools and community

◇ Increase community involvement in the schools and the education of their children

◇ Provide school-linked integrated service to the poor and those at-risk in Mancelona Public Schools and the community

◇ Address the immediate and long-term social and emotional issues and needs of students and families

◇ Increase student opportunities and achievement by improving the level of family literacy

◇ Examine the economic, social, educational, and environmental forces of the community and design a long-term community development plan

The mission of Project S.H.A.R.E. encompasses systemic educational reform; youth, community, and economic development; and the facilitation of countywide planning and service coordination. Woven throughout the day-to-day operation of the Mancelona Family Resource Center are significant inroads that address progress in achieving all six goals.

Both inside and outside the walls of this approximately 7,000 square-foot, newly built facility, significant change is occurring. This change is bringing the school with its resources and the community and its resources and needs into a closer and more harmonious working relationship. The Mancelona Family Resource Center represents, in many ways, the most significant, symbolic, and real evidence of what is achievable when communities and schools collaborate for self- improvement.

Among the many challenges that we are beginning to face is shared governance between the School Board and the Project S.H.A.R.E. Governance Board. Additionally, we have begun to take our message into the classrooms and incorporate into them Resource Center-based initiatives such as school-to-work, conflict resolution, peer service learning, and a life skills curriculum. The challenges ahead are formidable, and the opportunities exciting. Our earliest lessons are reminiscent of a phrase attributed to Jean Toomer, "We learn the rope of life by untying its knots."

Bhaerman, R. D. (1994). *Integrating education, health, and social services in rural communities: Service integration through the rural prism.* Philadelphia: Research for Better Schools, Inc.

Mancelona Public Schools/Project S.H.A.R.E.
Grove Street • Mancelona, Michigan 49659

Minnesota

Minnesota's system restructuring efforts began more than 20 years ago with legislation supporting the creation of intergovernmental and joint policy/service integration strategies and mechanisms such as regional development commissions, county human service boards, social services and public block grants, and increased local planning and service delivery flexibility.

Background: State and Community Governance Structure for System Development

The governance structure for children and family system development in Minnesota is anchored by an executive-legislative branch partnership, formalized horizontal linkages across 11 state agencies, local government-community collaboration supported by state grants, and intergovernmental capacity development and policy formulation mechanisms.

Interagency Linkage at State Level

Children's Cabinet. The Children's Cabinet was created in February 1992 to provide leadership on issues affecting children and families, foster public-private involvement in these issues, develop plans for achieving the state's long-term vision for children and families, develop interagency service delivery and resource allocation strategies, and build linkages to local communities.

Legislative Commission on Children, Youth, Their Families. During its early years, the Children's Cabinet and the Legislative Commission on Children, Youth, and Their Families collaborated on several policy and program development ventures. Although the Commission's responsibilities have been transferred to another joint legislative committee, close executive-legislative branch working relationships continue.

Policy Group and Focus Team. Policy development across state agencies consists of a policy group with membership including assistant commissioners representing the major agencies and local government/communities and four focus teams made up of state and local agency professional and technical staff and parents. These groups are responsible for advising the Children's Cabinet on major policy issues and directing certain interagency planning and service delivery initiatives.

Local Collaboration

Major Stakeholders. The major local stakeholders in Minnesota's effort to improve outcomes, improve accountability, and integrate fragmented service delivery are a variety of private nonprofit agencies, county governments, school districts, and community action agencies. Since creation of a local collaboration grants program in 1993, the state has invested about $23 million in locally initiated system-change strategy development. State policy ensures five years of support for each collaboration. Currently, there are 54 collaboratives that span 90 percent of Minnesota's 0-18 population.

Role of Local Governments and Role of the Collaboratives. In Minnesota, state government has a relatively minor direct service delivery role. School districts and county governments have major responsibility for and heavy investments in early childhood development, family health, and a range of social services. State government backs local investments with diverse state categorical and block grants. Over the years, strong state, local, and federal funding has created a quality, but somewhat fragmented, delivery system. The job of local collaboration is to eliminate fragmentation by developing joint accountability and a continuum of population-focused services that reflect family support principles and practice. Governance and service

delivery strategies designed to meet local needs and perspectives are facilitated by state legislation allowing the creation of diverse policy and service structures.

Local Funding Consolidation and Focus on Outcomes. Marshaling of federal, state, and local resources to address local collaboration strategies was made possible by a 1995 local funding consolidation law and previously existing authority of the state Board of Government Innovation and Coordination. This legislation frees local grantees, at their option, of procedural requirements of state categorical grant programs, shifting the system-change focus from service activities to community/population outcomes.

State-Local Relations

Local Capacity Development. State-local partnerships for children and families in Minnesota stress the development of local capacity to improve accountability for outcomes across jurisdictional lines and to shape policy formulation and service delivery. Tangible products of this strategy are local evaluation plans developed by the family services collaboratives. To date, 13 family services collaboratives have filed outcome evaluation reports. These plans are supported by state technical assistance/consultation and statewide outcome indicator models/guidelines developed by several intergovernmental teams. The state-local partnership also coordinates ongoing statewide quarterly conferences on collaboration designed to foster exchange of information and to develop both state and local capacity to support system change.

Intergovernmental Joint Policy Formulation. Intergovernmental policy formulation and technical assistance are supported by a state-level interagency policy group and state-local focus teams working in the areas of governance, service delivery, evaluation/information management, and finance. These groups are linked to the Children's Cabinet.

History of Restructuring Efforts

Minnesota's system restructuring efforts began more than 20 years ago with legislation supporting the creation of intergovernmental and joint policy/service-integration strategies and mechanisms such as regional development commissions, county human service boards, social services and public block grants, and increased local planning and service delivery flexibility.

County Human Services Boards. Legislation allowing counties to merge social service, public health, and corrections functions by creation of a joint board has been implemented on a limited basis. However, counties have developed a range of local strategies addressing this same goal.

