Collaborating across systems for program implementation

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Introduction

Successful implementation of cross-system interventions that link or integrate services (e.g., clinical pathways or service cascades) often depends on strong collaboration between public agencies and private community based organizations in different systems. There are many ways to collaborate across systems and each type of partnership can serve a different goal. The Collaborating Across Systems for Program Implementation (CASPI) Toolkit was developed to help support your collaboration decisions. Use Parts 1, 2 and 3 of this toolkit as stand-alone sections or jointly—whatever meets your organization's needs. If using electronically, you may click on the section links below to navigate.

TOOLKIT PURPOSE

The purpose of this toolkit is to introduce collaboration strategies, which we define as ***methods for aligning organizational operations and services***. These are actionable strategies for building and maintaining collaboration between children services and behavioral health organizations to implement cross-system interventions. This toolkit was designed to offer practical guidance on selecting an approach to collaboration, specifying the terms of a partnership agreement, and engaging external support for cross-system collaboration. We offer examples of how these collaboration strategies can be used by implementers including agency leaders, administrators, and technical assistance providers.

TOOLKIT STRUCTURE

The CASPI includes three sections that cover different elements of collaboration:

- **Part 1 — Collaboration Strategies for Implementation.** This first section describes seven specific strategies for collaborating across public agencies and private organizations. These strategies are used for staffing, promoting service access, and aligning case plans.
- **Part 2 — Developing Formal Partnership Agreements.** The second section is a step-by-step guide for using formal partnership agreements (e.g., Memorandums of Understanding, contracts) to support effective collaboration. We include key considerations for planning, designing, managing, and evaluating formal partnerships.
- **Part 3 - Engaging Behavioral Health Boards.** The third section describes ways of engaging regional boards in implementation to help align systems and support collaboration.

DEVELOPMENT PROCESS

This toolkit was developed based on research on cross-system collaboration and implementation of Ohio START (a cross-system intervention linking public children services and private substance use treatment). To illustrate how each strategy can be used, we offer a practical example based on Ohio START implementation. We also draw on existing knowledge about best practices, and a series of workgroup meetings with experts from the community and implementation scholars to describe how these strategies might lead to better implementation. As new knowledge is generated about collaboration and implementation, it is likely that this toolkit will be updated and adapted.

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Guide to acronyms

Alcohol Drug and Mental Health (ADAMH)	County-operated, state-supervised authorities or boards that plan, evaluate, and fund MH and SUD services. These boards contract with BH providers for their services in prevention, treatment, and recovery support for local communities.
Behavioral Health (BH)	An individual provider or organization that offers evidence-based interventions for the treatment of mental health issues and/or substance use disorders.
Child Welfare (CW)	An agency that provides child protective services.
Family Peer Mentor (FPM)	An individual in long-term recovery with previous children services inolvement. A FPM provides recovery coaching and support navigating the PCSA system to families.
Mental Health (MH)	The emotional, psychological, and social well-being of an individual.
Ohio Sobriety Treatment and Reducing Trauma (Ohio START)	An evidence-informed children services-led model that brings together caseworkers, behavioral health providers, and family peer mentors into teams dedicated to helping families struggling with co-occurring child maltreatment and substance use disorders.
Public Children Services Association (PCSA)	A public county-based agency that provides child protective services.
Substance Use Disorder (SUD)	Occurs from a recurrent use of alcohol and/or drugs that impairs an individual's behavior, mood, and actions and negatively interferes with life activities. Also called drug addiction.

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Collaboration strategies for implementation

What are collaboration strategies for implementation?

Implementing cross-system interventions or models depends on strong collaboration between organizations in different service systems. *Collaboration Strategies* are specific ways of aligning program operations and services across systems.

HOW DID WE INVESTIGATE COLLABORATION STRATEGIES?

With a subset of 17 counties that are implementing a cross-system intervention that links child welfare and substance use treatment systems, we gathered information from (1) formal partnership agreements (e.g., contracts, Memoranda of Understanding), and (2) 48 small group interviews with 104 staff from child welfare agencies, behavioral health providers, and regional behavioral health boards involved in implementation. We identified 7 strategies and used the data to describe each. Then we held a series of meetings with leaders from child welfare and behavioral health systems, intervention developers, and implementation scientists to review each strategy, their definitions, how they can lead to stronger implementation, and considerations for their success.

WHAT DID WE FIND?

Organizations used 7 different strategies to accomplish 3 main functions during implementation. These strategies are used by professionals in leadership, supervisory, and front-line roles:

Function	Strategy	Who uses it?	Potential impact
1. Staff the model	Contract for expertise	•Agency leaders • Procurement • HR staff	• Increase organizational capacity • Enhance feasibility
	Co-locate staff	• Agency leaders	• Improve relationships and interactions • Improve fidelity
	Joint supervision	• Supervisors	• Build staff skill • Enhance support • Improve fidelity
2. Promote service access	Expedited access agreements	• Agency leaders	• Shared understanding of processes • Improve fidelity • Timely service access
	Referral protocols	• Supervisors	

Function	Strategy	Who uses it?	Potential impact
3. Align case plans	Shared decision-making meetings	• Supervisors • Front-line staff (with buy in from leaders)	• Facilitate information sharing • Build buy-in and consensus • Enhance acceptability with families • Enhance family centeredness • Improve satisfaction • Improve fidelity
	Sharing data		• Facilitate information sharing • Improve fidelity

PHASES OF IMPLEMENTATION

Throughout this module, we describe when these strategies might be used during implementation. We refer to four phases of implementation work:

1. **Exploration:** implementers consider community needs, identify the evidence-based interventions that best fit, and decide whether to adopt.
2. **Preparation:** implementers explore the barriers and facilitators of implementation, consider the need for adapting an intervention, and develop an implementation plan or blueprint. This work often culminates with staff training.
3. **Implementation:** implementers initiate the new intervention, and the first families are served. Implementers monitor progress, problem-solve issues, and make adjustments as needed to help make the new intervention part of every-day care.
4. **Sustainment:** the new intervention continues to be delivered with fidelity to benefit the community.

For more detail, visit episframework.com

NOTES

Collaboration strategies to staff the model

Organizations might collaborate in three ways to staff the model.

I. CONTRACT OUT FOR EXPERTISE

Contracting out for expertise involves outsourcing a staff role needed to implement a particular model to another organization. This entails an agreement that the staff person in this position is employed by another organization for purposes of supporting the model in the focal organization.

Specific application example:

Child welfare agencies outsource the family peer mentor position to their behavioral health partner. The behavioral health organization is the employer of the family peer mentor, although responsibility for hiring/supervision/administration of the family peer mentor position is shared by both the child welfare and behavioral health partners.

