

A Discussion on the Evolution of DHS

Recently, we sat down with DHS Director Marc Cherna, Executive Deputy Director for Integrated Program Services Pat Valentine and Integrated Programs Initiatives Manager Walter Smith to discuss their vision for the future of DHS. The following interview, while lengthy, discusses many important developments within DHS and attempts to provide some insight into what these developments mean for the continuing evolution of the Department. A general overview of the topics discussed here can be found on the DHS website in a new section on Advancing Integration.

When DHS was created in 1997, the public helped craft a vision of an integrated human services system for the county. How far have we come to achieving it?

Marc Cherna (MC): We've come a long way, but we still have a long way to go. Day to day, sometimes I look at things and say "there is so much left to do," but when I look back to where we were 16 or 17 years ago, an awful lot has happened. In fact, just this morning I took a call from a director from another county who is considering forming a human service department. He told me they'd read the history of our redesign on our website and said "This is amazing. How'd you do this?" It causes me to think about how much time it's taken, but also that we've really made great strides in Allegheny County.

It seems that we are re-focusing on integration at this time and especially looking at what we can do to support programmatic integration. Why now?

MC: We've always wanted to focus on programmatic integration, but first we really had to do the structural pieces. We've consolidated some common functions and are robust with our administration/information management and with our communications. We're really moving on data analysis and structurally getting it supported to the degree we need. We're also looking again at common functions that cross the Department –such as planning, policy development and monitoring.

We've had a few things change over the last couple of years that have given us opportunities to direct more energy to programmatic integration. First, we had approval to fill an executive deputy job for integrated program services – which Pat is now in. This is advantageous because one person is now responsible for all DHS programs and services and is poised to really drive the integration. Another huge opportunity has come from the state. Their creation of a block grant, bringing together seven categorical funding sources, gives us much more flexibility than we ever had. In addition, Pennsylvania's participation in the Title IV-E Waiver from the federal government is another opportunity for us since we are among the participating counties. Both of these give us a lot more flexibility and ability to integrate programs. Our direction aligns with

both the state and feds. The federal government is really encouraging collaboration, coordination and integration, most especially in supportive housing.

Pat, what are your priorities now that you've had a year to assess and begin planning? What have you focused on during this year?

Pat Valentine (PV): Well, I think it is important that DHS acts as one department as opposed to various service offices and various units within those service offices. That's a shift for us in terms of program because everybody is sort of used to doing their own thing: mental health does it this way, child welfare does it that way, aging does it that way. Adopting shared, common practices is something we are going to have to build up to, so – in the immediate future - we are focusing on the infrastructure of programming and on examining other common functions at DHS. We're looking at making our monitoring of our funded provider agencies more consistent and as streamlined as possible across DHS. One of the things that I've heard consistently from our provider partners over the years is just how often they are reviewed, and often it is done by different offices within DHS. Also, the state monitors – separately from DHS – if the service is licensed, and then, if it's a Medicaid service, Community Care Behavioral Health conducts a review, too. Providers feel as though they are constantly hosting – or as some of them have said 'baby-sitting' – the people who are evaluating and monitoring. What we want to do is begin to really look at how do we streamline monitoring? How do we make it consistent? How do we make it objective as opposed to subjective?

Coordinated planning is another huge area for us to tackle. Up until now, the various offices and even units within the offices have planned pretty much in isolation. What we want to do is have an overarching DHS plan that the other plans emanate from. We also want synergy among those subset plans as they relate among themselves and to the DHS plan.

The creation of policies and procedures is another infrastructure area. Presently, each office writes its own policies and procedures. We want our policies to be DHS policies. Of course, they may relate to a certain area, but each will still be a DHS policy or DHS procedure rather than a specific office policy or procedure. Finally: training. We've got some excellent training opportunities for staff within parts of DHS that up until now have not been available to people in other parts of DHS. We want to make sure that appropriate training opportunities are available to all DHS staff and that we make appropriate training available to providers and others with whom we're working.

So, these trainings aren't going to just affect DHS staff? This will eventually also influence the way services are provided by our provider agencies?