Creation of Block Grants. Social service, public health, and corrections block grant programs created in the late 1970s continue to be major sources of state support for county service delivery. However, state policy in the 1980s tended to favor the creation of categorical and "demonstration" grants focusing on target populations.

State Government Organization. State government experienced only minor reorganization in the employment/training, human services, and education sectors during this period until the creation of the Department of Children, Families, and Learning in 1995. This agency replaces the abolished Department of Education and brings under one roof a variety of core children/family programs that were previously housed in six separate state agencies.

State-Local Relations and Incentives for Performance. Several initiatives are being developed to provide incentives to local governments focused on outcome-based accountability. One effort designed to coordinate these efforts includes the development of an integrated performance reporting system that is being piloted with several local family services collaboratives.

Mandate Reform. During the late 1980s and the early 1990s, several themes dominated restructuring efforts in Minnesota: the need for greater flexibility, development of incentives for local performance, and cooperation/coordination among local agencies. These themes were implemented by such initiatives as state-mandate reform, limited use of performance incentives, and state grants for local innovation and cooperation.

Local Collaboration. Creation of Minnesota's Family Services Collaborative grants program in 1993 was a natural outgrowth of the Action for Children Commission during 1991-92, especially its *Kids Can't Wait* report, formation of the Children's Cabinet, and the state's involvement in the Pew Charitable Trust's Children's Initiative national competition during 1992-1993.

Key Initiatives of the Department of Children, Families, and Learning (DCFL); Other State Agencies; and Local Governments and Communities

Action for Children. The Governor created the Action for Children Commission in 1991. Appointees included representatives of the private

business sector, nonprofits, children's advocates, legislators, and government. During its first year, the commission developed a vision for children and families and a major report, *Kids Can't Wait: Action for Minnesota's Children*. Among its recommendations were the following: overhaul the service delivery system for better results; require improved coordination of programs at the local, county, state, and federal levels; improve accountability for results; discontinue ineffective/inefficient services; and support services that produce results. This ad hoc commission, which was the foundation for the changes of the past five years, was phased out during the last year.

Children's Initiative. During 1992 and 1993, state agencies and three local partners; (City of St. Paul, Becker County, and Cass County) participated in an intensive redesign planning process sponsored by the Pew Charitable Trusts. This process brought a new discipline to interagency and intergovernmental analysis of the delivery system. The state received $1.5 million from the Trusts to support five implementation strategies: unification of system change, development of evaluation capacity, removal of critical barriers, health care service and system access improvement, and enhanced information management. Implementation work is now entering the third and final year.

Grants for Local Collaboratives. The state's local collaboration grants program discussed above provides incentives for achieving improved outcomes in areas such as health, school readiness, stable community and family environments, and basic academic skill development.

Creation of the DCFL. Creation of the new Department of Children, Families, and Learning provided a critically needed leadership focus for system change. DCFL seeks to enhance local decision making, achieve maximum flexibility in program design, delivery, and funding; improve the focus on prevention; measurably improve the well-being of children and families, and enhance public accountability.

Evaluation Capacity Development. A major thrust of Minnesota's system change work has been the development of organizational and staff capacity to systematically generate performance data and analyze/report on the applications of this feedback. Work includes: a standardized process for measuring outcomes adaptable to local system structures; statewide reports describing the impact of new service strategies; and improved local evaluation/reporting capability that can be transferred to all areas of the state.

Statewide Outcome Indicator Development. The 1996 report on the status of the Minnesota Milestones was issued by Minnesota Planning Commission earlier this summer. The milestone measures and data are being used as a framework for the development of local family services evaluation plans.

Information Management Capacity Development. Minnesota is entering the second phase of a statewide performance reporting initiative, under the leadership of the Office of the Legislative Auditor and the Department of Finance. This work, which extends state agency reporting capability to include both agency operations and local delivery system impacts, will link up to local evaluation capacity work. In the children and families service sector, performance reporting is being facilitated by the development of statewide outcome indicators discussed above. Performance reporting and outcome indicator development are complemented by information management work required to support information/referral, intake/eligibility, case management, and public accountability system building. This work is led by a state-local "focus team."

Local Funding Consolidation. Statutory authority for decategorization of state grant programs—and eventually federal assistance—is a natural outgrowth of the local collaboration strategy. During the past year, state-local teams have produced guidelines for local funding consolidation and a model plan based upon an innovative blending of funds by Itasca County. Implementation of this new authority in sensitive local collaborative political environments is occurring somewhat slower than expected.

Integrated Reporting and Performance Measurement Linkages. Work on the several fronts discussed above has set the stage for a new state/local effort to develop pilot integrated reporting systems for several collaboratives, link these systems to the state's performance reporting system, and establish a framework for modifying current state and federal reporting requirements. Work on the Community and State Reporting and Performance Measurement Project will continue over the next 15 months.

Future Plans

Assessing Where We Are. Minnesota has developed a broad organizational and system-building agenda for improving children and family outcomes. This agenda is being undertaken in a rapidly changing, national political environment that may fundamentally alter federal, state, local, and private sector roles. Thus future work in Minnesota is expected to focus on:

- Assessing "where we are" in light of the changing environment.
- Facilitating and providing improved incentives for effective resource utilization.
- Evolving new funding strategies through funding consolidation efforts; promoting collaboration as a strategy to blend funding and services.
- Simplifying and enhancing service and accountability systems.

◇ Continuing state/local governance system building through the family services collaborative initiative.

Changes in Governance Structure. During the 1996 legislative session, the authority of the Children's Cabinet was enhanced when the functions of the State Children's Mental Health Coordinating Council were transferred to the Children's Cabinet. This brought the initiatives together under one governance structure and decision making body. As a result, the children's mental health collaborative initiative activities have become further integrated into the work of the local family services collaboratives. In addition, family services collaboratives are developing mental health components.