> *"So out of necessity, we were looking for partnerships within the community to provide some of the services that we were no longer able to provide the families, based on a lack of personnel."*
>
> - Public children's services agency in a small county

> *"It worked out really well too when we were recruiting for a family peer mentor … in [the behavioral health organization's] capacity they provide with peer mentoring services for recovery across multiple counties, and so it was helpful … because they already knew who was engaged in the recovery community and who wasn't."*
>
> - Public children's services agency in a small county

How does this strategy lead to better implementation?

Organizations contract out for specialized staff to secure the needed capacity/personnel to deliver the new model. In some instances, contracting out allows an organization greater flexibility in hiring and qualifications, and brings in expertise around hiring, supervising, and supporting this specialized position. This can lead to securing and retaining a qualified candidate who can implement the model with stronger fidelity. Contracting out could help organizations work around hiring restrictions (e.g., limitations on the number of full-time employees), lengthy job search procedures, and tap into new resources (e.g., funding if a partner is able to bill for services) leading to quicker model launch and fidelity. Contracting out also provides greater flexibility to organizations which could improve perceived feasibility (although perhaps might affect long-term sustainment).

When is this strategy used?

Contracting out for expertise might be used for the entire duration of a model's use and sustainment. During Planning, the details of the arrangement should be included in the contract or partnership agreement. During Implementation and Sustainment phases, the arrangement might be revisited quarterly and renewed annually.

What key considerations might affect the success of this strategy?

- Engage human resource professionals in conversation and planning.
- Develop a specific job description; these details can be included in the contract or Memorandum of Understanding or as attachments.
- Strong and detailed agreements are important because difficulty hiring and supporting a staff position has potential to harm families and the reputation of your model in community.
- Contracted staff might have difficulty tapping into all the resources and benefits offered to your employees. This might affect staff retention. Hiring staff expertise in-house instead might provide greater model stability in the long term.
- Behavioral health or healthcare partners might be able to bill insurance (e.g. Medicaid) for some services provided, that others are not.

II. CO-LOCATION

Employees from a partner organization work within another organization and are provided the same organizational resources/supports as other employees (e.g. desk, building access) to facilitate intentional interaction and communication among staff within and across organizations. Co-location is considered the foundation that helps move toward more seamless coordination and integration.

Example application:

A Family Peer Mentor employed by a behavioral health organization physically works in the child welfare office and is treated the same as an employee of the child welfare organization. The family peer mentor has their own designated space and equipment near their caseworkerpartner. they also have access to data and information systems to support close working relationships with their caseworker partner.

> *We have one primary provider of substance use disorder treatment, that is who employs our family peer mentors. However, our family peer mentors are co-located in our offices with the child welfare team. They spend more time here than they do in their technical employer's office. I think our onboarding of family peer mentors, the joint, we've done a lot of dual or joint job descriptions, evaluation, interviewing. We do a lot of joint meetings and supervision. I think that has gone very well.*

- Public children's services agency in a small/medium county

> *Each new family peer mentor has brought in some new energy, which is awesome... I treat them the same as I do any other case worker from Children's Services so we don't limit our affiliation or our close contact with just [this program].*

- Public children's services agency in a large county

How does this strategy lead to better implementation?

Co-location could align model staffing and build interorganizational teams. Bringing individuals into closer proximity with one another enhances access to partners and stimulates interactions among them so they can build trust and strong working relationships. This teamwork/collaboration should lead to information sharing, alignment of case plans and treatment approaches, and ultimately strong fidelity to the model.

When is this strategy used?

Co-location is begun in the Preparation phase and continued during Implementation and Sustainment. Co-location happens daily.

What key considerations might affect the success of this strategy?

- Physical space of co-located staff should be in close proximity with the staff they are expected to collaborate with (i.e., same building, same floor, same time).

- Physical space and close proximity are critical but not sufficient for strong alignment; leaders might also need to take additional steps to fully integrate co-located staff into the organization (e.g. set expectations for staff meetings, invitations to social events).
- Co-located staff should be treated equally with other staff (potentially to avoid power differentials and promote strong collaboration).

III. JOINT SUPERVISION

Supervision for a staff person is delivered by individuals from more than one organization. This supervision might be delivered at the same time or separately; specific types of supervision might be split across organizational supervisors.

Example application:

The family peer mentor is supervised by both the child welfare agency supervisor and the behavioral health supervisor. The child welfare supervisor typically offers day-to-day supervision on child welfare case work whereas the behavioral health provider delivers specialized peer support supervision. The behavioral health supervisor might also be designated with administrative supervision if the FPM is employed directly by the BH agency. In theory, regular review of cases with the caseworker-family peer mentor dyad could be done jointly by CW and BH supervisors (although this is not the norm).

> *"Co-supervision — that is something that we're working toward as well that is one of the START fidelity models. The point and purpose of having the co-supervision is so the peer mentors and the staff members working closely with the agencies have a better understanding of the standards and procedures and the practice of CPS, for example, works very differently than [behavioral health partner] and vice versa. So it's again, just to bring everybody up to a common understanding."*
>
> **- Behavioral health provider in a medium-sized county**

How does this strategy lead to better implementation?

Clinical, educational, and administrative supervision delivered by supervisors in multiple systems improves staff skill/capacity to implement an intervention which could lead to strong fidelity. Joint supervision also builds a team and support system for staff — this promotes trust and role clarity which could help reduce staff turnover/improve staff retention, prevent discontinuation/promote sustainment, and expand the model's reach.

When is this strategy used?

Joint supervision should happen at least monthly per fidelity standards. Support should be always available ("drive by" supervision) and is likely to vary across organization.

What key considerations might affect the success of this strategy?

- Role clarification: make sure both supervisors understand the role of the staff person.
- Develop a formal written joint supervision plan to ensure shared expectations.
- Emphasize strong relationships between supervisors based on trust and communication.
- Supervisors will need to be familiar with the roles and skills of the partner agency.
- Consider how to align organizational, system, and licensing requirements for supervision.

NOTES

Collaboration strategies to promote service access

I. DEVELOPING FORMAL AGREEMENTS TO EXPEDITE SERVICES

An explicit and formal agreement between two organizations to provide services to one another's clients to implement a new model in a particular way, for a specified price/term, and other conditions.

Example application:

A contract or Memorandum of Understanding (MOU) between the child welfare agency and behavioral health partner that details how the behavioral health organization will deliver treatment to participants within a recommended timeline, and in a collaborative way with the child welfare agency. Having a formal agreement can help solidify and institutionalize the agreement so that collaboration continues even if staff and circumstances change.

> *"We signed the contract probably right before [the program] was getting ready to get started just to be a newer health provider of theirs in which we would prioritize their referrals. We'd get assessments done within a certain timeframe. They were struggling with some of their current providers in the area having long waiting lists. And so they reached out to us, and because we were in neighboring counties. And they put an RFP out and we responded to it and were awarded the contract."*
>
> **- Behavioral health provider in a large county**

How does this strategy lead to better implementation?