PV: Correct. Much of what we're doing on the service side with the common assessment and common service summaries is trying to look at the DHS experience from a consumer's or family's point of view.

We need to ask ourselves: what would we want our experience to be? We would not want to have to repeat ourselves over and over. If we were involved in multiple services, we would not want to be pulled in different ways and not be offered services in an integrated fashion. We are moving – and moving pretty quickly – to try to assure that there is a common assessment and a single assessment and that we are integrating our services through Family Team Conferencing (FTC).

This relates to a process that we've gone through with about 50 DHS senior managers to define and embrace a universal practice model and identify the practices that we feel are important to make more universal so that we can serve people in a much more comprehensive and standard way, correct?

PV: That's right. And part of the DHS practice model relates to ideals and philosophies, but if you go beyond those, how do you translate those into action? Into reality? That's where we need a common assessment and an integrated planning process for any individual or family in need. Of course, that doesn't mean that everybody will need to go through this process. Some people who may just be coming in for something that may be relatively simple may not need a Family Team Conference, but others may really benefit from it. We want to make sure that it is offered to them and available to them.

At what point in the service continuum might it be offered?

PV: It's really going to depend because various services operate very differently. For instance, within child welfare, we start the process here within DHS. Within mental health or drug and alcohol, it's done through providers. What we want to do is make sure that Family Team Conferencing is employed.

So, Family Team Conferencing will be used at the provider level as well if it's appropriate?

PV: Yes, if it's appropriate. It's going to take a while to get there. We're starting internally first. What I can say is there are some providers who are very anxious to be trained on FTC and who really see the potential benefit of this.

Could you elaborate on Family Team Conferencing and how is it different from Family Group Decision Making (FGDM) that has been used in child welfare over the past decade?

Walter Smith (WS): There are some important distinctions between them. Family Team Conferencing is a planning process that involves engaging the family and involves organizing services around the goals and needs that families identify that they have. In that vein, it's very similar to FGDM. With Family Group Decision Making, the planning meeting happens once. In Family Team Conferencing, these meetings happen continually throughout the time that families are engaged in services. Gathering will occur regularly, but also any time that the plan needs to change. With some families these changes occur pretty often – a child returns from

placement, a family member is hospitalized or an illness arises in the family. In those situations, there is a need to re-gather and really re-form that plan. So, how often folks gather is an important difference. Another difference is that with Family Team Conferencing, the caseworker, the case manager and the in-home staff who first engages the family will all be trained in FTC methods. These professionals are the facilitators. We will be employing staff we already have to accomplish our work through conferencing. So, Family Team Conferencing is not a service that you refer to, it's how you do the work. It's what we do the first moment we engage families, and that is fundamentally different from High Fi Wraparound or Family Group Decision Making. Right now, those are referral services. And because Family Team Conferencing will be used as a platform for integration, all kinds of service providers can be at these meetings and services can be integrated. It's also less costly, and the cost issue isn't a small issue. It's an important issue.

MC: One of the important distinctions right now between FTC and FGDM is that FGDM provides a meaningful opportunity for a family to gather and discuss their family matters privately, without professionals present. That 'private family time' is very important and valued by all participants in the process – family members and professionals alike. At this point, we employ multiple models of conferencing with families: there are Family Team Conferencing, Family Group Decision Making, and High Fi Wraparound. Our task, as we move forward, is to make sure we offer the right methodology to individuals and families to meet their needs. We are still figuring out how all of this fits together, but the key is that we are going to be employing a team approach for most of our residents - individuals and families - who need services. The FGDM approach of a private, family-only, single meeting may work to prevent folks from formally entering our service system or may be good at the end of involvement. It might work outside of child welfare, and our Block Grant may permit its utilization in other service areas. The important thing is that DHS is committed to engaging those in need of services and committed to employing an integrated team approach whenever appropriate.