Achievement in Future Direction. During the 1995 legislative session, the Department of Children, Families, and Learning received an additional $14.5 million appropriation from the legislature for family services collaborative activities. This appropriation allowed the Children's Cabinet to approve a significant additional number of collaborative initiatives. There are now 54 family services collaboratives, statewide, that cover approximately 90 percent of the children in the state of Minnesota. A number of communities have requested approval as family services collaboratives in addition to these communities.

Challenges to Implementation. Systems-change initiatives continue to be a challenge at both the state and local levels. Challenges encompass the usual obstacles to change, including the reluctance of organizations to give up funds or areas of responsibility. Each distinct professional field has developed its own body of work and principles that guide provision of services. This may include usage of a particular jargon or unique methods of organizing and analyzing work. Working within and among each of these organizations and encouraging collaboration and cooperation requires a significant amount of trust building and time. It will continue to be the challenge of the Children's Cabinet to work with each of these unique organizations and encourage partnerships throughout all levels of government using our state's family services collaboratives initiative as the framework for these systems change efforts.

Response to the changes at the federal level permeate our work at all levels of governance in the state of Minnesota. As the governing authority for the family services collaboratives, the Children's Cabinet continues to build partnerships with local communities and work within this statewide collaboration infrastructure to build a cohesive response to shifts in government accountability and responsibility.

Strategies include the support of a partnership with First Call Minnesota (a nonprofit organization) to develop a statewide infrastructure for information and referral. The partnership knows that families need information about services foremost when they are in crisis. More current and comprehensive information about services will provide us with an improved method of identifying gaps in services, eliminating duplication of services, and building partnerships among service providers. This effort includes the development of a statewide information and referral database and the establishment and support of regional hubs that will keep information current and up to date.

In addition, the Children's Cabinet is working across agencies to develop joint legislative initiatives to allow for more flexible funding through the establishment of block grants or through the submission of funding consolidation plans by local governments. Rather than allowing financing structures to create the service for families, these initiatives will allow communities to integrate services. Financing structures will then be forced to follow the services integration structure. As a part of these activities, Children's Cabinet is working with several local initiatives to establish outcomes-based accountability systems as a part of funding the consolidation plan.

Key contact persons:

Barb Yates, Director
Community Service for Families
Minnesota Department of Children, Families, and Learning (DCFL)
Capitol Square Building, Room 989
550 Cedar Street
St. Paul, MN 55101
(612) 296-9010

Erin Sullivan-Sutton, Assistant Commissioner
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155
(612) 296-24887

Barbara Columbo, Assistant Commissioner
Minnesota Department of Health
Box 9441
717 Delaware Street
Minneapolis, MN 55440
(612) 623-5705

Karen Carlson, Supervisor
Community and Systems Change Team
Minnesota Department of Children, Families, and Learning
550 Cedar Street
St. Paul, MN 55101
(612) 296-4059

Ohio

Essential Elements

Ohio Family & Children First (OFCF) promotes coordination and collaboration among state and local governments, nonprofit organizations, businesses, and parents for the benefit of Ohio's children. Specifically, the initiative focuses Ohioans on achieving National Education Goal 1: By the year 2000, all children in America will start school ready to learn.

OFCF represents a historic first. Never before have the state's education, health, and social service systems and families concentrated together on achieving school readiness. This collaboration is critical because no single system has the resources or the capacity to meet this goal alone.

To accomplish this goal, OFCF focuses on three main objectives: (1) assuring that infants and children are healthier, (2) increasing access to quality preschool and child care for families desiring enrollment, and (3) improving services to aid family stability. To achieve these objectives, the initiative is bringing service providers together to "cut through red tape," increase local flexibility, and refocus programs on families and children. In addition to helping prepare children for school, these efforts are designed to help families overcome barriers to self-sufficiency and improve the overall success rates of state programs. Policy and funding emphasis is on prevention and early-intervention activities that will minimize the need for more costly efforts later.

Current Status

Of Ohio's 88 counties, 77 have either voluntarily created or are now forming an OFCF Council. At the state level, the initiative's coordinating body is the OFCF Cabinet Council, composed of the superintendent of public instruction and the directors of the departments of Alcohol and Drug Addiction Services, Budget and Management, Health, Human Services, Mental Health, Mental Retardation and Development Disabilities, and Youth Services.

The Cabinet Council provides statewide policy leadership and spearheads efforts to streamline state management and redirect funding toward prevention and early-intervention activities. The Cabinet Council also fulfills local requests for technical assistance and determines the viability of "regulation-free zone" waivers requested by the counties.

OFCF's work is accomplished through a cross-agency state team and multiple subcommittees. The subcommittees are composed of individuals representing state agencies, local providers and consumers, public and private organizations and institutions, and business.

The initiative was restructured this spring to renew its focus on prevention and to design support systems that will reduce the need for more costly interventions and help children stay in school and reach their full potential. In addition to hiring a full-time executive director, a state action team, which is composed of loaned staff from seven agencies, has been established to provide the support needed to carry out the work. The Department of Education has three representatives on this state action team. Regional technical assistance teams, which include parents, have been created to facilitate state and local change by renewing partnerships with local agencies.

At both the state and local government level, OFCF builds on and unifies existing successful partnerships, such as the Clusters for Youth with Multiple Needs and the Early Intervention collaboratives. It also opens the door to creative partnerships with nonprofit entities, businesses, charitable organizations, and philanthropic organizations.

At the state level, OFCF has engaged corporate sponsorship to produce one of the largest public health and family support campaigns ever undertaken in Ohio called Help Me Grow. Major corporate sponsors include Ronald McDonald's Children's Charities, McDonald's restaurants, Nationwide Insurance, Pfizer, Inc., and Kroger Food and Drug. Ohio's major state health-care provider associations are also crucial members of this public/private partnership. With respect to Department-specific initiatives, OFCF staff are represented on the Urban Schools Initiative work strands, and connections are being made with the Department of Education's Parent and Family Involvement Initiative.