Formal agreements reflect a shared understanding of how two organizations will work together on a case and a commitment to timeliness. Formal agreements to expedite service access could improve the speed that referrals are accepted so that treatment can be delivered quickly, and consistent with the model standards (fidelity, timeliness). This might also enhance the compatibility of the intervention with time-sensitive needs of a high-risk client population. A formal agreement to expedite services might also ensure the appropriateness of a model because it leverages a client's readiness and motivation to engage in treatment. These agreements also benefit partner organizations because it helps them bring in new clients who are likely to come in and continue services (e.g., reduced no shows). A formal agreement can be useful for sustaining the partnership and intervention.

When is this strategy used?

This strategy is used during Planning (initial development of the agreement), and Implementation and Sustainment phases (where it is revisited and refined). Formal agreements might be used with one or more provider partners.

What key considerations might affect the success of this strategy?

- Having a dedicated case manager to handle incoming referrals could enhance the success of this strategy.

II. ESTABLISHING REFERRAL PROTOCOLS

Supervisors and other agency leaders develop and carry out agreed-upon procedures for referring clients for services. There may or may not be a formal written agreement between the two organizations.

Example application:

Representatives from the child welfare agency and behavioral health organization determine the criteria for referring parents for treatment based on the services offered and the types of clients who benefit most from those services. Representatives also determine the information about parent/case to be shared by the child welfare worker, the behavioral health point of contact who should receive the referral/information, and procedures for following up with the original referring caseworker to confirm that the referral has been received. Program caseworkers at the child welfare agency refer parents in the model to behavioral health organizations for specialized SUD treatment as part of their case plan.

> *"The referral process is more streamlined...It's really helped to improve that coordination in terms of this is somebody who's being sent as part of the program, the understanding is there that the weekly reports will be sent out at that point, and it just makes the process much more streamlined."*
>
> **- Behavioral health provider in a large county**

How does this strategy lead to better implementation?

Protocols reflect a solidified and shared understanding about how two organizations will work together on a case to share and receive referrals. Developing referral protocols provides a clear workflow for front-line workers making and accepting referrals that can improve the likelihood of treatment delivery (fidelity) and expedite service access (timeliness).

When is this strategy used?

This strategy is used during Planning (developing referral protocols), Implementation, and Sustainment phases (revised and refined over time). Referral protocols are executed every time a client is referred.

What key considerations might affect the success of this strategy?

- Protocols should ideally include procedures for closing the feedback loop after a referral (making sure that there is follow-through after referral, and the original referrer is aware that the referral was accepted).
- Identified point of contact at organization who is designated for cases who handles additional follow up and communication could enhance success.
- Real time data on service availability could facilitate referrals.
- Referral success requires familiarity with the services provided, and the client groups who benefit most from those services.

NOTES

Collaboration strategies to align case plans

I. SHARED DECISION-MAKING MEETINGS

Joint meetings of all front-line workers, peer specialists, family members, and client/family supporters to discuss the case goals, progress, and plans for a family or client consistent with a new model. These meetings are intended to set objectives and align services for a client or family.

Example application:

Behavioral health clinicians join family team/shared decision-making meetings held by the child welfare caseworker to discuss and align case plans.

> *"It is very important that they feel the trust, and that we're all there working for them. Which is why the family team meetings help so much... When we are at the team meetings I think they see us there as more for them. If there is a problem I will bring it up but I bring it up under the context of the treatment piece rather than that punitive piece and I think that they really see that through Children's Services too, that it's more helpful than punitive."*
>
> - Behavioral health provider in a metro county

> *"I feel like it [family team meetings] helps bring everybody that's involved with the family together and make sure that they're all on the same page. If they have any questions, they can be answered… it also gives them the chance to have a voice and say what they feel and need to say. … So far, it's been going great. I think it's super helpful in helping the case move forward."*
>
> - PCSA in a small/medium county

How does this strategy lead to better implementation?

Shared decision-making meetings align front-line workers and clinicians' knowledge of a case to improve coordination of treatment. Having case workers, clinicians, and family members together facilitates information sharing, a shared understanding of the situation, and sets clear expectations. These conditions are intended to improve the quality of decisions about services to ensure that the client or family is always centered. Using this strategy is also intended to empower families, which may make the model more acceptable to parents and improve their satisfaction.

When is this strategy used?

This strategy is used during the Implementation and Sustainment phases. This strategy is used every 90 days or whenever there is a crisis or significant change (e.g. case closure, transitions in treatment, life event, placement change).

What key considerations might affect the success of this strategy?

- Clients and families are partners in change; asking them about who they would like to be there to support them shifts power for decision making into their hands. The success of shared decision-making meetings could be compromised if participants do not believe in shared power.
- Family members, clients, and professionals at the table need to have a shared understanding of one another's responsibilities; this shared understanding can influence the success of shared decision-making meetings.
- Partnership building should happen before this strategy is used.
- If a professional is not available to attend, a designated coordinator from the agency who has knowledge of the cases could help carry out this strategy, or the meeting might be conducted virtually.

II. SHARED DECISION-MAKING MEETINGS

Exchanging information about client case plans, service needs, progress, and completion to implement the new model. This can take multiple forms including formal reports shared regularly with partners, inputting data and using a shared data system intended for sharing case files, or more ad-hoc information sharing about cases.

Example application:

Child welfare workers send information about the concerns that motivated the initial referral, any screening, previous child welfare history, or other case details that could affect services to the behavioral health clinicians at the time of initial referral, and throughout the life of the case. The behavioral health provider provides weekly written reports on client attendance at treatment sessions, no-shows, results of drug testing, and other information that might indicate a safety risk for children in the home to the child welfare caseworkers and family peer mentors and this information is entered in the Needs Portal.

> *Especially in this last year we've put a lot of energy into sharing information from agency to agency and giving each other insight into how we make our decisions... Whether it's family focused or person focused, I think our perspectives are though we're always working toward a common goal. Our perspectives can be very different at times, and I think because of the closeness of our two agencies, just personality-wise, I think we do a really good job of sharing that information and bringing both levels up.*

- Behavioral health provider in a medium-sized county

> *I keep open contact and communication with my providers even if I'm having a face-to-face during the week and something's just not normal with my family. I would send an email directly to the provider so that the provider could talk to that family regarding that type of behavior. I also send assessment tools that I use in my interviews with...my providers so that they can also look out the same lens that I'm looking out of, as well, so that we can all stay on the same page. And give them the services that the family needs and the treatment.*

- Public children's services agency in a small/medium county

How does this strategy lead to better implementation?