PV: I agree there are opportunities in other service areas for Family Group Decision Making. I'm thinking right now of a man who's been in the intellectual disability system for many, many years and who has recently had to go to one of the Kane nursing homes for care. He's got – due to the death of his parents and his brother –very limited family supports. Certainly, he doesn't need ongoing care since he's at Kane. But, it would be advantageous to have one Family Group meeting to explore and to plan who would be able to support him and those who presently serve as his nuclear support. Other extended family members might be able to provide a little relief for them. The family doesn't need repeat teaming, but could use one good private meeting to talk things through.

WS: The goal of our system in terms of self-reliance is really trying to support families doing as much as they can themselves and our not substituting roles that we can provide as professionals for what can naturally occur in families.

Are there other current DHS practices we are looking to employ more universally?

PV: The other one I would like to mention is Family Finding. Many individuals who are served by DHS wind up being isolated for one reason or another and do not have many family or natural support connections. This may be because family can't support them anymore; family members die; or even in the case of transition age youth, the youth might have been isolated from their family and not formed other natural connections. We believe that nobody should only be supported by people who are paid to support them. So, one of the things that we are going to be working on across DHS is to offer Family Finding to more people. It will assure them they've got natural supports that they can lean on and who, conversely, can lean on them from time to time for all of life's normal things, from holidays to crises. We really want to assist people to increase their pool of natural supports. And even though it's called Family Finding, it goes beyond family. It's not just blood or legal family. These can be friends. It can be people who have a meaningful place in that person's life.

So, Family Finding will not to be used just for placement in child welfare and it will not be used just for children?

PV: No, it will be used throughout DHS. It can be a very valuable tool for placement of children, but it can also be a very valuable tool for kids who are transitioning out of the child welfare system or who are in the children's mental health system and who, like all of us at that point in our lives, need natural supports for "Where do I go for Thanksgiving? How do I find out if I have family history of this disease or that disease? Where can I find this family recipe? How do I buy a car?" We want people to have access to all of those kinds of everyday supports.

MC: It also fits for folks who are homeless to try to find long-lost relatives and supports for them. It might assist seniors who are struggling to stay in their home. Assisting individuals to identify all of their natural supports will help in all areas of our service system.

Will Family Finding complement our teaming efforts?

WS: Yes, as we begin to engage and meet individuals or families for services, it will be an ideal place to utilize Family Finding. It might be the case that early on, the caseworker or case manager recognizes that an individual is really cut off and isolated from a large, extended support system that could be available to them if only the individual knew who those persons were or knew how to find them. Family Finding would facilitate that reconnection.

WS: I would like to add another practice we currently employ: FDC – Family Development Credentialing. It certainly cuts across many service areas that we have and really assures we have a whole program to develop the skills and abilities of key staff in every area to provide essential services to families.

We've talked about common practices to be employed and I am wondering if there are any strategies DHS employs that are important to underscore?

WS: We have a vision to reduce the barrier and the distance between services and the community that we are serving. There are a lot of strategies to do that. One, of course, is to continue to embrace our consumers in our planning processes and our design processes as we move forward. Another is hiring people who formerly were involved with services, like our Youth Support Partners. We fund Allegheny Family Network, an entire nonprofit organization that supports the work of families and is run by family members. Beverly Jewel Wall Lovelace hires people who live in communities to actually do the work. We want to continue employing strategies that reduce the distance that can exist in so many places between the professional services and the community, and recognize that we are one interlocking relationship in which sometimes we ought to be guided by the people that we are serving and we ought to be using their abilities or experiences in the services that we provide.

MC: True. We will continue, as we have in the past, to look for opportunities to reduce the 'distance.' We also fund PSAN, peer support folks in the drug and alcohol field, and those involved in homeless outreach....

PV: Yes, we offer various behavioral health recovery supports: message carriers, peer support network, and we provide some support also to NAMI Southwest. Again, along with support, NAMI provides CART, the Consumer Action Response Team, which does our consumer satisfaction work in mental health. There are many ways that we can support those who are currently in the system though the skill of those who have been in the system.

So Marc, you talked about the creation of the Office of Integrated Programs and Pat's position. Are there other structural or staffing changes you have recently made or are planning to make?