Next Steps

The Department of Education continues to participate on the Cabinet Council, provide staff on loan to the state action team, and ensure that the appropriate linkages with the Urban Schools and Parents and Family Involvement Initiatives are made.

A new element of the OFCF and Department of Education partnership centers around the development of school readiness resource centers in six of the urban school districts, which will be funded from the $1.8 million appropriated in the state's recent corrective budget bill. Department of Education staff were heavily involved in the design and selection process of these centers and will continue to support their implementation in conjunction with the OFCF.

Primary Source Documents

"The Ohio Family & Children First Initiative: A Record of Results Toward School Readiness," Office of Governor Voinovich, March 1996

"Ohio's Children," a fact sheet, Office of Governor Voinovich, July 1995

Ohio Family & Children First video, Office of Governor Voinovich, 1995

OFCF represents a historic first. Never before have the state's education, health, and social service systems and families concentrated together on achieving school readiness. This collaboration is critical because no single system has the resources or the capacity to meet this goal alone.

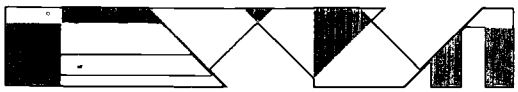
Key Contact Persons:

Jacqui Sensky
Office of Governor
George V. Voinovich
77 South High Street, 30th Floor
Columbus, OH 43266-0610
(614) 644-0973

Jane Wiechel
Ohio Department of Education
Division of Early Childhood Education
65 South Front Street, Room 309
Columbus, OH 43215
(614) 466-0224

Linda McCart
Ohio Family & Children First
77 South High Street, 30th Floor
Columbus, OH 43266-0610
(614) 752-4044

Mary Lou Rush
Ohio Department of Education
Division of Early Childhood Education
65 South Front Street, Room 309
Columbus, OH 43215
(614) 466-0224



Ohio Family & Children First Initiative:

A Record of Results of School Readiness

Excerpted from the briefing from the office of the Governor, March 1996

The Ohio Family & Children First Initiative promotes coordination and collaboration among state and local governments, nonprofit organizations, businesses, and parents for the benefit of Ohio's children.

Ohio has been unique in not only developing true collaboration among its agencies, organizations, and businesses, but also in creating an environment where all persons have a deeper respect for one another and value the contributions that each brings to the table. This has been the best and most important public-private partnership of all. Below are just a few of the accomplishments that the state and counties have achieved through this Initiative.

State Initiative Successes To Date

Family Representation. All Family & Children First committees include family representatives.

Head Start and Public Preschool. Ohio successfully tackled service integration issues vital to enrolling an additional 6,369 children in Head Start in the 1994-95 school year. Ohio leads the nation in state funding for Head Start and leads all major industrial states in the percentage of eligible children in the classroom. Sixty-four percent of Ohio's eligible children now participate in Head Start and public preschool, which also meets the Head Start performance standards. The FY 96-97 Budget funds more than 6,000 additional Head Start slots. By June 1997, over 57,000 Ohio children will attend Head Start and public preschool annually.

Head Start and JOBS Child Care Partnership. Ohio is taking the lead nationally in partnering Head Start programs with full-day JOBS child care programs. This technically and fiscally complex partnership will allow sites to provide children with full-day child care that includes Head Start's educational and social services. This comprehensive care is being provided in both Head Start and child care center locations. Pilot programs are now serving approximately 500 children in Cuyahoga, Franklin, Greene, Jefferson, Lucas, and Lawrence Counties. The FY 96-97 Budget allocates 56 million annually to provide full-day services in this integrated model. This ensures funding for up to 800 children, almost twice as many as currently served.

Drug Prevention with Head Start. The Ohio Department of Alcohol and Drug Addiction Services and Head Start have teamed up to provide drug prevention education to Head Start providers and to parents with children enrolled in Head Start.

Ohio Early Start. Currently, children from birth to age three who are identified with developmental disabilities receive early intervention services. Ohio Early Start allows babies and toddlers and their families, who are identified with significant risk of abuse, neglect, or future developmental delay, to also receive services. A total of $8 million in federal and state funds will serve 2,000 young children in FY 96 and 4,000 in FY 97.

Help Me Grow. The Initiative is launching a public/private partnership around the need for comprehensive prenatal/postnatal and well-baby care for expectant mothers and their babies. The Help Me Grow campaign involves a public education campaign, a wellness guide featuring incentives for health care visits and a comprehensive state helpline that provides information to families seeking local referrals or assistance. Primary corporate sponsors include Ronald McDonald Children's Charities, Kroger Food and Drug, McDonald's Restaurants, Nationwide Insurance, Pfizer Pharmaceuticals, Dayton Hudson-Marshall Field's-Target Stores, and Rite

Aid Pharmacies. First Lady Janet Voinovich serves as Help Me Grow's official spokesperson.

In its first year of operation, 250,000 wellness guides were distributed to pregnant women and families with children under the age of two and the helpline fielded more than 62,000 calls.

GuardCare. The Initiative worked with the Ohio adjutant general to obtain federal approval for National Guard medical personnel to provide preventive health services in underserved areas. Through GuardCare, children receive immunizations, and well-baby and dental care. To date, the Guard has administered 740 childhood series immunizations to more than 400 patients and performed more than 140 vision, hearing, dental, and physical screenings. In 1996, GuardCare will target a medically underserved area for two weekend events providing expanded preventive health services with coordinated follow-up with service providers.

Kiwanis/Rotary Partnership on Immunization. These two community service organizations are partnering with the Initiative and state and local health departments to promote the importance of childhood immunization. This is the first joint project between these service organizations. The organizations will be:

- ◇ Individually reminding new parents about the need for immunizations.
- ◇ Staffing immunizations efforts at county fairs, health fairs, and other outreach sites.
- ◇ Asking organizational members who are medical personnel to staff immunization drives.
- ◇ Mounting educational campaigns, and so on.