This strategy aligns professionals' knowledge of a case across different organizations. Sharing information should trigger a response by professionals in both organizations to adjust services rapidly based on evolving client or family needs. Good information shared regularly is anticipated to lead to better, and more coordinated services.

When is this strategy used?

This strategy is used during the Implementation and Sustainment phases. Information sharing should happen at least weekly and whenever family needs/circumstances that affect service delivery change.

What key considerations might affect the success of this strategy?

- Caseworkers, family peer mentors, and behavioral health providers likely need to have a foundational understanding of the values, practices, and structures of both the child welfare and behavioral health systems to support data sharing.
- Support from high-level leaders is important for encouraging front-line communication.

NOTES

What other collaborative strategies might be useful?

There might be other collaborative strategies that support implementation that were not discussed in our study. Those include:

STEERING COMMITTEE

Steering committees are advisory groups that bring external and internal stakeholders together to offer guidance and direction to a model. Convening a steering committee lays a strong foundation for future collaboration and therefore might be one of the first strategies used during planning and preparation phases. Steering committees can help support implementation by:

- Building awareness and buy-in for a model among external partners to enhance public perceptions of the model, and willingness to collaborate.
- Creating a space for regular communication and information sharing.
- Engaging multiple stakeholders in collaborative planning and decision making.
- Coordinating efforts and resources with key partners.

CROSS-TRAINING

Cross training involves training and preparing staff to work in different roles or settings. For instance, this might involve training behavioral health partners about child protective services (e.g., risk and safety factors for families), and training child welfare staff on substance use disorder treatments (e.g., Medication Assisted Treatment). This strategy is intended to familiarize staff from different systems with the functions, services, goals, and work of their partners.

NOTES

2

Developing formal partnership agreements

What is the contract guide?

This section of the toolkit is a step-by-step guide to help counties use contracts to facilitate effective collaboration among their partners when implementing cross-system interventions. The toolkit identifies the purpose, people, and resources needed to meet model goals at each stage of the contract. The toolkit was built upon the lessons learned from Ohio START (a cross-system intervention linking public child welfare agencies with private substance use treatment organizations). We also draw on best practices in human service contracting. The term "contract" is used throughout the toolkit to refer to any signed document between partners that formalizes a partnership (e.g., service agreement, MOU). For an explanation of terms and acronyms used throughout the toolkit, refer to the Glossary of Terms.

HOW DO WE USE THE CONTRACT GUIDE?

The guide is organized by each stage of the contract lifecycle and is intended for counties to reference when needed. Each stage includes guiding questions and examples to facilitate discussion and support collaboration.

THE CONTRACT LIFECYCLE IS ORGANIZED INTO FOUR STAGES:

1 PLANNING
Determine our readiness to implement the model and our partnership needs

2 DESIGNING
Write the contract to meet the model's objectives tailored to our agency's needs

3 MANAGING
Implement the contract and monitor performance

4 EVALUATING
Assess effectiveness of our contractual partnership and determine whether our contract should be renewed, modified, or terminated

HOW DOES THE CONTRACT LIFECYCLE FIT INTO THE PHASES OF IMPLEMENTATION?

Contracting can be a complex process that can be organized into several different stages that occur across different phases of implementation.

- The first two stages of contracting (**Planning** and **Designing**) take place during the Preparation phase. During this phase, implementers explore barriers, make adaptations, and develop detailed implementation plans. This is the time to explore partnership needs, write contracts, and establish the formal partnerships needed to launch the intervention.
- The third and fourth stages of contracting (**Managing** and **Evaluating**) take place during the Implementation and Sustainment phases. During implementation, the first families are served, and implementers begin to monitor the partnership's performance. Implementers use information and data about the effectiveness of the partnership to make decisions about renewing, modifying, or terminating the partnership so that the intervention is sustained.

NOTES

Contract lifecycle

The contract lifecycle includes the objectives, people, and goals that should be considered at each stage of the contract process. You might have access to procurement professionals, technical assistance providers, and other consultants who can serve as resources throughout the lifecycle.

1 PLANNING

Objectives:

- Establish guiding questions to discuss before partner identification
- Review the guiding questions to determine partnership needs

People:

- Administrators and supervisors responsible for program/staff decisions (from both systems)
- Procurement staff and HR staff
- Potential providers
- Other community partners and/or funders, as appropriate
- Resource: technical assistance consultants

Goals:

- Project plan for contract process with schedule and deliverables specified
- Partner identification and solicitation
- Staff identification and hiring needs
- Initial needs assessment for training and infrastructure

2 DESIGNING

Objectives:

- Identify elements and language to be included in the contract
- Review the guiding questions to determine which elements need to be codified based on the contract needs

People:

- Administrators and supervisors responsible for program/staff decisions
- Supervisors and coordinators to capture front-line perspectives
- Procurement staff and HR staff
- Other community partners and/or funders, as appropriate
- Resource: technical assistance consultants

Goals:

- Draft contract
- Negotiated contract that is completed and signed by all parties

3 MANAGING

Objectives:

- Begin model implementation with established contract
- Review the guiding questions to determine how to move forward with implementation and manage the ongoing contractual relationship(s)

People:

- Administrators and supervisors responsible for program/staff decisions
- Supervisors/coordinators to capture front-line perspectives
- Procurement staff and HR staff
- Staff involved in model delivery
- Other community partners and/or funders, as appropriate
- Resource: technical assistance consultants

Goals:

- Contractual partners understand the model and their roles
- Oversee the functioning and compliance of a contract
- Identify and address any challenges that may arise in service delivery

4 EVALUATING

Objectives:

- Establish criteria for assessment of contractual partner(s)
- Review the guiding questions to determine the status and process for evaluating a contractual partnership

People:

- Administrators and supervisors responsible for program/staff decisions
- Supervisors/coordinators to capture front-line perspectives
- Procurement staff and HR staff
- Other community partners and/or funders, as appropriate
- Resource: technical assistance consultants

Goals:

- Assess the performance and compliance of contractual partner(s)
- Determine if a contract should be renewed, modified, or terminated

Planning

OVERVIEW

Objectives:

- Establish guiding questions for agency leaders to discuss before partner identification
- Review the guiding questions to determine partnership needs

People:

- Administrators and supervisors responsible for programming/staffing decisions (from both systems)
- Procurement staff and HR staff
- Potential partners
- Other community partners and/or funders able to influence model success
- Resource: Technical assistance providers

Goals:

- Project plan for contract process with schedule and deliverables specified
- Partner identification and solicitation
- Staff identification and hiring needs
- Initial needs assessment for training and infrastructure