MC: Walter Smith was brought on as integrated programs initiatives manager to help design and implement integration strategies, implement FTC and lead DHS training efforts. Also, we are currently building more capacity in, strengthening and broadening the projects of our Quality Assurance (QA) unit. We want QA to be much more robust across our department. We need continuous quality improvement. Given the importance of planning that Pat talked about, we need to have a locus of responsibility; someone responsible for coordinating all of these planning efforts. Right now, we have planners in every office, but no one coordinating and

ensuring we work together. The same thing goes with policy and procedure development. We need someone to lead and coordinate these policy development efforts.

We've been concentrating on our analytics now that we have much better data and a more robust system. We're looking at much more in terms of analyzing who we're serving, how we're serving them and our outcomes. Ultimately, we want to get to predictive analytics around these so we can, based on populations and based on risk factors, help drive how we deliver services. We're looking at performance-based contracting and hopefully will have that going within a year starting with placement agencies in children and youth, but ultimately expanding the whole piece. That's a big change. And we're looking at our programs, especially our in-home parenting programs. Much of this is a result of the IV-E Waiver. We're looking at what's working, what's not, what we need to eliminate and what we need to do differently. We are seeking good, evidence-based programs that may help improve our outcomes.

PV: We have some exciting changes happening with training we have not as yet discussed.

WS: We are forming a Family Team Conferencing Institute which is really going to be responsible for driving out the competencies and skills for all of the staff involved in Family Team Conferencing. Beginning with this institute – and eventually with all areas of training – we want to implement consistent competency training. Such training is going to drive our utilization of common practices. The fundamental model that we're going to use to try to improve practice is didactic training of skills coupled with continuous coaching over some period of months to make sure that people acquire skills. With Family Team Conferencing, we're hiring coaches to be part of the institute to follow staff for a number of months to ensure they really acquire the skills necessary to be good facilitators or good coaches. That's one level of training we are looking at. The second one is DHS taking more of a leadership role on some global training issues that affect our county. For example: mandated reporting. We think we should figure out some ways in which we begin to make sure that there is good, accessible training – that I think ought to be culturally competent – for mandated reporters to learn under what conditions they are responsible and accountable to do reporting. We are looking at training on other evidence-based practices: a trauma-focused cognitive behavioral therapy for example. With those sorts of trainings, we have to begin to think about how to assure that all who work with families – DHS staff and provider partners – have good, fundamental skills.

What can staff and providers do to be ready for these changes?

MC: Well, I would hope, first of all, that people understand that it's not really so much a change, as an evolution. I think that our community-derived vision and our guiding principles are solid and are still what drives what we do. We just keep trying to move forward. This is a journey and no jurisdiction across the country has figured it all out. Taxpayers pay our salaries, and they have a right to demand excellence and receive excellence. That means that we've constantly got to be looking forward to improve how we do business. We hope staff and providers are excited by that, buy into it and operate accordingly. We hope that more and more staff don't identify themselves by their unit or program office

or by their categorical funding, but look at us as the Department of Human Services in a holistic way. We're all part of a whole and each of us do our part – whether in a direct service or in a support capacity – to improve service delivery to people. I don't see it as anything brand new, but think of it as the next step in the evolving process to continually improve our service system

Our funded provider agencies are invaluable partners in this evolution. 88% of our funding goes to the providers to deliver services, so a huge bulk of what happens in delivering services and meeting our vision and guiding principles lies with them. Our providers are critical to this. Their successes become our successes and their failures become our failures.

Do you have any final thoughts?

MC: We are currently in a funding environment where there are fewer resources. We've had periods of growth in the past and we are now in a period of contraction, yet the demand for our services keeps increasing. Our challenge is how do we continue to meet the needs of our residents and continue to improve how we meet those needs with fewer resources? It means we have to think more creatively. We have to think a little differently and be willing to change how we do business. Ultimately, we have to really be accountable for what we do and be good stewards of our funds.

PV: I asked staff at our last management meeting whether any would like to practice in human services the way we did 20 years ago. Nobody said, "I would!" We've evolved over the past 20 years and need to continue to evolve. Otherwise, we'll be left in the dust and, more importantly, our consumers will be as well.