Earlier Prenatal Care and Increased Well-Child Care. The Initiative continues to promote early and consistent prenatal care. Of all women receiving prenatal care funded by the Ohio Department of Health (ODH), the percentage of women receiving this care in the first trimester of pregnancy has remained at 67 percent during the last year. This represents a 20 percent increase since the inception of the Initiative. The ODH continues to fund targeted local community projects that help identify pregnant women and secure early and continuous prenatal and well-child care.

Family Stability Incentive Fund. Seventeen counties are now participating in the Family Stability Incentive Fund, a system of incentives to communities to divert children away from unnecessary out-of-home placements. The selected counties have established target diversion goals. In addition, the counties and the state team are working together to determine technical assistance needs of the counties. To participate, counties established intersystem diversion teams to evaluate all potential placements. These teams must have access to pooled community funds to provide the services that can prevent potential out-of-home placements not required for the safety or treatment of the child. Approximately $5.3 million will be made available for this incentive fund in 1996.

Public-Use Facility Licensure. Complex licensing requirements and multiple facility inspections traditionally have proven discouraging and expensive to Ohioans operating child care centers, Head Start classrooms, and so on. A new public-use facility licensure model is being piloted in four local sites (Cincinnati, Toledo/Lucas County, Clemont County, Stark County), and legislation is being drafted for statewide implementation for consideration by the Ohio General Assembly. The new model consolidates and coordinates the facility licensure functions of seven state agencies. These functions focus on the health and safety of a building. This consolidation results in universally agreed-upon standards, dramatically reducing the amount of paperwork, time, and money spent to obtain facility licensure by providers.

LINCCS Computer Project. The LINCCS (Linking Interagency Networks for Comprehensive Computer Systems) project connects computer systems that already exist in several state agencies so that information can be easily and regularly exchanged regarding children from birth to age eight. At the state level, accurate aggregate data without personal identifiers will improve policy development, budget planning, accountability, service delivery design, and evaluation. The privacy of individual children and families will be protected throughout the project. The LINCCS project is a cooperative effort between the Departments of Health and Education and the University of Cincinnati. It is funded for three years by a U.S. Department of Education grant.

Collaborative Early Childhood Centers. Early Childhood Centers have become more collaborative, involving as many as 13 agencies in some communities. Collaborative funding and technical support for these centers involves the Departments

of MRDD, Mental Health, Human Services, and Education. To date, a total of $14 million has been spent on 21 centers.

Family Resource Centers. In 1995, the Initiative awarded $1.2 million to Family & Children First Family Resource Centers in 18 Ohio counties. Several different resource center approaches were funded, including centers that will be school linked, school based, or mobile units. The 18 projects are located in Adams, Ashtabula, Ahens, Belmont, Clark, Clemont, Delaware, Franklin, Greene, Lorain, Madison, Marion, Mahoning, Mercer, Ottawa, Shelby, Wayne, and Wyandot Counties. Grants ranged from $50,000 to $90,000.

Regulation-Free Zones. To date, the state Family & Children First Cabinet Council received 17 requests to waive state regulations in order to permit local project flexibility. Eight waivers were granted, four requests are being facilitated with technical assistance from the state, four requests were denied due to fiscal liabilities, and one request is pending.

Bureaucratic Rule Reduction. In an ongoing effort to eliminate red tape and remove administrative hurdles, the Initiative eliminated just over 14 percent of the rules governing its seven state agencies. As a result of this success, the Governor has challenged all state agencies to reduce their rules by five percent in 1996. Initiative agencies are working to meet this additional goal.

Cross-System Training. As a first step toward ensuring collaboration in cross-training initiatives, all state training grants issued to local jurisdictions now include legal language facilitating the blending of state training funds.

Family Reunion Conference. The Initiative now joins with many other Ohio organizations to host annual Family Reunion Conferences. This Conference, designed for families, provided a forum for families and service providers to exchange information and perspectives on today's issues. More than 750 Ohioans participated in the second reunion held in March 1996.

County Initiative Successes to Date

Participation. Ohio's 88 counties are now creating Family & Children First Councils and are now working cooperatively toward coordinated service delivery. To date, 81 Councils received formal Certificates of Recognition from the Governor.

Service Coordination Plans. All 13 pilot sites have successfully implemented Service Coordination Plans, a breakthrough in coordinating the activities of courts, schools, and social services around the needs of abused, neglected, dependent, delinquent, or unruly children. The plans feature binding local dispute resolution mechanisms. These mechanisms help ensure that children receive necessary services without their families or a local agency having to resort to court action. The Ohio General Assembly has now approved statewide implementation of binding Service Coordination Plans in all counties.

InterSystem Training. Hamilton County is providing new employees of its education, health, and social service systems with information about all services available to families. Employees of nonprofit providers are also participating in this comprehensive orientation training. Lawrence County is also providing cross-system training for support services to families and on the new intake and referral process.

Streamlined Intake/Referral. Ashtabula, Erie, Fairfield, Hamilton, Lawrence, Montgomery, Stark, the Hopewell region, and several other counties are piloting intake and referral systems that eliminate red tape, computerize cross-agency systems, and seek to make more appropriate referrals to families seeking services.

Case Management. Lorain County has developed a single case management, cross-agency focus team that more accurately emphasizes case management as a partnership.

Crisis Response System. Hamilton County is implementing a 24-hour emergency response for families in crisis, regardless of the service system involved.

Next Steps

These are just samples of the good work being achieved by Family & Children First Councils throughout Ohio. Many Councils are working on complex shared financing arrangements and management processes as well as changes at the programmatic level.

Building on this record of success, a number of proposals are under development. The following projects will fundamentally reform existing state systems in order to better meet the needs of children and their families.