CHECKLIST

Step 1: Assess our partnership needs and resource		
Guiding questions	**Considerations**	**What action, if any, should we take to put in place?**
Identify the type of partner that is the best fit for us		
• What are the goals of our partnership? • How can we develop a shared understanding of the model?	• Refer to manuals and other resources for the specific model to understand objectives, policies, and strategies • Allowing adequate time for development of shared understanding and goals	
• How should we raise awareness to attract partners and inform them of the new model?	• Initiating contact with potential partners for recruitment • Conducting informational sessions to spread awareness • Engaging regional coordinating boards and/or other community partners	
• How will we determine if a partner would be a good fit for our clients?	• Prior experience • Location and accessibility • Service capabilities • Treatment modalities offered • Market factors (i.e., number and quality of providers in/around county)	
• What type of formal partnership is most appropriate for us — contract, MOU, other agreement?	• Enforceability • Prior experience • Organizational norms	
Identify the type of relationship we seek in our partner		
• Do we have an existing relationship with the provider?	• Prior experience with provider • Provider capacity for cases	
• Will we partner with one organization or multiple BH providers to increase coverage possibilities to support client choice?	• County requirement for RFP • Sufficient market for competitive bidding on the contract • Accessibility of an array of treatment services	
• Will we use a formal agreement to codify our community partnership (Boards, courts, and service provider(s))?	• Existing partnership with a partner or provider that may facilitate model engagement • Formalizing and codifying relationship for the model	

CHECKLIST (CONTINUED)

Step 2: Assess our infrastructure and capacity needs		
Guiding questions	**Considerations**	**What action, if any, should we take to put in place?**
Identify the resources we have available internally and what we will need to contract for		
• What are our HR requirements for having a contractor working in the building? • Who are the people that we will need to contract with to hire for the model?	• Adequate number of staff to handle the caseload • Designated supervisor and possible coordinator to coordinate the relationships with providers, and facilitate meetings and collaboration • Staff hired directly or through the partner • Integrating new staff roles into the team (co-location space)	
• What trainings are needed and/or would be helpful for us?	• Required and recommended model trainings • Data-sharing permissions (e.g., PHI, CI, ROI) • Onboarding and integrating new staff into organizational policies and practices • Cross-trainings across all partners	
• What infrastructure resources do we need?	• Capacity for in-person and/or virtual meetings and for intake assessments • Technology for information sharing and reporting • Financial reporting and invoicing	

NOTES

Designing

OVERVIEW

Objectives:

- Identify the elements and language that need to be included in the contract
- Review the guiding questions to determine which elements need to be codified based on the contract needs

People:

- Administrators and supervisors responsible for programming/staffing decisions
- Procurement staff and HR staff
- Supervisors/coordinators to capture front-line perspectives
- Other community partners and/or funders able to influence model success
- Resource: Technical assistance providers

Goals:

- Drafted contract
- Negotiate a contract that is completed and signed by all parties

CHECKLIST

Guiding questions	Considerations	What action, if any, should we take to put in place?
Identify how we will align our contracts with the model		
• Have we identified the model-specific practices and requirements? • Have we clarified what is different about the model?	• Unique attributes of the model staff roles, team meetings, information exchange and documentation, case coordination) • Key component of the model to include in contracts	
• Have we specified our goals and the goals of our partners?	• Individual goals and shared goals across all partners • Shared outcomes for clients/families	
Identify our existing capacities and resources needed		
• Should we incorporate hiring practices into the contract?	• Responsibility for hiring, reviewing resumes, interviews • Required and preferred qualifications for the staff role and providers	
• What trainings are needed and/or would be helpful for us?	• Tailor to specific organizational role based on required, recommended, or suggested • Policy trainings, model trainings and other related trainings (e.g., evidence-based treatment modality strategies)	
• Do we or our partners require any unique infrastructure resources to implement the model?	• Capacity for in-person and/or virtual meetings and for intake assessments • Channels for reporting and sharing information • Co-location space for shared staff • Supplies and/or reimbursement (e.g., cell phone, office space and supplies, transportation/gas) • Contingency resources and mechanisms (e.g., inclement weather, pandemic)	
Write our Scope of Work		
• Have we set a clear start and end date for the period of performance?	• Timeframe identified for service provision • Deadlines identified for information-sharing and reports (e.g., frequency, channel for communication, to whom)	
• Have we clearly specified the scope of work for each partner?	• Clearly defined scope for each organizational partner, as well as shared scope across partners	

CHECKLIST (CONTINUED)

• Do we have clear expectations for roles and responsibilities?	• Specific tasks and deadlines • Specific shared roles between partners • Participation and attendance at meetings	
• If we are partnering with multi-purpose/service provider, is each domain of service clearly specified?	• Clear expectations for each domain (e.g., SUD, MH, trauma, child vs. adult)	

• Does our scope of work include work to be performed that is tailored to the partner?	• Providers
	  • *Participation on team — attendance at meetings, shared decision-making, and input*
	  • *Information-sharing process*
	  • *Referral process, proper documentation, process for sharing, and responsibility for referrals*
	  • *ROI, CI, and PHI*
	  • *Client needs assessment process and adherence to model timelines*
	  • *Services provided, number of clients served, timing of services*
	  • *Weekly progress reports and proper documentation and process for sharing*
	  • *Process for working wit crises/emergencies (e.g., relapse and/or potential endangerment to the child*
	  • *Documentation requirements*
	• Model-specific staff (in addition to those listed above for partners)
	  • *Model staffing guides*
	  • *Specific job description*
	  • *Shared workspace, equipment, parking, and reimbursement plan*
	  • *(Co-)Supervision plan and communication protocol between co-supervisors*
	  • *Travel and transportation of clients*
	• Community Partners (Courts, Boards)
	  • *Shared vision and goals*
	  • *Attendance at meetings*
	  • *Referral processes*
	  • *Services provided*
	  • *Communication protocols*
	  • *Information-sharing, CI, and PHI*
	• Performance expectations (communication, boundaries, attendance, potential relapse, criminal charges, child maltreatment report or case opened)
	• Method for how the work will be evaluated for performance and fidelity
	• Minimum contractor qualifications
	• Sources of payment (payors — grant, Medicaid, local funds, etc.) and payment(s) amount for each specific component (e.g., salary, benefits, overtime, travel, mileage, training, supervision, equipment, etc.)
	• Process for reimbursement/billing that is attached to a specific client/family vs. meetings and trainings that are not attached to a specific client/family	

CHECKLIST (CONTINUED)