- ***Wellness Block Grant.*** Nearly every state department participating in the Ohio Family & Children First Initiative administers various categories of funding available for prevention services. The state is now pursuing a plan to pool prevention funds, which will then be made available to the counties. It will be up to the county to develop and implement local prevention plans as long as the plans address progress in state-defined prevention indicators. The initial focus of the Wellness Block Grant will be the prevention of teenage pregnancy.
- ***System Access.*** The state is taking the lead in developing a common data dictionary to be used by child-serving agencies to reduce unnecessary and duplicative paperwork and/or computer work locally.
- ***School Readiness Resource Centers.*** Building upon the success of this neighborhood service approach throughout Ohio, the Initiative hopes to enhance the Family Resource Centers and Early Childhood Resource Centers in urban school districts.

Wisconsin

State-level coordination between education and human services in Wisconsin centers on the Comprehensive School Health Program (CSHP) initiative. CSHP encourages family-school-community partnerships that include coordination with human services. As part of this initiative, Wisconsin is developing a strong, effective state-level infrastructure supporting CSHP that includes education, human service, and health state agencies. This infrastructure includes personnel and organizational design, funding and authorization, communications and connections, and human and technological resources. Through this CSHP initiative, Wisconsin has developed a common vision for: healthy, successful, resilient learners; a local CSHP that includes collaboration and cooperation among education, health and human services systems; and a state CSHP that includes collaboration and cooperation among state health, human service, and education agencies and organizations.

Also available are CSHP guiding principles, links to education and health goals, and descriptions of the inter-relatedness of four orientations (prevention, health, resiliency, and youth development) that are common among education, human service, and health leaders.

Wisconsin has developed and/or continued to support education-health-human service interagency work groups on Comprehensive School Health Programs as well as on youth health/human service problem areas such as alcohol and other drug abuse (AODA), tobacco use, violence, AIDS/HIV, nutrition, and teen pregnancy. Education staff serve as liaisons to groups that include human service professionals, organizations, or agencies. These groups carry out a wide variety of collaborative and coordinated activities.

Discretionary grant programs, partnership councils, and staff development initiatives support human services coordination at the local level. Grant programs include Family and Schools Together (FAST), which is based on human services-education coordination for families. The AODA Grant Program, based on the CSHP model, encourages coordination with human services on a variety of youth health and safety issues. Partnership councils in 60 counties bring together education and human services professionals (among others) for coordination on AODA and other youth health issues. Some of these councils are well organized into coalitions and formal nonprofit organizations for the express purpose of community-wide coordination of work on youth health and safety issues, especially AODA.

Wisconsin's plans include continuing to develop a strong state CSHP infrastructure that enhances education-human services-health coordination and collaboration. This work will include enhancing interagency communications and joint decision making processes. This will include a CSHP social marketing initiative to be carried out in a coordinated way by education, human service, and health systems.

Wisconsin will develop a model leadership development institute on CSHP for school community teams (including human service and education) and state leaders. Grants for these teams will be provided to support improved coordination within schools and among schools and human services and health. A regional network of technical assistance consultants will be available to support this work, which will include continuing to develop successful models of coordination between education, health, and human services.

Education staff serve as liaisons to a wide variety of groups that include human service professionals, organizations, or agencies. These groups carry out a wide variety of collaborative and coordinated activities.

AODA grant programs will continue to support human services, health, and education coordination, especially in the FAST and AODA program grants.

Wisconsin will also develop a description of key local CSHP efforts and will feature characteristics of coordination among education, health, and human services. State resources supporting CSHP in the human services, health, and education systems will be described. These will be available through the World Wide Web.

Efforts to improve the evaluation systems for CSHP will be coordinated with related prevention efforts in the human services and health systems.

The Wisconsin Department of Public Instruction will continue to participate in state-level efforts to enhance coordination such as state councils, boards, and committees.

Key contact persons:

At the Wisconsin Department of Public Instruction:
Doug White, Comprehensive School Health Program Project Director
Mike Thompson, Team Leader, Student Services/Prevention and Wellness Team
Nancy Holloway, Director, Student Services/Prevention and Wellness Team
125 South Webster Street (zip code: 53702)
P. O. Box 7841 (zip code: 53707-7841)
Madison, WI

At the Wisconsin Department of Health and Family Services:
Jody Diedrich, Interim Comprehensive School Health Program Project Director
P. O. Box 7850
Madison, WI 53707-7850

Other Resources

Melaville, A. I., Blank, M. J., & Asayesh, G. (1993). *Together we can: A guide for crafting a profamily system of education and human services*. Washington, DC: Center for Study of Social Policy; Washington, DC: Institute for Educational Leadership.

North Central Regional Educational Laboratory. (1996). Human services coordination: Who cares?!, *Report No. 1, Policy Briefs*. Oak Brook, IL: Author.

School-linked comprehensive services for children and families: What we know and what we need to know. (1995). Washington, DC: American Association of Colleges for Teacher Education; Washington, DC: American Educational Research Association; Reston, VA: Association of Teacher Educators; Washington, DC: Office of Educational Research and Improvement; Philadelphia, PA: Temple University, National Education Center on Education in the Inner Cities.

Williams, H. S., Webb, A.Y., & Phillips, W. J. (1991). *Outcome funding: A new approach to targeted grantmaking*. Rensselaerville, NY: Rensselaerville Institute.

U.S. Department of Education. (1996). *Putting the pieces together: Comprehensive school-linked strategies for children and families*. Washington, DC: Author.

Reforming Human Services Delivery for Outcomes-Based Accountability

by Robin LaSota, Program Associate, North Central Regional Educational Laboratory, and Evaluation/Policy Associate for the Illinois Governor's Task Force on Human Services Reform

Increasingly, states and communities across the nation seek to measure outcomes, develop accountability systems, and create outcomes-based budgeting systems in order to achieve improved, measurable results for children and families. State and local governments, service delivery systems, and organizations find that it is no longer enough to measure success in terms of hours of service provided, number of people served, or amount of materials distributed.

The increasing emphasis on outcomes and accountability stems from growing recognition across states and communities that (a) current service systems are failing poor children and families; (b) service systems must become much more flexible and coordinated in order to achieve positive outcomes for children and families; and (c) comprehensive, cross-system, and collaborative strategies must build collective responsibility to achieve desired outcomes.

Generally, there are eight primary outcome areas of service integration initiatives:

1. Organizational and systemic change
2. Child and family health
3. Family functioning
4. Child development
5. School performance
6. Youth maturation and social integration
7. Child mental health
8. Economic self-sufficiency (Ingram et al., 1996)

Contextual factors in states and communities—demographics, core beliefs and values, who leads the initiative, and geographic boundaries—strongly influence the design and core outcomes of the comprehensive reform initiative.

Oregon and Minnesota have led the nation in developing state benchmarks or measurable indicators of progress to guide public policies and public expenditures. These goals include improving the health and well-being of children and families, strengthening the quality of life and environment, and improving the state's economy. States such as Colorado, Georgia, Iowa, Missouri, Vermont, and Washington have also undertaken collaborative processes to determine statewide ome measures and can offer valuable assistance in this area.

Advantages of Outcomes Accountability Systems

Some core advantages of "results-accountability" or outcomes-based accountability emerging from research in states and communities leading this effort (Center for the Study of Social Policy, 1996; Schorr, 1994) are as follows:

- Consensus on desired outcomes and acceptance of accountability for those outcomes facilitates collaboration, since one agency or organization cannot accomplish the most important outcomes alone.
- Results-based accountability strengthens the role of local communities in deciding the best strategies to solve local problems and how to use resources effectively to produce desired outcomes. For example, Washington, Oregon, Georgia, Kentucky, Missouri, Vermont, and Illinois have negotiated explicit agreements with communities, providing increased authority over local service delivery in exchange for accountability on measurable outcomes.
- When service providers are rewarded for improving outcomes with additional resources, they are motivated to make continuous improvements in service delivery, which achieve desired results. Moving towards outcomes-based accountability fuels change in budgeting, contracting, and financing processes. Based on these outcomes, resources can be directed at improving core outcomes for high-priority populations rather than generate funding based on tradition or popularity of programs.
- A collective focus on outcomes orients every person in service delivery systems in new roles. Senior state officials shift their role from developing compliance regulations to facilitating the work of local communities in deciding core strategies and outcomes. Front-line workers serve as coaches for families and respond to self-described needs instead of merely doing eligibility determinations and offering prepackaged services.
- Focusing on results helps to clarify whether allocated resources are adequate to achieve the outcomes expected by the funders and the public. Outcomes-based budgeting, for example, can assist in matching program costs to desired outcomes and help to determine whether outcome expectations must be scaled down or intervention investments scaled up.

- ◇ Information about results strengthens community and agency capacity to judge the effectiveness of their efforts and make changes based on timely information on core outcomes.

Challenges in Measuring Outcomes

While there are risks in making the shift to results-based accountability, the stakes for children and families are too high not to proceed. There is bound to be confusion in charting new territory, but it is important to take on challenges, provide leadership, design and implement a strategy, and be prepared to learn from mistakes. Some of the challenges in defining outcomes stems from several issues: (a) prioritizing core outcomes across multiple agencies and programs, (b) looking at outcomes in the context of important factors in agencies and communities, such as core beliefs and values, critical stakeholders and leaders, and demographic factors, (c) determining the best level to measure outcomes given data currently available, and (d) proceeding to develop outcomes without a step-by-step effectively proven process.

Of these issues, "determining the best level to measure outcomes" needs further explanation. There are five basic levels at which outcomes can be measured:

1. The individual client level, e.g., an individual's reading ability, income from work, parenting skills
2. The aggregate of client-level data for program outcomes, e.g., adding up total number of clients who abstain from alcohol/drug use for at least six months after treatment
3. The aggregate of program information for agency or department outcomes, e.g., combining data on outcomes from all programs in the child welfare system such as the reduced number of confirmed child abuse/neglect reports and the increased number of children living in permanent homes, succeeding in school, receiving adequate health care and immunizations, and so on
4. The compilation of agencies' and departments' outcomes for system or community outcomes e.g., the child welfare system, the educational system, the alcohol and drug treatment system, and so on
5. Communitywide outcomes, which measure community conditions as a whole, such as combining indicators of community safety, economic prosperity, health, education, housing, transportation, and so on

(Young, Gardner, Coley, Schorr, & Bruner, 1994)

The use of communitywide outcomes can strengthen consensus building around sharing resources in order to achieve a collective vision for children and families in a community. Sidney Gardner of California State University/ Fullerton characterizes use of communitywide outcomes as a "scorecard" approach to establish local accountability. This approach proposes that communities take responsibility for selecting and monitoring specific indicators of child and family well-being. Such a scorecard can be used to set up benchmarks for agencies and programs and can also serve as a periodic reality check for agencies allocating their own resources.

Framework for Developing Outcome Measures

Even though there is no success formula for using an outcomes framework to guide service delivery, Young et al. (1994) set out a six-part framework in developing outcome indicators within comprehensive service integration initiatives. This graphic depicts the progression of the six elements:

Needs/Assets → Goals → Resources → Activities → Short-term Outcomes → Long-term Outcomes

Defining outcomes of a comprehensive service integration initiative must be seen as an integrated part of an overall agency or community approach to goal-setting, management, and evaluation. Before setting outcomes, there are four questions to consider:

1. What are the most important needs to address in the agency or community and what are the core assets present to address those needs?
2. Given basic needs in the agency or community, what are the key goals you seek to accomplish?
3. What resources are available to accomplish the goals? Are they sufficient? Do they need to be redistributed?
4. Given the resources available, what programs and activities will work to accomplish the goals?

Outcomes must translate into measures or goals agreed upon by some legitimate group representing all the key interests of an agency or community. Outcome measures imposed from outside an agency or community have little or no legitimacy, which necessitates a local consensus building process around the outcome measures linked back to needs, goals, resources, and program activities. Once there is a shared understanding of all these elements, a collaborative group can take on the responsibility of defining and using short-and long-term outcomes to improve programs and achieve positive results.