Identify how we will align our contracts with the model		
• Do we have concrete language around deliverables and expectations?	• Information included in the written weekly reports of treatment/progress • Information included in the monthly progress reports • Method and frequency of communication	
• How will we share data?	• ROI and consent forms • Screening, referrals, assessments • Assessment reports • Weekly provider reports	
• What are our expectations of privacy and information-sharing?	• CI and PHI permissions	
• What are our expectations for participation in case coordination meetings?	• Accessibility and availability for attendance and sharing information • Specific expectations of the model	
• What is our process for submitting, approving, and processing invoices and other financial reports?	• Method, frequency, and information to be included	
Identify our deliverables		
• Have we clearly identified the services to be provided?	• Specifying units and timeline(s) • Linking services to the intended outcome(s)	
• What type(s) of information and documentation do we require?	• Channel(s) for sharing/submitting for each information type • Clear timelines and deadlines	
• How do we define the successful delivery of a service?	• Map to the Scope of Work	
Identify our performance expectations and accountability measures		

• Have we clearly specified expectations of roles and responsibilities?	• Specific and clearly defined for evaluation (observable, measurable, trackable)
	• Service Access (for Clients)
	  • *Clear referral protocols*
	  • *Expediting service - timelines*
	  • *Treatment delivery — services to be provided*
	• Case Alignment (for Workers)
	  • *Participation in decision-making and family meetings*
	  • *Data sharing and reporting*
	  • *Coordinating care*	

• Do we have separate measures for the contractual partnership expectations as well as for the provision of client services?	• Measurable and quantifiable • Expectations for employees and clients	
• Do our measures align to the model, Scope of Work, and deliverables?	• Clearly specified for the partner • Avoid vague and ambiguous wording — potential for misinterpretation and difficult to measure/evaluate (e.g., “as soon as possible”; “of an approved type”)	

CHECKLIST (CONTINUED)

• How will we monitor fidelity?	• Clearly specified for the partner • Map back to the Scope of Work, model manual	
• What is our process to provide feedback for unsatisfactory performance?	• Opportunities to address concerns and enhance communication • Sanction and/or termination process	

NOTES

Managing

OVERVIEW

Objectives:

- Begin model implementation with established contract
- Review the guiding questions to determine how best to move forward with managing the ongoing contractual relationship(s)

People:

- Administrators and supervisors responsible for programming/staffing decisions
- Procurement staff and HR staff
- Supervisors/coordinators to capture front-line perspectives
- Staff involved in delivering the model
- Other community partners and/or funders able to influence model success
- Resource: Tchnical assistance providers

Goals:

- Contractual partners understand the model and their supporting roles
- Oversee the functioning and compliance of a contract
- Identify and address any challenges that may arise in service delivery

CHECKLIST

Guiding questions	Considerations	What action, if any, should we take to put in place?
Identify how we will bring together our partners		
• How do we begin implementation?	• Kick-off meeting to bring together all relevant stakeholders • Distribution process of signed contract — how and for whom	
Identify our readiness and preparedness for contract implementation		
• Are our partners ready to begin the implementation of the contract?	• Capacity and infrastructure are established • Resources are hired/assigned	
• Are we conducting the trainings?	• Required and recommended trainings for staff • Onboarding and integrating new staff into the organization	
• Have we started serving families?	• Determine what needs to be addressed	
Identify how we will ensure contract performance		
• What is our process/ structure for contract monitoring? Who is the lead?	• Formal mechanisms and informal/relational mechanisms	
• How do we communicate contract expectations among partners?	• See Contract Design Checklist	
• Do we have opportunities for feedback and check-ins with all stakeholders?	• Designated forum for questions, feedback, troubleshooting, and course correction while the contract is in-progress (e.g., disciplinary issues, job performance) • Job performance and review for promotion • Responsibility for overseeing and delivering feedback	
• How do we track information?	• Documentation of performance and record • Process for sharing among the relevant stakeholders	

CHECKLIST (CONTINUED)

• How do we address contingencies, conflict, or non-compliance?	• Process for sharing contract guidelines, expectations, and deliverables with all stakeholders • Sanctions or termination	
• What is **not** in the contract that we should monitor or include in the next contract revision/solicitation?	• Elements of implementation not meeting expectations	
Identify how we will oversee the management of contract performance		
• Do we have an understanding among management on how to manage the contract effectively?	• Duties associated with contractor, timeliness, productivity, and performance	
• Have we established the contract manager's responsibilities?	• Regular contact/meetings to assess progress and status • Rating systems and monitoring methods • Procedures for review of problems or disputes • Default contingency plans • Acceptability of reports/deliverables • Resolution of conflicts between parties • Mediating/preventing an adversarial relationship • Negotiation of demands that may be out-of-scope or extend beyond identified responsibilities	

NOTES

Evaluating

OVERVIEW

Objectives:

- Establish criteria for assessment of contractual partner(s)
- Review the guiding questions to determine the status and process for evaluating a contractual partnership

People:

- Administrators and supervisors responsible for programming/staffing decisions
- Procurement staff and HR staff
- Supervisors/coordinators to capture front-line perspectives
- Other community partners and/or funders able to influence model success
- Resource: Technical assistance providers

Goals:

- Assess the performance and compliance of contractual partner(s)
- Determine if a contract should be renewed, modified, or terminated

CHECKLIST

Guiding questions	Considerations	What action, if any, should we take to put in place?
Identify the criteria we will use to assess contract effectiveness		
• How will we assess how well our partner meets performance expectations for processes and outcomes?	• Evaluation based on components indicated in the Scope of Work • Performance expectations included in the contract (e.g., fidelity to contractual agreement, model)	
• Do we have a feedback loop that allows us to make adjustments for the next contract cycle or with a new partner?	• Process for mid-term modifications, amendment, renewal, or termination • Budgeting time for renewal, re-bidding, and re-signing the contract	
Identify our next steps		
• Do we renew the existing contract or create a new contract?	• Continue with existing partner or initiate a new partnership	
• Do we release a new solicitation for competitive bid?	• Changes in the market • Changes in client needs and provider capacity	

NOTES

Glossary of terms

Alcohol Drug and Mental Health (ADAMH)	County-operated, state-supervised authorities or boards that plan, evaluate, and fund MH and SUD services. These boards contract with BH providers for their services in prevention, treatment, and recovery support for local communities.
Amendment	Addition, revision, or renewal to the original contract.
Behavioral Health (BH)	An individual provider or organization that offers evidence-based interventions for the treatment of mental health issues and/or substance use disorders.
Confidential Information (CI)	Information that is meant to be kept private (e.g., medical, financial, legal). It cannot be disclosed to a third-party without documented consent to protect against unauthorized access, sharing, and using.
Contract	An umbrella term that refers to any written document (e.g., MOU, service agreement) between parties that formalizes a partnership and governs their rights and responsibilities.
Government Performance and Results Modernization Act (GPRA)	Federal legislation enacted to link resources and management decisions to improve program performance. GPRA requires agencies to set goals, measure results, and report progress.
Human Resources (HR)	Staff that are responsible for managing the employment process, including recruiting, hiring, onboarding, and training of new employees. HR also refers to policies regarding employment.
Memorandum of Understanding (MOU)	Not a legally binding contract but is a formalized written document that identifies the intentions of the parties.
Mental Health (MH)	The emotional, psychological, and social well-being of an individual.
Needs Portal	Web-based information system that collects information about families involved in the childre welfare system, including substance use and trauma exposure. The system also serves as a referral system, helping to connect families with behavioral health providers and tracking servies provided.
Partner	External organization or provider with whom you have a contract with. Sometimes referred to as “party.”