Guidelines for Developing Outcome Measures

Drawing on the model of outcomes development proposed by Young et al., University of Minnesota researchers Ingram, Bloomberg, and Seppanen (1996) offer the following guidelines:

Concentrate on outcomes and indicators that relate directly to the key program elements of the service integration/reform initiative. Exclude indicators beyond the scope of an ini-

tiative, yet consider what the primary needs and issues in the community are, and then focus on implementing the program elements to influence them. For example, if a primary community need is reducing teen pregnancy, the community may design a program with a school-based health clinic, sexuality education in schools, teen parent programs, and other supportive services to influence core indicators of teen pregnancy reduction: increased use of contraception, reduction in repeat teen pregnancies, increased graduation rate among sexually active and pregnant teens, and so on.

Specify intermediate or short-term indicators that demonstrate progress towards longer-term goals. For example, data regarding the rates of timely and complete immunizations is a short-term indicator of the incidence of communicable diseases (long-term indicator). For instance, Iowa has developed a three-tier system of indicators: benchmarks (5- to 20-year goal), state priority areas (3- to 5-year goal), and program performance measure (1- to 2-year goal).

Be realistic about timelines. It takes time to affect community conditions that have developed over many, many years.

Prioritize which indicators to use, while adequately representing the status of children, families, and the service system as a whole. The number of indicators must not be so large that required data cannot be easily collected and reported by local collaborative sites.

Conclusion

This work is not without challenges, largely because it is experimental and comes at a time of intense public scrutiny about public dollars for education and human services. States and communities are immersed in developing increasingly sophisticated and comprehensive prototypes for new service delivery systems, and it takes a lot of trial and error to fine-tune those systems. As Charles Bruner of the Child and Family Policy Center points out, "In the effort to improve outcomes through new service delivery approaches, we are not simply replicating a proven technology. This is not rocket science—it is much easier to precisely guide a piece of metal through space than to predictably nurture family growth and development."

There are many unanswered questions as states and localities make the shift to "results-based accountability." What are the most meaningful and measurable indicators of child and family well-being? How will states and communities use outcomes data for decision making, and how can misuse of data be prevented? What systems and strategies will effectively hold institutions accountable for achieving defined outcomes? The experimentation and reform efforts occurring across states and communities provide useful answers to these questions as well as raise new questions.

While daunting, reforming service systems to be outcomes-[illegible]n, community-based, family-focused, prevention-oriented, flexible, voluntary, comprehensive, and consumer driven has become the new way of "doing business." While such reform holds great promise to achieve positive outcomes for children and families, there is no panacea. Every state and community must shape its own future, even though social, economic, and political forces strongly interact with the leadership and ideas across states and communities. On the road to reform, we must continue to learn from each other's trailblazing efforts and continuously document the many milestones we achieve.

References

Center for the Study of Social Policy. (1996, August). *Beyond lists: Moving to results-based accountability.* Washington, DC: Author.

Ingram, D., Bloomberg, L., & Seppanen, P. (1996, March). *Collaborative initiatives to develop integrated services for children and families: A review of the literature.* Minneapolis, MN: Center for Applied Research and Educational Improvement, University of Minnesota.

Schorr, L. B., Farrow, F., Hornbeck, D., & Watson, S. (1994). The case for shifting to results-based accountability. In N. Young, S. Gardner, S. Coley, L. Schorr, & C. Bruner, *Making a difference: Moving to outcome-based accountability for comprehensive service reforms* (pp. 13-28). Des Moines, IA: Child and Family Policy Center/National Center for Service Integration.

Young, N., Gardner, S., Coley S., Schorr, L., & Bruner, C. (1994). *Making a difference: Moving to outcome-based accountability for comprehensive service reforms.* Des Moines, IA: Child and Family Policy Center/National Center for Service Integration.

Glossary of Terms

In undertaking any large-scale reform effort, new terms can get confusing. The Center for the Study of Social Policy (1996) offers some guidance in defining key terms.

Goals, Outcomes, or Vision: A general, desired condition of well-being for children, families, or communities (e.g., children and youth succeeding in school, economically self-sufficient families, safe families and communities)

Benchmarks, Indicators, or Results: A measure, for which data are available, to help quantify the achievement of the state's goals and outcomes (e.g., number of children achieving above grade level in reading and math, percentage of families living above the poverty level, rate of crime in communities)

Program or Performance Measures: A measure of the effectiveness of an agency or of a program's service delivery (e.g., number of people in job training programs who receive jobs, number of foster care children placed in a permanent home, number of children who are fully immunized by age two)

Process Measures vs. Outcome Measures: Process measures refer to measurements of service delivery (e.g., increase number of participants in a specific program, increase consumer satisfaction with agency services, reduce number of people on waiting lists for services). Outcome measures refer to measurements of whether programs have resulted in outcomes for children and families (e.g., reduced teen pregnancy, more people staying in jobs, reduced alcohol/substance abuse)

Performance Targets: A specific projection for an agency or program in meeting a defined goal or outcome, for which data is available (e.g., reduce teen pregnancy in Cook County by 30% by the year 2000; increase number of public aid recipients who obtain and retain jobs for one year or more by 25% in 1997)

This *Policy Report* is a publication of the
Evaluation and Policy Information Center (EPIC) of NCREL.

Policy Report

North Central Regional Educational Laboratory
1900 Spring Road, Suite 300
Oak Brook, IL 60521-1480
Telephone: (630) 571-4700
FAX: (630) 218-4989
E-mail: info@ncrel.org
Internet: http://www.ncrel.org

Jeri Nowakowski, *Executive Director*
Nancy Fulford, *Editor, Policy Report*

NCREL

North Central Regional Educational Laboratory
1900 Spring Road, Suite 300
Oak Brook, IL 60521-1480

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement (OERI)
Educational Resources Information Center (ERIC)

ERIC®

NOTICE

REPRODUCTION BASIS

☒ This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.

☐ This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").