Glossary of terms

Protected Health Information (PHI)	Identifiable information that reveals an individual's personal health status (e.g., medical history, diagnoses, test results, health status (physical and mental), treatment plans, insurance). HIPPA law requires physical, administrative, and technological safeguarding of PHI to ensure confidentiality for storing, sharing, and using.
Release of Information (ROI)	Authorization that allows for personal or confidential information (e.g., medical, financial, legal) to be disclosed, shared, or used for a specific purpose. The owner of the information needs to provide documented consent in order for a recipient to receive, review, and use the information.
Request for Proposal (RFP)	Document that communicates the needs of a proposal in order to seek out potential bids for a contract.
Scope of Work (SOW)	Statement that specifies the roles, deliverables, and performance expectations. Also referred to as a Service Plan.
Substance Use Disorder (SUD)	Occurs from a recurrent use of alcohol and/or drugs that impairs an individual's behavior, mood, and actions and negatively interferes with life activities. Also called drug addiction.

3

Engaging regional behavioral health boards for system alignment

The role of behavioral health boards

Behavioral health authorities or boards (referred to as "Boards") are public bodies established by local governments. Boards are often tasked with *coordinating regional services* for mental health and substance use disorders by planning, funding, and evaluating services. Services include prevention, treatment, and recovery support. Given their role in the behavioral health system, our goal was to identify and describe specific system alignment strategies that regional behavioral health boards use to support collaboration between organizations that are implementing cross-system interventions.

HOW DID WE INVESTIGATE BOARD STRATEGIES?

Data were drawn from group interviews we conducted with behavioral health boards, child welfare, and behavioral health stakeholders from 17 counties implementing Ohio START.

WHAT DID WE FIND?

We learned about three strategies that behavioral health boards use to align systems for implementing cross-system interventions: planning, brokering, and resourcing strategies. We also heard how general coordination services (that are not specific to an intervention) also support system alignment.

Strategies for Aligning Systems for Cross-system Intervention Implementation

Strategy	Potential impact
Planning	• Build buy-in and enthusiasm in the community for the model • Share information about resources • Align new models with other resources and initiatives
Brokering	• Expedite new partnerships • Strengthen relationships
Resourcing	• Increase organizational capacity • Enhance feasibility and sustainability
General regional coordination	• Facilitate information sharing • Ensure shared understanding of processes • Increase organizational capacity • Enhance model feasibility • Facilitate timely service access • Improve fidelity

PHASES OF IMPLEMENTATION

Throughout this module, we note when these strategies might be used during implementation. We refer to four phases of implementation work:

1. **Exploration:** implementers consider community needs, identify the evidence-based interventions that best fit, and decide whether to adopt.
2. **Preparation:** implementers explore the barriers and facilitators of implementation, consider the need for adapting an intervention, and develop an implementation plan or blueprint. This work often culminates with staff training.
3. **Implementation:** implementers initiate the new intervention, and the first families are served. Implementers monitor progress, problem-solve issues, and make adjustments as needed to help make the new intervention part of every-day care.
4. **Sustainment:** the new intervention continues to be delivered with fidelity to benefit the community.

For more detail, visit episframework.com

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How do behavioral health boards align systems for cross-system intervention implementation?

Boards support alignment between child welfare and substance use treatment systems using three main strategies: Planning; Brokering; and Resourcing. Each of these three strategies might have a different impact on cross-system intervention implementation.

I. PLANNING

Asking Board representatives to be involved in local planning, steering, or advisory groups can support collaboration and implementation. Given their responsibility for coordinating regional behavioral health services, Board representatives often have extensive knowledge about service models in the community including availability, eligibility criteria, and treatment modalities. By engaging Board representatives in planning activities, their specialized knowledge can inform programmatic, implementation, and collaboration decisions.

Example application:

Boards can support implementation by disseminating information within their communities and sharing information about available substance use treatment services, evidence-based models, and peer support resources with staff. Many teams invite Board representatives to participate in their local Planning and Steering Committees [note, this is different than routine case review meetings where providers discuss individual families].

> *"She [Behavioral Health Board member] is on the board of [a Coalition]. And she was able to help us and get us on the agenda and make sure we have time every month, so that meets our guidelines for the steering committee meetings that are required."*
>
> **- Child Welfare agency in medium-small county**

> *We always had the players in[volved]… you know, the top-level people would meet. But then we really expanded the steering committee so we could have a better feel of the county as a whole. And [the Board's] role has been to help us know about some services that are available that we didn't know about.*

- Large county behavioral health provider

How does this strategy lead to better implementation?

By providing information about the substance use treatment providers, Boards can help child welfare agencies identify potential partners that offer needed services for families. This information might help agencies establish a partnership and launch a new model quickly. Engaging Boards in planning could also help ensure that the new model is well-connected to existing prevention, treatment, and recovery services, which can be important for improving families' access to care, outcomes, and model sustainment.

When is this strategy used?

Planning is a continuous process that happens throughout all phases of implementation (Exploration, Preparation, Implementation, and Sustainment). However, the earlier that Boards can be engaged in planning, the more local implementation teams might benefit from their contributions.

What key considerations might affect the success of this strategy?

- Engaging Boards early in the planning phase maximizes their ability to facilitate collaboration and inform model implementation.
- Asking Boards to collaborate on Steering Committees is consistent with their role in the community.
- In counties with very robust behavioral health systems (with many providers delivering highly specialized services), or where there have been many changes (e.g., new providers, rapid growth or transformation), Boards might serve an especially critical role helping child welfare leaders understand the behavioral health service landscape in their area.
- Engaging Board representatives in Planning and Steering Committees offers an opportunity to advocate for other services. By participating in planning discussions, Board representatives might learn about service needs and gaps that are unique to families involved in the child welfare system (e.g., a lack of inpatient treatment facilities for parents that allow their children). This information could be used to inform and advance other Board-related initiatives that improve services for the community.
- Child welfare leaders might consider inviting their Board representatives to attend trainings (e.g., overview sessions, or those intended for behavioral health partners) to familiarize them with the model.

II. BROKERING

Boards also support cross-system intervention implementation by brokering relationships among organizations and people in different organizations. This might involve helping organizations identify potential partners, facilitating introductions, and providing support for the relationships.

Example application:

Boards share information about local behavioral health agencies and the evidence-based interventions they deliver to help child welfare agencies identify potential partners who can provide needed treatment for families. Board representatives might also facilitate introductions, and help negotiate around specific model elements (e.g., asking for priority status/expedited service delivery). In some circumstances, Boards might be involved in helping to create, negotiate, and execute formal contracts or partnerships. Given their connections to peer support groups, Boards might also be very helpful for recruiting or identifying potential peer mentors.

> *"Our board in the beginning was critical with our development. They really did get us connected to [a behavioral health provider] to have that peer connection. We would have spent much more time in the beginning without them finding that connection."*
>
> **- Child Welfare agency in medium-sized county**

> *"They [Board] have their pulse on all the providers in the area… I'm not always sure of the quality of those services and the Board can vet those places for us to make sure that we're sending people to quality drug and alcohol treatment centers."*
>
> **- Child Welfare agency in metro county**

> *"Based on the lack of providers and resources in our community, being a rural community, being in a situation where we don't have a whole lot to access or turn to, the Board is a focal point for helping us locate service providers or provide assistance or guidance or recommendations when we're having struggles."*
>
> **- Large county behavioral health provider**

How does this strategy lead to better implementation?

Boards that can directly connect leaders with one another across service systems could lead to quicker establishment of collaborative relationships and implementation. Brokering could also help child welfare agencies improve the fit of their partners; having a good partnership fit could lead to strong and long-lasting collaborative relationships between child welfare and substance use treatment systems which could result in better model fidelity and sustainment.

When is this strategy used?

Brokering activities are useful during the Preparation and Implementation phases of implementation.

What key considerations might affect the success of this strategy?

- Brokering might be especially helpful in counties with larger behavioral health provider networks or where the behavioral health landscape has changed rapidly (e.g., new providers or models, mergers).
- In areas where behavioral health services are limited, Board representatives might help child welfare agency leaders identify and connect with potential alternatives outside of the county.
- Boards representatives might want to avoid making direct partnership recommendations to avoid expressing preference or favoritism.

III. RESOURCING

Providing necessary financial, in-kind, or other types of resources is another important way Boards can support implementation and alignment. These activities could involve directly providing resources to a new model, or indirectly supporting a model by providing resources for families involved in child welfare systems.

Example application:

Boards might provide resources directly for the model. For instance, Boards might provide financial support for staff positions. This could support additional family peer mentors, or new coordinator positions at behavioral health partner organizations (who can respond to referrals, participate in shared decision-making meetings, etc.). Boards might also be able to provide resources for families (e.g., hotel vouchers, food and gas cards) or help develop new family-focused services in the community (e.g., prioritize support for needed family-friendly inpatient treatment). Child welfare agency leaders might also consider asking Boards to partner or provide letters of support on grant applications or requests for funding to expand services for families.

> *"[The Board is] receptive to ideas that we have. So we're really fortunate to have them... they jumped on board with that right away. They did a lot of things with the community, pooling agencies together around substance use disorders and mental health."*
>
> **- Behavioral health provider in medium-small county**

> *We applied for a grant for families, for some things that were not covered. So [the Board was] very critical in that… we've had a lot of good support from them.*

- Child Welfare agency in medium-small county

How does this strategy lead to better implementation?

Boards play a major role in implementation as funders of behavioral health services. Providing resources to the new model could expedite the launch, support the expansion/scale-up and reach in the community, and sustain the model. Robust support for community-based services and supports tailored to the needs of families involved in the child welfare system might also help expand service availability and support timely service access for parents.

When is this strategy used?

As funding is a continuously necessary component of model services, resourcing activities could happen during any phase(s) of implementation (Exploration, Preparation, Implementation, or Sustainment).

What key considerations might affect the success of this strategy?

- Some boards cover multiple counties; resource requests might need to be considered in light of equity and need across the region.
- Available funding might also vary across different regions depending on whether behavioral health tax levies are in place.
- There might be other non-financial resources that Boards can help provide.

IV. GENERAL REGIONAL COORDINATION

Boards are responsible for other regional coordination activities, many of which can help support collaboration and implementation in the community. Other strategies that Boards can use promote cross-system collaboration that are not model-specific include: 1) Local Assessment; 2) Policy Development; and 3) Assurance.

Local assessment activities

Boards serve an important role in the region by identifying unmet community needs. Being part of Steering Committees and other conversations with representatives from child welfare agencies

might help Board staff learn about unmet needs specifically for families involved in the child welfare system. They can also assess service and resource availability. This information might be useful for local planning.

Policy and model development activities

In response to community needs, Boards develop regional plans, policies, and support for needed models/services. This could include plans to allocate resources for new models or designing community initiatives to prevent or address behavioral health issues. Boards also convene networks of providers, community members, elected officials, and representatives from other systems to communicate, advocate, and coordinate around local public behavioral health initiatives.

Assurance activities

Finally, public groups like Boards help ensure that services and models are accessible, high quality, and meet community needs. This involves active deployment of resources and supports to the community (beyond a specific model). Examples include providing funding for new or existing services, organizing, supporting the development of a drug court coordinator, delivering training and education for local providers, and evaluating the impact on community behavioral health issues. Other activities might also focus on linking community members to services, such as developing standard release of information and referral forms, or creating centralized referral agencies/resources in the region can help support service access and coordination.

> *"Our mental health board is very focused on wanting to make sure it's meeting the needs within the community, so the board works very closely with all of the community stakeholders to ensure that the needs are being met so they will send out surveys or have conversations with all of the stakeholders to see what gap areas need attention and things of that nature."*
>
> **- Behavioral health provider in large county**

How do these strategies lead to better implementation?

Understanding local unmet needs through assessment activities has potential to identify unmet needs and inform planning for new policies and models. As Boards convene providers and community members in these planning activities, they facilitate information sharing (potentially about the model and other local programs). As Boards direct resources and other supports (e.g., training, evaluation) to community-based providers through their assurance activities, they build providers' capacity to deliver services. Greater availability, accessibility, and quality of behavioral health services enhances the feasibility of implementing cross-system models, ensuring timely substance use treatment access, and adherence to the model's essential components and fidelity standards.

When are these strategies used?

Boards' general coordination efforts are ongoing — this work likely has a long history in each region and therefore could inform the exploration and preparation phases. Changes in the way Boards assess, develop, and assure behavioral health services have potential to influence implementation and sustainment phases.

A few thoughts about building relationships between child welfare agencies and behavioral health boards

Within child welfare agencies, the agency leaders and supervisors who are implementing this model and convening steering committees might not know who from their Board to engage.

- It might be useful for leaders to ask their Director or Administrator to help make a connection with their local Boards. Many leaders we spoke with knew the Board executives in their region since both often participate in other county workgroups and councils.
- Some Boards have a dedicated staff person focused on children's issues who might be a strategic partner.

NOTES